MAGEE GENERAL HOSPITAL

CHARITY CARE COVERAGE AND FINANCIAL ASSISTANCE POLICY

ELIGIBILITY CRITERIA:

The following patients will be eligible to qualify for partial or full charity care coverage:

1. Any patient presenting qualifying evidence that his or her household’s income is between 0‑400% of the federal poverty guidelines applicable for the year prior to the year that service was provided.
2. Any patient that presents qualifying evidence that his or her household income has changed significantly from the years prior tax return and provides current information that meets Magee General Hospitals FPL guidelines.

A patient qualifying for charity care coverage will receive a discount of the patient’s hospital bill for emergency and other medically necessary services not covered by insurance.

“Household income” is all income from active or passive activities for all members of the household.

Evidence of FINANCIAL eligibility:

Magee General Hospital will accept the following documentation as evidence of financial eligibility for charity care coverage:

1. Copy of the patient’s tax return for the year prior to the year the service was provided;
2. Acceptable verification from employer(s) of the patient’s household income at or below the applicable federal poverty level for the year prior to the year the service was provided, or verification of income exceeding no more than 400% of the federal poverty level;
3. Signed notarized letter stating that patient’s household had no income in the year prior to the year the service was provided; or
4. If the patient is a dependent of another person, that person’s information as listed in items 1, 2, and 3 above.

CriterIA For DISSEMINATION:

1. Any uninsured patient admitted through the ER or as an inpatient will be given a charity care application by the admitting office free of charge.
2. Any patient identified as uninsured after admission will be given an application free of charge.
3. Any patient who in a phone call states that he or she is unable to pay the hospital charge may be told that he or she may apply for charity care coverage by completing the application and attaching the appropriate evidence of financial eligibility.
4. The application is available online, at request from a Registrar or Financial Counselor, and in hardcopy in the main lobby of the hospital (all free of charge).

UP-FRONT CHARITY APPROVAL

1. Patients who present at registration for medically necessary services can apply for presumptive eligibility with the assistance of the “Affordable Balance Worksheet” which considers the patient’s portion over the Federal Poverty Level threshold. These parameters are outlined in the Hospital’s “affordability calculator” and shall be approved by a Charity Committee Member. These patients can be granted temporary upfront eligibility until a full determination is completed either by the full committee or the outsourced charity vendor.

PROCESS:

1. A patient requesting charity care coverage will be asked to complete the Application for Charity Care Coverage and provide the information described under “Evidence of Financial Eligibility” above.
2. Using the Eligibility Criteria above as a guide, the Magee General Hospital Charity Committee will evaluate the patients’ Applications for Charity Care Coverage on a monthly basis.
3. Magee General Hospital personnel will use the federal poverty level information available for the year prior to the year that the service was provided in determining a patient’s eligibility to receive charity care coverage.
4. Magee General Hospital personnel may contact the patient’s employer, if any, to verify the patient’s uninsured status or may request additional documentation of income.
5. Magee General Hospital will perform a third-party review of all Private Pay accounts registered the previous month on a monthly basis, to check for patients who are eligible for charity care. Patients identified as eligible, will have their account balance adjusted to charity.
6. Magee General Hospital will perform a third-party review of all Private Pay accounts returned as uninsured after billing on a monthly basis, to check for patients who are eligible for charity care. Patients identified as eligible, will have their account balance adjusted to charity.
7. Magee General Hospital will notify all patients who fill out the Charity application and are approved for charity through mail, that their accounts have been adjusted to charity.
8. Patients who are approved for charity coverage either through application or through the third-party private pay review will not be subject to extraordinary collection activities, which are described in the MGH Collection Policy. This policy is available on request from the MGH Financial Counselor free of charge.
9. This policy applies to patients without regard to the patient’s race, gender or creed.
10. Magee General Hospital will periodically review this policy and procedure to determine whether the charity care coverage is permissible under federal and state law. Magee General Hospital will strive to keep this Charity Policy consistent with all governmental guidelines applicable to our facility.

**PROVIDERS EXCLUDED AND INCLUDED FROM THE CHARITY CARE POLICY:**

The Internal Revenue Service (IRS) regulations defined under 26 CFR Parts 1, 53, and 602 (Federal Register Volume 79, 250) require Magee Benevolent Association to list all providers excluded from the Charity Care Policy for Magee General Hospital. In accordance with this requirement, the providers excluded from the Charity Care Policy for Magee General Hospital are as follows:

All services provided by physicians not employed by Magee General Hospital which includes but not limited to:

* All services provided by Keystone Healthcare Management and ERX
* All services provided by the Radiological group
* All services provided by the Southern Anesthesia Group
* All professional services provided by Restorix Health
* All professional services provided by Healthcare Plus, LLC
* All services provided by VRC radiology group

All services provided by physicians employed or contracted by Magee General Hospital which includes but not limited to:

* All services provided by Comprehensive Radiology Services, PLLC

CHARITY COMMITTEE

**REVENUE CYCLE DIRECTOR**

**BUSINESS OFFICE DIRECTOR**

**BUSINESS OFFICE BILLING MANAGER**

**FINANCIAL COUNSELOR**

**CONTROLLER**

**HIM DIRECTOR**

**AP/REVENUE SPECIALIST**

A copy of Magee General Hospital’s Billing and Collections Policy is attached.

**POLICY NUMBER:**

**TITLE:  Patient Billing and Collections Policy**



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| --- |
| **EFFECTIVE DATE:     3/1/19 REVISED DATE:                      RETIRED DATE:** |
|  |
| **ORIGINATING DEPARTMENT: Business Office ORIGINATION DATE: 2/12/19** |
|    |
| **APPROVED BY:  Hospital Board APPROVAL DATE: 2/27/19**  |
|  |

**POLICY: Patient Billing and Collections Policy**

**PURPOSE:** Magee General Hospital and associated clinics is a not-for-profit hospital committed to providing high quality and affordable health care services to the communities we serve. All patients/guarantors will be treated equitably, with dignity, with respect, and with compassion during the billing and collections process.

**PROCEDURE:**

**I. PATIENT PAYMENT EXPECTATIONS AND REQUIREMENTS**

 The hospital will provide, without discrimination and in full compliance with the Emergency Medical Treatment and Labor Act (EMTALA), care for emergency medical conditions to individuals regardless of their eligibility for charity care, financial assistance or government assistance. Patients with the ability to pay are expected to pay for their health care, including the requested co-pay, any co-insurance, deductible, and, for some services, a deposit, at the time of service. When necessary, patients are expected to participate in and adhere to interest-free payment plans for prior, current or future services. Regardless of their insurance status, patients without the ability to pay for some or all of their care are expected to request financial assistance or make their inability to pay known to the hospitals so that their financial status can be verified. The hospital’s Business Office may be contacted at (601) 849-7337. A copy of this Policy as well as a copy of the hospital’s Charity Care and Financial Assistance Policy may be reviewed on the company web site at [http://www.mghosp.org](http://www.mghosp.org/getpage.php?name=financialservices&sub=Financial+Services). Patients requiring assistance may download and print a copy of the hospital’s Charity Care and Financial Assistance application from the company web site or may request a paper copy by contacting the hospital’s Business Office.

**II. AMOUNTS GENERALLY BILLED (AGB)**

**Amounts Generally Billed (AGB):** The AGB is based on an average percentage using one year of paid claims data for all insurance plans. The AGB includes the full amount allowed by insurance plans, the amounts insurance plans paid and the amounts owed by patients. As required by law, the availability of the hospital’s AGB for Uninsured patients shall not form any part of any advertisement or solicitation to potential patients or referral sources. If a patient obtains approval for charity care or financial assistance as outlined in the hospital’s Charity Care and Financial Assistance Policy, they may be eligible for discounts in lieu of the hospitals’ AGB.

 **III. PATIENT BILLING AND PRE-COLLECTIONS PROCESS**

1. **Billing Statements:** For balances due for services rendered to patients by the hospital, the hospital and/or a third-party vendor will collectively mail to the patient or the patient’s guarantor a minimum of two (2) billing statements followed by two (2) letters for patient/guarantor balances. Each billing statement will include a brief statement, in easily-understandable language describing the services rendered, date of services, charges for such services, balance due on the account, and a telephone number and contact information to connect the patient or patient’s guarantor to the hospital’s Business Office. To make patients aware of the hospital’s Charity Care and Financial Assistance Policy, the billing statements will also advise patients how to obtain information regarding charity care and financial assistance.
2. **Telephone Contact to Patients**: Concurrently with the billing statement process previously outlined, balances may be pursued by method of telephone calls to reach the patient or the patient’s guarantor. The method making telephone calls to a patient or the patient’s guarantor may include calls made by the hospital’s internal staff within the Business Office or by use of an outside vendor working on behalf of the hospital. Telephone contact with the patient or the patient’s guarantor is intended to supplement the billing statement process to ensure all patients are aware they have an outstanding balance with the hospital and aware of the available payment options. All calls will be made in a professional manner that is consistent with the goals and objectives of the billing collection process of the hospital.
3. **Payment Plans**: If a patient is unable to pay a balance in full after receiving a billing statement, they may establish an interest-free payment plan by contacting the hospital’s Business Office. The terms of a payment plan are at the discretion of the hospital’s Business Office.
4. **Payment Plan Modification Availability:** If a patient or the patient’s guarantor is having difficulty meeting the financial demand of an established payment plan, they may request a modification of the established payment plan.
5. **Payment Plan Default**: If a patient or the patient’s guarantor has defaulted on an established payment plan, the hospital’s internal staff or vendor may attempt to contact the patient or the patient’s guarantor to notify them of their payment plan default and seek payment in full.
6. **Presumptive Charity Care and Financial Assistance:** There are instances when a patient may appear eligible for charity care or financial assistance, but there is no financial assistance application 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 or financial assistance. In the event, there is no evidence to support a patient’s eligibility for charity care or financial assistance, the hospital will make reasonable efforts to determine whether the individual is eligible for assistance prior to engaging in any extraordinary collection activities (ECA). Presumptive eligibility may be determined based on individual life circumstances that may include:

1. Gross income as a percent of the Federal Poverty Level (FPL);

2. State-funded prescription programs;

3. Homeless or received care from a homeless clinic;

4. Participation in Women, Infants and Children programs (WIC);

5. Food stamp eligibility;

6. Subsidized school lunch program eligibility;

7. Eligibility for other state or local assistance programs that are unfunded (e.g. Medicaid spend-down);

8. Low income/subsidized housing is provided as a valid address; and

 9. Patient is deceased with no known estate.

Refer to the hospitals’ Charity Care and Financial Assistance Policy for additional details regarding the sliding scale discounts available to patients.

1. **Uninsured Discount:**  Magee General Hospital has a commitment to providing care to patients that are in the greatest financial need. Patients who do not have governmental or private insurance coverage are eligible for an Amounts Generally Billed (AGB) discount for medical care and services. This uninsured discount does not relieve any point of service payments that may be required to pay.
2. **Conduct and Documentation:** All contacts with patients or the patient’s guarantor regarding their financial responsibility will be handled respectfully, and all accounts will be pursued with the intent of being fair and consistent in the application of this Policy. All contacts with patients or the patient’s guarantor will be documented with sufficient detail [in the notes section of the patient’s billing record] so that any person who subsequently contacts the patient or the patient’s guarantor regarding a balance owed can follow-up on any prior conversations. In addition, all telephone inquiries will be recorded for quality review purposes.

 **V. PATIENT COLLECTIONS (BAD DEBT) PROCESS**

Sending an account to collections (also known as Bad Debt) will be used only after the hospital has taken the steps as described in this Policy to advise the patient of their outstanding balance with the hospital or the patient, or the patient’s guarantor, has refused to cooperate or been unresponsive in establishing a payment plan, modifying a payment plan, or adhering to an established plan.

1. **Pre-Placement:** If the patient or the patient’s guarantor fails to pay the balance owed in full or to establish a payment plan by the one-hundred and twentieth (120) day following the date of the hospitals’ first post discharge billing statement mailed, the account will be recommended for external collections once the account has exceeded 121 days post discharge and 121 days following the hospital’s first post discharge billing statement mailed.
2. **Post-Placement:** Once the account has been sent to a collection agency, the agency will follow collection processes for a period of at least two-hundred and forty (240) days following the date of the hospital’s first post discharge billing statement mailed before reporting any outstanding balances to a credit bureau. Accounts that are $2,000 or less at the agency more than 120 days without a payment being received will be returned. Accounts that are greater than $2,000 at the agency more than 365 days without a payment being received will be returned.

 **VI. USE OF VENDORS**

 Any vendors used to implement this Policy shall be contractually required to adhere to the standards of this Policy, including, without limitation, the conduct requirements for all communications with patients.

1. **Understanding of the Hospital’s Policies:** Vendors are expected to understand the hospital’s Charity Care and Financial Assistance Policy as well as all aspects of the hospital’s Billing and Collections Policy. While working on the hospital’s behalf, vendors are expected to appropriately direct patients or the patient’s guarantor to the hospital’s Business Office for financial assistance when appropriate and are expected to explain, in plain and respectful language, the next step(s) in the billing and collections process and how to restore the account to status.
2. **Compliance with Law and ACA International Guidelines**: Vendors are expected to adhere to all applicable laws and regulations, including, without limitation, the Fair Debt Collection Practices Act, the Health Insurance Portability and Accountability Act, the Affordable Care Act, the Fair Credit Reporting Act, and to provide services in accordance with all applicable consumer protection laws and mandates. All vendors providing services pursuant to this policy shall be required to adopt and abide by the “Health Care Collection, Servicing and Debt Purchasing Practices – Statement of Principles and Guidelines” of ACA International. In no event, shall any vendor resell any of the hospital’s account receivables. This limitation does not preclude the hospital from selling account receivables if deemed appropriate.