

Charity, Uninsured, and Uncompensated Care Plan

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Subject: Financial Assistance, Uninsured and Uncompensated Care Policy

PURPOSE / STATEMENT:

The Board of Trustees of Charleston Area Medical Center, Inc. (CAMC) has approved this policy on 11/18/2015 and recognizes the provision of services to the indigent population and the uninsured is compatible with CAMC's mission. The CAMC Board of Trustees is committed to providing indigent care to the extent possible while also maintaining its commitment to education and services to the population as a whole, in concert with the financial stability of the medical center. In fulfilling this commitment, an annual review of cost and free care will be established through an operational budgeting process designed to monitor the level of indigent care.

The ability of CAMC to care for the indigent and uninsured is determined by the availability of resources to finance such care. CAMC has an obligation to all patients; indigent and non-indigent alike, insured and uninsured, to provide emergency medical care or medical care for the treatment of a life-threatening condition. Financial assistance will be available to all individuals that are admitted to CAMC on an emergency basis and do not have the resources to pay for the services, regardless of residency or citizenship status. CAMC will also make proper arrangements for the transfer of patients to another provider if the needed services are not available at CAMC.

Financial Assistance may be granted to United States citizens or lawful permanent residents in the CAMC service area. CAMC will maintain a financial assistance and uninsured program to identify patients who have a limited ability to pay for emergency medical care, general admissions and/or non-elective services. In conformity with CAMC's general admission policy, the financial assistance policy will be extended to all patients without distinction on the basis of race, color, sex, national origin, or religious affiliation. CAMC will not abandon this basic philosophy of humanitarianism in the process of evaluating the financial data offered by the patient or his/her family.

GENERAL PHILOSOPHY:

It is the philosophy of CAMC that all individuals who receive medical care at CAMC should be held responsible for their financial obligations. It must be recognized that a segment of the community has a limited ability to pay and, therefore, CAMC's financial assistance policy was established to recognize the needs of individuals and families who do not have the financial resources to meet some or all of their obligations and uninsured.

The policies and guidelines outlined in this plan were developed to insure that eligibility is determined in a fair and equitable manner. Financial assistance will be granted, if qualified, without regard to gender, race, creed, color or national origin. Also, it will insure that all eligible services remain available to all qualified recipients.

Before CAMC determines eligibility for financial assistance, an attempt will be made to obtain reimbursement from third parties such as Medicare, Medicaid, and private insurance for those patients who qualify for such third party reimbursement. Patients having no third party payment sources (uninsured) must either pay their obligations (with an uninsured discount) from their own private resources (self-pay) or they must meet the applicable eligibility requirements for charity services.

Patients who have third party coverage and elect not to have payment made by the third party or refuse to participate in our Third Party Eligibility program will not be eligible for financial assistance consideration. This does not apply to patients who participate in CAP (Community Access Program) or receive primary care services from HealthRight.

POLICY AND PROCEDURES:

1. Definition of Financial Assistance and Uncompensated Care

Financial Assistance

Financial Assistance care covers non-elective medical care services that are rendered to individuals who meet our financial guidelines. An assessment of the patient's financial status will be made to determine their eligibility. Based on this assessment, the services may be covered by this policy. CAMC will make qualification criteria available on its website, signs, brochures, and have applications and guidelines at all locations.

Financial Assistance forms are available:

- On our website at www.camc.org
- 501 Morris Street Charleston, WV 25301
- At each registration area
- Financial Counselors are available at each division to assist in the application process
- By calling the Financial Assistance Unit at (304) 388 6496 or (304) 388-6406

Uninsured Discount Program

All Medically uninsured patients are given a discount from standard billed charges at the time of billing that is greater than the average discount given to Medicare and Commercial payers. In the event the patient is covered by a Third Party Liability (auto, homeowners, and liabilities) an uninsured discount may apply but is determined on a case-by-case basis for the patient portion.

2. Scope of Service

CAMC provides care for medical conditions to individuals, without discretion and regardless of FAP eligibility. CAMC disallows actions that discourage individuals from seeking medical care, i.e. demanding emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care.

Services that are eligible for consideration under the financial assistance policy are known as non-elective services.

Elective services will not be made available to those who cannot pay for them. The following types of procedures or care are illustrative of those that will not be provided on a financial assistance basis:

1. Cosmetic Surgery
2. Elective Abortions
3. Private Room Differentials
4. Reversals of Sterilizations
5. Elective Sterilizations
6. Gastroplasty (where non-life threatening)
7. Bariatrics
8. Cardiac Rehabilitation
9. In Vitro Fertilization
10. Other Elective Procedures

Patients admitted for elective services are expected to pay an estimate of total charges prior to the procedure, then pay in full any difference after the service is provided.

3. Eligibility Criteria

CAMC is committed to providing necessary care for free to those individuals who meet applicable criteria. To determine criteria for financial assistance, applicants must provide the following documentation:

- Signed, completed Financial Assistance Application form

- Proof of income for household members
 - Pay stubs
 - Most recent tax return
 - Pay check stubs (for three most recent periods)
 - Retirement check stubs
 - Social Security letters or deposit slips
 - U.S. unemployment check stubs
 - Other governmental program check stubs
- Bank account information for household members.
- Monthly expenses

No financial assistance will be approved without the proper documentation.

The Financial Assistance Application (Exhibit 1) may be completed in the Financial Counselor's office or the patient may complete the application and return it.

If a patient is receiving any assistance from a State agency, they may be eligible for presumptive approval. Proof of income or assets is not required. However, verification of enrollment in the agency is required. Examples include, but are not limited to:

- (WIC) Women, Infants, and Children
 - (SNAP) Supplemental Nutrition Assistance Program
 - (CHIP) Children's Health Insurance Program
 - Medicaid with a spend-down
 - (QMB/SLIMB) Qualified Medicare Beneficiary
 - HealthRight
 - (CAP) Community Access Program
1. Financial assistance may be requested at any time by the patient and a determination can be made at any point in the billing and collection process. The notification period for the availability of the financial assistance program begins on the date the care is provided to the patient and ends on the 120th day after the first billing statement is issued. Collection efforts may begin after this notification period, however, financial assistance applications must be accepted, processed, and an eligibility determination made within 240 days after the first billing statement is issued. It is the goal of CAMC to make a determination concerning the patient's eligibility for financial assistance as soon as sufficient information is available concerning the patient's financial resources and eligibility for governmental assistance.

2. For patients who have multiple visits yearly, an application will be required every year to ensure all information is accurate.
3. For patients who have a third party insurance (health, auto, homeowners), CAMC must receive payment or EOB (explanation of benefits) from the Third Party Payer before the financial assistance application will be process.
4. Each Financial Counselor will have the patient, guarantor, spouse or patient's Power of Attorney complete the financial assistance application (FAP) (Exhibit 1). A credit check will verify this information.
5. Each application must have the applicant's signature and date.

If needed, the financial counselor will discuss the information with the person completing the application.

ELIGIBILITY GUIDELINES

A. Income

Definition: Income for purposes of CAMC's financial assistance policy means the total annual cash receipts before taxes from all sources, with the exceptions noted below. Income includes money wages and salaries before deductions; net receipts from self-employment; regular payments from social security; retirement income; unemployment compensation; strike benefits from union funds; workers' compensation; veterans payments; public assistance and training stipends; alimony, child support and military family allotments; private pensions, government employee pensions and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, capital gains; and net gambling or lottery winnings.

Exceptions to Income: Income does not include the following types of money received: any assets drawn down as withdrawals from a bank, the sale of property, a house or a car, tax refunds, gifts, loans, lump-sum insurance payments, or non-cash benefits.

Family Size	Year at 200%	Month at 200%	Year at 300%	Month at 300%
1	\$24,980.00	\$ 2,082.00	\$ 37,470.00	\$ 3,123.00
2	\$33,820.00	\$ 2,818.00	\$ 50,730.00	\$ 4,228.00
3	\$42,660.00	\$ 3,555.00	\$ 63,990.00	\$ 5,333.00
4	\$51,500.00	\$ 4,292.00	\$ 77,250.00	\$ 6,438.00
5	\$60,340.00	\$ 5,028.00	\$ 90,510.00	\$ 7,543.00
6	\$69,180.00	\$ 5,765.00	\$ 103,770.00	\$ 8,648.00

7	\$78,020.00	\$	6,502.00	\$	117,030.00	\$	9,753.00
8	\$86,860.00	\$	7,238.00	\$	130,290.00	\$	10,858.00

For families/households with more than 8 persons, add \$4,320.00 for each additional person.

1. Patients at 200% or below the Federal Poverty income level will receive 100% financial assistance. Patients 200% to 300% of the Federal Poverty income level will receive 50% discount off the balance due.

2. An uninsured patient will receive a 55% discount from gross charges for all non-elective acute care services.

3. See Explanation of Amounts Generally Billed – Exhibit 3

B. Asset Guidelines

Patients must have less than \$50,000 in total assets, excludes primary residence and primary car to become eligible.

Examples of assets which may be considered are:

1. Real property
2. Automobile
3. Recreational vehicles
4. Bank accounts
5. Rental property
6. Other investments
7. Exception to income items

C. Presumptive Eligibility

CAMC may also determine presumptive eligibility using a financial assistance estimator. This financial assistance estimator process will only be used to approve individuals or identify patients for financial assistance eligibility. The determination is made by information accessed through public record databases.

CAMC does not deny coverage of financial assistance under the use of the financial assistance estimator or with any other presumptive methods.

D. Collection Efforts

1. No collection efforts will be pursued on a financial assistance account until a determination for financial assistance eligibility is made unless a subsequent default occurs under this policy. The determination of eligibility may be valid for a period of up to one year.
2. Agreements with collection agencies must state that they will not begin collection efforts until CAMC has made reasonable efforts as indicated in this policy to determine whether the individual is eligible for financial assistance. If the individual is determined to be eligible, the collection agency must take all reasonably available measures to reverse any collection efforts, taken against the individual to collect the debt at issue.
3. If a determination is made that a patient does not meet the Financial Assistance Policy Guidelines for their health care services and payment is subsequently not received, the rendering of the service becomes subject to further collection activities. These further collection efforts consist of statements, phone calls and if the balance has not been resolved from within 120 days of your first statement, placement at a collection agency or legal services may occur.

Patients may not be covered under this financial assistance policy if they are covered by a commercial company that:

- A. Does not have a contract with CAMC and will not pay out-of-network benefits to CAMC; and
- B. Does not authorize services to be rendered at CAMC

Patients are ineligible if they do not provide all required information to CAMC or to their insurance company. If the patient chooses to receive non-emergency, elective care at CAMC, even though they know the services will not be covered, the patient will be responsible for payment of the estimated amount of the claim in full prior to service.

- A. If it is determined that a patient may qualify for a government-sponsored program but the family refuses to apply for assistance, the bill will not be considered for financial assistance. The family will be responsible for the entire balance and payment of the estimated amount at the time of the services.
- B. Elective procedures may not qualify for financial assistance. Elective procedures must be approved in advance by the CEO or CFO of CAMC to be eligible.

SUBSTANTIALLY RELATED ENTITIES

CAMC Physician Group
HealthNet Aeromedical Services, Inc.

LIST OF PROVIDERS

See Exhibit 2 – Link is on website

PUBLICIZING CAMC'S FINANCIAL ASSISTANCE POLICY

CAMC will widely publicize information in this Financial Assistance Policy by:

1. Making paper copies of this Financial Assistance Policy and its application form available upon request and to the public free of charge
2. Conspicuously displaying items like signs or brochures with general information about the availability of charity and financial assistance in public areas of the medical center;
3. Notifying members of the community likely to need financial assistance of its availability by providing Financial Assistance Policy summary information sheets for distribution at local agencies and nonprofit organizations that address the health needs of the community's low-income populations, along with instructions on how they may obtain more information;
4. Posting this Financial Assistance Policy, a summary of it, and the application form on the CAMC website, so that these forms may be easily accessed, downloaded, viewed, and printed without the need for special software;
5. Providing a direct URL or website address where individuals can find information about the financial assistance program and application upon request;
6. Notifying individuals about the availability of financial assistance in all oral communications made regarding the amount due for care that occurs within 240 days after the individual is provided with their first billing statement for care rendered. Once an application has been received, notifications may cease; and
7. Provide a plain language summary of this Financial Assistance Policy and an application form if requested before the patient is discharged from CAMC. This will usually occur during the registration process.

PATIENT FINANCIAL APPLICATION

EXHIBIT 1

ACCOUNT # _____
501 Morris St.
PO Box 1547
Charleston, WV 25326

Name: _____ DOB: _____

Patient Address: _____ Phone#: _____

Employer: _____ Employment Status: _____

Name of Guarantor and/or Spouse: _____ Relationship: _____ DOB: _____

No. of dependents in Family: _____ (under 18 or under 21 full-time student)

Presumptive Eligibility: The Patient/Guarantor is currently enrolled in a state-sponsored entitlement or financial assistance program.

Program Name: _____

Name of Document(s) Verifying Program Eligibility: _____

INCOME: Please list income for family (even if qualifying under presumptive eligibility shown above). Provide copy of the most recent Federal Tax Return and most recent Pay Stubs. If not qualifying under Presumptive Eligibility above.

Check here ___ if not required to file a federal tax return.

WAGES for Family monthly:

EMPLOYMENT:	\$ _____	SELF EMPLOYMENT:	\$ _____
UNEMPLOYMENT COMP:	\$ _____	SOCIAL SECURITY/Pensions(s):	\$ _____
WELFARE/PUBLIC ASSIST:	\$ _____	CHILD SUPPORT/ALIMONY:	\$ _____
DISABILITY INCOME:	\$ _____	MISC. (INTEREST, RENT)	\$ _____
ALL OTHER INCOME:	\$ _____		

ASSETS FOR Family:

OWN HOME: _____	CURRENT BALANCE: \$ _____	VALUE: \$ _____
OTHER PROPERTY OWNED: _____	CURRENT BALANCE: \$ _____	VALUE: \$ _____

Auto 1: _____ MAKE/MODEL: _____ YEAR: _____	CURRENT BALANCE: \$ _____	VALUE: \$ _____
Auto 2: _____ MAKE/MODEL: _____ YEAR: _____	CURRENT BALANCE: \$ _____	VALUE: \$ _____

RECREATIONAL: _____ MAKE/MODEL: _____ YEAR: _____	BALANCE: \$ _____	VALUE: \$ _____
ADDITIONAL ASSETS _____	BALANCE: \$ _____	VALUE: \$ _____

Bank:

SAVINGS ACCOUNT:	CURRENT BALANCE: \$ _____
CHECKING ACCOUNT:	CURRENT BALANCE: \$ _____
STOCKS/BONDS:	CURRENT BALANCE: \$ _____

Assets exceed charity criteria? Y N

EXPENSES MONTHLY:

MORTGAGE/ RENT: \$ _____	HEATING: \$ _____
ELECTRIC: \$ _____	WATER/SEWAGE: \$ _____
CABLE/SATELLITE: \$ _____	PHONE/CELL/LANDLINE: \$ _____
CREDIT CARD(S): \$ _____	MEDICAL BILL(S): \$ _____
INSURANCE/ LIFE: \$ _____	PHARMACY: \$ _____
FOOD: \$ _____	MISC. (list) \$ _____
CAR PAYMENTS: \$ _____	

I solemnly swear/or affirm that the forgoing statements in this application are true and correct to the best of my knowledge and belief. I further authorize the employer, institutions and/or Credit report to release information to CAMC.

Signature of Applicant: _____ DATE: _____

FOR HOSPITAL USE ONLY

INCOME VERIFIED BY:

_____ EMPLOYER VERIFICATION

____ PAYROLL STUBS/SOCIAL SECURITY
____ INCOME TAX RETURN
____ CHECKING AND/OR SAVINGS ACCOUNT
____ PROGRAM ELIGIBILITY DOCUMENTATION PROVIDED FOR PRESUMPTIVE

BUDGET ANALYSIS

INCOME:

GROSS: \$ _____
OTHER INCOME: \$ _____
TOTAL INCOME: \$ _____

LESS EXPENSES:

FROM EXPENSE PAGE: \$ _____
BALANCED OWNED/REQUESTED: \$ _____

AMOUNT OF CHARITY REQUESTED: \$ _____

DISPOSITION:

APPROVED: ____ YES ____ NO

REASON: _____

SIGNATURE: _____

DATE: _____

DISPOSITION (IF ANY) TO HFS:

SETTLEMENT AMOUNT: \$ _____

APPROVED MONTHLY PAYMENT(s): \$ _____

APPLICATION TAKEN BY: _____ DATE: _____

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EXHIBIT 2

Link is on website

EXHIBIT 3

Explanation of Amounts Generally Billed

Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) for emergency or other medical care provided to individuals with insurance covering that care.

At CAMC the AGB is determined through the "Look-back method" which is calculated as follows:

1. The AGB is calculated by reviewing *all* past claims that have been paid in full to the hospital facility for medically necessary care by Medicare fee-for-service together with all private health insurers paying claims to the hospital in a prior 12-month period. This amount can include co-insurance; copayments and deductibles. Current AGB is 47.04%.
2. The AGB for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages").
 - a. The percentages are calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.
 - b. Multiple AGB percentages may be calculated for separate categories of care (for example, in-patient verses out-patient care; or care provided by different departments) or for separate items or services.
3. The percentages are applied by the 45th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s).

Management at CAMC believes that the discounts currently offered in the Financial Assistance Policy (i.e. – 100% for patients under 200% Federal Poverty Level and 50% for patients that are between 200% and 300% of the Federal Poverty Level) are in excess of amounts generally billed.