Title: Charity Care, Financial Assistance, Free Bed Fund	Reference Number:
File Location: Finance/Patient Accounts	Issuing Department: Patient Accounts
Latest Review/Revision Date: 06/2011	Original Date: 06/2008
Endorsing Departments/Committees/Dates: Finance/Board of Directors 05/2011	
Authorizing Signature/Title/Date: Lugene A. Inzana, Vice President, Chief Financial Officer; 01/2012	

PURPOSE

It is the philosophy and policy of Lawrence & Memorial Hospital (hereafter "The Hospital") that medically necessary health care services should be available to all individuals regardless of their ability to pay.

POLICY

A. Eligibility Criteria Uninsured
   1. Patient Accounts staff is available to help patients apply for charity care.
   2. Charity care applies to all uninsured patients (defined as earning less than 250% of the poverty guidelines) as described in Statute 19a-673. The Hospital will meet or exceed the guidelines set-forth by CHA on the Statewide Discount Policy for Uninsured Patients.

      Statute 19a-673 states: "No hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of provided services." Cost of providing services means a hospital's published charges multiplied by the hospital's most recent relationship of cost to charges as taken from most recent audited financials that have been filed with OCHA."

B. Lawrence & Memorial Guidelines

   Any patient upon initial screening that may qualify for Medicaid or Husky will be required to have a determination by the state prior to applying for charity care.

   Based on a review of annual income, uninsured patients in Connecticut receiving medically necessary services should be offered discounted services as described below. The Hospital follows State procedure of looking back up to 5 years for transferred property and asset transfers:

1. Care will be provided free for those uninsured patients who request assistance and verify their annual income is less than 250% of the Federal Income Poverty Level (FPL). Liquid asset must not exceed $50,000 (Stocks, bonds, cash, 401, IRA, CD etc.) excluding primary residence and primary motor vehicle). Business assets, rental property, secondary residence, recreational vehicles and other such luxury items will be applied to the liquid assets.
2. Care will be provided at hospital cost, as established by the Office of Health Care Access (OHCA), for those uninsured patients who request assistance and their annual incomes is less than 250% of the FPL and have assets greater than $50,000 as described in 3-1.
3. Care will be discounted on a sliding scale for self-pay patients who have no third party insurance to cover services with an annual income that is between 250% and 400% of the FPL and have assets less than $50,000 as described in 3-1.
    - 251% - 300% = Cost of Charge
    - 301% - 350% = 40%
    - 351% - 400% = 30%
4. The Hospital will consider the total medical expenses faced by a family and the family's ability to pay for those expenses, and offer greater assistance when possible to those families facing catastrophic medical expenses.
5. Payment arrangements for partial Charity Care is available as established in The Hospital Credit & Collection Policy.

C. Notification to Patients
1. The Hospital shall post notices regarding the availability of financial assistance to uninsured patients. These notices shall be posted in visible locations throughout the hospital such as admitting/registration, billing office, emergency department and other outpatient settings.
2. Patient Financial Advisors will attempt to visit all inpatients registered as self-pay. A summary explaining available programs and charity care will be given to the patient or guarantor when this visit occurs.
3. Patients with no insurance will receive an initial letter within one week of discharge informing them that the hospital considers them "insured" per the Connecticut General Statues Section 19a-673. It is the responsibility of the patient to advise the hospital if they believe they qualify as "uninsured" (at or under 250% of the FPG).
4. A series of monthly statements will be sent following discharge. Each statement will remind the patient of the availability of charity care.

D. Gross Family Income
1. For the purpose of determining gross family income and qualifying accounts for charity care, the following rules apply:
    a. Family members are only immediate family members when they are the applicant, spouse, children under the age of 18 or students to the age of 26, and stepchildren under the age of 18 or students to the age of 26. Other dependents claimed on the federal income tax return may be considered.

b. Unmarried couples do not qualify as a family unless tax returns are filed as married. Only the applicant's income will be looked at for qualification for funds and only the applicant's accounts will be awarded charity care funds if qualified.
c. All self-employed applications must submit the entire tax return including all schedules. The Credit and Collection Manager or designee will review Gross Income from Schedule C to determine income. Adjusted gross will not be used in these cases.

E. Eligibility Determinations
1. The provision of health care should never be delayed pending an assistance determination.
2. Requests for charity care may be made before, during, or up to 2 years after the provision of care.
3. Consideration for charity care will occur once the applicant supplies a completed financial assistance application with supporting documents to the Patient Accounts office.
4. The Hospital will make every attempt to make charity care determinations, and notifications to patient, within 30 days of receiving a completed financial assistance application.
5. Acceptable forms of income verification includes one of the following:
   a. Most recent federal tax return, including all schedules when applicable, along with at least one of the following:
      - Last 3 months payroll check stubs.
      - Written verification from employer verifying income for the last 3 months.
      - Copies of any pension, alimony or other sources of income.
      - Copies of social security earnings.
      - Letter from person providing food, shelter, etc.
      - Any other information felt to be pertinent.
   b. Completion of IRS Form 4506-T "Request for Transcript of Tax Return", when:
      - Verification of non-filing is needed, and letter of support from person providing food, shelter, etc. –or-
      - Requesting copies of most recent tax return from IRS.
6. Charity care may be denied if the application is not complete and patient does not submit additional information within 20 days of request.

   Since charity care is the payer of last resort, an application will not be considered until the applicant has been screened for other assistance programs and all other sources of payment have been exhausted.
8. In extenuating circumstances, where it can support that a financial hardship exists, The Hospital may offer charity care at its own determination without a completed application. The Revenue Cycle Director or the CFO must approve these requests. Example: homeless patients.

9. Charity care may not be granted for non-covered procedures this includes, but is not limited to, all cosmetic procedures, sterilization reversals, hearing aids, dental procedures, Inter-Ocular Lens (IOL's).,
10. Charity care may not be granted to individuals that are eligible for other programs and have refused to apply spend down assets to become eligible for state assistance.
11. Falsification of application or refusal to cooperate will result in the denial of charity care benefits. The patient will be deemed "insured" and will be transferred to the self-pay collection process.
12. Applications will remain in effect for up to six months from date approved. The Hospital may request updated financial information at any time during the period and adjust accordingly.
13. The Hospital reserves the right to change benefit determination if financial circumstances have changed. The patient or guarantor will be notified in writing when this occurs (within 7 business days from date of change).

F. Appeals
   1. Responsible parties may appeal in writing a charity care determination by providing additional information, such as insurance verification or an explanation of extenuating circumstances. Notifications of re-determinations will be made in writing within 30 days of receiving appeal request.
   2. A. Level 1appeals should be made to the Credit and Collection Manager.
      B. Level 2 appeals should be made to the Revenue Cycle Director.
      C. Level 3 appeals should be made to Administration (CFO or COO).

G. Free Care Approval Guidelines
   Approvals will be as follows:
   1. Balances up to $10,000.00 will be approved by the Credit & Collections Supervisor.
   2. Balances from $10,001.00 to $30,000.00 will be approved by the Credit and Collection Manager.
   3. Balances above $30,000.01 will be approved by the Revenue Cycle Director.

PROCEDURE

PROTOCOL

Reference: Statute 19a-673

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Authorizing Signature/Title/Date: Lugene A. Inzana, Vice President, Chief Financial Officer; 01/2012	

PURPOSE

Lawrence & Memorial Hospital (hereafter "The Hospital") has a fiduciary responsibility to appropriately bill and collect for patient services provided. Our policy is to comply with state and federal law and regulations in performing this function. The Hospital does not discriminate on the basis of race, color, national origin, citizenship, religion, creed sex, sexual preference, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, low income patient status determinations, or in its billing and collection practices.

POLICY

A. Collecting Information on Patient Health Coverage and Resources

It is the patient's responsibility to provide the hospital with accurate information regarding health insurance, Demographics and applicable financial resources to determine whether the patient is eligible for coverage through an existing private insurance or through available public assistance programs.

At the time a patient is scheduled, or at a time of patient registration, Revenue Cycle Staff/Front Office Staff (ex: ASU, Pequot ASU, Rehab) will obtain and verify the financial information in order to determine responsibility of a payment of the hospital bill. If the patient or guarantor is unable to provide the information needed, and the patient consents, the hospital/Revenue Cycle department will make reasonable efforts to contact the appropriate parties for additional information while the patient is in the Hospital and at a time of discharge.

All information will be confidential in accordance with applicable federal and state privacy laws.

B. Patient Notice of Availability of Assistance

1. Signage
2. Signs will be posted in Patient Accounts and designated registration areas to notify patients of the availability of financial assistance and other programs of assistance. Notification Practices

a. The Hospital will provide information of the availability of financial assistance on all statements.
b. The Hospital will notify the patient that it offers an interest free payment plan up to 18 months on all claims approved for partial financial assistance.
c. The Hospital will provide a written notice of determination for all charity applications within 30 days of receiving a completed application and the required supporting documentation.

C. Payment Plans, Deposits and Adjustments

Payment Plans:

1. Payment plans will be offered to patients over charity care guidelines based on the total account balance:
   a. Balances from $50.00 - $149.99 will be set no less than $25.00 per month.
   b. Up to 6 months for balances between: $150.00 - $500.00.
   c. Up to 12 months for balances of $500.01 - $5,000.00.
   d. Up to 18 months for balances greater than $5,000.00 or patients receiving partial charity care (between 250% - 400% Federal Poverty Guidelines).
2. Arrangements outside of the above criteria will be managed by an outside company and will be considered a bad debt by The Hospital.
3. Any arrangements outside the normal criteria must be signed off prior to being offered by:
   a. The Credit & Collection Supervisor for balances less than $2,500.0.0
   b. Credit & Collection Manager for balances over $2,500.00.
   c. The Revenue Cycle Director for balances in excess of $10,000.00.

Deposits:

1. Non-covered Procedures
   a. Requires that the procedure is paid in full upfront.
   b. Includes, but is not limited to, all cosmetic procedures, sterilization reversals, hearing aids, dental procedures, intraocular lens (IOL's).
2. Elective and Urgent Procedures
   a. The Hospital may require a "pre-admission" or "pre-treatment" deposit of up to 100% for estimated charges.
   b. A deposit will not be required for a pre-admission from patients who require Emergency Care or who are determined to be "uninsured".
3. Patients qualifying for a partial charity care adjustment may be required to leave a deposit up to 20% of the estimated charges. Self-Pay Adjustments
   a. The Hospital may offer self-pay patients who are considered "insured" per the Connecticut General Statutes Section 19a-673, an adjustment up to 25% when Payment in Full is received within 30 days of verbal arrangement.
   b. The Hospital reserves the right to offer adjustments to settle disputed accounts.
      - The Credit & Collection Supervisor, Credit & Collection Manager, Billing Manager or Revenue Cycle Director is authorized to remove patient balances in the name of customer service with documented disputes or when hardships exist.
      - The Credit Collection Manager or Billing Manager is authorized to offer up to 25% to resolve disputed accounts.

- Percentages above 25% must be approved by Revenue Cycle Director.

c. Small Balance Adjustments
   - Small balance will be written off up to $24.99.
   - Individual divisions will base their small balance allowance on co-pays and business line will establish the amounts.

D. Charity Care
   See the hospital wide policy for Charity Care/Financial Assistance.

E. Lawrence and Memorial Collection Practices
   1. Internal Collection Practices
      a. An initial bill will be sent to the party responsible for the patient's personal financial obligations.
      b. The Hospital, or their designee, will document all subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes an effort to contact the party responsible for the obligation.
      c. Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service as "incorrect address" or "undeliverable".
      d. Documentation will reflect a continuous collection effort.
      e. A final notice will be sent giving the responsible party 10 days to make acceptable payment arrangements.
   2. Accounts eligible to be referred for external collections includes:
      a. Accounts that have received a final notice and are considered "Insured" and have not set up acceptable arrangements. Exception:
         - When a responsible party has multiple accounts already in Bad Debt or refuses to pay without a dispute, the Hospital may elect to issue a Final Notice before completing the entire internal collection process.
         - Patients who refuse to pay or cannot meet acceptable arrangements may default to the Final Notice.
         - Accounts that have defaulted on payment arrangements.
      b. The following situations may cause an account to be referred to an outside agency without receiving a final notice letter:
         - Accounts where the responsible party cannot be located (returned mail or unable to locate).
         - Complex Workers Comp, Auto, any account with an authorized representative or Third Party Liability case will be referred to our attorney who specializes in resolving these cases.
         - Patient states to only contact their attorney. We may refer these cases to our legal counsel and or collections.
         - Patients willing to make a payment arrangement that does not meet our criteria may be referred to an outside company to handle this arrangement.
         - Patients wishing to have a current balance combined with another account in collections.

   3. External Collection Practices

a. Under the supervision of the Credit & Collection Supervisor, combined balances under $3,000.00 will be turned over to an external collection agency.
b. Combined balances exceeding $3,000.00 will be referred to the Credit & Collection Manager, or designee, with asset and employment verification.
   - After review of assets, the Credit & Collection Manager, or designee, will make the determination to refer account(s) to a collection agency or Attorney to pursue legal activity.
     a. Accounts returned from collection agencies as uncollectable may be referred for further collection activity up to and including legal activity.
     b. The Hospital will not pursue collection efforts, directly or through collection agencies, on the portion of bill which patient has established eligibility for charity care.
     c. The Hospital will not add fees or interest in the pursuit of collecting outstanding balance owed by a patient unless the fee or interest is ordered by the court.
     d. The Hospital will not report a delinquent account to the credit bureau until after routine collections have been exhausted. The Hospital or its agent will send notification to each patient or responsible party that has been reported to the credit bureau.

F. Liens/Wage Garnishment
Should not foreclosure on a primary residence to satisfy a medical debt and will restrict the use of liens on real estate to recover payment when a future transfer of the residence occurs.
Should restrict the use of wage garnishment or seeking a bank execution to access a responsible party's funds to only those cases for which a hospital anticipates such responsible party has the ability to pay the outstanding balance.

PROCEDURE

PROTOCOL

Reference:

Archive Dates Reviewed Date: Revised: 06/2011 Supersedes: