SHARON HOSPITAL POLICY AND PROCEDURE	REFERENCE # 033 PAGE 1 of 3
POLICY: Uninsured Policy	**DATE ISSUED: 10/1/2003** **DATE REVISED:** **DATE REVIEWED: 4/2008**
MANUAL: Financial Services	
SECTION: Billing	
ATTACHMENTS:	

Purpose

To establish guidelines for the collection of all accounts due from the from "***UNINSURED PATIENTS"***

Definitions:

Hospital: Means an institution licensed by the Department of Public Health

Colllection Agent: Means any person, either employed by or under contract to, a hospital, who is engaged in the business of collecting payment from consumers for medical services provided by the hospital, and includes, but is not limited to, attorneys performing debt collection activities.

Cost of Providing Services: Means a hospitals published charges at the time of billing, of an "uninsured patient", multiplied by the hospital's most recent relationship of cost to charges as taken from the hospital's most recently available annual financial filing with the Office of Healthcare Access(OHCA)

Poverty Income Guidelines: Means the poverty income guidelines issued from time to time by the United States Department of Health and Human Services

Uninsured Patient: Means any person who is liable for one or more hospital charges whose income is at or below two hundred and fifty (250%) per cent of the poverty income guidelines who has applied and been denied eligibility for Medicaid or SAGA, and is not eligible for any other insurance or source of payment.

Policy:

Pursuant to State of Connecticut Public Act 03-266(Section 19a-673), Sharon Hospital and all collection agents of Sharon Hospital will reasonably make every effort to provide a summary to each patient that the hospital believes will have limited funds to pay any portion of the patients charges not covered by insurance.

The hospital will do the following to notify the patients:

1. Supply a summary sheet at the point of registration for all patients registered as "Self Pay".
2. Send a summary sheet along with all itemized bills for all self pay patients.
3. Notify patient on generated statement they may be eligible for Charity Care under Uninsured Guidelines
4. Post Notices in conspicuous public places
    - Admissions/Registration

- Patient Accounts
- Emergency Room
- Social Services Office
- Patient Waiting Areas

All summaries and posted notices will be in both English and Spanish

The hospital will follow the following protocol:

- Day 1 (Final Bill) Itemized Bill with Summary
- Day 14 (Statement) Generated statement with message
- Day 28 (Statement) Generated statement with message

The patient or guarantor will have 45 days to notify the hospital that they are "uninsured".

No response from the patient/guarantor will deem the patient to be insured.

Collection process will continue.

QUALIFICATIONS OF ***"UNINSURED"***:

1. The patient is at or below 250% of FPIG
2. Has applied for and been denied for Medicaid and SAGA
3. Is not eligible for any other insurance or source of payment.

Once the patient/guarantor has notified the hospital or collection agent either in writing or by telephone the dunning/collection process will cease.

All accounts placed with a collection agency or billing agency will be closed and returned to the hospital.

The closure notification from the agency will reflect message "Closed pending Uninsured Qualification"

The agency will notify the hospital that patient has applied for ***"uninsured'*** status.

The patient/guarantor will have 45 days in which to supply the hospital with sufficient information to demonstrate that he or she qualifies under the ***"Uninsured"*** status.

If complete information is not received within 45 days, the account will be referred back to the agency.

The hospital will have 30 days from the day that complete information is received to determine eligibility.

The hospital will place the account on hold until qualification is determined.

The hospital will assign a unique insurance mnemonic for tracking purposes.

All accounts will be placed under this insurance category until determination is complete.

The hospital will notify the patient/guarantor in writing of the qualification decision.

All qualified applications will be signed off by the Office Manager/Director.

All records will be maintained by the Office Manager/Director for reporting and audit purposes.

QUALIFIED UNINSURED:

The hospital bill will be reduced to reflect the cost to charge ratio as filed with OCHA.

The patient/guarantor will be billed for the balance after reduction.

The insurance will be changed back to a self pay status.

Normal dunning and collection effort will resume if balance is not paid.

UNQUALIFIED UNINSURED:

Denial Notice will be sent to patient/guarantor within 30 days of receiving completed information.

The insurance will be changed back to a self pay status.

Dunning and collection effort will resume immediately.

SHARON HOSPITAL POLICY AND PROCEDURE	REFERENCE # 007 PAGE 1 of 5
POLICY: Charity Care	**DATE ISSUED: 4/12/2002** **DATE REVISED: 2/04, 2/06, 2/08** **DATE REVIEWED: 2/2006, 2/08**
MANUAL: Financial Services	
SECTION: Billing	
ATTACHMENTS:	

Purpose: To provide services to residents of the community who are uninsured or underinsured and do not have adequate financial resources to pay for necessary healthcare services provided by the hospital.

Policy: It is the policy of the Hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care.

All services of this facility will be available as uncompensated services. The determination should be made at admission, or as soon as possible, thereafter. Charity is defined as the demonstrated **inability of a patient to pay**, versus bad debt as the unwillingness of the patient to pay. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt.

Charity care includes services provided to:

- Uninsured patients who do not have the ability to pay based on criteria set.
- Insured patients whose coverage is inadequate to cover a catastrophic situation.
- Emergency patients, because of the hospital's inability to assess a patient's financial situation prior to rendering services.
- Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large medical bills.
- Patients who demonstrate ability to pay part but not all of their liability.

Determination of eligibility for uncompensated care will remain valid for 6 months for all necessary hospital services. If there is a change in financial circumstances, an updated or new application must be completed.

The charity care budget will be established once a year during the annual budget Process.

Write-offs $0-2,000 will be approved by the Business Services Director. Write-offs over $2, 000 will be approved by the CFO.

PROCEDURE:

1 Consider the following factors when determining the amount of charity service for which a patient is eligible at the time of service:

1.1 Patient must reside in the hospital's primary/secondary service area. Out of area applications will be reviewed upon the request of a physician or collection supervisor.

1.2 Gross income generally should fall within federal standards for determination of poverty level with consideration to family size, geographic area, and other pertinent factors.

1.3 Consider individual or family net worth including all liquid and non-liquid assets owned less liabilities and claims against assets.

1.4 Consider employment status along with future earnings potential.

1.5 Consider family size.

1.6 Evaluate other financial obligations including living expenses and other items of a reasonable and necessary nature.

1.7 Consider the amount(s) and frequency of hospital and other healthcare/medication related bill(s) in relation to all of the factors outlined above

1.8 **All other resources must be applied first, including third-party payers, Victims of Crime programs and Medicaid.**

1.9 If a patient does not have Medicaid but would qualify, he/she must cooperate with the application process. If the application is denied, consider for uncompensated care.

1.10 If the patient has Medicare but no secondary coverage and income is within the federal poverty guidelines contained in this policy, and updated each April in the Federal Register, ask the patient to apply for Medicaid.

2 Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. *If the patient does not pay the amount deemed to be his/her responsibility, the uncollectible remainder would become bad debt.*

3 **VERIFICATION** of Income must be provided with the application. Acceptable verification includes:

- Prior Year Tax Returns, and:
- Current Pay Stubs
- Written verification of wages from Employer
- Unemployment Letter

Credit reports may be utilized to evaluate eligibility as well.

4 If full or partial charity is approved, send a letter to the attending physician to request that he/she extend similar charity to the patient.

5 Patients within the Federal Poverty Guidelines will automatically be approved on a semi-annual basis. Charity care provisions will be reevaluated for a patient's eligibility when the following occur:

5.1 Subsequent rendering of services
5.2 Income change
5.3 Family size change
5.4 When any part of the patient's account is written off as a bad debt or is in collections.
5.5 When six months has passed since the last application or when circumstances change, whichever comes first.

6. Determine eligibility for charity service at the time of admission/registration, or as soon as possible thereafter.

7. Financial counselors, administrative associates, or Business Office staff will initiate charity considerations. However, any hospital employee can inform patients about the charity program.

8. Applications for charity care will be reviewed and approved within 10 business days.

9. Business Services will retain all records relating to charity care for seven years.

10. Notify patients and physicians in writing, regarding approval, denial or pending of uncompensated/charity care.

11. Denials may be appealed with supporting documents that prove inability to pay that weren't part of the initial consideration.

HOSPITAL CHARITY CARE INCOME GUIDELINES

Methodology: "Sliding Scale Method" with income guidelines as published in the Federal Register each April to determine the dollar amount to be considered as charity care for eligible patients utilizing the following procedure:

Procedure:

Family Size	2009 FPL	Maximum Income
1	$ 10,830.00	$ 27,075.00
2	$ 14,570.00	$ 36,425.00
3	$ 18,310.00	$ 45,775.00
4	$ 22,050.00	$ 55,125.00
5	$ 25,790.00	$ 64,475.00
6	$ 29,530.00	$ 73,825.00
7	$ 33,270.00	$ 83,175.00
8	$ 37,010.00	$ 92,525.00
9	$ 40,750.00	$ 101,875.00
10	$ 44,490.00	$ 111,225.00
11	$ 48,230.00	$ 120,575.00
12	$ 51,970.00	$ 129,925.00

If the patient's annual family income is below or equal to 100% of the Federal Poverty Limits then the patient responsibility is 0%.

If a patient's annual family income is below 250 percent of the Federal Poverty Limit but above 100% of the Federal Poverty Limit, use the following formula to calculate the percentage of charity write off to which the patient is entitled.

- Determine the annual household income.
- Use the Federal Poverty Limits Guidelines as established annually to determine the eligibility of medically needy individuals.
- Express the annual household income as a percentage of the Federal Poverty Limits.
- Divide the amount derived above by 150 percent. The resulting percentage is the amount the patient is responsibility percentage.
- Multiply the patient responsibility percentage times the unpaid balance to determine the amount owed.
- If the patient responsibility amount determined above is greater than 60% of the annual income amount, then the maximum patient responsibility is 60% of the annual income.
- Subtract the maximum patient responsibility determined above from the unpaid balance on the account. The resulting amount is the charity care write off amount.

Payment arrangements may be established when the patient has out of pocket. If the patient does not honor the payment arrangement or pay his/her share, the amount that did not qualify for charity will be considered bad debt.

References:

Regulations/Standards:

Date policy to be re-reviewed: