

Notice of Availability for Uncompensated Care

Eastern Connecticut Health Network, Inc. will provide assistance for those patients who fall within the guidelines below.

To be eligible to receive uncompensated care, your family must be at or below the following current guidelines.

Family Gross Income Levels

2012 Federal Poverty Guidelines	125%	150%	175%	200%	250%	300%	400%
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% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	13,963	16,755	19,548	22,340	27,925	33,510	44,680
2	18,913	22,695	26,478	30,260	37,825	45,390	60,520
3	23,863	28,635	33,408	38,180	47,725	57,270	76,360
4	28,813	34,575	40,338	46,100	57,625	69,150	92,200
5	33,763	40,515	47,268	54,020	67,525	81,030	108,040
6	38,713	46,455	54,198	61,940	77,425	92,910	123,880
7	43,663	52,395	61,128	69,860	87,325	104,790	139,720
8	48,613	58,335	68,058	77,780	97,225	116,670	155,560

Add \$3,960 for each additional member

Patient Responsibility	0%	10%	20%	30%	40%	50%	60%
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If you feel you may be eligible, you may request free or discounted services at the Patient Financial Service Office. Requests may be made prior to admission, during the stay or at time of discharge. A financial evaluation form and application will be provided for the applicant upon request. The Hospital will make a final determination of your eligibility for uncompensated services.

When Third Party coverage is available (Medicare, State, Medicaid LIA, etc) all applicable benefits must be applied first. Patient convenience items such as private room differentials are not covered.

Refusal to take reasonable actions necessary to obtain these available benefits can exclude the granting of uncompensated services.

Source – Federal Register Income Poverty Guidelines

**PATIENT FINANCIAL SERVICES
POLICIES AND PROCEDURE**



SUBJECT: Financial Assistance

POLICY NO: 500

- I. TITLE: FINANCIAL ASSISTANCE / CHARITY CARE
- II. OBJECTIVE: ECHN is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate those who are poor and disenfranchised, ECHN strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.
- III. PURPOSE: To identify those patients that qualify for charitable assistance and to complete write-off procedures that in keeping with state and federal regulations.
- a. ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
 - b. It is the policy of ECHN to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy is to describe how applications for Federal Assistance should be made, the criteria for eligibility, and the steps for processing each application.
 - c. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financials Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.
 - d. Race, gender, sexual orientation, religious or political affiliation, social or immigration status will not be taken into consideration.
 - e. ECHN has seen an increase in Emergency Room visits from patients who are not eligible for or do not have any insurance coverage and have demonstrated significant difficulty in paying for healthcare services. To further ECHN's commitment to their mission to provide healthcare to patients seeking emergency care, ECHN reserves the right to grant financial assistance with an abbreviated application being made by their uninsured patients being seen in the Emergency Room. The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage.
- IV. DEFINITIONS: The following terms are meant within this policy to be interpreted as follows:
- a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.
 - b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.
 - c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims

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someone as a dependant on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.

- d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
 - i. Includes earnings, unemployment compensation, workers' compensation, Social security, Supplemental security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
 - ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
 - iii. Determined on a before-tax basis
 - iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)
- e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
- f. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.
- g. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.
- h. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

V. **GUIDELINES**: In order to provide the level of aid necessary to the greatest number of patients in need, and protect the resources needed to do so, the following guidelines apply:

- a. Patient
 - i. Services are provided under charity care only when deemed medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.
 - ii. Any patient who believes that they are qualified may apply for financial assistance under the hospitals' charity care policy or discount policy.
 - iii. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
 - iv. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.
 - v. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.
- b. Hospital
 - i. ECHN will maintain an understandable, written financial assistance policy for low income uninsured patients, addressing patients, addressing the hospital's charity care policy, as well as it's discount payment policy for the low-income uninsured.
 - ii. ECHN's financial assistance policy should clearly state the eligibility criteria (i.e., income, assets) and the process used by the hospital to determine whether a patient is eligible for the financial assistance. Such process should take into account where and how a particular patient falls relative to existing Federal Poverty Guidelines (FPG). See Exhibit A for current FPL).
 - iii. ECHN will use their best efforts to ensure that all financial assistance policies are applied consistently.
 - iv. In determining a patient's eligibility for financial assistance, ECHN will assist the patent in determining of he/she is eligible for government- sponsored programs.
 - v. Annually ECHN will file the hospital's policies on charity care with the State Office of Health Care Access.
 - vi. ECHN is required to file a mandatory annual report to the Office of Health Care Access indicating the number of applicants and the dollar amount provided to each patient.

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VI. COMMUNICATION:

- a. Notification about charity care available from ECHN, will include a contact number, shall be disseminated by ECHN by various means, which may include, but not limited to, the publication of notices in patient bills and posting notices in emergency rooms, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as ECHN may elect. Information shall also be included on our facility websites and the Conditions of Admission form. Such information shall be provided in the primary language spoken by the population serviced by ECHN. Referral of patients for charity may be made by any member of the ECHN staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and the religious sponsors. A request for charity care may be made by the patient or a family member, close friend, or associate of the patient, subject to privacy laws.
- b. Every posted notice regarding financial assistance policies should contain brief instructions on how to apply for charity care of a discounted payment. The notices also should include a contact telephone number that a patient or family member can call to obtain more information.
- c. ECHN will ensure that appropriate staff members are knowledgeable about the existence of the hospital's financial assistance policies. Training should be provided to staff members (i.e., billing office, financial department, etc.) who will directly interact with patients regarding their hospital bills.
- d. When communicating to patients regarding their financial assistance policies, hospitals should attempt to do so in the primary language of the patient, or his/her family, if reasonable possible, and in a manner consistent with all applicable federal and state laws and regulations.
- e. ECHN will share their financial assistance policies with appropriate community health and human service agencies and other organizations that assist such patients.

VII. PROCEDURES:

- a. **Services Eligible Under This Policy**
 - i. For purposes of this policy, "charity care" or "financial Assistance" refers to healthcare services provided by ECHN without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:
 1. Emergency medical services provided in an emergency room setting;
 2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
 3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
 4. Medically necessary services, evaluated on a case-by-case basis at ECHN's discretion.
- b. **Eligibility for Charity Care**
 - i. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy.
 - ii. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.
- c. **Determination of Financial Need**
 - i. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
 1. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
 2. May rely upon publically available information and resources to determine the financial resources of the patient or a potential guarantor;
 3. Include reasonable efforts by ECHN to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
 4. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

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- ii. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.
 - iii. ECHN's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and ECHN shall notify the patient or applicant in writing within 15 days of receipt of a completed application.
- d. Presumptive Financial Assistance Eligibility
- i. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance.
 - ii. In the event there is no evidence to support a patient's eligibility for charity care, ECHN could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts.
 - iii. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
 - 1. State-funded prescription programs;
 - 2. Patient is homeless or received care from a homeless clinic;
 - 3. Patient files bankruptcy
 - 4. Participation in Women, Infants and Children programs (WIC);
 - 5. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
 - 6. Food stamp eligibility;
 - 7. Subsidized school lunch program eligibility;
 - 8. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
 - 9. Low income/subsidized housing is provided as a valid address; and
 - 10. Patient is deceased with no known estate.
 - 11.

VIII. PATIENT CHARITY GUIDELINES

- a. To be considered for charity care, patients must cooperate with the hospital to explore alternative means of assistance, if necessary, including Medicare and Medicaid. Patients will be required to provide necessary information and documentation when applying for a discount, charity care, or other private or public programs.
 - i. The following guidelines have been established to assist in determining whether or not an individual is eligible for charity care;
 - 1. The application must be fully completed and signed by the patient / responsible party
 - 2. Proof of income for applicant (and spouse if applicable) is verified by two forms of documentation:
 - a. Last four paystubs
 - b. Previous Year Federal Income Tax Form
 - c. Previous Year W-2 Form
 - d. Social Security Statement
 - e. Unemployment Benefit Statement
 - 3. Other documentation that could be required:
 - a. Proof of disability compensation
 - b. Medicare patients will need copy of social security benefits, pension or retirement benefits and/or bank statements showing deposits
 - c. Workers compensation patients showing deposits
 - ii. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination.

ECHN Financial Assistance Program for Emergency Room Services

Financial Assistance Gross Family Income Levels

2012 Federal
Poverty
Guidelines

Family size	125%	150%	175%	200%	250%	300%	Over 300%
1	13,963	16,755	19,548	22,340	27,925	33,510	
2	18,913	22,695	26,478	30,260	37,825	45,390	
3	23,863	28,635	33,408	38,180	47,725	57,270	
4	28,813	34,575	40,338	46,100	57,625	69,150	
5	33,763	40,515	47,268	54,020	67,525	81,030	
6	38,713	46,455	54,198	61,940	77,425	92,910	
7	43,663	52,395	61,128	69,860	87,325	104,790	
8	48,613	58,335	68,058	77,780	97,225	116,670	

3,960 for each additional family member

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
Discount	100%	90%	80%	70%	60%	50%	40%

Patient responsibility	0%	10%	20%	30%	40%	50%	60%
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Point of service payment	\$0	\$50	\$75	\$100	\$100	\$100	\$125
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Max Bill	\$0	\$75	\$150	\$200	\$300	\$400	\$500
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Patient balance with point of service payment	0	\$25	\$75	\$100	\$200	\$300	\$375
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Pay Plan Option - sign contract

2 (\$100)

3 (\$100)

3 (\$125)

**Updated 2/1/12

**PATIENT FINANCIAL SERVICES
POLICIES AND PROCEDURES**



SUBJECT: Pre-Collect and Bad Debt Policy
SECTION:

POLICY NO: 4005
PAGE

- I. TITLE: Departmental Pre-Collect and Bad Debt Policy and Procedures
- II. POLICY: This policy applies to the Manchester Memorial and Rockville General Hospitals Patient Financial Services
- III. PURPOSE: To ensure that bad debt accounts are appropriately identified and consistently processed within the guidelines of the hospital's credit and collection policy.
- IV. RESPONSIBILITIES:
 - A. To ensure that accounts with outstanding patient balances beyond 120 days are written off to bad debt. Accounts are considered bad debt once reviewed by the Self Pay Team and the Pre-Collections Unit as uncollectible. It must be determined that the accounts meet the following criteria:
 - a. The account has aged 120 days from the date the balance became the responsibility of the patient / guarantor without payment in full.
 - b. No reasonable response from the patient in the previous 120 days.
 - c. Guarantor has received at least four statements.
 - d. Third party carrier has denied in writing the responsibility for any payment (partial or full) towards the account and the collector has documented the patient / guarantor's refusal for payment or financing when applicable.
 - e. Guarantor has defaulted on an "agree to payment plan" (for two consecutive months or more)
 - f. The account has been flagged as a "bad address" or "mail return".
 - B. If the above criteria has been met, and at the 4th statement, the account is transferred to the pre-collection list for potential bad debt and is designated to be analyzed for the month end bad debt / write off function. Steps to occur are:
 - a. On the 25th of the month
 - i. Run is run to capture all accounts set to receive 4 statements from the 25th thru the 24th of the next month.
 - ii. Individually review each account to determine if meets criteria for pre-collect letter
 1. Guarantor has received at least 4 statements
 2. Account not paid in full
 3. defaulted on pay plan
 - A. PFS will ensure that the guarantor has been notified in writing that they are in default and in danger of going to collection, after first missed month.
 4. Identified as return mail. Researched, collector changed, and 2 months noted on account.
 5. "Dirty buckets" (money in insurance and self pay) need to be resolved prior to pre-collect letter.
 6. The total pre-collect dollars can not exceed the established bad debt turnover number.
 7. Only one pre-collect letter will go out on each account.
 8. Identify accounts that are not eligible for write off-due to established criteria, Medicaid eligibility, bankruptcy, or the patient is deceased.
 9. Document in financial comments the reason that any account is not eligible for bad debt write off.

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- b. Once the monthly pre-collect accounts have been identified and worked, change the self pay collector for the pre-collect code designated for that month and year .
 - c. On the fourth day of the month
 - i. Finalize pre-collect review
 - 1. Produce and send out pre-collect letters.
 - A. Ensuring that the total dollars do not exceed the bad debt turnover number
 - B. No account has been previously send a pre-collect letter
 - 2. Retain copy of pre-collect report for our records.
 - d. By the 3rd Friday of the month
 - i. Review pre-collect accounts for payments
 - ii. Review pre-collect accounts for Medicaid Eligibility
 - iii. Request bad debt write off according to the following monetary guidelines:
 - 1. Balance of between \$20 and \$999 - no approval necessary
 - 2. Balances between \$1,000 and \$3,900 – reviewed by Non Governmental Specialist
 - 3. Balances between \$4,000 and \$9,999 – reviewed and approved by Non Gov Manager
 - 4. Balances greater than \$10,000- reviewed and approved by Department Manager
 - iv. Report bad debt turnover number to management
 - e. On the twenty fifth of the month
 - i. Review pre-collect accounts for payments
 - ii. Review pre-collect accounts for Medicaid Eligibility
 - iii. Received appropriate approval from management according to established monetary guidelines, which are retained for our records.
 - iv. Review reports to agree with final dollar amount and account age prior to account transfer
 - v. Electronically transfer the selected accounts to bad debt status
 - f. On the last day of the month
 - i. Ensure that the self pay payments have been posted for the month
 - ii. Review bad debt accounts for payments
 - iii. Review bad debt accounts for Medicaid Eligibility
 - iv. Report final month end Bad Debt totals to management
 - g. On the third business day after conclusion of month end process
 - i. Final review of bad debt accounts for payments
 - ii. Final review of bad debt accounts for Medicaid Eligibility
 - iii. Transmit electronic file to collection agency
 - iv. Run bad debt report and retain copy of our records
- C. It is essential that in conjunction with the bad debt process, that the following areas also need to be kept current and worked daily
- a. Bankruptcies to be worked daily
 - b. Mail Return to be worked daily
 - c. Charity Care to be worked daily
 - d. Pay Plans to be reviewed and worked daily

VII. INDIVIDUAL RESPONSIBLE FOR REVISION: Director, PFS

VIII. ORIGINATED: 11/04 REVISION DATE: 3/12
11/09