Unique Identifier: HWP12027	DAY KIMBALL HEALTHCARE Hospital-Wide Policy Manual Section – Leadership Page 1 of 6
TITLE: Charity Care/Financial Assistance	RESPONSIBLE PARTY (IES): Director of Revenue Cycle Vice President, Financial Services
FORMERLY KNOWN AS: Charity Free Care	
EFFECTIVE: 1/99	REVISED: 2/02, 1/03, 11/1/04, 2/1/05, 5/2/05, 10/16/06, 3/21/07, 3/1/08, 5/1/10, 4/11
REVIEWED: 4/11	
REGULATORY STANDARD:	

I. GENERAL STATEMENT OF PURPOSE:

It is the philosophy and policy of Day Kimball Hospital that medically necessary health care services should be available to all individuals regardless of their ability to pay. The policy has been written in accordance with Section 9007 of the Patient Protection and Affordable Care Act (Act), signed into law on March 23, 2010, which adds new sections 501(r) and 4959 to the Internal Revenue Code. Section 501(r) includes a series of specific requirements for hospitals to receive and maintain Section 501(c)(3) ("tax exempt") status.

II. POLICY STATEMENT:

Day Kimball Hospital's Patient Accounts Department will maintain procedures to assist both uninsured and underinsured patients with meeting their financial obligations to the hospital.

III. POLICY:

A. Uninsured Patients

1. Day Kimball Hospital may not collect from uninsured patients, who meet the definition as outlined in Connecticut State Statute 19a-673 more than the cost of providing services. DKH will adhere to the framework and guidelines set-forth by the Connecticut Hospital Association 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 OHCA."

2. All DKH patients who are found to have no insurance for a given date of service will have their associated charges adjusted to the hospital's cost by using the most recently filed cost to charge ratio reported to the State of Connecticut Office of Health Care Access.

3. Charity Care Eligibility for the Uninsured

   Uninsured patients who show proof of denial from the State of Connecticut DSS office may qualify for a 100% charity care discount to the cost of their care if they meet all of the following criteria:

   a. Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).

   b. Annual income is less than 250% of the current Federal Income Poverty Level (FPL).

   c. Liquid assets must not exceed $100,000 (includes stocks, bonds, cash, 401K, IRA, CD, property and business value, and recreational vehicles).

   DKH will consider the total medical expenses faced by an uninsured family and the family's ability to pay for those expenses, and offer greater assistance when possible to those individuals or families facing catastrophic medical expenses.

B. Insured Patients

1. Insured patients may qualify for a 75% charity care discount on the remaining uncovered cost of their care after insurance payments are made if they meet all of the following criteria:

   a. Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).

   b. Annual income is less than 250% of the current Federal Income Poverty Level (FPL).

   c. Liquid assets must not exceed $100,000 including (Stocks, bonds, cash, 401, IRA, CD, property and business value and recreational vehicles).

   d. Insured patients who have no additional coverage (and have documentation that they have exhausted their insurance) for the remainder of their plan year will be deemed "uninsured" under Section A of this policy. If granted charity care, it will be one-time granting.

2. Cost is calculated by applying the hospital's reported cost to charge ratio per statute 19a-673 to the total charges. Any portion of the insurance payment(s) that does not cover the calculated cost (uncovered cost) will be eligible.

C. Processing Guidelines:

1. All self-employed applications must submit the entire tax return including all schedules as well as the most recent P&L statement. The Director of Revenue Cycle or designee will review these documents to determine income.

2. Notification of charity care determinations will be mailed to the patient/guarantor within 30 days of receipt of completed application.

D. Notification to Patients

1. Signage indicating the availability of charity care is posted in English and Spanish in Patient Accounts, Patient Access, the Lab, Physician Practices and Satellite locations. Summaries of additional programs are available on the DKH website.

2. Patient Financial Advocates will attempt to visit all non-psychiatric inpatients registered as self-pay at a point in time deemed appropriate by the clinical care providers attending to a given patient. Patient Financial Advocates will work to assist them in either securing a payment source or, as a last resort, assisting them with the DKH Charity Care Application process and guidelines.

3. Psychiatric inpatients will be counseled while in house for state application or charity care application assistance only.

4. A series of monthly statements will be sent to patients with a balance following discharge. Each statement will remind the patient of the availability of funding assistance through the hospital's charity care program if the eligibility criteria are met.

E. 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.

F. Eligibility Determinations

The provision of health care should never be delayed pending an assistance eligibility determination.

1. Patients must be a Connecticut resident in order to qualify. Non-Connecticut residents will only be eligible for charity care if their services at Day Kimball Hospital were provided via the emergency room or through an emergency admission.

2. Day Kimball Hospital will make every attempt to conduct all charity care determinations within 30 days of receiving a completed charity care application.

3. Patients will have 30 days to complete a DKH charity care application. Failure to provide all required pieces of documentation within 30 days will deem the application incomplete. A letter of the hospital's intent to deny and close their application due to missing information will be mailed to the applicant at day 31. Applicants will be given another 14 calendar days grace period to provide all outstanding materials before the application will be terminated.

4. Application to the DKH Financial Assistance/Charity Care Program can be submitted up to six months after the provision of care and will be in effect for six months forward from the last date of service listed on the application at the time of approval.

5. Acceptable verification of income includes 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
        - Most recent P&L statement if self employed
        - Schedules C from tax return if self employed
        - Schedule E from tax return for other real estate or rental income
        - 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
        - Any other information felt to be pertinent

    b. If a patient claims that he/she does not submit a federal tax return or has lost their most recent tax return, we can require that they complete IRS form 4506-T (request for transcript of tax return). The patient can either request a copy of their federal tax return or a confirmation that they have not filed a federal tax return.

c. As charity care is the program of last resort, an application will not be considered until the applicant has been screened for other assistance programs and it has been validated that all other sources of payment have been exhausted.

6. In extenuating circumstances where the situation reasonably demonstrates that a financial hardship exists, Day Kimball Hospital may offer additional charity care at its own determination without a completed application. Either the Director of Revenue Cycle or the CFO must approve these requests. Example: homeless patients.

7. Applications will remain in effect for up to six months from date approved. Day Kimball may request updated financial information at any time during the period and adjust accordingly.

8. Day Kimball 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).

9. Falsification of application will result in the prospective or retrospective denial of charity care benefits.

G. Appeals

1. Responsible parties may appeal a charity care determination by providing additional information, such as insurance verification or an explanation of extenuating circumstances to Patient Accounts within 30 days of receiving notification.

2. First Level of Appeal should be made to the Director of Revenue Cycle who will review the appeal and the responsible party will be notified of the appeals outcome.

3. Second Level of Appeal should be made to Administration (CEO, CFO, or CNO) who will review the appeal and the responsible party will be notified of the appeals outcome.

H. Financial Assistance Balance Approval Guidelines

Approvals will be as follows:

- Balances up to $10,000.00 will be approved by the Patient Accounts Manager or the Patient Accounts Administrative Assistant.
- Balances between $10,001.00 to $20,000.00 will be approved by the Director of Revenue Cycle.
- Balances above $20,000.00 will be approved by the Vice President and CFO.

Approval Signatures:

Director of Revenue Cycle — Date: 5/23/11

Vice President and CFO — Date: 5/26/11

I. GENERAL STATEMENT OF PURPOSE:

Day Kimball 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. Day Kimball Hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, 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.

II. 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 time of patient registration, the Patient Access staff/Financial Counselors will obtain and verify the financial information. This is necessary to determine responsibility for payment of the hospital bill. If the patient or guarantor is unable to provide the information needed, and the patient consents, the hospital/Patient Access Department will make reasonable efforts to contact the appropriate parties for additional information while the patient is in the Hospital and at 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. Signs

   To notify patients of the availability of financial assistance and other programs of public assistance:

   a. Notice of availability of financial assistance and other programs of public assistance are posted in the following locations:

      1) Inpatient, emergency room, ancillary admissions/ registration areas, cashiers window for patients, and Financial Counselors' offices

2. Notification Practices

   a. Day Kimball Hospital will provide information of the availability of financial assistance programs to all self-pay patients expected to incur charges.

   b. The Hospital will include a brief notice about the availability of financial assistance on all statements.

   c. The hospital will notify the patient that it offers several pay plan options.

C. DKH Collection Practices

1. Deposits and Pre-payment plans

   a. Patient or guarantor is expected to pay the full liability for services rendered, within thirty (30) days of receipt of the first bill or in accordance with a mutually agreed upon installment payment plan. See Exhibit 1 for acceptable payment arrangements.

   b. The Hospital shall request a "pre-admission" or "pre-treatment" deposit of 100% up to $1,000.00. For balances over $2,000.00 a deposit of not less than 50% of estimated charges to follow with a payment arrangement. However, it will not request pre-admission and/or pre-treatment deposits from patients who require Emergency Care or who are determined to be "uninsured".

2. Discounts:

   a. Self-Pay Discounts – Day Kimball Hospital offers self-pay discounts to all uninsured patients in an amount equal to the most recently filed cost-to-charge ratio with the Office of Healthcare Access.

   b. Prompt Pay – Day Kimball Hospital may offer self-pay patients a prompt pay discount of 10% when Payment in Full is received within 10 days of first statement date.

   c. Day Kimball reserves the right to offer adjustments to settle disputed accounts.

      - The Director of Revenue Cycle or Physician Practices is authorized to remove co-pays and deductibles in the name of customer service when documented disputes or hardships exist.

      - The Patient Accounts Manager or Physician Practices is authorized to offer up 25% to resolve these accounts.

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

      - No professional courtesy discounts or balance forgiveness is provided to physicians, nurses or staff.

   d. Small Balance Adjustments

      - Hospital small balances will be written off up to $24.99.

      - Physician Practices will base their small balance allowance on co-pays and business line, and will establish the appropriate amount.

3. Internal Collection Practices

    a. An initial bill will be sent to the party responsible for the patient's personal financial obligations.

    b. Day Kimball Hospital 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 undertaken on a regular and frequent basis.

    e. A final notice will be sent giving the responsible party 10 days to make acceptable payment arrangements.

    f. Installment plans will be made available according to terms in Exhibit 1 (attached).

4. Accounts eligible to be referred for external collections includes:

    a. Accounts at day 75 with a balance greater than $250 will be automatically referred to CarePayment – a long term, interest-free patient financing program.

    b. Accounts that have received a final notice and have not set up acceptable arrangements. DKH standard time frame is 120 days before this process is complete. 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.

        - Accounts that have defaulted on payment arrangements.

c. 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 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.
- 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.

5. External Collection Practices

a. Under the supervision of the Patient Accounts Manager, combined balances under $2,500.00 will be turned over to an external collection agency.

b. Combined balances exceeding $2,500.00 will be referred to the Director of Revenue Cycle with asset and employment verification.

- After review of assets, the Director of Revenue Cycle will make the determination to refer account(s) to a collection agency or Attorney to pursue legal activity.

c. Accounts returned from collection agencies as uncollectable with a balance greater than $1,000 may be referred to legal for further collection activity up to and including legal activity.

D. Charity Care

See the hospital wide policy for **Charity Care/Financial Assistance – HWP12027**

E. Liens

Neither Day Kimball Hospital nor its agents will seek to execute a lien against the primary residence or motor vehicle of a patient or guarantor without the express approval of Administration. Liens will only be placed as a last resort, when assets exist and the patient and/or guarantor have not made acceptable payment arrangements. Per policy as stated above.

Attachment: Exhibit I

Exhibit 1

Payment arrangements

1. Payment plans will be offered to patients: charity care guidelines based on the total account balance.

    a. Internal payment plans up to six months will be offered to all patients interest-free regardless of balance. In order to execute a payment arrangement the following must happen:

        1) A signed contract along with 1st payment must be received (Check by Phone or credit card preferred). Prior good faith payments cannot be used to execute a payment arrangement.

    b. External payment plans with Care Payment will be offered > 6 months for balances greater than $250.

    c. Arrangements outside of the above criteria will be managed by an outside company and will be considered a bad debt by Day Kimball Hospital.

2. Any arrangements outside the normal criteria must be signed off prior to being accepted by:

    a. A Patient Accounts Manager for balances less than $1,000.00.

    b. The Director of Revenue Cycle for balances over $1,000.00.

    c. The Vice President of Finance for balances in excess of $10,000.00.

References (if applicable):

Related Policies (if applicable):

Approval Signatures:

_____	_____
Director of Revenue Cycle	Date
_____	_____
Vice President, Financial Services	Date
_____	_____
President and CEO	Date

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Unique Identifier: HWP 12039	DAY KIMBALL HEALTHCARE Hospital-Wide Policy Manual Section – Leadership Page 1 of 5
TITLE: Medicare Bad Debt	**RESPONSIBLE PARTY (IES):** **Director of Revenue Cycle** **Vice President, Financial Services**
FORMERLY KNOWN AS:	
EFFECTIVE: 8/15/05	**REVISED: 4/11**
REVIEWED: 1/7/09, 4/11, 5/5/11	
REGULATORY STANDARD:	

I. GENERAL STATEMENT OF PURPOSE:

To establish consistent policies and procedures that will allow the facility to record the cost report reimbursement benefit in the current period when allowable Medicare Bad Debts are written off and qualified in the cost report settlement.

II. POLICY STATEMENT:

Accounts written off to Medicare Bad Debt Expense must meet the criteria given in the Medicare Provider Reimbursement Manual, Part 1, Section 308.

III. POLICY:

A. CRITERIA FOR ALLOWABLE BAD DEBT

A Medicare Bad Debt must meet all of the following criteria to be an "allowable bad debt" for cost report reimbursement purposes:

1. A reasonable collection effort must be made:

    a. To meet these criteria, the collection effort on Medicare deductible and co-insurance amounts must be similar to the effort to collect comparable amounts from non-Medicare patients. It must include issuing a bill on or after discharge (or death) to the guarantor, subsequent bills, collection letters, and telephone calls or personal contact which constitutes a genuine, rather than token, collection effort.

    b. Collection agency usage must be consistent with our Credit & Collection Policy Medicare as well as non-Medicare accounts.

2. The charge must be related to covered services.

    a. The bad debt must be related to covered services, and derived from the deductible and co-insurance amounts for hospital charges only.

b. Provider based physician's professional components and non-covered charges for this purpose are not a Medicare bad debt and cannot be considered as bad debt.

c. Charity Care with asset testing may be claimed for deductible and/or co-insurance amounts.

d. Deductible and/or co-insurance amounts approved, but zero paid by any State Medical Assistance Program may also be claimed.

3. Write-off timing:

a. The debt may be deemed uncollectable at 120 days from the day the first bill is mailed to the guarantor, after receipt of the remittance advice.

b. Indigent or medically indigent patients:

1) Indigence or medical indigence may be established at any time.

a) Medicaid eligibility proves medical indigence when Medicaid does not cover the deductible or co-insurance.

b) The facility's customary method of determining indigence, Charity Care Policy, will be used for all cases other than Medicaid. A patient's signed declaration alone cannot be considered proof of indigence.

c) There should be no other legal source of responsibility for payment.

d) Documentation of how indigence was determined must be maintained in the file along with all backup information to substantiate the determination.

4. Recoveries

a. A partial payment made after write-off, which is not specifically identified, is to be applied proportionately to Part A Deductible and Co-insurance, Part B Deductibles and Co-insurance and Non-Covered services. The basis for allocation of partial payments is the proportionate amounts owed in each category.

B. LOGS

Medicare bad debt logs are to be maintained and updated on a monthly basis for the Medicare Audit if the facility wishes to reduce current period bad debt expense by the amount of bad debt to be recovered from Medicare.

C. EARLY OUT BAD DEBTS

"Early out" refers to situations where once indigence is established, the debt may be deemed uncollectable without applying any further collection efforts.

D. COLLECTION EFFORT

1. Once Medicare has paid the claim, and the remaining deductible and co-insurance amounts are known, the facility's collection effort will begin.

2. Monthly mailings must be made to patients to confirm accounting entries on their account.

3. The facility's collection effort must continue for 120 days.

4. Once 120 days of collection effort has been completed and no payment has been received, the facility will write off the account to a collection agency.

5. Medically Indigent determinations should not be assigned to the collection agency, but immediately claimed as an allowable bad debt.

6. The collection agency should complete the customary collection effort.

E. RECOVERIES

1. A partial payment posted to an account will be pro-rated between the Part A Deductible and Co-insurance, Part B Deductible and Co-insurance and Non-Covered Services, if payment application is not specified.

2. A listing of recoveries must be maintained on a monthly basis.

F. DOCUMENTATION REQUIREMENTS

1. The following documents must be maintained:

    a. The monthly bad debt log listing patient accounts written off to a collection agency.
    b. The monthly bad debt log listing recoveries made to patient accounts.

2. Accurate Medicare bad debt logs must be maintained by the Patient Financial Services office in order to maximize reimbursement.

G. LOG FORMAT

The following guidelines provide minimum information to be accumulated.

1. Separate logs must be maintained for inpatient accounts and outpatient accounts on a monthly basis.

2. Write-offs must be listed separately from recoveries.

3. The following information should be accumulated for write-offs:

    a. Patient Name
    b. Account Number
    c. HIC#
    d. Date of Admission
    e. Total Covered Medicare Charges
    f. Professional Component/Non-covered Charges
    g. Facility Deductible
    h. Facility Co-insurance
    i. Amount Transferred to Bad Debt
    j. Amount Being Claimed to Medicare Bad Debt
    k. Remittance Advice Date
    l. Date of First Statement
    m. Write off Date
    n. Type of Account: B = Collection, C = Charity, S = State

4. The following information will be kept with the spreadsheets for future audits:

    a. Medicare Remittance
    b. State Remittance

5. The following information should be accumulated for recoveries:

    a. Patient Name
    b. Account Number
    c. HIC#
    d. Month/Year of the Bad Debt Log of the Original Write-off
    e. Original Write-off Amount
    f. Recovery Amount
    g. Notes/Comments

6. Day Kimball Hospital does not have free bed funds. Therefore, Medicare regulations allow us to be reimbursed through the Medicare cost report process for co-insurance and deductible amounts approved, but zero paid by the State Medical Assistance Program, and co-insurance and deductible amounts for patients eligible under Day Kimball Hospital's charity care guidelines.

   Medicare regulations require these co-insurance and deductible amounts to be written off to bad debt.

   The effect of this policy will decrease the Medicaid and Charity Care allowances, and will increase the bad debt expense.

Approval Signatures:

_____ _____
Vice President, Financial Services Date

_____ _____
Director of Revenue Cycle Date