Navicent Health Baldwin

POLICY AND PROCEDURE **NAVICENT HEALTH BALDWIN**

SUBJECT: Indigent and Charity **POLICY: BO-PFS-031**

Applies To: Patient Financial Services **Approved by: VP Finance/CFO**
Revision Date: October 2017 **Department: Business Office**

PURPOSE:

To establish guidelines for recognizing and processing accounts for patients who qualify for indigent care, charity care, or government assistance programs.

POLICY:

In order to provide community benefit, Navicent Health Baldwin (NHB) offers several payment options and financial assistance programs for our patients. NHB supports the provision of medical services to medically indigent persons so that they may receive care without charge or at a reduced rate. This applies to emergent and medically necessary care provided by the hospital.

PROCEDURE:

I. Eligibility Criteria:

A. The hospital shall apply standard eligibility criteria for each person requesting free or reduced charge care that enables the hospital to:

1. Provide services to persons with incomes below 125 percent of the federal poverty level.

2. Provide services for no charge or reduced charge based on a sliding fee scale for persons with incomes between 125 and 250 percent of the federal poverty level.

3. Provide services to persons where income and family size cannot be verified, otherwise referred to as presumptive eligibility (see section below).

II. Income Qualifications:

A. Income is the family's gross income. Use either the average monthly income for the previous three months or for the previous year, whichever is more favorable to the applicant.

B. For self-employed individuals, the amount of income to be counted is gross income minus work expenses directly related to producing the goods or services and without which the goods or services could not be produced. A W-2 form may be required.

C. For money that may be considered as a non-recurring lump sum (insurance settlements, accumulated back RSDI payments, etc.), consider the gross amount received in the month received.

D. Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family member should be excluded.

E. Do not count income from any person who is not financially responsible for the patient. For example, do not count income from one sibling as available to another sibling for the purposes of paying medical bills. Likewise, do not count income from any child (minor or adult) in considering eligibility for free or reduced level of care.

III. Processing Indigent/Charity Care Accounts

A. Apply the following guidelines when processing indigent/charity care applications:

1. Have the patient complete a financial statement, whenever possible, for all self-pay and underinsured patients to determine if criteria are met. Provide assistance to the patient in completion of the form if needed.

2. Financial applications must be accepted even if collection effort has been initiated.

3. Outline the supporting documents needed from the applicant in order to evaluate the application. This may include bank statements, pay stubs, copies of last tax return, employer statements, award letters, or support statements from others. The hospital reserves the right to verify all submitted documentation.

4. Make indigent/charity care determination prior to discharge whenever possible following the screening for other programs such as Medicaid.

5. Perform a financial analysis identifying eligibility resources for Medicaid, Vocational Rehabilitative Services, State funding, disability, etc. on all self-pay and underinsured patient accounts.

6. Applications are good for four months and can be used to include bad debt accounts which are no older than one year from the date of service.

7. Assist the applicant in the completion of the necessary forms for Medicaid and other community and state programs.

8. Applications will be submitted to the Patient Financial Services Director for approval.

9. The approved or denied determinations must be made within five (5) business days from the date of application.

10. Issue written notice to the applicant informing them of the results of the determinations. If an applicant is determined ineligible, include the reasons and the information you relied upon to make the determination.

11. Include in the notice information on how to be reconsidered if the patient disagrees with the initial decision. Someone different from the person who made the initial determination of eligibility will be appointed to reconsider the application.

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13. You must then issue a written final determination of eligibility. Include the information for Indigent Care Trust Fund, Division of Medical Assistance's toll-free telephone number 1-877-261-3117 or local 404-463-5827 to call if the applicant still disagrees with the determination you have made.

14. Applications are available to print from the Financial Assistance section at www.oconeeregional.com.

IV. Family Unit/Size:

A. The family unit consists of individuals living alone, with spouses, and parents and their children under age 21 living in the same household.

B. A family unit may include minor children living with a legal guardian. The child, legal guardian, and the legal guardian's family unit living in the same household may comprise a family unit.

V. Other Program Requirements:

A. Signs must be posted in all registration areas and the business office informing the patient of the availability of financial assistance.

B. Provide individual written notices to each patient potential eligible for free or reduced care. These written notices may also be included with letters and other billing forms. Include the information for Indigent Care Trust Fund, Division of Medical Assistance's toll-free telephone number 1-877-261-3117 or local 404-463-5827.

C. All notices and signs must be made available in both English and Spanish or any other language that might become necessary.

D. Staff is to communicate the notice information for those patients who might be unable to read.

All forms and notices are available from the financial counselor or available on NHB website. Exceptions should be rare and approved by management before using.

VI. Other Indigent/Charity Care Eligibility–Presumptive Eligibility

A. Patients/guarantors may qualify for free or reduced care even when we are unable to obtain the completed application. The following will service as a guideline in determining presumptive eligibility:

1. Other medical financial obligations.
2. The amount and frequency of healthcare services.
3. Types of services provided (e.g., elective vs. emergency).
4. The patients are usually unemployed and have a high probability that they are unemployable; homeless; do not meet eligibility requirements of other programs; or have a history of inability to pay.
5. Patient/guarantor demographics and credit reports may also assist in determining presumptive eligibility.
6. Accounts returned from Collection Agencies as uncollectible based on specific written criteria. At this time these accounts would be reclassified to Indigent.
7. Deceased patients without an estate or third party coverage to fully cover his/her medical care costs.
8. Patient's address (lives in a zip code known to have a per capita income below the FPG).
9. Terminal Illness.
10. Out-of-State Medicaid eligibility

B. There must be complete documentation of why the decision was made and criteria used to determine the level of financial assistance provided.

C. In cases such as these, you would follow the same steps listed above along with your recommendation as to the disposition of a bill supported by documentation.

D. This process always requires the approval of management.

VII. Indigent/Charity–Catastrophic Illness/Medical Bills

A. There may be circumstances which present where a patient's medical expenses are such that they are unable to pay them within a reasonable length of time or without extreme financial hardship. Cases such as this are classified as "catastrophic." The hospital performs an Income Test to determine if the patient may be eligible for free or reduce care using the following guidelines:

1. The Hospital will multiply the family income by 30 percent.
2. The Hospital will determine that patient's allowable medical expenses.
3. The Hospital will compare 30 percent of the family income to the total of the patient's allowable medical expenses.
4. If the total of the allowable medical expenses is greater than 30 percent of the family income, then the patient meets the catastrophic charity care qualifications.
   a. The Hospital will limit patient liability for medical expenses to 30 percent of the family's income.
   b. Amounts that exceed this limit will be eligible for charity care.
5. Example: A family's income is $70,000.00 per year and they have medical expenses of $45,000.00. Thirty (30) percent of the family's annual income is $21,000.00; the family's medical expenses of $45,000.00 exceed this amount. The Family should then be eligible for a charity write off of $24,000.00.

VIII. Government Eligibility

A. Interview/screen all self pay inpatients/walk ins/phone calls.

1. Screen for Medicaid eligibility
   a. LIM – children in the home.
   b. ABD – disabled patients who are eligible for spend-down.
   c. SSI/SSDI – patients who will be eligible for disability.

2. Screen for indigent/charity eligibility
   a. Household size.
   b. Household income.

c. Other assets/resources.

3. Screen for VOC (Victims of Crime)
   a. If patient is VOC, have them sign paperwork.
   b. Submit with itemized bill.
   c. Pick up police report and send in.

4. Have patients fill out necessary paperwork and go over the paperwork with patient.
   a. Outline what the process is and what they can expect from ORMC.
   b. Tell patient what documentation they need to return to ORMC.
   c. Ask all questions needed to complete a disability application.

5. If patient is not eligible for indigent/charity or government programs, go over payment options:
   a. Payment plan.
   b. Discount for PIF.
   c. Patient will be provided contact information to discuss available options.

IX. Process for Government eligibility

A. LIM – Medicaid for adults of children with extremely low income.
   1. Have the patient fill out and sign application.
   2. Gather documentation.
      a. Picture ID.
      b. Proof of income – food stamps, pay stubs, unemployment, child support, etc.
      c. Birth certificate, if born outside of Georgia.
   3. Submit application to DFACS in county of patient residence.
   4. Check status of case on weekly basis and document as necessary.
   5. Once patient has been approved for Medicaid, info is given to Medicaid biller to attach to account(s).
   6. If Medicaid has been denied, gather financial application from patient for indigent/charity care.

B. RSM – Medicaid for children and pregnant women.
   1. Have parent/guardian or pregnant woman fill out and sign application.
   2. Gather documentation:
      a. Picture ID.

b. Proof of income – food stamps, pay stubs, unemployment, child support, etc.
c. Birth certificate, if born outside of Georgia.
d. If applying for pregnant woman, must submit confirmation of pregnancy.
e. If applying for woman after delivery, must submit confirmation of birth.
f. If Applying for EMA, must have Physician sign 526 form.

3. Submit application to DFACS in county of patient residence.
4. Check status of case on weekly basis and document as necessary.
5. Once patient has been approved for Medicaid, information is given to Medicaid biller to attach to account(s).
6. A Retro-precert has to be obtained.
7. If Medicaid has been denied, gather financial application from patient for indigent/charity care.

C. ABD/Medically Needy – Medicaid spend-down for aged, blind or disabled who are over income for regular Medicaid, but can "spend-down" their current medical bills.
1. Have patient fill out and sign Medicaid application.
2. Gather documentation.
a. Picture ID.
b. Proof of income – food stamps, pay stubs, unemployment, child support, etc.
c. Birth certificate, if born outside of Georgia.
3. Submit application to DFACS in county of patient residence.
a. Submit with itemized bill.
b. If ongoing spend-down, just submit I-bill.
4. Check status of case on weekly basis and document as necessary.
5. Once patient has been approved for Medicaid, information is given to Medicaid biller to attach to account(s).
6. If Medicaid has been denied, gather financial application from patient for indigent/ charity care.
7. If patient approved for ABD spend-down, gather financial application to see how much the patient qualifies for to cover what their responsibility will be after Medicaid pays the "spend-down".

D. SSI/SSDI–Social Security Disability
1. Have patient sign all paperwork and help them fill out paper portion of application.
2. Interview patient.
a. Work history.
b. Medical history.
c. Marital history.
3. Fill out online application.

4. Fill out work/medical report online.
5. Submit paper application to local SSA.
6. Submit Log & Deny to DFACS to lock in Medicaid eligibility dates.
7. Periodically check status of case and document as necessary.
8. Respond to correspondence that is received from SSA and get necessary information from patient to SSA.
9. If patient is approved for SSI/SSDI, check for Medicaid eligibility.
    a. If approved for Medicaid, give to Medicaid biller to attach to account(s).
    b. If over income for Medicaid, follow ABD process to apply for Spend-down.

Financial Counselors have a procedure manual available in the department.

X. Miscellaneous processes–Monitoring of Assigned Accounts.
    A. Run reports monthly.
        1. In-house.
        2. FA.
    B. Combine accounts and set up payment plans.
    C. Respond to referrals from doctors/clinics.
    D. Refer patients to community clinics.

REVIEW RESPONSIBILITIES:

Chief Financial Officer
Revenue Cycle Director

FORMS:

None

REFERENCES:

None

APPROVAL SIGNATURES:

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VP Finance/CFO **Revenue Cycle Director**

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Policy and Procedure Review Committee

Revision Date: March 2007
May 2009
August 2010 (Policy Name Changed from Financial Counseling)
March 2013
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October 2017

Date:_____