

Unique Identifier: HWP12027	DAY KIMBALL HOSPITAL Hospital-Wide Policy Manual Section – Leadership Page 1 of 5
TITLE: Charity Care/Financial Assistance	RESPONSIBLE PARTY (IES): President and CEO Senior Vice President and CFO Director of Revenue Cycle
FORMERLY KNOWN AS: Charity Free Care	
EFFECTIVE: 1/99	REVISED: 2/02, 1/03, 11/1/04, 2/1/05, 5/2/05, 10/06 , 3/21/07, 3/1/08
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.

II. POLICY STATEMENT:

Day Kimball Hospital’s Patient Accounts Department will maintain procedures to assist patients with meeting their financial obligations to the hospital.

III. 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 as described in Statute 19a-673. DKH 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 OHCA.”

3. DKH Guidelines

Any patient upon initial screen for Medicaid or Husky that may qualify 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. Day Kimball 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 \$10,000 (Stocks, bonds, cash, 401, IRA, CD, business value, etc. excluding primary residence and primary motor vehicle).
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 income is less than 250% of the FPL and have assets greater than \$10,000 as described in 3-1.
3. Care will be discounted by 30% for those uninsured patients who request assistance and verify their annual income is between 250% and 400% of the FPL.
4. DKH 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.

B. Guidelines for Insured Patients

1. Insured patients at or below 250% of the Federal Poverty Guideline with assets of less than \$10,000 including (Stocks, bonds, cash, 401, IRA, CD, property and business excluding primary motor vehicle) will receive 100% charity adjustment on any balance after insurance.

C. Processing Guidelines:

1. All self-employed applications must submit the entire tax return including all schedules. The Director of Patient Financial Services or designee will review these to determine income. Adjusted gross will not be used in these cases.
2. Notification of charity care determinations will be mailed to the patient/guarantor within 30 days of receipt of completed application.
3. Payment arrangements can be extended up to 18 months based on a fully executed patient contract.

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 the programs will also be available in those areas.
2. Patient Financial Advisors will attempt to visit all inpatients registered as self-pay patients. A summary explaining 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 Statutes 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.
5. A Patient Financial Advisor will attempt to contact all self-pay patients with balances over \$500.00 advising them of charity care and other payment options.

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 25, and stepchildren under the age of 18 or students to the age of 25. 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

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. Day Kimball Hospital will make every attempt to make charity care determinations within 30 days of receiving a completed financial assistance application.
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.
 - 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.
6. Charity care may be denied if the application is not complete and patient does not submit additional information within 20 days of request.
7. 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, Day Kimball Hospital may offer charity care at its own determination without a completed application. The Director of Patient Accounts, Director of Physician Practices or the CFO must approve these requests. Example: homeless patients.
9. Charity care may not be granted for some procedures, such as elective cosmetic surgery or some special situations, such as that of an individual who is eligible for other programs and has refused to apply spend down assets to become eligible for state assistance.

10. 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.
11. 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.
12. 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).

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. Level 1 appeals should be made to the Director of Patient Financial Services who will review the appeal and the responsible party will be notified of the appeals outcome.
3. Level 2 appeals 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. Free Care Approval Guidelines

Approvals will be as follows:

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

Unique Identifier: HWP12048	DAY KIMBALL HOSPITAL Hospital-Wide Policy Manual Section – Leadership Page 1 of 7
TITLE: Credit and Collection Policy	RESPONSIBLE PARTY (IES): President and CEO Vice President and CFO Director of Revenue Cycle
FORMERLY KNOWN AS: General Information, Credit and Collection of Patient Accounts – HWP12048 & Use of Collection Agencies – HWP12024	
EFFECTIVE: 4/01	REVISED: 2/02, 1/03, 2/1/05, 5/2/05, 5/06, 7/06, 3/21/07
Reviewed: 2/16/09	
REGULATORY STANDARD:	

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 / Patient Advisors 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

The following text will be posted on signs to notify patients of the availability of financial assistance and other programs of public assistance:

- a. If you are not able to pay your hospital bill, please contact the hospital Patient Financial Advisors at 860-928-6541 x3316 or 2219 from Monday through Friday, 8:00 am to 4:30 pm. The Patient Financial Advisors will assist you with alternate coverage options.
- b. Notice of availability of financial assistance and other programs of public assistance are posted in the following locations:
 - 1) Inpatient, emergency room and ancillary admissions/registration areas
 - 2) Patient Accounts

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 an interest free payment plan up to 18 months on all claims approved for partial financial assistance.
- d. The Hospital will provide a written notice of determination for all applications within 30 days of receiving a completed application and the required supporting documentation.

C. Deposits, Installment Plans and Adjustments

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 require a “pre-admission” or “pre-treatment” deposit of 100% up to \$1,000.00. For balances over \$2000.00 a deposit of not less than 50% of estimated charges to follow with a payment arrangement. However, it will not require pre-admission and/or pre-treatment deposits from patients who require Emergency Care or who are determined to be “uninsured”. Patients qualifying for a charity care adjustment may be required to leave a deposit limited to 20% of the estimated charges up to \$500.00.

Example 1 – An “insured” self-pay patient: Scheduled for a non-emergent procedure, the charges are estimated at \$3,400.00. The patient would have to leave a deposit of \$1,700.00 and have the option to pay the balance in full within 30 days for a 15% adjustment or set up a payment arrangement.

Example 2 – The patient is receiving a charity care adjustment of 25% for a procedure with estimated charges of \$3,400.00. They would be required to leave a deposit of \$500.00 and the remaining balance of \$2,050.00 (\$3,400.00 - \$850.00 (25% charity adjustment) - \$500) would be budgeted over 18 months.

2. Self-Pay Adjustments
 - a. Day Kimball may offer self-pay patients who are considered “insured” per the Connecticut General Statutes Section 19a-673, an adjustment up to 15% when Payment in Full is received:
 - Within 30 days of initial bill = 15% adjustment
 - 30 – 60 days of initial bill = 10% adjustment
 - No adjustment after 60 days of initial billing

- b. Patients who have been making payment may be offered up to a 15% adjustment if the outstanding balances are paid in full within 30 days of the offer.
- 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 with documented disputes or hardships exist.
 - The Director of Revenue Cycle or Physician Practices is authorized to offer up 25% to resolve these accounts.
 - Percentages above 25% must be approved by Administration.
 - No professional courtesy discounts or balance forgiveness is provided to physicians, nurses or staff.
- d. 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 amount.

D. Charity Care

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

E. Day Kimball Hospital’s 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. 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.

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. 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 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 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.

3. 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 may be referred to legal for further collection activity up to and including legal activity.

F. 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.

Exhibit 1

Payment arrangements

1. Payment plans will be offered to patients over the 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 six months for balance over \$150.00 - \$500.00.
 - c. Up to 12 months for balances of \$500.01 - \$5000.00.
 - d. Up to 18 months for balances greater than \$5000.01 or patients receiving partial charity care (between 250 – 300% 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 Day Kimball Hospital.
3. 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.
4. In order to execute a payment arrangement the following must happen:
 - a. 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. Terms must be within the limits set above.

Unique Identifier:	DAY KIMBALL HOSPITAL Hospital Wide Policy Manual Section – Leadership Page 1 of 5
TITLE: Medicare Bad Debt	RESPONSIBLE PARTY (IES): Sr. Vice President/CFO Director of Patient Financial Services
FORMERLY KNOWN AS:	
EFFECTIVE: 8/15/05	REVISED:
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 this criteria, the collection effort on Medicare deductible and coinsurance 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 coinsurance 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 coinsurance amounts.
 - d. Deductible and/or coinsurance amounts approved, but zero paid by the 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 coinsurance.

 - 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 Coinsurance, Part B Deductibles and Coinsurance and Non-Covered services. The basis for allocation of partial payments is the proportionate amounts owed in each category.

B. LOGS

1. 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 coinsurance 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 prorated between the Part A Deductible and Coinsurance, Part B Deductible and Coinsurance 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.

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 Coinsurance
 - 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 coinsurance and deductible amounts approved, but zero paid by the State Medical Assistance Program, and coinsurance and deductible amounts for patients eligible under Day Kimball Hospital's charity care guidelines.

Medicare regulations require these coinsurance 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.