Financial Assistance – HCAP and Charity

Title:	**Financial Assistance – HCAP and Charity**
Applies to:	**Memorial Health System**
Department:	**Finance; Patient Access; Physicians Care Express; Physician Clinics; MHCPI**
Date Reviewed:	**5/3/2021**
Reviewer:	**Melissa Athey**
Date Revised:	**12/1/2020**
Reviser:	**Melissa Athey**
Document Type:	**Policy**

I. Policy Statement: In keeping with is founding mission, Memorial Health System provides financial assistance to those without the financial resources to fulfill their payment obligations for medically necessary health care services received at Memorial Health System facility (see listing of covered facilities). To provide financial assistance to individuals with income below/above the Federal Poverty Guidelines (FPG) and lacking the resources to pay for all or a portion of their health care services at Memorial Health System (MHS).

a. Determination Process:

i. Appling for financial assistance includes these steps:

1. Complete and submit the financial assistance application, including any required documents. Please see Access to Policies and Financial Application section on how/where to obtain the application.
2. Income, family size, and state of residency, will be reviewed to determine the level and/or type of assistance available.
3. Patients will be encouraged to pursue other resources/insurance available.
4. MHS will contact patients to communicate whether or not financial assistance is available or if additional information is needed.
5. Payment plans can be arranged for remaining balances due or for services not eligible for financial assistance.

b. Definitions:

i. AGB: Amounts Generally Billed for emergency or other medically necessary services to patients who have insurance. AGB are updated annually by MHS.

ii. Charity: A hospital specific financial assistance program based on FPG and AGB.

iii. FPG: Federal Poverty Guidelines established by the U.S. Department of Health and Human Services. FPG are updated annually.

iv. HCAP: Hospital Care Assurance Program is specific to the State of Ohio and sets forth the criteria to provide free medically necessary services to patients who are residents of Ohio with income below the FPG.

v. Insured: Patients with insurance or other third party coverage.

vi. Uninsured: Patients with no insurance coverage.

c. Covered Facilities: This policy applies to the following:

i. Marietta Memorial Hospital (includes hospital-based clinics/physicians and Belpre)

ii. Selby General Hospital

iii. Medac (Anesthesia Services)

iv. Professional Billing Services (Dr. Macatol)

v. RevMD (Early out/Collections representative for MHS)
vi. Riverside Radiology (Imaging Services)
vii. Non-hospital based clinics/physicians in private practice are not covered under this policy.

d. Emergency Services:

i. All patients shall receive, without discrimination, care for emergency medical conditions, screening examinations, stabilizing treatments, and referring/transferring to another facility when appropriate regardless of ability to pay or whether they are financial assistance eligible. Please see the "EMTALA – Medical Screening" policy for additional information.

e. Eligible Services:

i. Emergency Care and Medically necessary services are covered under this policy. Services not covered include: services deemed not medically necessary, cosmetic services, bariatric services, infertility services and charges with non-covered revenue codes per the Ohio Administrative Code Appendix A.

f. Access to Policies and Financial Assistance Application: The application and policy are available at:

i. At MHS 401 Matthew Street, Marietta, Ohio 45750
ii. At SGH 1106 Colegate Drive, Marietta, Ohio 45750
iii. At MHS 802 Wayne St, Marietta, Ohio 45750
iv. At MHS 807 Farson St, Belpre, Ohio 45714
v. Financial Counselor at (740) 568-5263
vi. Public website: www.mhsystem.org
vii. Email request to: financialassistance@mhsystem.org

g. Amounts Generally Billed:

i. A patient eligible for financial assistance under this policy will not be billed for full gross charges or amounts generally billed. MHS uses the "Look-back Method" as set forth by the IRS 501r regulations to determine the amount generally billed and is reflected in the sliding scale used to apply the charity discount. Annually, MHS evaluates the AGB and adjusts the sliding discount scale accordingly.
    1. Family Income at 0 to 400% of FPG
        a. Full Financial Assistance: $0 is billable to the patient depending on family size.
        b. Partial Financial Assistance: AGB is maximum billable to the patient up to 400% of FPG depending on family size.

h. Actions taken for non-payment:

i. Please refer to the Billing and Collections policy which explains the actions MHS may take if a medical bill for services is not paid. MHS offers other options for patients who do not qualify for financial assistance under this policy. For further information please refer to the Billing and Collections Policy which covers discounts, payment plans, etc. and is available at mhsystem.org or by contacting a financial counselor.
ii. Applications will not be accepted for accounts included in an MVA suite or lawsuit in which the patient received the settlement payment directly and deemed responsible to pay the related medical debt to MHS

iii. Applications will not be accepted for accounts that have aged to collections and have reached a status that MHS is pursing thru legal actions.

i. MHS offers two financial assistance programs:

i. HCAP: This program is specific to the State of Ohio and the patient must be a resident of Ohio and have income below the FPG to be considered for eligibility. The Ohio Administrative Code sets forth the requirements for this program.

1. HCAP Requirements:
    a. Residency: Must be a resident of the State of Ohio on the date of service.
    b. Family Size: "Family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s) children, natural or adoptive under the age of eighteen who live in the home.
    c. Income: "Income" shall be defined as total salaries, wages, and cash receipts before taxes; receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Income will be calculated by multiplying by four (4) the person's or family's income, as applicable, for the three (3) months preceding the date of hospital services were provided or twelve (12) months of income prior to the date of services, which ever helps qualify the patient.
    d. Assets: None.
    e. Application: A complete application is required prior to determination of eligibility. The application must contain income, family size and eligibility for the Medicaid program. The patient or a legal representative is required to sign the application. If the application is not signed, a hospital representative must document the reason as to why it is not signed.
    f. Eligibility Period: For outpatient hospital services, a hospital may consider an eligibility determination to be effective for three (3) months from the initial service date, during which a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five (45) days of discharge for the same underlying condition.
    g. Application Period: MHS will accept application for services without charge until three (3) years from the first statement date. Collection efforts will be suspended upon receipt of the application until the application is considered complete, approved, or is denied.
2. Charity: This program is hospital specific and patients are evaluated based on income and family size, and where the patient lives is not a factor. MHS uses a sliding discount scale based on the FPG to apply charity/financial assistance awarded.
    a. Charity Requirements:
        i. Residency: None

ii. Family Size: "Family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, and biological minors that reside in a household, that are financially supported by a biological relative due to the absence of the parent. Child will count in family size and income will be calculated for the household.

iii. Income: "Income" shall be defined as total salaries, wages, and cash receipts before taxes; receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Income will be calculated by multiplying by four (4) the person's or family income, as applicable, for the three (3) months preceding the date hospital services were provided or twelve (12) months of income prior to the date of service, which ever helps qualify the patient. Documentation for proof of income is required; patient must provide paycheck stubs, tax return, etc. as requested.

iv. Assets: While this is an income based program, there are Medicare guidelines requiring the documentation of assets. The Value of Assets section of the application must be completed and support provided as requested for consideration.

v. Application: A complete application is required prior to determination of eligibility. The application must contain income, family size and eligibility for the Medicaid program. The patient or a legal representative is required to sign the application. If the application is not signed, a hospital representative must document the reason as to why it is not signed.

vi. Eligibility Period: An approved application is valid for six (6) months from the initial date of service, providing there have been no changes in income, family size, etc.

vii. Application Period: MHS will accept application for services without charge until three (3) years from the first statement date. Collection efforts will be suspended upon receipt of the application until the application is considered complete, approved, or is denied

j. Refund of Patient Payment:

i. If a patient qualifies for HCAP, all patient payments made must be refunded and can't be applied to other outstanding account balances. If a patient qualifies for Charity, patient payments in excess of AGB must be refunded (unless <$5.00). Patient payments for non-eligible services or non-covered facilities do not have to be refunded.

k. Other Considerations:

i. MHS may elect to re-evaluate applications not approved for financial assistance based on the Charity requirements above. In situations such as hardship, catastrophic circumstances, etc. MHS may grant Charity to all or a portion of the patient's medical bill.

ii. Uninsured patients or patients with no third-party insurance coverage may receive an uninsured discount off total charges and are not subject to above referenced financial application and approval procedures (Please see Patient Financial Obligation policy for details). Should a patient be classified as financially or medically indigent, the uninsured

discount will be reversed, and the applicable charity adjustment be posted for the appropriate charity discount.

iii. Patients with out of network insurance, electing to seek services at MHS are excluded from charity assistance. Reference Out of Network Financial Clearance Policy.

l. Attachments: Financial Assistance Application and Charity sliding discount scale.

m. Presumptive Charity Care:

i. Patients are presumed to be eligible for financial assistance on the basis of individual circumstances as documented below. Patients determined to have presumptive financial assistance eligibility will be provided 100% financial assistance. Presumptive charity criteria include:

1. Patients discharged to a skilled nursing facility
2. Patients who are deceased with no estate
3. Patients who have documented homelessness
4. Patients eligible for WIC, food stamps, or other federal/state subsidy program
5. Patients who are deemed indigent based on propensity to pay
6. Patients determined for SLMB thru Medicaid, verified by eligibility tool

ii. MHS may also use a tool/vendor to determine propensity to pay in evaluating accounts for presumptive eligibility. MHS works with an outside vendor to score analytics to segment, process and work receivables on accounts. They use a blend of tools and databases to create and assign this score. It is a combination of traditional payment incidence score, historic payment trends and fresh credit data per guarantor to develop a propensity to pay score. In a score range of 400 to 800, the lower score i.e. 480, indicate a guarantor's lack of propensity to pay when combined with "no" payment history and "self-pay" as a data markers. Accounts with a score of <480 will be adjusted to the presumptive eligibility code.

n. Catastrophic: MHS has limited Catastrophic financial assistance for patients at the Strecker Cancer Center and Wound Center patients whose medical (condition) debt and/or changes to income have caused extreme financial hardship. Financial assistance may result in a full or partial discount depending on the review of the patients' income, assets, and situation. The patient must submit a financial assistance application complete with income and asset information, along with a brief summary outlining the hardship situation, including medical indebtedness. These applications will be reviewed/approved by the Financial Assistance supervisor and the patient will be notified accordingly of the decision, if applicable, and any remaining balance due.

II. References: Non-applicable.

Approved By: Chief Financial Officer

Endorsements:	**Finance Committee**
Regulating or Accrediting Organization:	**Standard**
Healthcare Facilities Accreditation Program (HFAP)	**# :**
Ohio Department of Health (ODH)	**# :**

Centers for Medicare and Medicare Services (CMS)	**# :**
Other:	**# :**