Community Hospitals and Wellness Centers
CHWC Montpelier Hospital (CAH)
CHWC Bryan Hospital
CHWC Archbold Medical Center

PATIENT ACCOUNTS POLICY AND PROCEDURE MANUAL

DATE INITIATED: 12/94

REVISED: 07/98, 04/00, 03/02, 11/04, 10/06, 10/07, 06/11, 03/13, 6/13, 6/14, 11/15, 8/16

REVIEWED: 07/98, 04/00, 03/02, 11/04, 10/06, 10/07, 06/11, 03/13, 6/13, 6/14, 11/15, 8/16

SUBJECT: FINANCIAL ASSISTANCE PROGRAMS

PA0004

OBJECTIVE: In accordance with Community Hospitals and Wellness Centers core values of compassion, integrity, honesty, respect and accountability, CHWC has established a financial assistance policy to ensure that all patients receiving emergency and medically necessary care, will be provided the opportunity to apply for financial assistance. The financial assistance program will allow patients to meet their financial obligations, without undue financial hardship to the patient or the patient's family.

POLICY: It is the policy of Community Hospitals and Wellness Centers to provide emergency and medically necessary care (refer to Ohio Administrative code 5160-1-01), to all patients, without discrimination or regard to ability to pay (refer to hospital EMTALA policy ER000099). The hospital facility disallows actions that discourage individuals from seeking medical care.

It is also the intent of CHWC to provide financial assistance to all patients meeting the financial guidelines established within the hospital Financial Assistance Program. CHWC will make every effort to assure that patients are aware of the financial assistance options. CHWC will make information available regarding the policy and requirements to apply for Financial Assistance, to all patients receiving emergency and medically necessary care. This policy is applicable to all 3 locations of Community Hospitals and Wellness Centers, including Bryan, Archbold and Montpelier.

PROCEDURE:

Definitions:

Amounts Generally Billed (AGB) – The amount generally billed to a CHWC patient who has insurance coverage as defined in IRS Section 501 (r)(5)

EMTALA - Federal emergency Medical Treatment and Active Labor Act

Financial Assistance – Discount or elimination of payment for health care services provided to eligible patients with documented and verified financial need.

Plain Language Summary – Summary of financial programs offered by CHWC and process for applying for financial assistance.

Application Process – A process by which a patient or their appropriate representative completes a for with information on the patient's income, family size and assets. All completed applications will be evaluated by a CHWC Patient Representative for eligibility for a financial discount.

Extraordinary Collections Actions – Actions which require a legal or judicial process, reporting adverse information to credit agencies or bureaus. CHWC will determine charity eligibility prior to taking any extraordinary collection actions. Written notice must be provided at least 30 days in advance of initiating specific ECAs.

Federal Poverty Guidelines (FPG) – Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services and in effect at the date(s) of service for which financial assistance may be available.

Gross Charges – The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Gross Income - An individual's income before tax and other deductions are applied.

Notification Process:

All patients registering for emergency or medically necessary care will be offered a financial application and "plain language summary" at the time of registration. CHWC will also follow up with uninsured patients within 3 to 4 weeks of service, if a financial application is not received or Medicaid application is not completed by that date. Follow up consists of a phone call to offer the patient assistance with the Medicaid application and discuss financial assistance options.

Patient billing statements include on the back side, information on the HCAP and hospital financial assistance programs, including current poverty levels, as required by HCAP policy. The options for requesting a financial application are also listed on the statement. Reference to the financial assistance information will be clearly noted on the front side of the statement.

The plain language summary, financial application, Billing and Collections Policy, and this Financial Assistance policy are displayed on the hospital website.

In compliance with the 5-percent/1000 person threshold under the HHS guidance safe harbor and 501r regulations, the Spanish version of the FAP, financial application and Plain language summary is also available at all hospital locations and on the hospital website.

Signage is posted at all 3 hospital buildings in customer areas including Admissions Office, Billing Office, Cashier area and Emergency Department. The signage will provide information on the hospital financial program and the application process.

Copies of the financial application and Plain language summary are distributed to the Compassion Clinic in Williams County. This is a 'Free Clinic' and patients are encouraged to complete the application if they need follow up services at the hospital.

CHWC will periodically include information on the hospital financial assistance policies, in the quarterly newsletter that is mailed to residents in the 4 county area.

Methods of Applying for Financial Assistance:

Financial applications may be requested by insured and uninsured patients, by calling the Patient Accounts office at 419-630-2149 or emailing a request to Patient Accounts at billing@chwchospital.org. Applications can also be picked up at the admissions office at all 3 locations at any time. Patients may also download the financial application from the hospital website at URL: https://www.chwchospital.org/patient-services/chwc-financial-assistance/ . Completed applications can be dropped off at the admissions office of all 3 locations, or mailed to the CHWC Patient Accounts office at the Bryan address listed on the financial application.

Eligibility Criteria:

Services must be considered as emergent and/or medically necessary care. CHWC follows Ohio Medicaid policy in determining services that meet medical necessity (reference Ohio Administrative Code 5160-1-01). Most cosmetic surgery is not considered to be medically necessary.

A patient must complete a financial application to be considered for financial assistance, with exceptions noted below. For patients eligible for the Ohio HCAP program, financial applications will be accepted and processed for up to 3 years after the date of service. For patients above the HCAP income levels, CHWC will accept financial applications for a minimum of 240 days after the initial patient statement date.

For the HCAP program, a new financial application must be completed every 90 days for out-patient services, based on the date of service of the eligible account. In-Patient visits require a new application 45 days after the initial in-patient date of service. For the hospital financial assistance program, a new financial application must be completed every 90 days for in-patient and out-patient services.

CHWC may accept verbal clarifications of income, family size or any information that may be unclear on an application. The Person receiving the information will note 'verbal from XXX' and initial the update.

Uninsured patients are strongly encouraged, but not required, to apply for Medicaid or insurance through the Health Insurance Marketplace, before consideration of a financial

discount. If a patient has applied for Medicaid and has completed a financial application, financial discounts will not be applied until a final eligibility determination is received from Medicaid.

Basis for Calculating Amounts Charged to Patients:

A patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the AGB percentage. The AGB (amount generally billed) will be calculated by CHWC annually and will be incorporated into the hospital charity levels within 30 days of publication of the new poverty levels. The AGB will be based on the Look-back Method (as defined by the Treasury Regulations under section 501r of the Internal Revenue Code of 1986). The current Amount Generally Billed amount for Bryan and Archbold Hospitals is 56% and Montpelier Hospital is 88%. The hospital minimum charitable discount is 50%.

Discounts are generally determined by a sliding scale of gross income, based on the Federal Poverty Guidelines. Federal poverty levels are issued each year in the Federal Register by the Department of Health and Human Services. Current and historical Federal Poverty Levels are available at http://aspe.hhs.gov/poverty/index.cfm. Bank account balances exceeding 200% of the total amount eligible for a discount, will reduce the discount % by 1 level, unless an exception is approved by Administration and the Board of Directors. Following are the CHWC charity discount levels based on the Federal Poverty Guidelines

101% - 200% of FPG = 100% adjustment
201% - 250% of FPG = 75% adjustment
251% - 300% of FPG = 50% adjustment

The income and sliding discount levels by family size are included as an appendix to this Financial Assistance Policy. The discount levels for patients eligible for charity are updated yearly, after the poverty levels are published and after CHWC completes calculation of the AGB (average generally billed).

Ohio residents with gross income at or below the Federal Poverty Level, are eligible for a 100% write off of medically necessary gross charges or patient balances following insurance payment, under the HCAP program.

Following is information on the criteria used to determine eligibility for the HCAP program and the Financial Assistance Program.

<u>HCAP</u>

1. The guarantor/patient was a resident of Ohio on the date of service.
2. The guarantor/patient provides written documentation that the family income is at or below the federal poverty level. The federal poverty levels are usually updated each year. The new levels are updated on the hospital HCAP forms and are applicable to any accounts with dates of service as of the date the new poverty guidelines are published. Income includes total salaries, wages and cash receipts before taxes. CHWC will follow the guidelines in "OAC

5160-2-07-17" to determine amounts included as income.

3. For visits with date of service on and after 12/14/2000, the guarantor has 3 years from the date of service to apply. For visits with date of service prior to 12/14/2000, there is no time limit to apply for HCAP.
4. Only basic medically necessary hospital level charges can be adjusted off to HCAP. Professional fees and charges with revenue codes not listed in the Medicaid covered UB04 revenue code list are not eligible for HCAP adjustments. Reference "OAC 5160-2-07.17".
5. Any charges covered by either state plan Medicaid or managed care Medicaid plans are not eligible for HCAP.
6. The family size includes the parents, spouse and all children, natural or adoptive, under the age of 18 and living in the home. Step-parents and step-children, in relationship to the patient, are not included. Both person's of the same sex who are legally married in another state are counted when determining family size. For additional clarification on family size determination, refer to "OAC 5160-2-07.17".
7. When the patient is a child under the age of 18, both natural or adoptive parents income is included in determining total family income. If a parent does not live with, have any communication with or provide any type of support to the family, this information should be documented on the financial application, and the income for the parent with all rights and responsibility for the child is the only income counted. The family size will include the parent that is not providing any financial support to the family.
8. For patients over the age of 18 with a spouse that is not living in the household, and does not or will not contribute to the family's income, the patients income alone will be counted to determine income level. The patient is asked to provide written and signed notification that the separated spouse does not provide any financial income to the household. The separated spouse is included with the family size, regardless if he/she is providing any income.
9. Proof of income, if available, for either the 12 months or 3 months multiplied by 4 prior to the date of service, is included with the application. Income is figured based on gross income. If the patient fails to write the income on the HCAP application under the 3 month or 12 month column, but provides exact proof of income for the months, the Rep may note the income on the application. If the patient fails to write the income on the application and does not provide exact proof of the required months, the Rep will either return the form to the patient to complete, or contact the patient by phone to get the income amount and note it on the application. One of the following verifications of income is necessary to determine a patient's eligibility for HCAP write off. An attempt should be made to obtain the information listed first and if unavailable, the 2nd listed support of income may be used. As a last resort, if no other proof is available, a signed statement is acceptable.

    a. A copy of the pay check stubs or a letter from the employer giving the patient's income for the 3 month or 12 month period prior to the date of service. The hospital will use whichever figure makes the patient HCAP eligible.
    b. Federal income tax returns or W2s from the most recent year, noting the current year income, but using the tax return/W2 as a back up for the income listed. Block 5 of the W2 and block 22 of the 1040 are used to determine yearly income. This will not provide exact proof of income but will support the income information listed by the patient on the application.
    c. A signed, sworn statement or affidavit declaring the applicant's income for the 3 months

or 12 months prior to the service date, and an explanation of how the patient is surviving financially when –0- income is reported.

Financial Assistance

1. Current gross income is used to determine the level of discount, and income for the months prior to service, or expected income for the months following the date of service can be used to support any additional discounts that may be appropriate through the exceptions process. The Patient Accounts Director may also use bank balances and other written documentation about the family's financial situation, to request a higher discount through the exceptions process.
2. Any proof of income provided with the application is reviewed to verify accuracy with the written information on the application. Proof of income is not required for the hospital charitable assistance program but is usually provided to determine if the patient is eligible for HCAP.
3. Block 5 of the W2 and block 22 of the 1040 are used to determine total yearly income.
4. The family size determination varies from the HCAP program. Step-children and step-parents, in relationship to the patient are included if they reside in the same home. Also, children over 18 are included in family size, if the child is still supported by the parent (child is still a student).
5. If a patient is separated from his/her spouse and written proof is provided indicating that the separated spouse does not provide any financial assistance to the household, the income of the patient alone may be used to determine financial assistance.
6. Child support paid is subtracted from gross income to determine the appropriate income level, when the child is not included with the family size. Child support received is added to the gross income when the child is included with the family size. If a child is the patient and is in a family with split custody, with no child support paid by either parent, and the parent responsible for paying the medical bills applies for financial assistance, the child is counted as ½ when determining the family size. A discount level ½ way between the income level for the family size including the child, and the income level for the family size excluding the child, is figured and used to determine the charity level. Add the 2 discount levels together and divide by 2 to determine the amount that is ½ way between the 2 figures. If there is an even number of children in the family, count ½ of the children to figure family size, when there is split custody, and one parent is responsible for paying the medical bills. When a child is the patient and is in a family with split custody with no child support paid, and both parents are responsible for paying the medical bill, both biological parents income should be obtained and the family size will include the child, both biological parents and any other biological or adopted siblings to the patient.
7. The patient's checking and savings account balances (or parents if the patient is a minor) are reviewed to determine if resources are available to pay on the outstanding balances. A general guideline is followed to determine a reduction in the discount level based on the patient's checking and savings account balances. If 50% of the savings and checking account balance is equal to or greater than the outstanding account balance, the percent of discount determined by the income may be reduced by one level, unless the Patient Accounts Director, CEO or CFO determine other circumstances allow the full discount with no reduction.

Financial Assistance for Catastrophic and other extenuating circumstances:

The hospital President/CEO or EVP of Finance may also determine a visit to be eligible for financial assistance, based on information they have received from the patient that may or may not include the financial application. The President/CEO or EVP of Finance will provide written notice to the Patient Accounts Director to apply the discount.

Presumptive Eligibility:

Visits determined to be charity eligible through the I-Solutions program, will receive charity discounts according to the "self pay/collection policy". I-Solutions is an electronic screening process that provides a score relating to the patient's ability to pay.

Presumptive eligibility is determined immediately prior to sending an account to collections. Patients receiving a financial discount from the I-Solutions process may also complete a financial application to determine eligibility for a higher discount, as long as the application is completed within 240 days of the 1st statement date. The patient does not receive notification of the charity discount applied based on presumptive eligibility as the account has already met the hospital guidelines for placement with a collection agency and is immediately forwarded to the agency for collection of the remaining balance. The collection agency will encourage completion of a financial application, if they determine the patient is likely eligible for financial assistance, regardless if the account has already received a discount based on presumptive eligibility.

Refunds:

If a patient completes a financial application within 240 days from the 1st statement date and is eligible for a discount, patient payments that exceed the patient amount due following eligible charity discounts, will be refunded to the patient.

Notification of eligibility status:

For patients completing a financial application, letters are sent informing the patient/guarantor of financial assistance eligibility. Letters are also sent to patients/guarantors that do not qualify for financial assistance.

Patient Cooperation:

CHWC will attempt to contact patients to obtain information needed for incomplete financial applications. Contact will include a minimum of 2 phone calls followed by mailing of a completed information request form to the patient/guarantor. A standard form is used to clearly identify the additional documentation required to process the financial application. If the patient does not cooperate with providing the additional information, the financial application will be moved to an 'incomplete' file and noted on the patient account. The incomplete application will be held, and the requested information will be accepted through day 240 from the initial patient statement date. CHWC will not apply financial discounts to accounts that are pending insurance. Patients are required to cooperate with insurance requests before their account can be considered for financial assistance.

Actions in the event of non-payment:

Actions taken in the event of non payment or lack of cooperation with the financial assistance process are listed in the 'Self Pay Billing and Collection Policy". This policy is also available at the following URL: https://www.chwchospital.org/patient-services/chwc-financial-assistance/ , on the hospital website.

Providers Covered by the Financial Assistance Policy:

This policy is applicable to services received at all 3 locations of Community Hospitals and Wellness Centers including Bryan, Montpelier and Archbold, including physicians billed by CHWC.

Following is a list of providers that are not billed by CHWC but provide services associated with CHWC, along with information if the provider accepts financial discounts determined from the financial applications processed by CHWC.

Providers Covered by the Financial discount determined by CHWC:

- Samaritan Emergency Physicians
- Dr. Michael Nosanov
- Dr. Jodi Tinkel

Providers not covered by the Financial discount determined by CHWC:

- Fort Wayne Radiology
- Dr. Thomas Kindl
- Dr. Daniel Murtaugh
- Parkview Physicians Group of Ohio
- Toledo Radiation Oncology

DOCUMENTATION:
Not applicable

REFERENCES:
Not applicable

APPROVALS:
Board of Directors: 07/11, 04/13, 06/13, 7/14, 11/15, 8/16