Title: [Title] Charity Care, Finacial Assistance, Free Bed Fund	Reference Number: Click here to enter text.
File Location: Finance / Patient Accounts	Issuing Department: Finance – Revenue Cycle
Latest Review/Revision Date: 4/14	Original Date: 6/08
Endorsing Departments/Committees/Dates: July 29, 2013 Westerly Hospital Board of Directors March 24, 2014 L+M Healthcare Finance Committee March 31, 2014 Lawrence & Memorial Hospital Board of Directors	
Authorizing Signature/Title/Date: _____ Jim Moylan, Interim CFO	

PURPOSE

It is the philosophy and policy of L+M Corporation, Incorporating L+M Hospital and LMW Healthcare, Inc (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 Financial Counseling staff is available to help patients apply for State Assistance, Funds available and Charity Care as last resort.
   2. Charity care applies to all uninsured, patients (defined as earning less the 250% of the poverty guidelines) as described in Statutes 19a-673 and R23-17.14-HCA. The Hospital will meet or exceed the guidelines set-forth by CHA and HARI following Statewide Discount Policies for Uninsured Patients.

B. Hospitals Guidelines
   1. Hospital shall provide full charity care to patients if the patient's: (a) annual income is up to and including 250% of the Federal Poverty Guidelines, taking into consideration family unit size: and (b) assets do not exceed $50,000 which complies with asset threshold (as defined in the Rhode Island Statewide Standards for the Provision of Charity Care; See R23-17.14-HCA).
   2. Any patient upon initial screening that may qualify for Medicaid will be required to have a determination by the state prior to applying for charity care.
   3. Hospital shall provide discounted care on a sliding scale for self-pay patients if the patient's: (a) annual income is between 251% and up to 400% of the Federal Poverty Levels, taking into consideration family unit size; and (b) assets do not exceed $50,000 which exceeds the asset threshold (as defined in the Rhode Island Statewide Standards for the Provision of Charity Care; See R23-17.14-HCA).

Discounts will be authorized as follows:

- 251% - 300% = 50%
- 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. 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 or outside the provision of care timeline. The Revenue Cycle Director or the CFO must approve these requests. Example: homeless patients.

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 Counselors will attempt to visit all inpatients registered as self-pay. A summary explaining programs and charity care will be given to the patient or guarantor when this visit occurs.
   3. However, it is a patient's responsibility to advise the hospital if they believe they qualify for charity care.
   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. 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:
      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 must 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 Patient Financial Counseling Supervisor, 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 1 year 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 Financial Counselors office.
4. The Hospital will make charity care determinations and notifications to patient within 30 days of receiving a completed financial assistance application.
5. Acceptable forms of income verification include 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 patient.
    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 30 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.
7. 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).
8. 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.
9. 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.
10. 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.
11. 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 have changed. Notification of re-determination will be made in writing within 30 days of receiving appeal request.

- Level 1 appeals should be made to the Patient Financial Counseling Supervisor
- Leve1 2 appeals should be made to the Manager of Patient Access
- Level 3 appeals should be made to the Director of Revenue Cycle

G. Free Care Approval Guidelines – Approvals will be as follows:
   1. Balances up to $2,500.00 will be approved by Patient Financial Counselor
   2. Balances from $2,500.00 to $25,000.00 will be approved by the Financial Counseling Supervisor
   3. Balances from $25,000.00 to $100,000.00 will be approved by the Patient Access Manager
   4. Balances above $100,000.00 will be approved by the Director of Revenue Cycle

H. The Hospital's collections process is available upon request.

PROCEDURE

PROTOCOL

Reference:

Archive Dates Reviewed Date: Revised: 6/11; 4/14 Supersedes:

Title: [Title]Credit & Collection Policy	Reference Number: Click here to enter text.
File Location: Finance / Patient Accounts	Issuing Department: Patient Accounts
Latest Review/Revision Date: 4/14	Original Date: 6/08
Endorsing Departments/Committees/Dates: July 29, 2013 Westerly Hospital Board of Directors March 24, 2014 L+M Healthcare Finance Committee March 31, 2014 Lawrence & Memorial Hospital Board of Directors	
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PURPOSE

L+M Corporation, (L+M Hospital and LMW Healthcare), hereafter "The Hospital," has a fiduciary responsibility to appropriately bill and collect for patient services. 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-service deposits, payment plans, self-pay adjustments, refunds, charity care/financial assistance determinations, or in its collection practices.

POLICY

I. Collecting Information on Patient Health Coverage and Resources

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

B. At the time a patient is scheduled or at time of patient registration, hospital staff will obtain and verify the financial information in order to determine responsibility for payment of the hospital bill. If the patient or guarantor is unable to provide the information needed, hospital staff will make a reasonable effort to contact the appropriate parties for additional information.

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

II. Pre-Service Deposits

A. Non-covered Procedures (including but not limited to all cosmetic procedures, sterilization reversals, intraocular lens (IOL's), hearing aids, dental procedures) require upfront payment in full.

B. Elective and Urgent Procedures:
   1. The Hospital may require a pre-service deposit of up to 100% of the estimated out of pocket expense.
   2. In some cases, elective services may be postponed pending financial or state assistance determination.

C. A deposit will not be required from Emergency Care patients prior to a medical screening exam or from patients determined to be "uninsured" as outlined by the *Charity Care, Financial Assistance, And Free Bed Fund Policy*.

D. Patients qualifying for a partial charity care adjustment may be required to leave a deposit up to 20% of estimated charges.

III. Payment Plans

A. Formal 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. Balances from $150.00 - $500.00 must be paid within 6 months.
   c. Balances from $500.01 - $5,000.00 must be paid within 12 months.
   d. Balances greater than $5000.00 or patients receiving partial charity care (between 250% - 400% Federal Poverty Guidelines) must be paid within 18 months.

B. Arrangements outside of the above criteria must be considered a bad debt by the Hospital.

C. Any arrangements outside the normal criteria must be approved by management.

III. Self-Pay Adjustments

A. The Hospital may offer true self-pay patients 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:
   1. The Credit & Collections Supervisor, Patient Accounts Operation Managers, Patient Accounts Manager or Revenue Cycle Director are authorized to remove all or a portion of patient balances in the name of customer service for documented disputes or when hardships exist.
   2. Percentages above 25% must be approved by the Revenue Cycle Director.

C. Small Balances will be adjusted off up to $24.99; individual entities of the corporation will establish their own small balance allowances based on the business line.

IV. Refunds

A. The Hospital will monitor overpayments and take appropriate action to resolve the refund within 60 days of identification or within payer guidelines.
B. Patient credit balances will be transferred to accounts with open self pay balances that are up to 7 years old before issuing a patient refund. Exception: Credits from HSA (health savings account) or HRA (health reimbursement account) payments may only be applied to open accounts within the same year.
C. Unresolved/returned refunds for credits that are over 3 years old and where the patient has not had any chargeable visits within the past 12 months will be included in an annual report and escheated to the appropriate state Controller's office.
D. All escheatment's will be reported to the Finance Department for inclusion in their annual report to the Unclaimed Property divisions of Connecticut and Rhode Island.

V. Charity Care Determinations - See the hospital's *Charity Care, Financial Assistance, Free Bed Fund Policy.*

VI. Collection Practices

A. Internal Collection Practices:
   1. An initial statement will be sent to the party responsible for the patient's personal financial obligations.
   2. The Hospital, or their designee, will document all subsequent statements, 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.
   3. The Hospital, or their designee, will document alternative efforts to locate the party responsible for the obligation or to correct the address on statements returned by the postal service as "incorrect address" or "undeliverable".
   4. Documentation will reflect a continuous collection effort.
   5. A final notice will be sent giving the responsible party 10 days to make acceptable payment arrangements or payments in full.

B. External Collection Eligibility:
   1. Patients considered "insured" who have received a final notice and have not set up or honored a formal payment plan arrangement.
   2. Exceptions to the above:
      a. 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.
      b. Patients who refuse to pay or cannot meet acceptable arrangements may default to the Final Notice.
      c. Accounts that have defaulted on payment arrangements.
   3. The following situations may cause an account to be referred to an external collection agency without receiving a final notice letter:
      a. Accounts where the responsible party cannot be located (returned mail or unable to locate).
      b. 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.

c. Patient states to only contact their attorney. We may refer these cases to our legal counsel and or collections.
d. Patients willing to make a payment arrangement that does not meet our criteria may be referred to an outside company to handle this arrangement.
e. Patients wishing to have a current balance combined with another account in collections.

C. External Collection Practices:

1. After review of assets and employment information, the Patient Accounts Manager, or designee, will make the determination to refer account(s) to a collection agency or Attorney to pursue legal activity.
2. Accounts returned from collection agencies as uncollectable may be referred for further collection activity up to and including legal activity.
3. 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.
4. 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.
5. The Hospital may report a delinquent account to the credit bureau after routine collections have been exhausted.

VII. Liens/Wage Garnishment

A. The Hospital shall not foreclose 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.

B. The Hospital shall 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: 6/11; 4/14 Supersedes: