SHARON HOSPITAL POLICY AND PROCEDURE	REFERENCE # 003 PAGE 1 of 1
POLICY: Write-Offs- Bad Debt	DATE ISSUED: 4/12/2002 DATE REVISED: 11/18/04, 3/29/05 DATE REVIEWED: 4/2008
MANUAL: Financial Services	
SECTION: Billing	
ATTACHMENTS:	

Purpose

To manage accounts receivables in a manner which minimizes bad debt expense while providing proper internal controls.

Policies

1. Sharon Hospital will write off an account when one or more of the following conditions apply:

.

- The hospital receives discharge notice for Chapter 7 Bankruptcy
- The account has reached the end of its collection cycle (120 days), and has been referred to a primary collection agency.
- Hospital Management considers that all collection efforts have been exhausted.
- Accounts greater than 180 days will be placed with a secondary collector.
- Any account that defaults on contract payment arrangements.
- Mail returns

2. Approvals:
   - The Director of Patient Financial Services or Patient Account Manager will approve all hospital write-offs.
   - Monthly detailed reporting will be maintained by the Director Patient Financial Services.
   - Account will be moved from active AR status to BD status.

3. Payments:
   - Hospital will record and post payments for accounts in bad-debt status as they are received. Such payments will be recorded on a gross basis (prior to the deduction of any collection fee)
   - Hospital will report these payments to the collection agency on a daily work week schedule.

4. Procedures:
   - The assignment of these accounts shall be based on an alpha split or other equitable criteria. This is to ensure proper assignment of accounts for purposes of comparative performance evaluation.
   - Unique mnemonics shall be established for each collection agency. This will ensure proper segregation of agency accounts.
   - Accounts deemed uncollectible should be written off of the active accounts receivable at 120 days based on discharge and service dates
   - Medicare Bad Debt will be referred under separate agency designation to allow the hospital to track Medicare Bad Debt write off and recovery
   - The hospital will maintain a written business agreement with all agencies that outlines operational and contract issues.

_____ _____

Approved by
CFO Date

_____ _____

Director, PFS Date

SHARON HOSPITAL POLICY AND PROCEDURE	REFERENCE # 007 PAGE 1 of 4
POLICY: Charity Care	DATE ISSUED: 4/12/2002 DATE REVISED: 2/04, 2/06, 2/08, 5/10, 2/11,1/16 DATE REVIEWED: 2/06, 2/08, 5/10, 2/11, 6/14
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 $0-10,000 will be approved by the CFO. Write-offs over $10,000 will be approved by the CEO.

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 Hospital Charity Care Income Guidelines based on federal standards for determination of poverty level with consideration to family size, geographic area, and other pertinent factors.

1.3 Evaluate financial need by reviewing the completed Financial Statement Form.

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

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

1.6 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.

1.7 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.*

2.1 If the charity care applicant is the guarantor on immediate family member's accounts and the family members reside in the guarantor's household, those accounts should be included in the charity care application.

3 **VERIFICATION** of Income must be provided with the application. Applicants are encouraged to provide multiple forms of income verification. Acceptable verification includes:

- Prior Year Tax Returns,

(or recent bank statement if tax information not available),

- Current Pay Stubs
- Written verification of wages from Employer
- Unemployment Letter

Credit reports may be utilized to evaluate eligibility as well.

-- If patient requesting charity does not have a tax return, a signed statement detailing the reason why they don't will be required.

4. 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:
   - Subsequent rendering of services
   - Income change
   - Family size change
   - When any part of the patient's account is written off as a bad debt or is in collections.
   - When six months has passed since the last application or when circumstances change, whichever comes first.

4.1 If patient has Medicaid, they are considered at the federal poverty level and would qualify for 100% charity for current and all past tax years. Upon submission of 1 (one) additional prior year tax return, the patient could be eligible for further consideration of charity.

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

6. Any hospital employee can inform patients about the charity program. Financial counselors or Business Office staff will initiate charity considerations.

7. Applications for charity care will be reviewed and approved within 15 business days after receipt of complete packet from the applicant.

8. PFS will retain all records relating to charity care for ten years.

10. Notify patients 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 were not 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	2016 FPL	Maximum Income
1	$11,770.00	$29,700.00
2	$15,930.00	$40,050.00
3	$20,090.00	$50,400.00
4	$24,250.00	$60,750.00
5	$28,410.00	$71,100.00
6	$32,570.00	$81,450.00
7	$36,730.00	$91,825.00
8	$40,890.00	$102,225.00
9	$45,050.00	$112,625.00
10	$49,210.00	$123,025.00
11	$53,370.00	$133,425.00
12	$57,530.00	$143,825.00

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% 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.

RegionalCare HOSPITAL PARTNERS

Accounting Policy Guide

Policy Description:	Medicare Bad Debts
Policy No:	006
Replaces Policy Dated:	N/A
Effective Date:	July 1, 2014

SCOPE:
All services rendered to Medicare beneficiaries in the hospital setting.

PURPOSE:
To establish a consistent policy for the identification, collection effort, and documentation of allowable Medicare bad debts for inclusion in the Medicare cost report.

POLICY:
All hospitals will follow a standard procedure to ensure that uncollected Medicare patient liabilities due to the hospital are treated in a manner that complies with the Medicare PRM-15 Chapter 3, for proper recognition of Medicare Bad Debts. This policy is intended for traditional Medicare patient liabilities but may be applicable to certain Medicare replacement plans depending on contract language.

Note: This policy implies no change to maintaining AFDA prescribed at Policy #104, *Bad Debt Allowance for Doubtful Accounts.*

PROCEDURES:

A. Criteria for Allowable Bad Debts

To qualify as an allowable bad debt that will be reimbursed by the Medicare program, a bad debt must comply with **all** of the following requirements:

1. The bad debt must be related to services covered by Medicare ("covered services"), and derived from the related Medicare *deductible and/or coinsurance* amounts.

2. A Medicare deductible and/or coinsurance originating from a claim reimbursed under a fee schedule payment methodology does not qualify for potential allowable bad debt.

3. When an account has secondary insurance, the secondary insurer must be pursued for appropriate payment, in accordance with customary collection efforts.

4. Reasonable Collection Efforts must be made such as:

    a. In-house and external collection effort on the Medicare patient liability must be the same as the effort to collect comparable amounts on non-Medicare accounts.

        i. Collection efforts should include, but not be limited to, an initial bill on or soon after the patient is discharged
        ii. Subsequent bills, letters, telephone calls, and personal contact
        iii. Efforts should constitute a genuine, rather than token, collection effort. The efforts may include using or threatening to use court action if this is also used for non-Medicare accounts
        iv. A consistent policy must be used for Medicare and non-Medicare accounts turned over to a collection agency.

Policy Description:	Medicare Bad Debts
Policy No:	006
Replaces Policy Dated:	N/A
Effective Date:	July 1, 2014

b. Documentation of the collection efforts must be clearly denoted and accurately record and demonstrate the date bills and letters are sent to patients as well as document secondary efforts such as telephone calls and other collection efforts.

* Refer to **Section C** below for additional requirements regarding collection efforts.

5. Medicare patient liabilities derived from provider based physician professional components and non-covered services should be excluded from the determination of allowable bad debts.

Note: Patient liabilities due to the hospital that are generated from Medicare non-covered services, are not potential Medicare Bad Debts, even if appropriate ABN requirements have been followed. Refer to the hospital ABN policy for permissible collection efforts related to non-covered services.

B. Write-Off/Claiming/Logging Process and Recovery of Bad Debts

Write-off/claiming/logging of Medicare bad debt accounts should occur only after:

1. Sound business judgment establishes that the account is deemed worthless/uncollectible and there is no reasonable likelihood of recovery at any time in the future. An account is considered worthless only after all efforts have been consistently pursued in conjunction with the hospital's collection policy for all patient (Medicare and Non-Medicare) accounts.

2. If it is determined that the patient is indigent, customary collection efforts can be waived. Such determinations should be made in accordance with the hospital's indigent policy and include, but not be limited to, the following guidelines:

   a. Medicaid eligibility satisfies and proves indigence status only when Medicaid does not pay the Medicare deductible and coinsurance
   b. Proof of Medicaid eligibility should be retained in the patient's file.
   c. If a hospital relies on a ***financial assessment*** to determine indigence for non-Medicaid patients, all documentation of this determination must be consistent and maintained in the patient file in accordance with the retention requirements outlined in section F below. Standards to determine indigence, such as bankruptcy, should be established in a written policy that is presentable upon audit.
   d. A patient's signed declaration of indigence is not adequate proof of un-collectability. Indigence must be determined by the provider, in accordance with the hospital's indigent policy.
   e. Bankruptcy is an acceptable means to establish indigent status. Proof of bankruptcy is required.

3. All other legal sources of responsibility of payment should be pursued and exhausted prior to the account being written-off, and claimed/logged.

4. Returned mail does not constitute the account to be worthless and uncollectible.

RegionalCare HOSPITAL PARTNERS

Accounting Policy Guide

Policy Description:	Medicare Bad Debts
Policy No:	006
Replaces Policy Dated:	N/A
Effective Date:	July 1, 2014

C. Collection Efforts

1. The use and duration of internal and external collection services are prescribed by RCHP. Any deviation from the RCHP standards must be preapproved by the RCHP Corporate Office. Utilization of internal and external services must be deployed in a manner consistent for all payers.

2. At a minimum, combined in-house and external collection efforts should continue for at least 120 days from the day the patient is first billed for applicable deductible and coinsurance balances. If a patient begins making payments and later defaults, the collection efforts to restore the account to good standing shall continue for at least 120 days from the date of the last payment from the patient/guarantor. Only where indigence is determined in accordance with **section B (2)** can collection efforts cease prior to the 120 day policy.

3. While an account is placed with an outside collection agency (OCA) subsequent to in-house collection efforts, the account cannot be deemed worthless as collection efforts have not officially ceased.

    a. An account MUST be formally returned from the collection agency before the account can be written off.
    b. Accounts in an "inactive/warehoused" collection status with an OCA are still deemed by Medicare as being pursued for collection and do not qualify as an allowable bad debt.
    c. The timing and formal return of accounts from an OCA must be documented, and demonstrated to be the same for all payers (Medicare and Non-Medicare).

4. An account is deemed worthless when sound business judgment establishes that there is no likelihood of recovery at any time during the future.

D. Recoveries

Recoveries are payments received for the patient responsible balance after the account has been written off. A listing of recoveries must be maintained and included on the Medicare bad debt log discussed below in **Section F**.

1. A partial payment posted to an account should be prorated and applied to applicable Part A deductible and coinsurance, Part B deductible and coinsurance, non-covered services in accordance with hospital's ABN (Advance Beneficiary Notice of Non-coverage) policy, and provider based physician components.
2. Recoveries are to be reported on the Medicare Bad Debt Log in the month the recovery is received regardless of the period that the original bad debt was written off/claimed/logged.

E. RAC Recoupments

RAC recoupments that are indefensible (i.e. no appeal is made or an unfavorable decision from an appeal(s)) may sometimes occur on accounts that had a prior year Medicare bad debt claimed/logged. These must offset current Medicare bad debts on the current year's cost report.

RegionalCare HOSPITAL PARTNERS

Accounting Policy Guide

Policy Description:	Medicare Bad Debts
Policy No:	006
Replaces Policy Dated:	N/A
Effective Date:	July 1, 2014

F. Medicare Bad Debt Log, Documentation, and Retention

A Medicare bad debt log represents a standard schedule designed to provide an efficient means of compiling and reporting the minimal requirements in accordance with CMS's allowable bad debt regulations. The following guidelines must be met in congruence with the preparation of the Medicare bad debt log.

1. The RCHP Medicare Bad Debt Logs will be developed by the RCHP Corporate Reimbursement Department and any changes to the format of the logs must be approved by the RCHP Corporate Reimbursement Department. The RCHP standard Medicare Bad Debt Logs will comply with the CMS form 339 and are required to be completed on a monthly basis.

2. All fields of the bad debt log must be completed before the log is considered acceptable and compliant with Medicare regulations.

3. Documentation for all fields must be available in an orderly, transferable, and readily accessible means.

4. All requirements defined in **Section A** and B above must be met before the account is claimed/logged on the bad debt log.

5. Uncollected accounts cannot be included on the bad debt log prior to being deemed worthless by the final collection agency, and written off. As stated in Section B, certain situations such as indigency, bankruptcy and Medicaid eligibility will justify claiming/logging of these accounts and forgo the need to pursue bad debt collections.

6. Retention of the bad debt log and supporting documentation, including indigence determinations as described and required in the sections above, collection activity notes, and close and return reports (from the collection agency), must be maintained until the applicable cost report has completed a Medicare audit and received a Notice of Program Reimbursement, or until otherwise notified by the Corporate Reimbursement Department.

7. The facility CFO or a designated individual is responsible for the oversight of all requirements in **Section F**.

8. Medicare bad debt logs are expected to be fully completed each month prior to the month end financial accounting close. This includes providing the dollar amount to be claimed/logged for the month. The formally logged entries are to be included with the Third Party Contractual Package each month and available for review by the RCHP Reimbursement Department.

RegionalCare HOSPITAL PARTNERS

Accounting Policy Guide

Policy Description:	Medicare Bad Debts
Policy No:	006
Replaces Policy Dated:	N/A
Effective Date:	July 1, 2014

Approvals:

Michael Browder, EVP and CFO — Date: July 1, 2014

Steve Wilson, VP and Corporate Controller — Date: 7/1/14