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A REVIEW OF HOSPITAL BILLING AND COLLECTIONS PRACTICES

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

JUNE 24, 2004

Serial No. 108–107

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A REVIEW OF HOSPITAL BILLING AND COLLECTIONS PRACTICES

THURSDAY, JUNE 24, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:20 p.m., in room 2123, Rayburn House Office Building, Hon. James C. Greenwood (chairman) presiding.

Members present: Representatives Greenwood, Stearns, Burr, Bass, Walden, Ferguson, Rogers, DeGette, Allen, Schakowsky, and Waxman.

Staff present: Mark Paoletta, majority counsel; Anthony Cooke, majority counsel; Brad Conway, majority counsel; Michael J. Abraham, legislative clerk; Edith Holleman, minority counsel; Amy Hall, prsfessional Staff; Bridget Taylor, professional staff; Voncille Hines, research assistant; and Dave Vogel, legislative clerk.

Mr. GREENWOOD. The subcommittee will come to order. Let me begin by apologizing to all for the delay, it's the unavoidable exigencies of voting, but we welcome you all. The Chair recognizes himself for the purpose of making an opening statement.

We convene this afternoon to review hospital billing and collection practices for uninsured/self-pay patients. Today in this country an average working man or woman treated at a hospital can be stuck with a bill that is double what managed care or government programs pay. These are uninsured/self-pay patients who don't have the weight of an HMO to negotiate on their behalf, or don't qualify for government health assistance. Then, to add insult to their injury, they are sometimes aggressively pursued for these inflated debts. The situation is unfair and it is unjust.

To put these hospital charges in perspective, let us look at a simple chart that paints a troubling picture. This provides a basic breakout of hospital revenues and costs. Based on our research, these proportions seem common in the hospital industry.

The black column, second from the left, is the cost to the hospital for providing the service. On either side of the cost column, Medicaid and Medicare can be seen to pay, on average, a bit less and a bit more, respectively. Third-party payers, such as insurers and managed care, represented by the yellow column, pay within a wide spectrum but, on average, provide profitable reimbursement. The red column on the far right is what many hospitals expect the uninsured and self-pay patients to pay. This charge to uninsured and self-pay patients is, generally speaking, the hospital's "charge

master" rate. That term will come up a lot today, so let us talk about charge masters for a moment.

Charge masters are catalogs of prices for all services and supplies offered at a hospital. They sometimes run hundreds of pages and contain thousands of line items. The prices in a charge master, as indicated in the chart, can bear little relation to the actual cost to the hospital. Indeed, some items on a charge master can reach well over 1000 percent markup.

And these prices continue to grow each year increasingly out of proportion to costs. In California urban hospitals, for example, the average price mark-up over cost has risen from 174 percent in 1990 to 310 percent in 2003. Most hospitals, I think, will admit to being hard-pressed to justify these charges. Rather, hospitals will explain that charge master prices are the product of many complex and sophisticated market forces in health care, including government entitlements, managed care, and rising costs. There is, without a doubt, a number of significant and powerful moving parts in health care finance, but we must not allow the working class uninsured to get chewed up in these machinations.

Hospitals will say they address the matter of high charge master prices through their charity programs which provide care free or at a reduced cost to the needy. Unfortunately, this too often covers only some people for only certain services.

Further, I question whether we can be assured of the fairness or reasonableness of charges which, in some instances, are merely discounts from an already inflated number. For example, let us return to the chart using the 2002 numbers. Even if an uninsured patient had a 25 percent discount, he or she would still be paying twice the cost. A partial discount off an inflated number seems very arbitrary. Even given all the well-administered, generous and commendable charity programs offered by hospitals, ultimately, there are still individuals who are expected to pay these full charge master rates.

It would seem that through these charity programs hospitals are trying to include the uninsured in a finance and accounting system that appears simply not designed for or allowing for participation by individual consumers. And if, in the end, managed care, government programs and the uninsured are not paying the charge master price, then what purpose does the current charge master structure serve?

Let us turn to what happens when someone is eventually asked to pay these inflated bills. Hospitals will point out that they collect only pennies on the dollar and, based on our investigation, this would seem to be the case.

The question for our purposes here, however, is not what they actually collect, but what happens to the part they don't collect? In a September 2003 study, one nonprofit hospital in Connecticut was found to have had over a 9-year period medical liens on 7.5 percent of the homes in a community it purported to serve. A hospital may indeed only collect 10 cents, but the other 90 cents may be secured by the patient's home. Many hospitals have claimed to have recently revisited and revised their collection practices. While that is encouraging, I remain concerned, however, when I read articles like the two that appeared in the Wall Street Journal over the past

couple of weeks, about two of the systems appearing before us today.

In the first article, from yesterday, one hospital system conceded that as many as half of those uninsured patients, possibly eligible for discounts under a new charity program, were not told of their potential eligibility. And they offered this admission, unfortunately, only after being confronted with a report by an advocacy group alleging that large numbers of uninsured patients seeking care in their facilities were not learning about available charity discounts.

The second article from 2 weeks ago described the case of a man who recently had his bank account seized because of a 13-year-old hospital bill from one of the systems here today. Perhaps what is more troubling in the story and the age of the bill was the excuse offered by the hospital. The hospital indicated that this was a mistake on the part of a lower-level hospital staff that, when brought to the attention of senior executives, was immediately remedied.

Are the new commitments recently articulated by so many hospitals to reform their billing and collection practices only known at the management level? Are lower-level staff, who are actually the front-line staff, aware of these new policies?

Not to put too fine a point on this, but the awareness, participation, and cooperation of this front-line hospital staff is vital. How these hospital employees present payment options to a patient can mean the difference between having a bill covered by a charity program or placing the full amount on a high-interest credit card.

As a further illustration, one system with us today, in a customer service training manual produced to the subcommittee, made an explicit statement of "four main priorities when securing payment on a self-pay account. Priority 1, obtain any insurance information; priority 2, attempt to obtain payment in full or settle the account; priority 3, negotiate a payment arrangement; priority 4, determine fund eligibility."

The manual goes on to say that billing agents should use their discretion in applying these principles, but if an agent followed these priorities, as written, a needy patient might never learn about charity care before paying by a credit card or agreeing to an unmanageable and unreasonable payment plan with the hospital. How the billing process is executed and practiced by the hospital staff is more important than any new written policy or any promises or pledges from management.

At the outset of this investigation, hospitals generally acknowledged many of these concerns with billing and collection practices, but claimed Medicare rules, in some instances, tied their hands with respect to what they could do for uninsured and self-pay patients.

In December 2003, 5 months after the start of this committee's investigation, the American Hospital Association sought guidance from the Department of Health and Human Services on these rules. Two months later, both Secretary Thompson and the HHS Office of Inspector General responded, largely rebuking the industry's positions. The final panel of this hearing will feature two representatives of HHS, and will explore further with them this guidance.

In this regard, I will seek from HHS and the hospitals, an answer to the question of why steps to address the situation have not been taken until now. If hospitals believed that Medicare rules created roadblocks to doing the right thing for the uninsured, why did they not raise it with HHS earlier?

Cost-to-charge ratios are reported to HHS in Medicare costs that the Agency must have seen this growing divergence between cost and charges. Is no one at HHS watching to see whether their rules and regulations are causing harm?

In December 2002, Trevor Fetter, CEO of Tenet Healthcare, who is here with us today, made some very interesting remarks in an investor conference call shortly after joining Tenet. This was almost 1½ years ago, and in many ways he framed precisely the issues for which we come here today. Quoting Mr. Fetter: "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill at gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay. The problems that this creates are obvious. The bills are tremendous and incomprehensible to most people. The patient leaves the hospital, presumably after some traumatic event, and the hospital bill adds to the trauma. As a result, they don't pay. Thirty percent of the patients account for nearly 100 percent of the collections from this group, 70 percent of the patients pay virtually nothing, but Medicare requires that the hospitals make a bona fide effort to collect. The administrative costs are huge. The ill will that is generated among the patients is huge. And the whole situation is far from ideal, from a social or economic perspective. Tenet employs more than 5,000 people to render bills and attempt to collect from these patients. It is ridiculous."

Mr. Fetter could not have put more clearly into words what this committee's investigation is about. It is not unreasonable to assume that Mr. Fetter was not the only member of the hospital industry to recognize this problem. If so, why is there action only now? Were lawsuits and a congressional investigation necessary for the industry to address this?

Finally, we will likely hear today testimony and comments about the role of universal health coverage in the issues we are addressing in this hearing. In anticipation, let me say this: In Congress, we have debated, and will continue to debate, the critical matter of health care coverage. But since this committee started this investigation almost 1 year ago, we have seen concrete action improving the condition of uninsured and self-pay patients facing medical debts. Our focus on billing and collection issues has yielded specific and immediate results. I look forward to continuing and building this direct approach to these problems that is helping real people right now.

We welcome today representatives from the Department of Health and Human Services, and the Chief Executives of Ascension Health, Catholic Health Initiatives, HCA, New York Presbyterian, and Tenet Healthcare.

We also welcome our panel of experts and advocates, Dr. Anderson, Ms. Jacoby, Mr. Rukavina, and Dr. Collins. Thank you all for

joining us here today, and I look forward to your testimony. The Chair recognizes the gentlelady from Colorado for an opening statement.

Ms. DEGETTE. Thank you, Mr. Chairman. I agree with the chairman, this is a very important hearing on the hospital billing of the uninsured and underinsured. In particular, I want to extend a welcome to Kevin Lofton, who is the President and CEO of Catholic Health Initiatives in Denver, who is on the second panel today.

Each year, thousands of Americans without health insurance receive hospital care because of urgent and emergency situations. Through no fault of their own, though, these patients are unable to pay their bills. This puts both hospitals and patients in a quandary. The hospitals have spent money and manpower providing critical medical care, but they have no way to recover the cost. The patients have incurred catastrophic debts. The amount could be $1,000, $10,000, or even $100,000, and have no ability to get the amount of money necessary to pay off these bills in a proper period of time.

The problem stems from the inevitable collision of uninsured patients needing health care and hospitals needing to be paid for health care. Now, there are anywhere from 43 to 81 million Americans who go without health insurance for at least part of a year. This is a burden that neither our health care system or our patients can continue to bear. And as a result of this system, both patients and hospitals are facing severe financial pressures.

There is no question that some hospitals took collection efforts too far. Everyone here is aware of reports of body attachments and other types of financial penalties. The stories frankly are horrifying, and we must look into steps to protect patients from overzealous bill collectors. This hearing, though, must keep the problem of hospital billing in context. Too many Americans are unable to pay for health care because they do not have health insurance.

This subcommittee's investigation reinforces the reality that the entire health care system is extremely ill. Some hospitals seem to view uninsured patients as revenue enhancers. Studies uncovered that hospitals charge insured patients only 46 percent of the rack rate for services. This pricing reveals that it is essential that patients have an advocate in the discounting process. In the current system, the uninsured are the only ones who have no advocate. Like any other type of debt collection, hospital billing and collection practices can have a devastating effect on patients without the ability to pay. These patients, many of them still recovering from illness or surgery, may see their credit rating ruined and their financial lives destroyed.

As Professor Jacoby will describe, this could even mean denial of housing or employment. This can spiral into a vicious trap. How can these patients pay their hospitals without new income? And if the patients have left the hospital still recovering from their illness, how easy is it for them to negotiate with a billing department?

Now, one Wall Street Journal article I read talked about a man who was billed $22,000 for a 3-day hospitalization following emergency appendectomy surgery. He couldn't pay the $22,000. But the problem we have, I will bet he couldn't pay it even if under a fee

reduction program his bill was cut in half, to $11,000. And that is the problem we have.

Our second panel, comprised of hospital CEOs, will provide more information on this price system and the collection practices. They will also describe the steps that they are taking to improve their billing systems. I am looking forward to hearing the details of these plans for the uninsured because, up to this point, it has been unclear how robust these needed discount programs are.

The investigation of this subcommittee has been extremely comprehensive and valuable. Examination of this problem has brought to light some specific examples of egregious billing practices, but I hope that these stories do not overshadow the fact that both patients and hospitals are caught in the same vicious cycle. Hospitals cannot be expected to absorb all the cost of serving the growing number of uninsured and underinsured, and I am sure the chairman did not mean to imply that in his opening statement. What this country needs is a system in which everyone has access to and can pay for essential health care services, both emergency and preventive. Every American should have basic health insurance that is affordable.

As this hearing will show, the financial burdens that our uninsured patients and our hospitals struggle with every day make this an issue that can no longer be delayed and, frankly, it is a problem that is getting worse and worse, both for the un- and underinsured, and for the hospitals which are trying to bear an increasing burden of this.

Now, it would be easy for us to simply blame hospitals for overaggressive bill collection and too high rates, but it would miss the larger point. Too many Americans are unable to pay for health care services because they do not have health insurance. I hope this hearing serves as the impetus for us to address this larger issue that is at the root of the problem. And, Mr. Chairman, I would ask unanimous consent to put Mr. Dingell's opening statement in the record, and also any other member of the full committee who wishes to insert an opening statement in the record.

Mr. GREENWOOD. Without objection, that will be the order.

Thanks to the gentlelady. Recognize the gentleman from Oregon, Mr. Walden, for an opening statement.

Mr. WALDEN. Thank you very much, Mr. Chairman. I appreciate the fact of the work of the staff on this issue, and certainly your leadership on this issue, and recognize the problem that is before us.

I spent several years on a community hospital board, a nonprofit hospital board, before coming to the Congress, and every month we would go through our billing, and every month we would write off a goodly share for charity care. And I recall that the biggest shifter of cost—if that is the right word—in the system was both Medicaid and then Medicare that often had reimbursement rates that, frankly, didn't necessarily cover even the cost of care. And, so, those are issues I think we need to look at. Clearly the billing issue, though, is the legitimate one that needs to be examined, and I know many of the hospitals have begun to do that, many are in the process of doing that, and certainly the light that has been shed on this practice has moved that effort forward.

It is interesting to note, however, that when it comes to the uninsured, there are some folks that probably do have the ability to pay, and I got the census data. And it is kind of interesting to note that of those who went without health insurance for an entire year, 8.2 percent had household income in excess of $75,000, and 20 percent had household income over $50,000.

Interesting, too, as we look at how do you get health care coverage, especially insurance, for folks who are these folks—and, in some cases, obviously 20 percent have income over $50,000—43.3 percent are noncitizens of the United States, according to the census population study; 33.4 percent are foreign-born. So, you have 76, 77 percent are either foreign-born or not citizens of the United States, who are uninsured.

So, as we look at how do we reach out to provide affordable health care, there is clearly a target group there that stands out in certain need. And I know we work with those folks in many different ways.

I think this hearing is important. I think looking at the charge master and what people are being billed, and whether or not those are reasonable charges is very important for this subcommittee. And so I look forward to the testimony of the folks from the various panels, and hopefully together we can find a more equitable way to make all this work and still allow hospitals to be able to keep their doors open and provide care, including the enormous charity care that is already given.

Mr. Chairman, thank you for your leadership, and I look forward to the witnesses.

Mr. GREENWOOD. The Chair thanks the gentleman. Recognize the gentleman from California, Mr. Waxman, for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman. This hearing before the subcommittee today is a critical one. It is resultant from an investigation which focused on a number of billing practices by hospitals which have resulted in unconscionable practices in going after uninsured persons who owe debts far beyond their ability to pay.

Turning bills over to collection agencies who engage in practice of harassing individuals, garnishing their wages, going after their homes, freezing their bank accounts, these activities have no place in this country when the debt is occurred because of a person's critical need for health care. Uninsured people who facing bills of tens and even hundreds of thousands of dollars and no possible way to pay need help, not harassment. The fact that medical bills and the debt from those bills is the second leading cause of bankruptcy in this country is, simply put, unacceptable.

I want to make a couple of critical points. First, we all need to acknowledge that in the face of these revelations, the hospital industry has, by and large, responded with concern and a commitment to stop the more abusive practices.

We will hear today of the adoption of policies designed to address the more egregious abuses. And while I commend them for that, the real test, of course, will not be in the signing of pledges to do better, but in actually carrying them out and stopping these troubling practices.

The second point is, the clear and critical point here is that all these problems occur because we have so many uninsured people in this country. We know that over a 2-year period, over 80 million people find themselves without insurance for some period of time. This is completely unacceptable. We will never solve the problem we are discussing today until that situation changes.

Third point, we know that the practice of uninsured people facing the very highest charges is not just a problem for people getting hospital care. While the bills might be the most overwhelming, the fact is that uninsured Americans without drug coverage every day face the problem of paying the highest prices when they can least afford it. They pay more than people with insurance. They pay more than citizens of Canada and other countries. And this is also unacceptable, and I hope this subcommittee will show equal interest in the problem in this area. After all, they have no one negotiating for them to get lower drug prices, either.

Finally, I have to note that the policies now in vogue with the Republican Majority of pushing health savings accounts and high deductible insurance plans runs directly contrary to what is needed to give people the assurance of coverage and access to favorably negotiated prices. It is unfair to our hospitals to ask them to provide their most favorable discounted rates to insurers who have deliberately designed policies where people will face a long period of essentially being uninsured because the deductible is so high. Hospitals give discounts to insurers because they are assured of payment for essentially all of the services they provide, less a small deductible amount. Asking them to provide the same discount to a truly uninsured person is sensible and humane, but requiring them, in essence, to do the same for uninsurers with deliberately designed high deductible plans is another matter entirely. Asking hospitals to bear the brunt of the unmet cost in the long period before insurance kicks in, asking them to protect the profits of insurers is not a sensible policy and will ultimately hurt the very institutions that are on the front line of delivering care.

I look forward to hearing from our witnesses today and exploring this issue further with the members of the subcommittee.

Mr. GREENWOOD. The Chair thanks the gentleman, and recognizes the gentleman from New Hampshire, Mr. Bass, for an opening statement.

Mr. BASS. Thank you, Mr. Chairman. This is indeed a very interesting hearing. It is not simple. There are many different parties involved. There is, if you will, problems and issues to be shared by all. On the part of the hospitals, there are allegations of inflated billing to the uninsured, unethical collection practices, but yet, on the other hand, hospitals—most, if not in fact all hospitals, engage in significant and important charity programs that provide essentially deeply discounted services to the poor, and the reality is that hospitals are not great profit centers nationwide anyway, we know that. We just went through a debate on possible reimbursement from the Federal Government, and we provided significant increases in this area, and it wasn't because the hospitals were being over-reimbursed.

Patients are another factor. Most patients are insured, but those that are not are divided, as my friend from Oregon pointed out,

into some who can pay and some who cannot. And we do not want to establish a situation where individuals who do not choose to buy either managed health care or any form of health insurance can qualify for benefits or payments under those circumstances.

And, of course, the insurance companies are another factor because they are the biggest—besides the Federal Government—reimbursement mechanism, and they negotiate and they create differences in prices because of their negotiating power, which is another part of this complicated equation.

And, last, the Federal Government and its reimbursements for Medicare and Medicaid is, I guess, probably the biggest reimbursement single entity, and growing every day, that the relationship that the hospitals have to determine what element of discount occurs is a difficult one, and it is at times somewhat awkward or perhaps arbitrary. So there are no clear answers here, but there might be some interesting findings that come out of this hearing that will help make the system more predictable, help the hospital community perhaps make their collection processes and their billing processes more predictable and fair for those who really need health services and cannot afford to pay for them.

I would also point out that I think that—I appreciate my friend from California's comments relative to health savings accounts—but there are also other scenarios that could work out that would be very beneficial to the process, if consumers really have a voice in the process of paying for hospital care, at least the first-dollar hospital care, through health savings accounts which provide accountability and an incentive for patients to hold hospitals, doctors and other entities accountable for the bills that are sent out, rather than awaiting the lawyers to file suits, or interest groups, or committees of Congress to conduct investigations.

So, like all the hearings that this good subcommittee has, they are important, but—especially in this case—there are no clear villains and there are no clear heroes in the process of investigating this issue. And with that, I will yield back and look forward to hearing from our witnesses.

Mr. GREENWOOD. The Chair thanks the gentleman, and recognizes the gentlelady from Chicago, Ms. Schakowsky, for the purpose of making an opening statement.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, for holding this hearing on hospital billing and collection practices. Many of the issues that we will talk about today are the focus of attention in Illinois and are being considered by the Legislature, investigated by the State Attorney General's Office, and debated by the hospital community and the public.

I want to thank Mr. Greenwood, Mr. Dingell, and Ms. DeGette for including a report on the Chicago situation called "A Failing Mission: The Decline of Charity Care at Resurrection Hospital" in the hearing record. I would like also to ask unanimous consent to include a statement by the Service Employees International Union that also addresses billing and collection practices in Illinois in the hearing record.

Mr. GREENWOOD. Without objection, the material will be included in the record.

Ms. SCHAKOWSKY. Thank you. In fact, several Chicagoans have traveled here today to attend this hearing because they have been personally and extremely seriously affected. I want to recognize them. Zaida Perez was a hospital nurse for 21 years. Her troubles began when her working but uninsured husband was in a car accident in January 2003, and admitted to Advocate Lutheran General Hospital. Two days later, her father died, and she faced $13,000 in burial expenses. She was diagnosed with breast cancer and, fortunately, was treated at Cook County Hospital, which helped arrange payment for her bills. In March, Lutheran General sent her husband a bill for $12,000. Although she asked for help in devising a payment plan, no help was given, and in April the threatening calls began. After a payment plan was finally worked out and payments were being made, she was sued. Her husband's wages were garnished at the rate of $75 a week, until she finally got legal assistance to erase her debt.

Lesszest George is a working single mother. Her 19-year-old son spent 2 weeks in Illinois Masonic Hospital after he was shot in a case of mistaken identity. Asked after the surgery who would be responsible for the bill, Ms. George signed the paper that was put before her, thinking that her son was covered by her insurance but not realizing that he had lost that coverage upon graduation from high school. She received a bill for $52,000. The hospital did work to help her apply under the Victims' Assistance Fund, but she was denied. Instead of working with her for charity care, they filed a lawsuit. Her son is now doing well physically, but is still uninsured because, as a part-time student and part-time worker, he doesn't qualify for insurance.

Their stories underscore that hospital billing and collection practices can turn a medical injury into a financial nightmare as in the case of Lutheran General Hospital and Illinois Masonic Hospital. Or, as in the case of Cook County Hospital, those practices can provide the necessary financial assistance so that the focus is on getting well, not dealing with collection agencies and lawsuits.

We need to address charity care policies, discriminatory pricing, and abusive collection practices, but we must also recognize that our health care system itself has failed Zaida Perez, Lesszest George, and many other Americans. Despite working full-time, they are uninsured and facing medical debts that will be hard to dig out from and that make it hard to care for their families' ongoing needs.

As we will hear, the problems of medical debt and the lack of affordable health care are most acute for the uninsured. They are more likely to forego care, are charged more for care in hospitals and other settings, and are the most likely to face medical bankruptcy. But being covered by insurance isn't a guarantee by any means. As Sara Collins points out in her excellent testimony, more than one in three of the continuously insured reported problems paying medical bills. We know that access to affordable health care benefits, cost-sharing requirements and discounts varies not just by whether you are insured or uninsured, but on the type of insurance coverage you have. The bigger the group, the better the coverage.

We in Congress can act to solve these problems, or we can act to exacerbate them. High deductible plans and health savings ac-

counts will shift more cost onto individuals and families, increasing the likelihood of medical bankruptcy. Limited tax credits for the purchase of inadequate individual policies will not guarantee that policyholders will be able to pay their bills. Instead, it is time that we enact universal health care that assures access to comprehensive, affordable care. Thank you, Mr. Chairman.

Mr. GREENWOOD. The Chair thanks the gentlelady, and recognizes the gentleman from New Jersey, Mr. Ferguson, for an opening statement.

Mr. FERGUSON. Thank you, Mr. Chairman. I commend you for your interest in the problems of the uninsured, and your leadership in investigating how some of the Nation's largest hospital systems handle uninsured patients, and I have a great deal of interest in the topic of today's hearing.

There is much about our health care system in this country that we take for granted. Our hospitals are the finest in the world. Our doctors and nurses are the best trained. Our technology is the most advanced. At the same time, I, like many, am deeply concerned about the number of uninsured Americans.

About 1.2 million residents in my home State of New Jersey, or about 15 percent of our population, are uninsured. Most of them are from working families, good people who play by the rules, provide for their children, and pay their taxes.

I believe that every person should have access to quality health care, adj that we in the Congress should be working to make health insurance more affordable, but until that time it is imperative that our health care system treats the uninsured and the poor with respect and with mercy and with fairness.

From the evidence uncovered by this subcommittee, it is clear that although oftentimes that is the case, it doesn't happen every time.

I commend the subcommittee for its role in prompting hospitals across the Nation to examine how they handle uninsured patients. These examples do not take anything away from the many hospitals that, for decades, and in some cases for centuries, have provided charity care to the poor and the vulnerable. This is especially the case of many of the nonprofit hospitals in my home State of New Jersey and across the country that are sponsored by religious organizations. In New Jersey, I give examples like St. Michael's Medical Center in Newark and St. Claire's Hospital in Morris County.

In this day and age of making your numbers and creating shareholder value and growing the bottomline, I am awed by their continuing tradition and commitment to care for the poor. In many respects, our Nation's hospitals, especially those who focus exclusively on care for the indigent, are the health care providers of last resort. People can go to the hospital when they have nowhere else to go for care. The proof is in the numbers.

A recent study by the Kaiser Commission on Medicaid and the Uninsured estimated that uncompensated care in 2004 will total more than $40 billion. Hospitals will account for about 60 percent of that total.

Mr. Chairman, I ask unanimous consent that a copy of this study, the Kaiser Commission Study, be entered into the record.

Mr. GREENWOOD. Without objection, it will.

Mr. FERGUSON. Thank you. No one should feel good about these numbers. The cost of uncompensated care at hospitals should concern everyone. This is what Stuart Altman, a health policy expert who teaches at Brandise University recently said on NPR about unpaid bills at hospitals, and I quote: "They are a symptom of a much broader issue, which is whether the hospital system is financially in good shape, or not, and that affects both access to care and quality."

I urge my colleagues on this subcommittee and members of the audience here to heed those concerns. Again, I thank you, Mr. Chairman, for holding this critically important hearing, and I certainly look forward to hearing from several panels of our witnesses here today. I yield back.

Mr. GREENWOOD. The Chair thanks the gentleman, and recognizes the gentleman from Maine, Mr. Allen, for his statement.

Mr. ALLEN. Mr. Chairman, thank you for calling this hearing today. It is an important subject matter, and I welcome all of our witnesses.

Medical data is a serious problem faced by a growing number of Americans who are uninsured or underinsured, and the process by which hospitals charge and obtain payment from individuals without insurance deserves careful scrutiny, especially considering that medical data is a leading cause of personal bankruptcy in the United States.

Hospital bills are just one service that many uninsured are paying out-of-pocket. They also have doctors' bills, outpatient services, and prescription drugs. Most people accessing hospital services have some kind of third-party coverage, but those who are not insured and have no one negotiating on their behalf for setting a price, as happens with Medicare and Medicaid, have to pay the charge master rate.

I am willing to guess that very few of the 44 million people who lack health insurance today have a clue what a charge master rate is, nor would the average uninsured person know that if they go to the emergency room, they may be charged a good deal more than a health plan is charged by a hospital to provide the same care, often 2 to 3 times more. And while 120 days may seem like a reasonable time to pay a $100 or $200 bill, the average cost of an emergency room visit is between $500 and $1,000 for an individual without insurance. I suspect that many uninsured would have difficulty paying a bill of that amount or more within 4 months, and if they need just one overnight stay, they can wind up with a bill of $4,000 or so in just 24 hours.

Some things could help. Transparency in the billing process, enrolling patients who qualify in a charity care program, establishing reasonable payment plans for those who don't. All of that can help alleviate the anxiety associated with a daunting medical bill.

In Maine, all of our acute care hospitals are nonprofit. On average, self-paying patients make up about 7 percent of overall hospital payments. And, currently, most of our hospitals offer free care for patients who are between 175 percent and 200 percent below of the Federal poverty level. And our hospital CFOs in Maine have

been working together to develop guidelines regarding charity care, sliding scale fees, billing and collections.

I realize that the chairman's intention for calling this hearing today is to examine hospital billing and collection practices, but given the number of uninsured in this country and the rapid growth in health care premiums, we need to look deeper. Health insurance premiums in the U.S. rose 13 percent in 2003, the third consecutive year of double-digit inflation. As a result, many employers are forced to increase cost-sharing or switch to products which put a greater financial burden on employees, including so-called "consumer-driven high-deductible health plans," which I believe will only make the problem we are dealing with here today worse than it is.

Congress, someday, must focus on how to make affordable quality health insurance available to all Americans, but today Congress is simply stumbling along like a man shackled and bound in a straightjacket, not limited really by physical barriers, but limited by our ideological preconception about the role of government in the private sector when it comes to health care. We are limited by our own ideas in a way that is doing a great disservice to the people of this country, and if we are going to make progress on the larger issue in front of us, we have to work through that issue.

We won't solve all those problems today, but I do welcome the panels, and I thank the chairman for holding this hearing. With that, Mr. Chairman, I yield back.

Mr. GREENWOOD. The Chair thanks the gentleman, and recognizes the gentleman from Florida, Mr. Stearns, for his opening statement.

Mr. STEARNS. Thank you, Mr. Chairman. I congratulate you on having this hearing. I think all of us realize we are not here to be overly critical of the hospitals, or sort of beat up on, we are just trying to arrive at some explanation of the reality between the cost and the charges.

America's hospitals, urban and rural, for profit and not-for-profit, I think do a superb job of taking care of patients of every age and health condition. I am very proud of the charitable outreach of the hospitals in my congressional district and, with that, Mr. Chairman, I would like to put into the record a summary of my charitable hospitals into the record, with unanimous consent.

Mr. GREENWOOD. Without objection, the document referred to will be made a part of the record.

Mr. STEARNS. Anyone who enters their hospital is treated, without question, and I think they should seek payment for their services. They have to make a profit for their shareholders or, if they are not-for-profit, they still have to have enough profit so they can have capital expenses. However, Mr. Chairman, there is a great disparity between what a procedure costs and what is charged. This accounting creature is called a "charge master." Is it based on some realistic computation of the factors involved in the care of the individual, or is it a fictitious number in hospital finance? And we all remember the "average wholesale price," AWP system. And the pharmaceutical wholesale pricing system, remember the hearings we had on that, and the concerns we had on that.

Dr. Anderson's testimony says that in the 1960's, while there was a proliferation of uninsured Americans because they had become tax exempt, there were no discounts, everyone paid the same rates. The rates that insured and self-pay people paid were similar. Yet, today, on the average, "self-pay patients are currently being charged 2 to 4 times what people with health insurance coverage pay for hospital services." So, why are the self-pay patients paying 200 to 400 percent more? That is a legitimate question.

Also, as taxpayers have an interest in both Federal health programs and the tax benefits, I am interested to know the relationship, if any, between the charge master, the taxes and the Medicaid reimbursement.

So, the question is, after we finish this hearing, where do we go from here? Well, there are going to be some people that are going to call for a price control. I don't recommend that as a solution. I think that out of the box, we should not have price controls, but I think the three panels we have, and all the witnesses, are to be commended for coming here, and I look forward to an open honest debate on this. Thank you, Mr. Chairman.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Let me begin by thanking Chairman Greenwood for holding this hearing today. I share his concerns with what we have been learning about the billing and collection practices of too many hospitals with regard to uninsured/self-pay patients. Today I look forward to learning more about these issues as well as the steps the hospital industry is taking to address them.

Hospitals across America have long been community leaders in helping those less fortunate. Last year alone, hospitals provided $22 billion in charity care in their respective communities. For this, hospitals should be commended.

There has been a substantial group of needy patients, however, sometimes left out of these efforts. I am concerned that uninsured/self-pay patients are too often expected to pay far more than others for their care and then aggressively pursued for this inflated debt. This is particularly troubling for me because my home state of Texas, in 2002, had the highest rate of uninsured citizens at 28.5%. I am committed to ensuring fair and reasonable treatment by hospitals in their billing and collections practices—for every patient regardless of their means or manner of payment.

All hospitals have specific charges for each service they provide and compile these thousands of individual charges into one price-list catalog called the "charge master." However, these charge master rates do not reflect the actual cost and reasonable profit of providing that service. Mark-ups have rendered these charges sometimes hundreds of percent above the actual costs to the hospital.

As health care costs continue to rise, these mark-ups also continue to increase. A study just recently published shows that hospital prices increased 8% in 2003, the sixth straight year of accelerating price increases and the largest one-year spike in a decade. Managed care, commercial insurance, and the government pay hospitals substantially less than charge master rates. But the uninsured/self-pay patient is left with the short straw and the full charge. They are the ones often expected pay these full mark-ups. They are the ones paying the sticker price. They are the ones charged an arm and a leg in order to get one fixed.

The collection tactics sometimes used to pursue these inflated bills can be even more disconcerting. There have been a number of reports and articles over the past year describing some particularly aggressive collection practices. Collections are an unfortunate reality of business life, but every corporation has a duty to make sure any such policies and practices are measured and reasonable. And let me be clear, I hold the individual corporation responsible, particularly in health care, for knowing and monitoring the practices of any collection agent acting on its behalf.

I am encouraged that the industry has seemed to have heard the message and taken recent steps to revisit and enhance its billing and collection policies. However, we all know policies can be little more than talk; the proof is in the results. I look forward to hearing how your commitments have taken form in action—from the in-

dustry, to the systems, to the hospitals, to finance departments and to the men and women sitting across the table from an patient seeking to meet their fair obligations in a fair and respectful manner.

I want to also say that I am pleased this Committee has been able to facilitate communication between hospitals and the Department of Health and Human Services on these matters and I expect that dialogue to continue.

I thank Chairman Greenwood again for his efforts and I look forward to today's testimony.

Mr. GREENWOOD. The Chair thanks the gentleman, and would now call forward our first panel, consisting of Dr. Gerard F. Anderson, M.D., Professor of the Department of Health Policy & Management and International Health, at the Bloomberg School of Public Health. He is a professor in the Department of Medicine at Johns Hopkins School of Medicine, and he is the Director of the Center for Hospital Finance and Management, as well.

We also have with us Melissa B. Jacoby, Associate Professor, University of North Carolina at Chapel Hill, School of Law; Mark Rukavina, Executive Director of The Access Project in Boston; and Sara Collins, Ph.D., Senior Program Officer, The Commonwealth Fund, in New York. We welcome all of you this afternoon. I know that you expected to be sitting there an hour and a half ago, but we thank you for your indulgence.

It is the custom of this subcommittee to take testimony under oath, and so I need to ask if any of you object to giving your testimony under oath?

[No response.]

Seeing no objection, I also need to advise you that pursuant to the rules of the committee and the House, that you are entitled to be represented by counsel. Do any of you wish to be represented by counsel?

[No response.]

I didn't think so. If you would then stand and raise your right hands, please.

[Witnesses sworn.]

Mr. GREENWOOD. You are under oath, and we will start with you, Dr. Anderson. You are recognized for 5 minutes for your opening statement. Good afternoon.

TESTIMONY OF GERARD F. ANDERSON, DIRECTOR, JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, PROFESSOR, DEPARTMENT OF MEDICINE, JOHNS HOPKINS SCHOOL OF MEDICINE, PROFESSOR, DEPARTMENTS OF HEALTH POLICY AND MANAGEMENT AND INTERNATIONAL HEALTH, BLOOMBERG SCHOOL OF PUBLIC HEALTH; MELISSA B. JACOBY, ASSOCIATE PROFESSOR, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, SCHOOL OF LAW; MARK RUKAVINA, EXECUTIVE DIRECTOR, THE ACCESS PROJECT; AND SARA R. COLLINS, SENIOR PROGRAM OFFICER, HEALTH POLICY, RESEARCH AND EVALUATION, THE COMMONWEALTH FUND

Mr. ANDERSON. Good afternoon, Mr. Chairman. You said we had been waiting for an hour and a half, we have been waiting for several months for this opportunity. I am glad you waited for my birthday to give me the opportunity to testify today.

Mr. GREENWOOD. Which one is it, Dr. Anderson?

Mr. ANDERSON. Fifty-three.

Mr. GREENWOOD. Fifty-three. You are under oath, Dr. Anderson.

Mr. ANDERSON. I understand. I direct the Johns Hopkins Center for Hospital Finance and Management, the only academically based research center focusing exclusively on hospitals. My written testimony begins by explaining how we got to the current situation of self-pay patients paying 2 to 4 times more for hospital services than the uninsured patients. It concludes that the marketplace does not constrain hospital charges for self-pay patients, and the Members of Congress have done a better job than I could in explaining the reasons why.

What I would like to explain is why hospitals have these high charges. The first one is the Medicare payments, outlier payments, are partially based on charges. This encourages hospitals to maintain high charges.

Second of all, bad debt and charity care is typically calculated at full charges. High charges make it appear that hospitals are being more generous than they really are.

Third, some self-pay patients actually pay full charges. These self-pay patients fall into three groups. The first are a very few people with medical savings accounts. The second category are international visitors. These are typically affluent individuals who need a procedure that can be performed most effectively in the United States. These individuals are willing to pay full charges even at inflated rates. The third, and by far the largest group that is asked to pay full charges, are the 43 million Americans who are uninsured. The uninsured have very little bargaining power with hospitals. My review of hospital practices suggests that less than 1 in 20 uninsured patients actually negotiate a lower rate with hospitals.

Because hospital charges for a heart attack average about $30,000 per admission, most uninsured Americans, even those making $50,0000 or $75,000, are unable to pay full charges. Even if they don't pay, however, the toll on the uninsured can be substantial. People who do not pay are sent to collection agencies, and some are driven to bankruptcy. One study found that nearly half of all personal bankruptcies were related to medical bills.

The question, therefore, becomes what is a reasonable rate for hospitals to charge self-pay patients, given that the marketplace does not work? I propose four guiding principles for Congress to consider.

The first, that the rates should be above what insurers and managed care plans are currently paying hospitals; second, self-pay patients should not be asked to pay exorbitantly high rates; third, self-pay patients should know in advance what they are going to be asked to pay; and, fourth, the system should be easy to administer and to monitor.

And, therefore, I have two payment options for Congress to consider. My preferred option is to mandate that the maximum a self-pay patient should pay is the Medicare rate plus 25 percent. The rationale for allowing hospitals to charge 25 percent more than Medicare is based upon three factors. First, self-pay insurers pay about 14 percent more than Medicare. I then add 1 percent for prompt payment and, finally, I add an additional 10 percent be-

cause the amount paid by private insurers is an average, and some commercial insurers will pay more than the average. Adding these three factors together results in a proposed payment rate of Medicare+25 percent. The Medicare+25 percent rate is easily monitored and adjusts for the complexity of the patient. It would be continually updated by Medicare as Medicare updates its own PPS rates. The major disadvantage is that it is not market determined. In most markets, however, it would be above what the insurers and the managed care plans are paying, and so it wouldn't interfere with the marketplace.

A second option is to allow hospitals to charge the maximum they charge any insurer or any managed care plan. The advantage is that, in fact, it is market determined. However, I see four disadvantages with this option. First, it would require regulations and auditing to verify that the rate is really the maximum hospitals charge any insurer or any managed care plan. Second, in order to make the rate transparent, it would be necessary to keep the rate in place for an extended period of time, probably a year. Third, it would require hospitals to tell insurers and managed care plans who is the worst negotiator. And, finally, it requires all payments to be done on a per-day basis. Any other payment would probably make comparisons difficult, and all this does interfere with the marketplace.

Balancing the pros and cons of both options, therefore, I recommend Medicare+25 percent. It satisfies all four principles. It is above what the insurers are paying, it is a reasonable amount, it is transparent, and it is easy to monitor and verify.

In summary, both Congress and the hospital industry should recognize that hospital charges for self-pay patients are not determined by market forces and, second of all, Medicare+25 percent is a reasonable amount for self-pay patients to pay.

I would be happy to answer any questions.

[The prepared statement of Gerard F. Anderson follows:]

PREPARED STATEMENT OF GERARD ANDERSON

Mr. Chairman, members of the Committee; my name is Dr. Gerard Anderson. I have been working on hospital payment issues for many years. Between 1978 and 1983, I worked in the Office of the Secretary in the US Department of Health and Human Services. In 1983, I was one of the primary architects of the Medicare Prospective Payment legislation. Following passage of the Medicare Prospective Payment legislation, I joined the faculty at Johns Hopkins where I have been for the past 21 years. At Johns Hopkins, I direct the Johns Hopkins Center for Hospital Finance and Management—the only academically based research center focusing exclusively on hospitals. I am also a professor of Health Policy and Management and professor of International Health in the Bloomberg School of Public Health and Professor of Medicine in the School of Medicine at Johns Hopkins University.

I would like to begin my testimony by highlighting several milestones in hospital payment policy. Because of the evolution of hospital payment policy, self pay patients are currently being charged 2 to 4 times what people with health insurance coverage pay for hospital services. These are not market rates and need to be lower. After reviewing the milestones, I will then make a series of specific suggestions to the committee that will make the current hospital payment system more equitable to the self pay patients. My preferred option is that hospitals be limited to what Medicare pays plus 25 percent.

CRITICAL MILESTONES THAT HAVE LED TO MARKET FAILURE IN HOSPITAL PAYMENT

One hundred years ago most hospital care was either free or very inexpensive. In 1900, hospitals could provide little clinical benefit for most illnesses and were pri-

marily places for housing the poor and insane who were sick. Hospitals were primarily philanthropic organizations. They were established primarily in poor urban areas.

Beginning in the 1920s, the ability of hospitals to improve the health status of patients increased dramatically. For the first time, rich and poor Americans sought out hospital care when they became seriously ill. Anesthesia expanded access to surgery and antibiotics made it easier to treat infections.

Physicians had a wider range of services to provide to hospitalized patients. New drugs and new equipment became available and better and more highly trained personnel were required to provide these services. The cost of providing hospital care began to accelerate. In order to recover these higher costs, hospitals began to charge patients for services. Hospitals developed a charge master file. Initially there were only a few items on the list. It listed specific charges for each service the hospital provided. A hospital day had one charge, an hour in the operating room had another charge, and x-ray had a third charge, etc. As the number of services the hospital offered increased, so did the length of the charge master file. There are now over 10,000 items on most hospital charge master files.

Before 1929, there was no health insurance and patients paid the hospital directly. In 1929, Baylor Hospital in Dallas, Texas began a program selling health insurance to school teachers in the Dallas County School district. Baylor created this health insurance system because many of its patients were having difficulty paying hospital bills. It became the prototype Blue Cross Plan. As the depression worsened in the 1930s, the ability of people to pay their hospital bills also worsened. Blue Cross and other types of insurance programs proliferated. These insurers paid charges based upon the charge master file.

During this period, the charges were based on the cost of providing care plus a small allowance for reserves. The markup over costs was typically less than 10%.

Private health insurance received a major boost during World War II when Congress made health insurance tax exempt. After World War II, private insurers continued to pay the charges that hospitals had established. Over time, the ability of hospitals to improve the health status of their patients increased, the kinds of services provided by hospitals increased and the costs of hospital care began increasing at 2 to 3 times the rate of inflation. By 1960, the typical hospital had established a list of prices for approximately 5,000 separate items. There were no discounts; everyone paid the same rates. The rates that insured and self pay people paid were similar.

Hospitals set their prices for these 5,000 items on a few criteria. The most important factor was costs. Charges were typically set at a given markup over costs, usually 10 percent. The hospital would estimate how much it cost to deliver a service and then charge 10% more. The ability of hospitals to estimate cost for individual services, however, was extremely limited by cost accounting. No hospital really knew how much it costs to provide a particular service because cost accounting techniques were not sufficiently detailed.

Market forces determined charges for only a few services. Child birth for example, was one service for which patients could engage in comparative shopping. Pregnant women had almost nine months advance warning that they would be admitted to the hospital and their families could therefore engage in comparative shopping. In theory, they could compare differences in the out-of-pocket costs and the perceived quality between two hospital delivery rooms. Thus, hospitals kept delivery room charges at or below actual costs.

For most services, however, it was often impossible for consumers to engage in comparative shopping because either the admission was an emergency or their doctor had admitting privileges in only one hospital. For most admissions, they had no idea what services they would use during their hospital stay. They could not engage in comparative shopping if they did not know what services they were going to need. In addition, for most people, insurance paid the full bill and so patients had no financial incentive to engage in comparative shopping.

MEDICARE BECOMES INVOLVED

When the Medicare program was established in 1965, Congress decided that the Medicare program would pay hospital costs and not charges. This was the method of payment used primarily by Blue Cross. Congress recognized that charges were greater than costs and that the Medicare program would be able to exert little control over charges. A very detailed hospital accounting form called the Medicare Cost Report, was created to determine Medicare's allowable costs.

In order to allocate costs between the Medicare program and other payors, the Medicare program required hospitals to collect uniform charge information. Uniform

charges were necessary in order to allocate costs to the Medicare program. The Medicare Cost Report could determine allowable costs for the entire hospital, however, it needed a way to allocate these costs specifically to the Medicare program. Charges are used to allocate costs to the Medicare program. If, for example, 40% of the charges were attributed to the Medicare program, then the cost accounting system would allocate 40% of the costs to the Medicare program.

In order to prevent fraud and abuse, the Medicare program required hospitals to establish a uniform set of charges that would apply to everyone. Otherwise, the hospital could allocate charges in such a way that would result in more costs to the Medicare program.

Hospitals continued to have complete discretion on how they established their charges. The Medicare program did not interfere with how hospitals set charges for specific services. One hospital could charge $5 for an x-ray and another hospital $25 for the same x-ray. A number of studies conducted at the time showed wide variation in hospital charges.

People with insurance generally had little reason to scrutinize their bills because they had first dollar coverage. Insurance paid the full hospital bill. Also, patients did not know what services they would need and so they did not know what prices to compare. Insurance companies did little to negotiate with hospitals regarding hospital charges in the 1960s and the Medicare and Medicaid programs did not pay on the basis of charges.

In the 1970s, market forces still had a small impact on hospital charges. In reality, the hospital had virtual carte blanche to set the charges. The number of separate items that had a charge associated with them, doubled from 5 to 10,000 at the typical hospital, where it is today.

Two major changes occurred in the 1980s that had a major impact on hospital charges. First, Medicare created the Prospective Payment System which eliminated any need for using hospital charges to allocate hospital costs. Second, most insurers began negotiating discounts off of charges or using some other mechanism to pay hospitals. As a result, any market forces that existed to limit what hospitals could charge were almost completely eliminated.

In 1983, the Medicare program moved away from paying costs and instituted the Prospective Payment System (DRGs). As the Medicare Prospective Payment System became operational, the need for the Medicare Cost Report and therefore the need for a uniform charge master file to allocate costs became less and less important. Today, because nearly all of the Medicare program uses some form of prospective payment, the requirement of a uniform charge master file by the Medicare program is virtually unnecessary.

Managed care plans began to negotiate with hospitals in the early 1980s. They wanted discounts off of charges in return for placing the hospital in their network. They successfully negotiated sizeable discounts with hospitals. As insurers began to compete with managed care plans in the mid 1980s, they also began to move away from paying full charges and started negotiating their own deals. Some insurers decided to pay on a per day basis, others decided to pay discounted charges, or a negotiated rate. Nearly all private insurers and managed care plans stopped using full charges as the basis of payment by 1990. They simply could not compete in the market place if they paid full charges.

COST SHIFTING AND MARKET FAILURE

As each segment of the market developed a different way to pay hospitals, this lead to a phenomenon known as "cost shifting". As the Medicare program instituted the Prospective Payment System (DRGs), the Medicare program began to limit the amount that Medicare would spend. Faced with constraints on Medicare (and soon thereafter Medicaid) spending, the hospitals began to engage in "cost shifting".

To do this the hospital industry increased prices to commercial insurers. Given that most commercial contracts were written to reimburse hospitals based on the hospital's own charges, it was relatively simple matter for hospitals to raise their prices. When commercial insurers tried to raise prices to the employers, however, employers began to examine alternatives. Employers slowly and then rapidly embraced managed care. Managed care expanded rapidly using their market power to negotiate discounts off of charges with hospitals. Soon commercial insurers asked for similar discounts. Private insurers continued to pay more than Medicare however in most cases.

Without the federal government, state governments, private insurers, or managed care plans paying full charges, the regulatory and market constraints on hospital charges were virtually eliminated. By 1990, the only people paying full charges were the millions of Americans without insurance, a few international visitors and the

few people with health savings accounts. These individuals had limited bargaining power and were asked to pay ever increasing prices. Effectively, there was market failure in this aspect of the hospital market.

Without any market constraints, charges began increasing much faster than costs. In the mid 1980s charges were typically 25% above costs. Without any market constraints, it is now common for charges to be two to four times higher than costs. Charges are also two to four times what most insurers pay. Most insurers, including Medicaid, Medicare, and private payors, pay costs plus/minus 15 percent. Over the past twenty years, the difference between what the hospital charges and what it costs to provide care has grown steadily in nearly all hospitals.

Hospitals have been able to increase charges because self pay individuals have limited bargaining power when they enter a hospital. They first must find a team of physicians willing to treat them who also have privileges at that hospital. Then they must negotiate with the hospital. Often they wait until they are ill before they seek medical care. This further diminishes their bargaining power because it is now an emergency. Often the hospital wants prepayment. Because most self pay persons have limited resources and cannot make full payment in advance, this further diminishes their bargaining power.

Perhaps the most important constraint on their bargaining power, however, is that they do not know what services they will ultimately need. They do not know how long they will remain in the hospital, what x-rays or lab tests they will need, and therefore they cannot know in advance what services they will require and which of the 10,000 prices they should negotiate.

COSTS, AND WHAT INSURERS PAY IN PENNSYLVANIA

Using the most recent data available I compared what insurers pay and what hospitals charge in Pennsylvania. As noted earlier, charges vary considerably from hospital to hospital. Pennsylvania collects data on what hospitals charge and what insurers pay in Pennsylvania for different illnesses (www.phc4.org). For example, I looked at the charges that Philadelphia area hospitals charged for medical management of a heart attack in 2002. The average charge was over $30,000. Most insurers paid less than $10,000.

WHY ARE CHARGES SO MUCH HIGHER THAN WHAT INSURERS PAY?

There are three main reasons why hospitals set charges 2-4 times what they expect to collect from insurers and managed care plans. The first is that Medicare outlier payments are partially based on charges. The second is that bad debt and charity care is typically calculated at full charges. The third is that some self pay patients actually pay full charges.

In the Medicare program, a small proportion of patients are much more expensive than the average patient. These are known as outlier patients. Medicare pays for these patients outside of the DRG system. Medicare continues to use charges as part of the formula used to determine outlier payments.

Recent investigations have shown certain hospital systems manipulating the payment system in inappropriate ways to over charge the Medicare program for outlier patients. One aspect of this fraud was the exceptionally high amounts these hospitals charged. Lowering the charges would diminish the over charges in the Medicare program for outlier payments and would reduce the level of fraud.

Second, hospitals routinely quantify the amount of bad debt and charity care they provide. This helps with fund raising and is used to meet charitable obligations. However, by valuing bad debt and charity care at full charges, these numbers vastly over estimate the amount of bad debt and charity care the hospital actually provides.

There are three groups that still pay charges. The first are people who have health savings accounts. Some of these individuals may be able to negotiate discounts although most pay full charges. It is extremely difficult for one person to negotiate with a hospital, especially in an emergency situation. The hospital holds all of the cards. Lowering the charges will benefit people with health savings accounts.

The second category is international visitors. These are typically affluent individuals who need a procedure that can be performed most effectively in the United States. These individuals are willing to pay full charges, even at inflated prices.

There are compelling arguments to charge international visitors higher prices than Americans. Most can afford to pay and, in addition, they have not subsidized the hospital sector in the United States through tax payments and other public subsidies. On the other hand, in most other countries Americans are usually treated free of charges if they have an emergency. An American injured while traveling in Canada, Australia, France, etc would be treated free of charge or receive a very

small bill. Although there is no data that I know of that would allow us to compare the cost of care provided to Americans traveling abroad to the cost of care provided to foreigners receiving care in the U.S., I expect it would be similar. In that case it seems unfair to charge foreign visitors so much more for a service when Americans receive care free of charge overseas.

IMPACT ON THE UNINSURED

The third, and by far the largest group that is asked to pay full charges is the uninsured. There are 43 million Americans who are uninsured. The uninsured can theoretically negotiate with hospitals over charges, but they have little bargaining power. My review of hospital practices suggests that less than 1 in 20 uninsured patients actually negotiates a lower rate.

Many uninsured people are unable to pay full charges. In fact, most studies suggest that less than 1 in 10 uninsured people pay a portion of their charges and relatively few pay full charges. In fact, in most hospitals only 3 percent of total revenues comes from people who are uninsured. Self pay patients represent a very small proportion of hospital revenues.

The toll on the uninsured, however, can be substantial. There are numerous reports that show hospitals attempting to collect payments from the uninsured. The people who do not pay are sent to collection agencies and some are driven to bankruptcy. One study found that nearly half of all personal bankruptcies were related to medical bills (M.B. Jacoby, T.A. Sullivan, E. Warren, "Rethinking The Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," NYU Law Review 76, May 2001: 375). Another survey (D. Gurewich, R. Seifert, J Pottas, The Consequences of Medical Debt: Evidence From Three Communities, The Access Project, February 2003) found that hospitals were routinely requiring up front payments, refusing to provide care, or encouraging uninsured patients to seek new providers if they did not have health insurance. Many respondents found the terms the hospitals were offering were difficult to maintain given the hospitals' inflexible collection processes and their own financial situations.

Nearly all hospitals do this to some extent. For example, a series of stories in the Wall Street Journal examined the collection procedures at Yale-New Haven hospital. The Wall Street Journal found that in 2002, the Yale-New Haven hospital was lead plaintiff in 426 civil lawsuits, almost all of which concerned collections or foreclosure lawsuits against individuals, compared with 93 lawsuits at a similarly sized local hospital. Yale-New Haven Hospital also frequently engaged in aggressive collections measures, such as wage garnishment, seizure of bank accounts, and property liens. In 2001, the hospital filed 134 new property liens in New Haven, almost 20 times the number filed by the city's other hospital.

BENEFITS OF LOWER CHARGES

If charges were lowered there could be two beneficial outcomes. First and most important, fewer self pay individuals would declare bankruptcy. Second, more self pay patients would be able to pay their bills if the charges were more in line with prevailing rates.

GUIDING PRINCIPLES FOR SETTING RATES

The question therefore becomes what is a reasonable rate for hospitals to charge self pay patients given that neither market forces or regulations constrain hospital charges.

I propose four guiding principles. First, the rate should not interfere with the market place. The rate that self pay individuals should pay should be greater than what insurers and managed care plans are currently paying hospitals. Second, the charges should not be substantially higher than what insurers and managed care plans are currently paying hospitals. Individuals with limited bargaining power should not be asked to pay exorbitantly high rates because they lack market power. Third, the rate should be transparent to patients. Patients should know the prices they will be asked to pay when they enter the hospital. Fourth, the system should be easy to administer and to monitor.

TWO PAYMENT ALTERNATIVES

I have two specific suggestions for the Congress to consider.

The first is to mandate that the maximum a patient can pay is the amount paid by Medicare plus 25%. I call this DRG+25%. The rationale for allowing hospitals to charge 25 percent more than Medicare is based on three factors. First, private pay insurers pay an average of 14 percent more than Medicare for a similar patient.

I then add one percent for prompt payment. Finally, an additional amount (10%) is added because the amount paid by private insurers is an average and some commercial insurers pay more than the average. Adding the three factors together results in a proposed payment rate of DRG + 25%.

The advantages are that the DRG + 25% rate is easily monitored and adjusts for complexity of the patient. It would be continually updated by Medicare as Medicare updates the PPS rates. The disadvantage is that the rate is not market determined. In most markets, however, it would be above what insurers and managed care plans are paying.

A second option is to allow hospitals to charge the maximum they charge any insurer or managed care plan on a per day basis. The advantage is that it is market determined.

There are four disadvantages. First, it will require regulations and auditing to verify the rate is the maximum they charge any insurer or managed care plan. Second, in order to make the rate transparent, it will be necessary to keep the rate in place for an extended period of time, probably a year. This interferes with the market place. Third, it will require hospitals to tell all insurers and managed care plans who was the worst negotiator. This also interferes with the market place. Fourth, it requires all negotiations to be on a per day basis. Any other payment system would be too complicated. This interferes with the market place.

Balancing the pros and cons of both options, I recommend the DRG+25% option. It complies with all four principles—it is above what insurers are paying, it is a reasonable amount, it is transparent, and it is easy to monitor and verify.

RATE IS TOO LOW

Insurers may argue that they are entitled to more substantial discounts over self pay individuals for two reasons—prompt payment and volume discounts. The prompt payment argument has some validity. A two month delay in payment at a 6 percent interest rate is equivalent to a 1 percent savings. This is built into the DRG + 25% payment.

The volume discount argument is more complicated. In my opinion it has limited financial impact, especially on medical services. Most insurers and managed care plans do not guarantee a certain volume of patients and certainly they do not guarantee a certain case mix of patients. Instead, they agree to put the hospital on a preferred list of hospitals. The patient and the physician still make the final decision regarding which hospital to select. The choice, therefore is fundamentally different from a purchase in the manufacturing or retail sector where a large volume of goods or services is actually purchased.

The second part of the volume argument, however, is probably more important. The same medical services will be used if the patient is self pay or insured. The patient will use the same set of laboratory tests, spend the same time on the operating table, require the same nursing hours, etc. The medical services are what is most expensive in a hospital and this does not depend on the volume of patients that an insurer has.

INCENTIVES TO PURCHASE HEALTH INSURANCE

Some individuals with high incomes choose to self insure. An important and difficult question is whether these individuals should be able to get the benefits from these lower rates.

One argument is that these individuals have voluntarily chosen to go without health insurance and they should pay a much higher rate if they get sick. A second argument is that these individuals should be given financial incentives to purchase health insurance and that lowering the hospital rates for them will only induce them to go without coverage.

Although there is merit in both arguments, the question is what is a fair rate for them to pay when they get sick? When they need hospitalization they should pay a rate that is somewhat higher than people with health insurance coverage pay. The DRG +25% criterion meets this objective. This group of people should not be asked to pay for the bad debts of other self pay patients any more than the insured population. And, if the rates were reasonable they would be more likely to pay.

SIMPLIFICATION OF PAYMENT SYSTEM

The medical care system could be simplified if such a change were enacted. One major change would be the elimination of the Medicare Cost Report. A second simplification is that it would be easier to calculate any discounts that hospitals are offering to low income individuals.

The Medicare Cost Report was created in 1965 with the passage of the Medicare legislation and the decision by the Congress to pay costs. The Medicare cost report is now a document that is over 6 inches thick and requires many hours for hospitals to complete. However, with the passage of the Medicare Prospective Payment legislation in 1983 and subsequent adoption of additional Prospective Payment Systems for outpatient care etc., there is no longer a compelling reason for maintaining the Medicare Cost Report. Any information the Congress needs from hospitals to set hospital payment rates could be summarized in a few pages. The only relevant information is the profit of hospitals and some information used to calculate graduate medical education and disproportionate share payments.

Hospitals often give discounts to low income self pay patients. It is therefore key to understand what is the basis for the discount. A discount from full charges is not really a discount if it is still greater than what insurers and managed care plans would pay. A true discount would be below what public and private payors are expected to pay. If the payment system for self pay patients were simplified (DRG + 25%) then it would be easier for them to determine if they are really getting a discount and how much they were expected to pay. Currently the self pay person does not know the real extent of the discount or how much they will pay.

SUMMARY

In summary, what should be done?

Both Congress and the hospital industry should recognize that hospital charges are not determined by market forces. The only people paying full charges are those with limited or no bargaining power.

The maximum that self pay individuals should have to pay for hospital services should be DRG rate plus 25%.

I would be happy to answer any questions.

Mr. WALDEN [presiding]. Thank you, Dr. Anderson, we appreciate your comments and testimony.

Ms. Jacoby, you are next. Welcome.

TESTIMONY OF MELISSA B. JACOBY

Ms. JACOBY. I thank the subcommittee for inviting me to participate today. I am a law professor, and I study contracts and bankruptcy, and specifically medical bankruptcy, which many members of the committee have already mentioned, as has my co-panelist, and I have been researching the impact of medical debt, illness and injury on households of modest means, from the background of someone who looks at contracts and bankruptcy.

The main observation I want to offer you today is this: Uninsured patients of modest means actually may be paying a steep price for what hospitals and others characterize as "uncompensated care." In other words, charging uninsured patients the highest prices coupled with assertive debt collection affects patients and their families, even if the hospital ultimately writes off the entire bill. And I think that government, industry, and individual hospital policy should be evaluated with this in mind.

Millions of American families are in debtor/creditor relationships on account of medical care, and this certainly may not be problematic for those with generous incomes, high quality insurance and, frankly, those with good luck. Modest income families, on the other hand, struggle when they are personally liable for unexpected and undiscounted hospital bills. A bill of even $500 or $1,000, as many others have noted, can derail the budget of a working family, let alone bills of $5,000, $10,000, or more. And certainly it is evident that a lump sum often is infeasible. But even paying installments with accruing interest has the potential to leave a patient in a state of perpetual indebtedness.

Debtor/creditor laws are not self-executing and do not require that creditors call, pressure, threaten, sue, garnish, or record liens on patients' homes in an effort to get paid, and hospitals may believe no harm comes from trying to collect before they write off the bills as bad debts or before they consider charity care eligibility, and the complex way of the laws and regulations seem to make this the easier course, but there is harm to patients and their families even if the hospital never collects a dime.

We are finding a lot of medical related financial trouble in the bankruptcy system, and we do estimate that half of all personal bankruptcy filings are medical-related. In a study still underway, uninsured medical bankruptcy filers have reported an average of nearly $11,000 in medical bills since illness onset. And bankruptcy filers with most medical diagnoses identify hospital bills as their largest uncovered expense, or their largest medical expense.

Now, bankruptcy offers some benefits, some help to indebtedness patients. For example, it stops debt collection attempts, it removes liens that hospitals may impose on homes under some circumstances, and discharges some debts, although not all, but we all know that bankruptcy has a lot of consequences. Among other things, it ruins credit for 10 years, and may affect the ability to access nonemergency health care in the future. No one sees bankruptcy as a solution to the problems that we are talking about today. And of course bankruptcy filers really are the tip of the iceberg. The financial impact of hospital billing and collection extends to many households with similar problems, who never do file for bankruptcy. For these households, like their bankrupt counterparts, defaulting on a hospital bill sent to collection results in negative credit report notations. Medical debt collectors actively do report to credit bureaus.

Federal Reserve researchers who studied credit reports in 1999 estimated that medical bills accounted for more than half of collection agency actions listed on credit reports. Credit reports also may list hospital lawsuits, judgments and liens. Notations related to payment history and legal action reduce one's credit score, and a borrower with a low credit score, assuming she can get credit at all, may be expected to pay as much as several hundred dollars more every month for credit. This affects home buying, refinancing, and sending kids to college, among other things. And, when employers or potential employers or landlords also access these credit reports, the ramifications can multiply.

Beyond the financial impact, hospital billing and collection practices may have a health impact. First, debt and collection may induce stress, and a large body of interdisciplinary research suggests that stress adversely affects health. Second, hospital debt may affect future access to care. Half of medical bankruptcy filers report chronic health conditions. They need more care in the future like even those who do not have chronic conditions. Yet, health providers may turn away indebted or bankrupt patients, or patients may be too embarrassed or fearful to seek care after being subject to debt collection efforts.

So, I will conclude where I started. Uninsured patients of modest means pay a steep price for what so often is characterized or even touted as uncompensated care. This is an important piece of the

puzzle, as lawmakers, regulators, and health care providers work through the issues underlying this investigation.

I thank the subcommittee.

[The prepared statement of Melissa B. Jacoby follows:]

PREPARED STATEMENT OF MELISSA B. JACOBY, ASSOCIATE PROFESSOR, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Thank you for the opportunity to participate in this important hearing. I approach this issue from the perspective of a law professor who studies and teaches bankruptcy, contracts, and related subjects. While as a member of the Temple University faculty in Philadelphia, and now as I join the faculty of the University of North Carolina at Chapel Hill, I have been studying the impact of indebtedness and debt collection on individuals and families with illness or injury.

In the current health care environment, patients often are debtors of their medical providers.[1] Characterizing medical providers as creditors means little independently; the law gives creditors a set of tools to coax or require their debtors to repay,[2] but does not require that creditors use them. Creditors generally exercise their discretion in using, or refraining from using, their debt collection toolbox depending on the circumstances. Thus, for example, credit unions on the whole take a different approach to debt collection than retailers.

A confluence of circumstances makes the hospital billing and collection situation particularly troubling. Hospitals have zealously used their debt collection toolbox even against patients who did not expect this liability (at all, or of this magnitude), are of modest means,[3] and may be suffering income loss alongside their illness or injury.[4] Hospitals engage in debt collection activities amidst allegations that these practices conflict with their missions, and despite arguments that they already receive significant governmental support to subsidize their care of modest income patients. To the extent that hospitals pursue collection before dispositively determining charity care eligibility,[5] some patients subject to collection for undiscounted bills never should have been considered debtors in the first place.[6]

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[1] *See generally* Melissa B. Jacoby, *The Debtor-Patient; In Search of Non-Debt Alternatives,* 69 BROOKLYN L. REV. (forthcoming 2004). Courts routinely characterize patients and providers as debtors and creditors. *See, e.g.*, Trevino v. HHL Financial Services, 945 P.2d 1345, 1348-1349 (Colo. 1997) (describing hospital as patient's creditor, as patient received medical care for which he agreed to pay); Porter v. McPherson, 479 S.E.2d 668, 673, 675 (W. Va. 1996); Bashara v. Baptist Mem. Hosp. Syst., 685 S.W. 2d 307, 310-311 (Tex. 1985) (describing hospital patient relationship as debtor-creditor relationship).

[2] Those tools include informal communications and threats, along with more formal approaches invoking the power of the state, such as filing lawsuits and instructing the sheriff to levy on property.

[3] For a striking study showing low incomes of patients written off as bad debt after failed collection, see Joel S. Weissman, Paul Dryfoos, & Katharine London, *Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals; Does uncompensated care serve the truly needy,* 18 HEALTH AFFAIRS 156, 161 (1999). Yet, even uninsured and underinsured families better described as middle class have trouble paying hospital bills. Middle income households already have committed their incomes to important fixed costs such as housing, transportation, and child care, leaving little or no cushion. *See* ELIZABETH WARREN AND AMELIA WARREN TYAGI, THE TWO-INCOME TRAP: WHY MIDDLE-CLASS MOTHERS & FATHERS ARE GOING BROKE (2003).

[4] *See, e.g.,* Melissa B. Jacoby, *Collecting Debts from the Ill and Injured; The Rhetorical Significance, but Practical Irrelevance, of Culpability and Ability to Pay,* 51 AM. U. L. REV. 229, 238 (2001) (overlap in debtors reporting job problems and medical problems in chapter 13 bankruptcy); Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts,* 76 N.Y.U. L. REV. 375, 408 (2001) (overlap in debtors reporting job problems and medical problems).

[5] *See, e.g.,* Ray B. Lefton, *Developing Organizational Charity-Care Policies and Procedures,* HEALTH CARE FINANCIAL MANAGEMENT 52, 54-55 (April 2002) (describing hospital policies that permit collection attempts to proceed against charity care accounts); Health Care Financial Management Association, Principles and Practices Board Statement Number 15, Valuation and Financial Statement Presentation of Charity Service and Bad Debts By Institutional Healthcare Providers, *available at* www.hfma.org/resource/P__and__P__board/Statement__15.htm (last accessed June 1, 2004) (describing debt collection activity as part of "information gathering process" to determine charity care eligibility).

[6] *See, e.g.,* Universal Health Care Action Network of Ohio, *A Well Kept-Secret: The Challenge of Finding Out About Hospital Free Care in Cleveland Ohio* (Oct. 2003). They also may have been eligible but not enrolled in other programs that would have covered part or all of the costs of their care. See generally General Accounting Office, *Means Tested Programs: Determining Financial Eligibility is Cumbersome and Can Be Simplified,* GAO-02-58 (November 2001); Barents Group LLC, Final Report On "Review of the Literature On Evaluations of Outreach for Public

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The patient-hospital debtor-creditor relationship is different from many others in its origin. If a consumer does not like the terms a store offers for the purchase of a television, we expect that the consumer should be able to walk away. As one court put it, however, when a loved one legitimately needs medical care, "the option of walking away from the deal [is] simply unrealistic."[7] Patients or family members often seek hospital care and sign various hospital documents and agreements under trying circumstances.[8] These documents—frequently the basis of the hospital's creditor status[9]—may require that the patient or loved one promise to pay the full-charge rate, and sometimes have required payment of attorneys' fees, costs, interest, or even penalties, if the bill goes to collection.

Hospital decision-makers may believe there is little harm in charging full price and trying to collect before writing off these accounts as bad debt. Hospitals also may be responding to incentives built into the complex regulatory environment; even if current law and regulations do not expressly preclude discounts and more lenient collection practices, it likely is easier to ensure compliance with the regulatory scheme by imposing full charges and engaging in assertive collection.

Given this situation, it is important to set the record straight: hospital billing and collection practices can adversely affect patients and their families whether or not those practices produce payment or ultimately are written off as bad debt.

1. Hospital collection activity has credit report implications

Medical bill collection activity hurts patients' credit rating whether or not the activity produces payment for the hospital. In the words of Federal Reserve researchers, "[p]erhaps the most important factors considered in credit evaluation are a consumer's history of repaying loans *and any evidence of money-related public actions or non-credit-related collections*."[10] These researchers estimated that medical bills accounted for nearly one fifth (18.2%) of court judgments recorded on credit reports, and more than half (52.2%) of collection agency actions reported to credit bureaus, many for rather small amounts of money.[11] When a collection agency action, law-

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Health Insurance and Selected Other Programs" (Mar. 31, 2002), *available at* www.cms.hhs.gov/schip/outreach/rpt33100.pdf; Jennifer P. Stuber, Kathleen A. Maloy, Sara Rosenbaum & Karen C. Jones, *Beyond Stigma: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid?* (The George Washington University Medical Center, Issue Brief, July 2000); Dahlia K. Remler, Jason E. Rachlin & Sherry A. Glied, *What Can the Take-Up of Other Programs Teach Us About How To Improve Take-Up of Health Insurance Programs?* (National Bureau of Economic Research, Working Paper No. 8185, Mar. 2001); Michael J. Perry, Evan Stark & R. Burciaga Valdez, The Henry J. Kaiser Family Foundation, *Barriers To Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings From Eight Focus Groups In California With Parents of Potentially Eligible Children* (Sept. 1998), *available at* www.kff.org/medicaid/1436-index.cfm; Michael Perry, Susan Kannel, R. Burciaga Valdez & Chrstina Chang, The Henry J. Kaiser Family Foundation, *Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey* (Jan. 2000), *available at* www.kff.org/medicaid/2174-index.cfm.

[7] Valley Hospital v. Kroll, 2003 WL 23416577 (N.J. Super. 2003) ("terms contained in the form were non-negotiable. The hospital clearly exercised a decisive advantage in bargaining. Prior to any treatment, a patient—or in this case someone acting on his behalf—was compelled to sign it. The patient was in no position to reject the proffered agreement, to bargain with the hospital, or, in lieu of agreement, to find another hospital").

[8] For example, a mother rushed her son to the hospital after an accident left him unconscious and bleeding. After the hospital sued her for payment, she explained that "I signed where she told me to sign, so they would give him medical treatment because he needed it because he was bleeding out of his ears, out of his mouth, the bone out of his elbow was sticking out through the skin." Heartland Health Systems v. Chamberlin, 871 S.W.2d 8, 11 (Mo. App. W.D. 1993) (holding patient's mother liable under terms of admission agreement based on her signature). *See also* Bethesda Hospital v. Kessnick, 174 B.R. 481 (S.D. Ohio 1994) (hospital acknowledging that father signed form during very stressful time upon daughter's admittance to hospital).

[9] *But see, e.g.,* Doe v. HCA Health Services of Tennessee, Inc, 46 S.W.3d 191 (Tenn. 2001) (refusing to enforce hospital debt on basis of agreement due to indefinite price term, but considering value of services for purposes of holding patient liable on quantum meruit/unjust enrichment theory).

[10] Robert B. Avery, Paul S. Calem, Glenn B. Canner & Raphael W. Bostic, *An Overview of Consumer Data and Credit Reporting,* FEDERAL RESERVE BULLETIN 47, 60-61 (Feb. 2003) (emphasis added); My FICO (a division of Fair Isaac), www.myfico.com (reporting on credit history components, including judgments and liens).

[11] Robert B. Avery, Paul S. Calem, Glenn B. Canner & Raphael W. Bostic, *An Overview of Consumer Data and Credit Reporting,* FEDERAL RESERVE BULLETIN 47, 67, 69 (Feb. 2003). *See also* Sara R. Collins et. al, *The Affordability Crisis in U.S. Healthcare: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund Issue Brief #723 17-19 (March 2004); S. Felt-List, M. McHugh, & E. Howell, *Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?* 21 HEALTH AFFAIRS 277 (Sept/Oct. 2002) (reporting on collection agency contacting the uninsured).

suit, judgment, and lien all are listed on a patient's credit report, the adverse effects of one default not only multiply, but linger.[12]

As suggested above, the credit report and credit score are key determinants of whether a patient will receive credit and, if so, what the terms will be.[13] In addition, the Fair Credit Reporting Act permits credit reports to be used for a variety of other purposes, such as employment-related inquiries.[14] Thus, one expensive trip to a hospital, followed by zealous collection and reporting, can bring about a host of unexpected negative effects.

2. Large medical debts and collection activity contribute to bankruptcy

Bankruptcy researchers have discovered that almost half of personal bankruptcy filers have significant medical debts and/or say that illness or injury was a reason for their bankruptcies.[15] A variety of studies find between one third to more than half of bankruptcy filers owed debts directly to medical providers at the time of filing,[16] and these understate the problem because they do not include medical bills charged to credit cards or rolled into home mortgage loans. Bankruptcy filers sixty-five or older had the highest rate of reporting that illness or injury was a reason for filing bankruptcy.[17]

Even insured patients may see their credit ruined through medical-related bankruptcy.[18] The majority of those in medical-related bankruptcy say they have some insurance at the time of filing.[19] Among married joint bankruptcy filers who were

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[12] Accounts placed for collection, civil suits, and judgments can be reported for seven years for most purposes, but the seven-year period starts and ends at different times for each notation. Fair Credit Reporting Act § 605, 15 U.S.C. § 1681c. Information about failure to pay medical debts will affect credit nothwithstanding the fact that recent amendments to the Fair Credit Reporting Act impose additional conditions on the handling of medical information.

[13] Regularly updated charts on the "My Fico" website show that a borrower can pay several hundred dollars more on a loan *each month* because of a low credit score. www.myfico.com (last accessed June 4, 2004).

[14] *See, e.g.,* Fair Credit Reporting Act § 604, 15 U.S.C. § 1681b (listing permissible purposes of furnishing consumer report, including employment purposes, and specifying conditions); id at § 1681k (procedures relating to reporting of public record information for employment-related inquiries).

[15] *See* Melissa B. Jacoby, Teresa A. Sullivan, & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts,* 76 N.Y.U. L. REV. 375 (2001) (46.2% medical-related filings); Bruce Jancin, *Medical Bills Cited in 55% of U.S. Bankruptcy Cases,* SKIN AND ALLERGY NEWS (Aug 2003).

[16] *See, e.g.,* Hugh F. Daly III, Leslie M. Oblak, Robert W. Seifert & Kimberly Shellenberger, *Into the Red To Stay in the Pink: The Hidden Cost of Being Uninsured,* 12 HEALTH MATRIX 39, 56 (2002) (47% with medical debt among Legal Aid Society of Greater Cincinnati clients who sought assistance with bankruptcy filings in 2000-2001); Ed Flynn & Gordon Bermant, *The Class of 2000,* AM. BANKR. INST. J., Oct. 2001 (56.2% of chapter 7 no-asset bankruptcy filers with medical debt on bankruptcy schedules); Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts,* 76 N.Y.U. L. REV. 375, 387 (2001) (31.2% reported owing money to "health care providers, services, supplies" at time of filing bankruptcy); Champaign County Health Care Consumers Medical Billing Task Force, *How Medical Debt Affects Champaign County Consumers; A Community Report on Medical Debt-Related Bankruptcies and Small Claims Lawsuits* (July 11, 2002) (58% of cases in Central District of Illinois in December 2001 involved debts owed to medical providers). For a less recent study finding a high incidence of medical debt, see Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy,* 65 AM. BANKR. L. J. 675 (1991) (80% of judgment proof chapter 7 debtors in Tennessee district had medical debt, with mean amount of over $7,800 in mid-1980s). In a recent study, one couple owed $200,000 of medical bills not covered by insurance, while another debtor accrued $20,000 debt a year for care of her husband who had been in a coma for five years. *See* Melissa B. Jacoby, *Collecting Debts from the Ill and Injured; The Rhetorical Significance, but Practical Irrelevance, of Culpability and Ability to Pay,* 51 AM. U. L. REV. 229, 248-249 (2001).

[17] *See* Melissa B. Jacoby, Teresa A. Sullivan, & Elizabeth Warren, *Rethinking the Debates Over Health Care Financing: Evidence From the Bankruptcy Courts,* 76 N.Y.U. L. REV. 375, 397-398 (2001).

[18] *See, e.g.,* Fair Credit Reporting Act, § 605, 15 U.S.C. § 1681c (permitting bankruptcy cases to be listed for ten years "from the date of the entry of the order for relief or the date of adjudication).

[19] *See* Melissa B. Jacoby, Teresa A. Sullivan, & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts,* 76 N.Y.U. L. REV. 375, 399-400 (2001). Whether they experienced gaps in insurance, however, is an important question that warrants further study. *See generally* Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003) (nearly 60 million people were uninsured at any point within 1998); Hearing on the Uninsured, Committee on Ways and Means Subcommittee on Health (March 9, 2004) (statement of Douglas Holtz-Eakin, Director of the Congressional Budget Office, figure 1).

insured at the time of their bankruptcy filings, almost 40% reported owing debt to a provider of medical services or supplies.[20]

3. Large hospital debts and collection activities adversely affect patient health

In addition to financial costs, patients suffer health-related costs from hospital bills.[21] The first relates to the health impact of stress.[22] Some researchers are concerned specifically about the negative impact of indebtedness and related financial trouble on certain diseases or conditions.[23]

Owing a significant debt can be stressful on its own. The stress is exacerbated, however, by a zealously pursued debt collection process. While still in a hospital bed, a patient may receive a visit from a hospital representative to discuss payment.[24] Once home, the patient may start to receive letters and phone calls proposing ways of taking care of the bill. The calls will get pressing when the first debt collector takes over,[25] and get even more assertive if the hospital enlists the services of a secondary debt collector.[26] Debt collectors will threaten to report the patient's delinquency to credit bureaus and/or threaten to file a lawsuit. If they follow through on the latter,[27] the litigation process itself can be intimidating. Although

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[20] *See* Melissa B. Jacoby, *The Debtor-Patient; In Search of Non-Debt Alternatives,* 69 BROOKLYN L. REV. table 1 (forthcoming 2004).

[21] *See generally* Melissa B. Jacoby, *Does Indebtedness Influence Health? A Preliminary Inquiry,* 30 J. L. MED. & ETHICS 560 (2002).

[22] *See generally* M. Katz, *Stress, Control, and Psychological Interventions,* in STRESS AND HEALTH AMONG THE ELDERLY (M.L. Kykle et. al, eds., 1992); W.R. LOVALLO, STRESS AND HEALTH; BIOLOGICAL AND PSYCHOLOGICAL INTERACTIONS (1997); A. O'Leary et. al, *Stress and Immune Function, in* CLINICAL DISORDERS AND STRESSFUL LIFE EVENTS (T.W. Miller ed., 1997); Steven C. Ames, Glenn N. Jones, & Phillip J. Brantley, *A Prospective Study of the Impact of Stress on Quality of Life: An Investigation of Low-Income Individuals with Hypertension,* 23 ANN. BEHAV. MED. 112 (2001); P.A. Barnett, J.D. Spence, & J.R. Jennings, *Psychological Stress and the Progression of Carotid Artery Disease,* 15 J. HYPERTENS. 49 (1997).

[23] *See, e.g.,* Patricia Drentea and Paul J. Lavrakas, *Over the Limit: The Association Among Health, Race and Debt,* 50 SOCIAL SCIENCE AND MED. 517 (2000); Simon Hatcher, *Debt and Deliberate Self Poisoning,* 164 BRITISH J. PSYCHIATRY 111 (1994); Richard Reading & Shirley Reynolds, *Debt, Social Disadvantage and Maternal Depression,* 53 SOCIAL SCIENCE & MED. 441 (2001); Steven Hope, Chris Power, & Bryan Rodgers, *Does Financial Hardship Account for Elevated Psychological Distress in Lone Mothers?,* 49 SOCIAL SCIENCE & MED. 1637 (1999); G.W. Brown & P.M. Moran, *Single Mothers, Poverty and Depression,* 27 PSYCHOLOGICAL MED. 21 (1997); Robert J. Havlik, Allexander P. Vukasin, & Stephan Ariyan, *The Impact of Stress on the Clinical Presentation of Melanoma,* 90 PLASTIC AND RECONSTRUCTIVE SURGERY 57 (1992); Hilary Graham & Clare Blackburn, *The Socio-Economic Patterning of Health and Smoking Behavior Among Mothers With Young Children on Income Support,* 20 SOCIOLOGY OF HEALTH & ILLNESS 215 (1998); H.G. Morgan et. al, *Deliberate Self-Harm: Clinical and Socio-economic characteristics of 368 Patients,* 127 BRITISH J. PSYCHIATRY 564 (1975); J.H.J Bankroft et al, *The Reasons People Give for Taking Overdoses,* 128 BRITISH J. PSYCHIATRY 538 (1968). *See also* GILLIAN PARKER, GETTING AND SPENDING: CREDIT AND DEBT IN BRITAIN (1990); DAVID CAPLOVITZ, CONSUMERS IN TROUBLE: A STUDY OF DEBTORS IN DEFAULT (1974); M. RYAN, SOCIAL WORK AND DEBT PROBLEMS (1996); E. KEMPSON ET AL, HARD TIMES? HOW POOR FAMILIES MAKE ENDS MEET (1994).

[24] *See* Rhonda L. Rundle & Paul Davies, *Hospitals Start to Seek Payment Upfront,* WALL. ST. J., June 2, 2004, at D1; Patrick Reilly, *Extracting Payment; Hospitals try collecting before patients leave ER,* MODERN HEALTHCARE, Nov. 17, 2003, at 8.

[25] Healthcare collection is its own segment of the collection industry. *See, e.g.,* ACA International, The Association of Credit and Collection Professionals, *Collections Information, available at* www.acainternational.org (last updated 2/16/04); ACA International, The Association of Credit and Collection Professionals, Healthcare Collections (last updated 3/1/04). Hospitals mostly pay their collectors on contingency. See *id.*; Tom Jajny, *The What, Why and When of Collecting Patient Balances,* MEDICAL PRACTICE MANAGEMENT, July/Aug/2003, at 33. Debt collectors of course are expected to act within the limits permitted by the Fair Debt Collection Practices Act and related laws. *See, e.g.,* Federal Trade Commission Bureau of Consumer Protection Opinion Letter to J. Russell Gibson, III (February 21, 1990) *available at* www.ftc.gov/os/statutes/fdcpa/letters/gibson90.htm (opinion letter on whether "day 1" "pre-collection" services for hospital fall within FDCPA); Federal Trade Commission Bureau of Consumer Protection Opinion Letter to Thomas Isgrigg (November 10, 1992) *available at* www.ftc.gov/os/statutes/fdcpa/letters/isgrigg1.htm (opinion letter on whether activities of agency with respect to delinquent medical accounts fall within FDCPA).

[26] Robert M. Frohlich, *Effective reassignment of accounts can decrease bad debt,* HEALTHCARE FINANCIAL MANAGEMENT 36, 37 (1994) (describing use of subsequent collection agency placements, lawsuits, and credit bureau reporting).

[27] *See, e.g.,* Champaign County Health Care Consumers Medical Billing Task Force, *How Medical Debt Affects Champaign County Consumers; A Community Report on Medical Debt-Related Bankruptcies and Small Claims Lawsuits* (July 11, 2002) (in study of small claims court records, finding 20% of plaintiffs were not-for-profit health providers).

liability is determined quickly in many cases, other cases—and the associated stress and uncertainty—linger for years after the original hospitalization.[28]

Whether or not the lawsuit results in a court judgment, concerns about the magnitude of the hospital bill may increase if the patient's liability includes court costs, execution costs, and perhaps even the hospital's attorneys' fees. [29] Patients also understandably fear what comes after a court judgment: a judgment entitles a creditor to garnish wages, attach bank accounts, or direct a sheriff to levy on property within limits imposed by state and federal exemption laws. Even if a patient has property of little value, the prospects of loss can be frightening and devastating.[30]

Aside from the health impact of stress, large medical debts can dampen a patient's likelihood of receiving future medical care. Medical providers may refuse to give non-emergency care, or patients indebted for prior care may fear to seek more.[31] This is especially troubling for patients with chronic problems. Debt, therefore, may exacerbate the health care access problems experienced by the uninsured and underinsured.[32] Large hospital debts and related financial distress also make it harder to afford adequate food, safe housing and other basic necessities.[33]

4. Large hospital debts and collection activity directly affect patients' families

The financial and health effects of hospital bills and debt collection are not limited to patients. They apply to their loved ones as well. This is particularly true when hospitals seek to hold family members liable for patients' care. As noted previously, hospitals sometimes do so on the basis of signatures on admission forms. For example, in one case, an eighty-year-old widow was mourning the death of her husband, who had suffered several debilitating illnesses, when the hospital sued her for more than $257,000 for his hospital bills based on her signature.[34] Other times, hospitals seek to hold spouses liable on other grounds, such as the doctrine of necessaries.[35]

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[28] *See, e.g.,* County of Santa Clara v. Vargas, 139 Cal. Rptr. 537 (Cal. App. 1977) (medical care given in 1969, payments made until 1974, and this case report published in 1977); Mercy Hospital, Inc. v. Carr, 297 So.2d 598 (Fla. App. 1974) (published appeal in 1974 for debt incurred in 1968); Orthopedic & Reconstructive Surgery, S.C. v. Kezelis, 496 N.E.2d 1112 (Ill. App.1986) (reported decision in 1986 for dispute over medical bill for services in 1978).

[29] *See, e.g.,* Sholkoff v. Boca Raton Community Hospital, Inc., 693 So.2d 1114 (Fla. App. 1997) (interpreting and upholding patient authorization agreement imposing collection costs, attorneys' fees, and interest at the "highest rate permitted by law" if patient does not pay in full within 45 days). See generally William J. Woodward Jr., *Enforcements of Money Judgments: Objectives and Restrictions,* in 9 DEBTOR-CREDITOR LAW 37-24 (Theodore Eisenberg, ed. 1990) (discussing allocation of costs).

[30] Even among the lowest income quintile, 40.6% of families owned houses and 56.8% owned cars according to the 2001 Survey of Consumer Finance. Arthur B. Kennickell et. al, *Recent Changes in U.S. Family Finances: Evidence from the 1998 and 2001 Survey of Consumer Finance,* FEDERAL RESERVE BULLETIN 1, 19 (Jan. 2003).

[31] D. Andrulus et. al, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?,* The Access Project (Jan. 2003); Bruce Jancin, *Medical Bills Cited in 55% of U.S. Bankruptcy Cases,* SKIN AND ALLERGY NEWS (Aug 2003); ELIZABETH WARREN & AMELIA WARREN TYAGI, THE TWO-INCOME TRAP; WHY MIDDLE-CLASS MOTHERS AND FATHERS ARE GOING BROKE (2003); D. Gurewich, R. Seifert, & J. Prottas, *The Consequences of Medical Debt: Evidence from Three Communities,* The Access Project (Feb. 2003); Carol Pryor & Deborah Gurewich, *Getting Care But Paying the Price; How Medical Debt Leaves Many in Massachusetts Facing Tough Choices,* The Access Project (Feb. 2004).

[32] *See, e.g.,* U.S. Census Bureau, *Supplemental Measures of Material Well-Being: Expenditures, Consumption, and Poverty 1998 and 2001,* P23-201, 10 (Sept. 2003) (reporting on percentage of families who needed to visit doctor or hospital but did not go); John Z. Ayanian et. al, *Unmet Health Needs of Uninsured Adults in the United States,* 284 J. AM. MED. ASS'N 2061 (2000) (nearly ⅖ of long term uninsured adults and 1/3 of short term uninsured adults reported not being able to see physician when needed in the past year due to cost).

[33] *See generally* Sara R. Collins et. al, *The Affordability Crisis in U.S. Healthcare: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund Issue Brief #723 (March 2004); Carol Pryor & Deborah Gurewich, *Getting Care But Paying the Price; How Medical Debt Leaves Many in Massachusetts Facing Tough Choices,* The Access Project (Feb. 2004). *See also* U.S. Census Bureau, *Supplemental Measures of Material Well-Being: Expenditures, Consumption, and Poverty 1998 and 2001,* P23-201 (Sept. 2003) (reporting on households living with inadequate food, in homes with leaky roofs, and in neighborhoods with abandoned buildings, smoke or fumes, and where they are afraid to walk at night).

[34] *See* Valley Hospital v. Kroll, 2003 WL 23416577 (N.J. Super. April 17, 2003). Medicare and Medigap had paid the hospital hundreds of thousands of dollars, but the hospital argued it could balance bill the patient's widow for its full charge once Medicare Part A benefits had been exhausted. Nearly three years later, the court granted partial summary judgment in favor of the patient's widow on the balance billing issue.

[35] According to courts and commentators, hospitals have been the principal users of the doctrine of necessaries, leading to the conclusion that this doctrine is more of a hospital debt collec-

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Even if the spouse is ultimately is not held liable, he or she has been placed through an additional ordeal at a time of great emotional distress.

5. Medical-related financial products are not necessarily the solution

Various studies have observed the use of third party credit for medical bills.[36] This shifts the burden of collection and risk of non-payment away from the medical provider. Providers understandably find this prospect attractive even though they incur costs associated with processing credit card charges.[37]

Some health care providers and third parties are taking this to the next level: they are joining forces to offer medical-specific credit products to patients.[38] Many of these products do not shift the risk of non-payment entirely away from providers, but the risks and burdens on the whole seem far lower for providers than those associated with the traditional billing and collection process.

These products have received little systematic attention at this point and they raise a host of issues. According to a quote in the American Medical News, the director of the American Medical Association Institute for Ethics worries that these products may result in "further commercialization of the patient-physician relationship," and that cards targeted toward those with poor credit histories "are in essence endorsing the idea that impoverished patients who have the worst credit history should sign up for another credit card, which by the way will pay [medical providers] off first."[39]

For purposes of this hearing, however, it suffices to say that these products do not seem to address the needs of uninsured hospital patients. A $40,000 credit card bill is not much better than a $40,000 hospital bill, and may be worse. Some medical credit products offer interest free installments for limited periods, but the interest rates jump to 20% or higher thereafter. Even at a lower interest rate, the patient

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tion device than a spousal support device. *See* Medical Center Hospital of Vermont v. Lorrain, 675 A.2d 1326, 1329 (Vt 1996) ("virtually all necessaries cases are hospitals seeking payment, often due to last illness"); Shawn M. Willson, Comment, *Abrogating the Doctrine of Necessaries in Florida: The Future of Spousal Liablity for Necessary Expenses After Connor v. Southwest Florida Regional Medical Center, Inc.,* 24 FLA. ST. U. L. REV. 1031, 1043 (1997) ("In the last fifty years, all of the Florida cases in which a party invoked the doctrine involved unpaid medical expenses. In case after case, hospitals sought to trap an unwilling spouse into making payment on a debt for which he or she did not contract"). However, some state courts abolished the doctrine of necessaries on constitutional grounds, leaving to the legislatures whether to enact a gender-neutral statute. *See, e.g.,* North Ottawa Community Hospital v. Kieft, 578 N.W.2d 267, 273 (Mich. 1998) (holding doctrine of necessaries no longer is part of Michigan's common law, and thus "neither husband nor a wife is liable, absent express agreement, for necessaries supplied to the other").

[36] *See, e.g.,* Sara R. Collins et. al, *The Affordability Crisis in U.S. Healthcare: Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund Issue Brief #723 (March 2004) (among those with medical debt, approximately one fifth ran up credit card debt or incurred debt secured by home); Glenn B. Canner et. al., *Recent Developments In Home Equity Lending,* 84 FEDERAL RESERVE BULLETIN 241, 248 tbl.8 (1998) (increase in borrowers indicating medical expenses as use for home equity lines of credit and loans); Peter J. Brady et. al, *The Effects of Recent Mortgage Refinancing,* FEDERAL RESERVE BULLETIN 441, 446 (July 2000) (39% of 1998 and early 1999 refinancings used for consumer expenditures, which includes medical expenses among a list of other things). This is not an entirely new phenomenon, however. Even a study in the 1970s found medical costs a major reason for consumers taking out personal loans. Thomas A. Durkin & Gregory E. Eliehausen, 1977 Consumer Credit Survey, 80, table 15.1 (Washington DC Federal Reserve Board, 1978).

[37] *See, e.g.,* Julie A. Jacob, *Credit to your practice: Letting patients pay with plastic,* AMERICAN MEDICAL NEWS, July 29, 2002.

[38] *See, e.g.,* Tyler Chin, *In the cards: Getting Paid with Plastic; Innovations in the credit and debit card industry are giving physicians new options for collecting bills,* AMERICAN MEDICAL NEWS, Jan. 12, 2004; Mike Stobbe, *Credit card agency cuts hospitals' losses,* THE CHARLOTTE OBSERVER, July 11, 2003; www.accessonemedcard.com; Michael Unger, *Just What the Doctor Ordered; Schein's One-Stop Service Ranges from Equipment to Personal Finance,* NEWSDAY, Dec. 30, 1996, at C7 (discussing MedCash credit cards, with interest rates eventually rising to 19%); News Release, *PracticeXpert Launches Pxpert Medical Credit Card Program* (Sept. 4, 2003) (acquiring delinquent accounts from physician and transferring balance to credit card, which can be used for other purchases as patient re-pays); News Release, *King Thomason Group Enters into Agreement With Medical Capital Corporation to Market KTG's TotalCare Medical Accounts Receivable Credit Card Program* (April 23,2004); www.kgth.com/main/totalrecovery.htm (citing 95% approval rate for private pay patients); Citibank Health Card Program, www.citibank.com/us/cards/cardserv/healthcrd/cons—benefits.htm (card for family health needs, offering 3 month interest free period with rate of nearly 22% thereafter, and default interest rate of over 25%); HELPCard, www.helpcard.com (interest rate of prime plus 11.9%); www.healthEZ.com (encouraging employers to offer to employees as supplement to health plans); DeeDee DePass, *How HealthEZ Got Fit,* STAR TRIBUNE, www.carecredit.com.

[39] Tyler Chin, *In the cards: Getting Paid with Plastic; Innovations in the credit and debit card industry are giving physicians new options for collecting bills,* AMERICAN MEDICAL NEWS, Jan. 12, 2004.

may face a perpetual oppressive obligation.[40] To the extent lenders and providers encourage medical-specific home equity products, it is worth noting that undiscounted hospital bills rolled into home mortgage loans raise the stakes further; home equity loans for large medical bills reduce retirement security through the loss of equity, and may lead to home loss altogether.[41]

In addition, one again needs to consider the credit report implications. Credit cards and loans are trade accounts that have a wider range of credit-rating effects than medical debts. Thus, in addition to all of the previously discussed effects of medical debt, the mere existence of a trade account can affect the patient's credit score, particularly if the liability is large or if the patient recently opened other accounts. In addition, the lender is likely to regularly report any lateness in repayment, further affecting the patient's credit rating. Given these risks, medical-specific credit products are not likely to offer the solution to the problems being discussed today.

Thank you again for the opportunity to participate in this important hearing. I would be glad to help the Subcommittee however I can.

Mr. WALDEN. Thank you for your testimony, we appreciate it.

Mr. Rukavina, we appreciate your being here today, and look forward to your comments.

TESTIMONY OF MARK RUKAVINA

Mr. RUKAVINA. Thank you, and I would like to thank the subcommittee for this opportunity today. I am the Executive Director of The Access Project. We are a national resource center working with local groups that are trying to expand access to health care, and over the past few years we have produced a number of reports on medical debt.

Medical debt is an enormous problem in this country. The Commonwealth Fund recent survey identified that half of Americans with no health insurance had problems related to medical bills or accrued medical debt. And maybe surprising to some here today, more than half of the uninsured experiencing these problems used all or most of their savings to pay medical bills.

I would like to make three main points, then offer some recommendations. First, the uninsured are charged the highest fees for care. They are given a raw deal when it comes to hospital billing. Though many uninsured patients get the necessary medical treatment that they need from hospitals, they are charged the highest fees for that care. Paying for medical care is a burden, it is crushing for the uninsured. People with insurance pay a discounted rate, but uninsured patients pay full charges.

The Wall Street Journal reported on a 25-year-old uninsured woman from New York City, who was billed $14,000, not including doctor's fee, for a 2-day appendectomy stay. Medicaid would have paid about $5,000 for this procedure, and Medicare just under $8,000. She was ineligible for either program and was charged the full rate. This is wrong, and it is not isolated to New York State.

For years, as we have heard, hospitals have blamed this unfair practice on Federal Medicare rules and regulations. We were pleased when earlier this year Secretary Thompson clarified that

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[40] This essentially was the problem experienced by Quinton White with respect to his hospital bill payment plan. *See* Lucette Lagnado, *Twenty Years and Still Paying; Jeanette White is Long Dead But Her Hospital Bill Lives On; Interest Charges, Legal Fees,* WALL ST. J., March 13, 2003, at B1; Lucette Lagnado, *Twenty Years—and He Isn't Paying Any More,* WALL ST. J., April 1, 2003, at B1.

[41] *See, e.g.,* Federal Trade Commission, Facts for Consumers, cNeed a Loan? Think Twice About Using Your Home as Collateral, available at www.ftc.gov/bcp/conline/pubs/hoepa.htm (last accessed June 4, 2004).

hospitals could offer discounts to uninsured patients. Hopefully this will bring an end to the practice of price gouging uninsured patients, but discounting fees will not be enough.

My second point is that the uninsured need help to pay for their medical care, and to enroll in existing financial assistance programs. Most uninsured patients are not able to pay for their care in full. Fortunately, for some of the uninsured, programs exist to help them, programs like Medicaid, children's health insurance programs, and the hospital's own charity care policies. But many uninsured patients are simply unaware of these programs, and they need help in applying for them. Too few hospitals provide such assistance, but it doesn't have to be this way.

We found a very effective program at Cooley Dickinson Hospital in Northampton, Massachusetts. Hospital case managers visit each uninsured patient and review their individual health care needs. They help patients complete program applications, they refer them to a local network of physicians offering care on a sliding fee scale, and they help them apply for hospital charity care. They have enrolled hundreds of patients in Medicaid and other programs. The hospitals gain needed revenues, the patients avoid crushing debt, both are better off.

The crucial point here is that case managers review payment alternatives with patients at the front-end of the process, not when bill collectors are pounding on their doors. Without such help, many patients would be reluctant to go back to the hospital.

My final point is that the uninsured are intimidated and harmed by overly aggressive collection practices. Some collection tactics used by hospitals are simply deplorable. Aggressive practices have been well documented, we have heard of some of them already today. Patients have been hounded by collection agencies, sued and subsequently charged high interest rates, have wages garnished, liens slapped on homes, some have even been arrested and imprisoned for the bills that they have incurred.

In Illinois, a woman who incurred just under $1700 in bills due to a miscarriage, was briefly jailed after she missed two court hearings on hospital bills.

I have five recommendations for American hospitals. One, lower the fees charged to uninsured patients. Secretary Thompson clarified this can be done, just do it and do it now.

No. 2, help the uninsured pay for care. Hospitals must assist uninsured patients in applying for existing programs. This would provide hospitals with reimbursement for services, and help patients avoid this debt—the Cooley Dickinson example is but one—we believe other hospitals could and should implement such programs.

No. 3, stop the aggressive collection actions taken against uninsured patients. American hospitals are the finest institutions in the world. Unfortunately, the hospital billing departments and collection agencies used by some hospitals do harm patients, hauling low-income uninsured patients to court is senseless. Hospitals spend money to do this, with little financial gain, and such actions ruin the credit of uninsured patients.

No. 4, we challenge the American Hospital Association to demonstrate bold leadership and establish a financial assistance initiative for uninsured patients. An essential component of this pro-

gram would be to work in partnership with consumer and community advocacy organizations to ensure that these policies are sensible and understood by the uninsured patients in their community. It should be guided by one basic principle, and that is "do no harm." Hospitals must begin to treat patients who owe them money with respect and dignity, and hospitals should not ask Congress or the Administration for additional resources until doing so.

My final point, we urge all hospitals to join uninsured consumers in advocating for a comprehensive system of affordable health care for all.

Thank you for the opportunity to speak before you today.

[The prepared statement of Mark Rukavina follow:]

PREPARED STATEMENT OF MARK RUKAVINA, THE ACCESS PROJECT

Thank you for inviting me to speak before this panel on the important issue of hospital billing and collection practices with respect to uninsured patients.

My name is Mark Rukavina, and I am the executive director of The Access Project. The Access Project is a national resource center providing support to local organizations seeking to improve access to health care. The Access Project works in partnership with the Heller School for Social Policy and Management at Brandeis University in Massachusetts. In our work with local groups since 1998, we have undertaken numerous research and policy analysis projects and produced a series of reports on subjects relating to health care access barriers. Over the last four years, our work has increasingly focused on the problem of medical debt and its consequences. Through our research, and that of others, we have learned that the problem is widespread and its causes diverse. Hospitals practices around pricing, billing and collections are prominent among the causes of medical debt. The existence of medical debt on a large scale, and the consequences of this debt, belies many prevalent misconceptions about the uninsured and their ability to access health care. In my remarks, I would like to clarify some of these basic misunderstandings.

(1) The first misconception is that uninsured patients can get the care they need from safety-net institutions for free or at affordable prices.

The Access Project documented the actual experiences of the uninsured through a survey it conducted in 2000 of uninsured people who had received care in local safety-net institutions. *In the 24-site survey of nearly 7,000 uninsured respondents, 60 percent said they needed help paying for their medical care, and nearly half (46%) said they owed money to the facility where they received care. For those who received care in hospital emergency rooms, the percentages were even higher.*

These findings are reinforced by other national research. For example, the Commonwealth Fund's recent report, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey (March 2004),* found that two out of five adults in 2003, and 6 out of 10 among those who lacked insurance, had problems related to medical bills or accrued medical debt.

Moreover, medical debt has a direct effect on people's ability to access health care. In our 24-site survey, among the respondents with unpaid bills, almost a quarter said the debt would deter them from seeking care at the facility in the future. In another Access Project study, we interviewed low-income consumers with medical debts in three communities. More than half said their medical debts made it harder for them to get medical care. They reported that providers discouraged them from seeking additional services by requiring cash payment upfront, flatly refusing care, or encouraging them to seek new providers.

A 2000 study done by the National Association of Public Hospitals and Health Systems found that even safety-net providers do not automatically provide free care to uninsured patients. More than 80 percent of the public hospitals surveyed had implemented cost-sharing plans and an increasing number implemented pharmacy co-payment plans.

Medical debt can erode not only individuals' access to care, but also their overall financial security and that of their family. One survey found that more than a quarter of families in which one or more members were uninsured reported having to "change their way of life significantly" to pay medical bills, a figure that rose to nearly 40 percent when all family members were uninsured. *In the recent Commonwealth Fund survey, among the uninsured respondents who had medical bill problems or medical debt, almost 4 in 10 said they were unable to pay for basic necessities such as food, heat or rent; over half said they used all or most of their savings*

to pay medical bills; and more than 2 in 10 said they had taken on large credit card debt or loans against their homes to pay medical bills.

(2) Another misconception is that uninsured people expect to get their care for free, or are simply unwilling to pay for it.

In fact, the uninsured do pay a significant portion of their bills. As the Commonwealth Fund survey indicates, many exhaust their savings, take out loans, or assume large credit card debt to pay their medical bills. *A recent report by the Kaiser Commission on Medicaid and the Uninsured, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? (2004), estimates that people who are uninsured for an entire year pay over a third (35%)* of their health care costs out-of-pocket, considerably more than the 20 percent share paid by those with insurance. *According to the report, the uninsured can be expected to pay 32.6 billion dollars for their care in 2004.*

Our interviews with low-income people with medical debt found that many respondents had a strong desire to pay off their debt and tried to negotiate payment plans, but found that the terms of the plans hospitals offered were difficult to maintain, given inflexible hospital collection practices and their own tenuous financial circumstances. Here are what some of our survey respondents told us.

> "...they demanded I pay a certain amount bi-weekly. I couldn't afford it. They didn't want to help. I was willing to pay some money, as much as I could."
>
> "I (said) I couldn't pay $500, that I could pay $100, but the person answered no, that it had to be $500."

Moreover, not being able to pay their medical bills in full caused many people tremendous anxiety and stress. Again, here is what some of our respondents told us.

> "I am constantly worrying about my medical debt...I feel hopeless. I am a single mom and think that in the future I will not be able to better my life."
>
> "Owing money affects every part of your life. You don't stop worrying about it anytime."
>
> "I couldn't sleep...I just slept a few hours and it (the debt) even took my appetite away."

One factor that makes it especially difficult for uninsured people to cover the entire cost of their care is that they are often expected to pay more for the same services than other payers. Uninsured patients don't have access to the discounts negotiated by insurers or set by the government. Uninsured patients are expected to pay full charges or "the rack rate." A Wall Street Journal article in March of 2003 told the story of Rebekah Nix, a 25-year old uninsured woman in New York who was billed $14,000—not including doctor's fees—for a two-day stay for an appendectomy. The state's Medicaid program would have paid about $5,000 for the procedure, and Medicare about $7,800.

In testimony before the House Ways and Means Committee this past March, University of Southern California Professor Glenn Melnick showed that nationally, hospitals increased their mark-ups—the amount charged over and above the cost of care—from 159% in 1993 to 211% in 2003. Average mark-ups across states ranged from 135% to 300%. Given this, it's no surprise that the uninsured can't cover these costs.

Adding insult to injury, many hospitals enforce these payments through aggressive billing and collections practices, a situation that has been documented in the press and by various community groups. Reports of hospital billing and collections practices in Connecticut, New York and Illinois led to a series of articles in the *Wall Street Journal.* The *Journal* articles, as well as articles in other newspapers across the country, have detailed cases of the devastating effects of harsh collections practices in which people were hounded by collection agencies, charged high interest, had wages garnisheed and property attached, had liens put on homes, and were even arrested as they struggled to pay their bills. For example the *Journal* documented the case of Quentin White, who had been paying Yale-New Haven Hospital for over 20 years for the debt from his late wife's medical care. The hospital charged 10 percent interest, placed a lien on the White's home, and in 1996 nearly cleaned out Mr. White's bank account. Over the years, Mr. White paid nearly $16,000 on what was originally a bill of just less than $19,000. However, his outstanding balance had ballooned to about $39,000 in 2003 because of the interest charges. In another case in Champaign, Illinois, Marlin Bushman was arrested and jailed after missing a court hearing on a $579 hospital bill. Kara Atteberry was briefly jailed because she missed two court hearings on a $1,678 hospital bill incurred for a miscarriage.

Hospitals have used other tactics to improve their collection rate. Some have arrangements with commercial banks to facilitate the initiation of loans to cover medical expenses. Others have created open-ended credit accounts that are marketed as *Trouble-Free Payment Plans* but fail to disclose interest rates or other fees at the

time of application. We even know of a hospital that is issuing its own credit card to patients.

Some hospitals take drastic measures through their collection agents. Earlier this month, the Wall Street Journal reported on a practice in New York where hospital collection agencies attach the bank accounts of patients with hospital bills going back as far as 15 years. Some hospitals had even written off some of these bills and had received partial reimbursement from a state-run bad-debt pool.

There should be no place for such high-pressure tactics used against low-income people who have the misfortune of getting sick.

Given recent attention on this issue, the financial community is beginning to scrutinize hospital billing and collection practices. The Health Capital Group provides an illustration. The Health Capital Group offers services to hospitals and other medical providers relating to mergers, acquisitions and investment banking, as well as an array of other related "transactional" services including sophisticated valuation services. They recently expressed concern that hospitals failing to inform certain patients who might reasonably qualify for financial assistance or "charity care" would be exposed to class action lawsuits as well as the possibility of direct intervention from state attorneys general. They fear that this could create enormous contingent liabilities that could, in turn, significantly impair their access to capital.

As a result The Health Capital Group announced that they will cease issuing valuation opinions, validating bond ratings, rendering creditworthiness opinions, certifying debt capacity, making recommendations to bond funds or issuing compliance comfort letters and related analyses unless a hospital or hospital system demonstrates that it has written policies and procedures to inform patients of financial assistance, pricing and collection policies and publicizes these policies and procedures.

Just last week it was reported that a federal class action lawsuit was filed in federal courts in eight states against nearly one dozen non-profit hospital systems challenging whether tax exempt status should be granted to these institutions. Clearly the billing and collection practices of hospitals that have created problems for uninsured patients are now creating problems for the entire hospital industry.

(3) A third misconception is that the "truly needy" are not billed or subject to aggressive collection actions because they qualify either for public programs or for hospitals' indigent care programs.

While most hospitals do claim to have financial assistance programs to assist people without the means to pay for their medical care, *research indicates that many who might qualify for these programs never learn about them. In our 2000 survey of the uninsured, almost half (48%) of those needing help paying for care said they were never offered financial assistance,* such as being informed about the facilities' own charity care programs. Among those who received care in urban or suburban hospital emergency rooms, 70 percent said they were never offered assistance. This lack of information about available financial assistance is consistent with findings from subsequent research that The Access Project and others have done, and is a wholly avoidable cause of medical debt. Again, here is a comment from one of our survey respondents:

> "I would like the hospital to make the help office, the one that helps you pay the bill, more accessible to the people. Because I have a lot of bills that could have been paid, had they told me about that office sooner. Instead, my bills are now in a collector's office when I qualified for financial assistance, because they did not give me the necessary information . . ."

In this regard, I would like to share with you The Access Project's own experience trying to obtain hospitals' financial assistance policies. Last December, the American Hospital Association issued guidelines for its members recommending that all hospitals have written financial assistance policies that they disseminate widely in their communities. In 2003, both Tenet and HCA healthcare systems announced with fanfare programs to help the uninsured with discounts and sliding scales. Learning about the HCA program in the third quarter of 2003, and unable to find information on their website, I contacted the company to request a copy of the policy. I received no response. I made another request a month later. Finally, in December, I was told that while the policy had been implemented, HCA didn't want to post it until they saw if it "worked as intended", probably around the beginning of the new year. In February of this year, we invited HCA, along with Tenet and other area hospitals, to meet with community leaders in Florida to provide information about their financial assistance policies. Unfortunately, both HCA and Tenet declined to attend.

Only in late April, more than six months after we first requested information, did the hospitals provide us with their policies. The Access Project is hopeful that working with these systems will be far easier in the future. However, I share this story

to point out that if it takes the professional staff at a national health care resource center over half a year to find out about the hospitals' financial assistance program, one can imagine the difficulties faced by uninsured people who try to do so, especially while they are ill and vulnerable.

It is possible for hospitals to inform uninsured patients of the financial assistance programs that are available to them. However, providing information is often not enough. Hospital can and must do more than that. We recently identified a program at The Cooley Dickinson Hospital in Northampton, Massachusetts. Cooley Dickinson case managers visit each uninsured patient and review their individual health care needs. They help patients complete program applications, they refer them to a local network of physicians offering care on a sliding fee scale and assist them in applying for hospital charity care. By providing this assistance, they have enrolled hundreds of patients in Medicaid and other programs. The hospital gains needed revenues and the patients avoid crushing debt. The hospital and the patient are both better off. The crucial point is that case managers review payment alternatives with patients at the front end of the process, not after the bills have been sent to collection. Without such help, many patients would be reluctant to go back to the hospital.

(4) A final misconception is that hospitals and other healthcare providers bear the full burden of providing care for the uninsured.

I have already discussed that the uninsured themselves in fact pay a significant portion of the costs of their care. In addition, while hospitals definitely do bear a portion of this burden, they also receive funding from a variety of sources to help defray these costs. As Secretary of Health and Human Services Tommy Thompson pointed out in a letter to the American Hospital Association, "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals provisions to help hospitals bear the cost of caring for the poor and uninsured." In addition, most states and many counties and local communities have programs that help fund care for the indigent and uninsured.

A word is warranted here about the "uncompensated care" that hospitals provide. Most hospitals report their uncompensated care as a combination of bad debt and charity care, without disaggregating the two. While both types of uncompensated care similarly affect a hospital's bottom line, their effects on patients are starkly different. "Bad debt," even after a hospital has written it off, still burdens the patient. Collection efforts by outside collection agents may continue indefinitely, and the debt may be a blot on a consumer's credit record for years; it may hinder people from buying homes, getting loans, or even affect their employment. So while from the hospital's perspective the services are uncompensated (at least that portion of the bill a patient is unable to pay), from the patient's perspective the bad debt write-off is by no means "charitable" and should not be confused with the legitimate benefits of a hospital's charity care program.

Recommendations

The widespread problem of medical debt is clearly a symptom of much that is wrong with our fragmented health care system that leaves so many people exposed to lack of access to care and to financial ruin. While this situation cries out for systemic solutions, some steps can be taken in the interim to reduce the burdens of unaffordable health care costs on low-income uninsured people.

(1) Offer uninsured hospital patients discounts equivalent to those extended to people with insurance.

The current situation reflects the lack of clout that uninsured consumers have in the healthcare marketplace compared to all of the other players—employers, insurers, and providers. Charging the highest rates to those least able to pay is simply unfair, especially when it comes to necessary medical care.

By itself, however, this is not sufficient. From the standpoint of the low- or even middle-income consumer struggling to pay his medical bills, the salient issue is not only the prices a hospital charges but also the availability of financial assistance programs. Even with changes in hospital pricing practices—the immediate concern of the subcommittee—problems of medical debt will remain for those who require medical treatment but are unable to pay the (albeit reduced) fees for which they are responsible. For low-income people, or those with very high bills relative to their income, even discounted prices may not prevent devastating medical debt. For a family earning slightly more than the federal poverty level, reducing a bill from $50,000 to $25,000 does not provide enough help. For people at this income level, a bill of a few thousand dollars, or even less, may simply be beyond their means to pay.

(2) Screen uninsured hospital patients and provide assistance to all patients who are eligible for public programs to ensure that they are enrolled in them.

This is a win-win situation for the hospital and the uninsured patient; it provides hospitals with some reimbursement for services rendered, and it helps prevent people from being saddled with unmanageable debt. We know of hospitals that have adopted very proactive programs to ensure that all of their uninsured patients know where to get help in applying for these programs. And they have continued to fund these programs because they have found them to be financially beneficial to the hospital as well as the patient.

(3) Have consistent and well publicized charity care policies for hospital patients who are not eligible for public programs and stop aggressive collection actions as an integral part of a hospital's service to their communities.

In this regard, we are hopeful that the recent HHS guidance on billing and collections practices, as well new guidelines from the AHA and a number of state hospital associations, will help to reduce the role hospitals play in imposing medical debt and its harsher consequences. Hospitals must take a proactive role in informing their patients of charity care and they must stop aggressive collection actions against uninsured patients. Such actions cost hospitals money and provide little financial return while ruining the credit of uninsured patients.

(4) Establish clear rules of accountability for funds that hospitals receive through the Medicaid DSH program and other sources to help defray the costs of uncompensated care.

Disproportionate Share Hospital payments provide vital funding for America's healthcare safety net. Hospital receiving DSH payments should be required to provide details on how this funding is used to support services to poor and uninsured patients.

(5) Build on the American Hospital Associations Guidelines and Principles for Hospital Billing and Collection Practices by establishing a Financial Assistance Initiative for Uninsured Patients.

We call on the AHA to create an initiative with the purpose of providing financial assistance to patients with no insurance. An essential part of this effort would be for hospitals to work in partnership with community and consumer advocacy organizations that work with, and represent, people with no health insurance. These community and consumer advocacy organizations could assure that hospitals have transparent policies that are understood and supported by their uninsured patients. Hospitals participating in this initiative would have clear, written policies governing their practice for screening uninsured patients for financial assistance, as well as for billing, charity care, and debt collection practices related to uninsured patients. The AHA should enroll hospitals in this initiative to bring clarity and decency to billing and collection practices. One basic principle could drive the initiative—Do No Harm. Hospitals must start treating their patients of limited resources with dignity, respect and justice. If hospitals are unwilling to comply, legislation might well be in order.

It is only after hospitals improve their billing and collection systems, that they should seek additional funds to support the cost of providing health care to uninsured patients.

(6) Create a system of affordable health care for all.

We recognize that hospital bills are only one component of medical debt. As health care costs rise and employers and insurers shift more of the costs on to consumers, medical debt from all sources is likely to grow. While improved hospital financial assistance programs are an important step in alleviating this problem, systemic efforts that include all types of healthcare providers and significantly expand coverage will ultimately be needed to address the underlying factors that leave many patients—both uninsured and insured—with unmanageable medical debt.

On behalf of the more than 43 million American with no health insurance, thank you for the opportunity to testify today.

Mr. GREENWOOD. Thank you.

Dr. Collins.

TESTIMONY OF SARA R. COLLINS

Ms. COLLINS. Thank you, Mr. Chairman, for this invitation to testify today. I am a Senior Program Officer of The Commonwealth Fund. The recent reports of uninsured patients struggling to pay

exorbitant hospital bills have lent a human face to a health care system under enormous strain. Growing numbers of Americans are experiencing gaps in their insurance coverage, gaps that expose them to the routine cost of preventive care, as well as the catastrophic cost associated with serious accidents and illnesses. The number of people without health insurance climbed to 43.6 million in 2002, nearly 4 million more than 2 years before. At the same time, national health care spending grew at a rate of 9.3 percent, the highest annual increase in a decade. Health insurance premiums rose even more rapidly, increasing by 13.9 percent in 2003, the third consecutive year of double-digit inflation. Employers are responding to rising premiums by sharing more of their cost with employees and offering new insurance products that shift more financial risk to their workers.

The Commonwealth Fund Biennial Health Insurance Survey, a nationally representative survey of more than 4,000 adults, interviewed people about the extent and quality of their health insurance coverage in late 2003. The survey reveals growing instability in insurance coverage, particularly among people with low incomes and among minorities. More than half of adults under age 65 in households earning less than $20,000 per year were uninsured for some time during 2003. Nearly half of all Hispanics experienced a time uninsured, and coverage for African Americans has worsened considerably over the last 2 years.

The survey also found evidence of an erosion in the quality of benefits received by people who have health insurance. Nearly half of those who are insured all year through private coverage said that they had experienced either an increase in the amount that they pay for premiums, an increase in their share of medical bills, or cutbacks or new limits in their health benefits. Erosion in coverage appears to be impeding Americans' ability to get health care. The share of people with and without insurance coverage who reported problems getting the health care that they needed because of cost climbed to 37 percent in 2003. Those problems included not filling a prescription because of cost, and not going to a doctor when they were sick.

In addition, the survey found high rates of medical bill problems among the insured and uninsured alike. More than 70 million adults said that they had problems with their medical bills in the last 12 months, or were paying off medical debt accrued over the last 3 years. Problems included having difficult paying or being unable to pay bills, being contacted by a collection agency, or being forced to make significant life changes. Medical bills are creating financial hardship among many families. Among those who said they had a medical bill problem, more than one-quarter reported that they had been unable to pay for basic necessities like food, heat, or rent because of their bills. More than two in five said that they had used up all or most of their savings.

The recent conflict between uninsured patients and hospitals over payment is a symptom of two underlying trends in the U.S. health care system, growing instability in insurance coverage and rapid growth in health care cost. The practice of hospitals billing uninsured patients more than negotiated rates with insurers is troublesome and will only increase access and medical debt prob-

lems for uninsured families, and some hospitals' methods to attempt to recover medical debt from patients, charging high interest rates, having collection agencies harass them, and placing liens on their homes are simply deplorable. Developing policies that would discourage hospitals from either practice is necessary but, in the meantime, the pressures that gave rise to this conflict will continue to grow apace. In the end, small policy changes will need to be accompanied by broad policy solutions that address the root cause of the affordability crisis in U.S. health care, policies that would expand access to affordable health insurance and reduce the rate of health care cost inflation. Thank you very much.

[The prepared statement of Sara R. Collins follows:]

PREPARED STATEMENT OF SARA R. COLLINS, SENIOR PROGRAM OFFICER, THE COMMONWEALTH FUND

Thank you, Mr. Chairman, for this invitation to testify today on the growing affordability crisis in the U.S. health care system. The recent reports of uninsured patients struggling to pay exorbitant hospital bills have lent a human face to a health care system under enormous strain.[1] Growing numbers of Americans are experiencing gaps in their insurance coverage—gaps that expose them to the routine costs of preventive care as well as the catastrophic costs of serious accidents and illnesses. The number of people without health insurance climbed to 43.6 million in 2002, nearly 4 million more than were uninsured two years before (Chart 1).[2] At the same time, national health care spending grew at a rate of 9.3 percent in 2002, the highest annual increase in a decade (Chart 2).[3] Health insurance premiums rose even more rapidly, increasing by 13.9 percent in 2003, the third consecutive year of double-digit inflation (Chart 3).[4] Employers are responding to rising premiums by sharing more of their costs with employees and offering new insurance products that shift more financial risk to workers (Chart 4).[5] A severe fiscal crisis has led many state governments to restrict eligibility in public programs such as Medicaid and the Children's Health Insurance Program (CHIP)—a development that is likely to increase the number of people without coverage.[6]

The state of our nation's health care system is creating profound conflicts between providers, whose mission it is to care for patients, and patients, whose access to and trust in the health care system is crucial to the maintenance of a vital and productive society. Private and public health care providers spend an estimated $35 billion a year on care for uninsured patients that goes uncompensated.[7] At the same time, evidence from the recent Commonwealth Fund Biennial Health Insurance Survey shows that being uninsured or having gaps in insurance coverage interferes with people's ability to get the health care they need.[8] The Institute of Medicine warns

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[1] R. Abelson and J.D. Glater, "Nonprofit Hospitals Said to Overcharge Uninsured," *New York Times,* June 17, 2004; L. Lagnado, "Dunned for Old Bills, Poor Find Some Hospitals Never Forget," *The Wall Street Journal,* June 8, 2004; C. Pryor et al., *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt* (New York: The Commonwealth Fund, June 2003); C. Pryor and B. Seifert, *Unintended Consequences: An Update on Consumer Medical Debt* (New York: The Commonwealth Fund, June 2004).

[2] R.J. Mills and S. Bandhari, *Health Insurance Coverage in the United States: 2002,* Current Population Reports (Washington, D.C.: U.S. Census Bureau, September 2003).

[3] K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23 (January/February 2004): 147-59; K. Davis, *Making Health Care Affordable for All Americans,* Invited testimony before the Senate Committee on Health, Education, Labor, and Pensions hearing on "What's Driving Health Care Costs and the Uninsured?" January 28, 2004.

[4] J. Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs* 22 (September/October 2003): 117-26.

[5] J. Gabel et al.; S.R. Collins, C. Schoen, M.M.Doty, and A.L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, March 2004).

[6] M. Nathansan and L.Ku, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update* (Washington, D.C.: Center on Budget and Policy Priorities, March 21, 2003).

[7] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* Web Exclusive (12 February 2003): W3-66-W3-81.

[8] S.R. Collins et al., *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004).

that leaving more than 40 million people without insurance coverage costs the U.S. economy an estimated $65 billion to $130 billion annually in lost productivity.[9]

Rising health care costs are also creating conflicts in the workplace, as U.S. companies, for lack of other options, shift more health care risk to employees in the form of increased deductibles, greater premium sharing, and higher copayments. Yet, Americans already pay more out-of-pocket for their medical care than people in any other industrialized country.[10] Higher cost-sharing thus raises concerns that even people who have insurance coverage will forgo needed medical care, face out-of-pocket costs that might consume substantial shares of their income, or drop their coverage altogether.[11]

The Commonwealth Fund Biennial Health Insurance Survey, a nationally representative survey of more than 4,000 adults, interviewed people about the extent and quality of their health insurance coverage in late 2003. The survey revealed growing instability in insurance coverage, particularly among people with low incomes and minorities. In addition, the survey found evidence of erosion in the quality of benefits among people who have health insurance. Gaps in insurance coverage and rising health care costs are preventing large shares of both uninsured and insured Americans from getting the health care they need. The survey also found high rates of medical bill problems among uninsured and insured alike. Many families with medical debt face stark trade-offs between life necessities like food and rent and paying down their debt. Key findings from the survey and other recent reports are discussed below.

INSURANCE COVERAGE IS BECOMING INCREASINGLY UNSTABLE

The Commonwealth Fund Biennial Health Insurance Survey shows that health insurance coverage is becoming increasingly unstable. In the survey, respondents were asked whether they were insured at the time of the survey and whether they had lacked insurance at any time during the previous 12 months. Twenty-six percent of adults ages 19 to 64 had experienced at least some time uninsured in 2003: 17 percent were uninsured at the time of the survey, and 9 percent had been uninsured during part of the previous 12 months (Chart 5). In 2001, the last year that the Commonwealth Fund survey was conducted, 24 percent of respondents were uninsured for at least part of the year.[12]

Insurance instability is particularly acute among people with low incomes. More than half (52%) of adults ages 19 to 64 in households earning less than $20,000 per year were uninsured for some time during 2003, up slightly from 49 percent in 2001.[13] The erosion of health insurance was most marked for families with incomes between $20,000 and $35,000—35 percent were without coverage during the year, up from 28 percent in 2001.[14] Sixteen percent of adults in households with incomes between $35,000 and $60,000 experienced a time without health insurance in 2003.

Minorities experience similarly high rates of instability in coverage. Nearly one-half (47%) of Hispanics were without health insurance at some point during the year in 2003, with more than one-third reporting that they were uninsured at the time of the survey (Chart 6). African Americans experienced a significant loss of coverage in the 2001-03 period: the share without coverage jumped from 27 percent in 2001 to 38 percent in 2003, with most of the increase attributable to an increase in those who were uninsured at the time of the survey (14% to 23%).[15]

Other recent analyses of surveys that track people over time shows that many low-income workers and minorities remain without coverage for years at a time. Research by Pamela Farley Short and colleagues found that from 1996 to 2000, 42 percent of children and adults under age 65 with incomes less than 200 percent of poverty had been uninsured for more than one year, and nearly 3 of 10 (28%) were uninsured more than two years.[16] Michelle Doty and Alyssa Holmgren of The Com-

[9] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C: National Academy Press, 2003).

[10] K. Davis, *Making Health Care Affordable for All Americans,* Invited testimony before the Senate Committee on Health, Education, Labor, and Pensions hearing on "What's Driving Health Care Costs and the Uninsured?, January 28, 2004.

[11] S. Trude, *Patient Cost-Sharing: How Much Is Too Much?* Issue Brief No. 72 (Washington, D.C.: Center for Studying Health System Change, December 2003).

[12] Increase statistically significant at $p < .05$.

[13] Increase statistically significant at $p < .05$.

[14] Increase statistically significant at $p < .05$.

[15] Increase statistically significant at $p < .05$.

[16] P.F. Short and D.R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs* 22 (November/December 2003): 244-55; P.F. Short, D.R. Graefe, and C. Schoen, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem* (New York: The Commonwealth Fund, November 2003).

monwealth Fund found that 37 percent of Hispanic workers with incomes under 200 percent of poverty who had been employed full-time in the 1996-2000 period were uninsured for the full four years.[17]

Insurance instability is also a serious problem among young adults ages 19 to 29. In the Commonwealth Fund survey, 40 percent of young adults said that they were without coverage at some point during the year. This is nearly twice the rate found for those ages 30 to 64 who experienced a time without coverage in 2003. Age 19 is a critical turning point in insurance eligibility among both privately and publicly insured young adults. Nearly 60 percent of employers who offer health benefits stop covering dependent children at age 18 or 19 if they do not go on to college.[18] The Medicaid and CHIP programs reclassify all children as adults at age 19, meaning that most low-income young adults become ineligible for public coverage, since eligibility for adults generally is restricted to very low income parents or disabled adults. Jobs available to young adults are usually low wage or temporary—the type that generally do not come with health benefits. A recent Commonwealth Fund report found that more than half of high school graduates who do not go on to college experience a time uninsured in the year following graduation (Chart 7).[19] Among those who do go on to college, graduation also marks a break in coverage—nearly two of five college graduates experience a time uninsured in the year following graduation.

Workers without insurance coverage are concentrated in small firms, which face greater costs for coverage than do large employers and higher financial risks from providing benefits to only a small pool of workers.[20] But the long-term shift away from manufacturing in the U.S. economy, coupled with declines in the rate of unionization in the workforce, has led to an increase in the share of uninsured workers employed in large firms. A recent Commonwealth Fund report by researchers Sherry Glied, Jeanne Lambrew, and Sarah Little found that from 1987 to 2001, the proportion of uninsured workers who were employed by firms with more that 500 employees grew from 25 percent to 32 percent (Chart 8).[21]

THE QUALITY OF HEALTH BENEFITS IS ERODING

In addition to declining insurance coverage, the Commonwealth Fund Biennial Health Insurance Survey also finds evidence of erosion in the quality of coverage among those with health insurance. Working-age Americans reported that they were now paying more for their insurance coverage and more for their medical care than they were one year ago. Two of five (43%) adults under age 65 with private coverage who contribute to their premiums said that the amount they pay for premiums had increased by a moderate amount or a lot in the past year, with nearly one of five (19%) saying the amount had increased a lot (Chart 9, Table 1). More than half (58%) of those with coverage in the individual insurance market said that their premiums had risen by a moderate amount or a lot, with a third (34%) saying that their premiums had gone up a lot. More than a quarter (28%) of people with employer or individual coverage said that their share of medical bills had risen by a moderate amount or a lot.

In addition to paying more for their care, many privately insured adults also reported that their health plans are cutting back or placing new limits on covered benefits. The survey asked whether people had experienced reductions in the benefits covered by their insurance plans. Reductions could dropping coverage for prescription drugs, dental care, vision care, or mental health, or placing limits on benefits. About one-fifth (21%) of people with private coverage said that their benefits had been curtailed.

Taken together, increased premium shares, increased cost-sharing, and limits on benefits affected large percentages of the privately insured. Nearly half of those (49%) insured all year with private coverage said that they had experienced at least one of these erosions in the quality of benefits. People with coverage through the individual market were particularly hard-hit—61 percent reported a decrease in the quality of their benefits (Table 1). Among adults with employer coverage, erosion of

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[17] M.M. Doty and A.L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, April 2004).

[18] S.R. Collins, C. Schoen, M.M. Doty, and A.L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, March 2004).

[19] S.R. Collins, C. Schoen, K. Tenney, M.M. Doty, and A. Ho, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, May 2004).

[20] J. Gabel and J.D. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York: The Commonwealth Fund, April 2004).

[21] S. Glied, J.M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms* (New York: The Commonwealth Fund, October 2003).

health insurance benefits appeared to be most common among those in the highest income category, with 56 percent of those earning $60,000 or more reporting a decline in the quality of their coverage.

MANY AMERICANS SPEND SUBSTANTIAL SHARES OF THEIR EARNINGS ON HEALTH CARE

Depending on their insurance status or the particular provisions of their health plans, Americans pay different amounts for their health care and their insurance coverage. Most people with private insurance (employer-sponsored or individual) contribute to their health insurance premiums. According to the Commonwealth Fund survey, more than 75 percent of those with employer-sponsored coverage pay part of their premiums, with 10 percent of single policy holders and a quarter (26%) with family plans paying $2,500 or more annually (Table 2). Without an employer to shoulder part of their premium costs, and without the benefit of risk pooling in group plans, people with individual coverage pay much more for their premiums. One-third (34%) of single policy holders in the individual market pay $2,500 or more a year in premiums, and 15 percent have annual premiums of $5,000 or more. More than half (52%) of single policy holders in the individual market spend 5 percent or more of their income on premiums, and a quarter (26%) spend more than 10 percent.

Most (66%) adults with private insurance coverage have a deductible. Of those with employer-sponsored coverage, 15 percent have deductibles of $500 or more per year and 5 percent have deductibles of $1,000 or more (Table 2). Three-quarters of adults with coverage in the individual market pay a deductible: 44 percent have deductibles of $500 or more and 30 percent have deductibles of $1,000 or more.

Nearly everyone with private coverage pays something out-of-pocket when they obtain health care services. The Commonwealth Fund survey asks adults how much they had to pay out-of-pocket over the last 12 months, excluding premiums, for their own personal prescription medicines, dental and vision care, and all other medical services, including doctors, hospitals, and tests. Two of five (41%) adults with employer-sponsored coverage pay less than $500 annually in out-of-pocket costs, a third (36%) pay between $500 and $2,000 per year, 13 percent pay $2,000 or more per year, and 10 percent did not respond or did not know (Table 3). People with coverage in the individual market pay more than those with employer-sponsored coverage—23 percent have annual out-of-pocket costs of $2,000 or more.

Adults with low or moderate incomes spend the greatest share of their earnings on out-of-pocket health care costs. Of those with private coverage who had annual incomes of less than $20,000, 29 percent spent 5 percent or more of their income on out-of-pocket costs and 17 percent spent 10 percent or more (Chart 10). More than one-fifth (23%) of those in the next income bracket ($20,000 to $34,999) spent 5 percent or more of their income on out-of-pocket costs. Among those with annual incomes of $60,000 or more, just 2 percent spent that much on out-of-pocket costs.

The out-of-pocket costs of those who experienced a time uninsured are very different from those who were continuously insured by an employer. Nearly a quarter (23%) of those who were uninsured at the time of the survey had no out-of-pocket costs, while only 6 percent of those with employer coverage had no out-of-pocket costs (Table 3). This indicates that many of those without coverage did not access the health system, or received care that was partly or wholly subsidized. Still, for many of the uninsured, out-of-pocket payments account for a large share of their income: a third had annual out-of-pocket costs comprising 5 percent or more of their income, and 18 percent had costs of 10 percent or more. Those who were insured at the time of the survey but had experienced a time uninsured in the past year also spent large shares of their incomes on out-of-pocket costs. Nearly a quarter (23%) spent 5 percent or more of their income on out-of-pocket costs.

People who are insured by public insurance programs incur much lower out-of-pocket costs than do those in private plans. A third (31%) of those insured continuously by public insurance programs said they had no out-of-pocket costs. Another third (34%) had costs amounting to less than $500 per year. Yet, even low health care costs can figure prominently as a share of a tight household budget. One-fifth (19%) of those with public insurance coverage and household incomes under 200 percent of poverty spent 5 percent or more of their incomes on out-of-pocket costs. Those with employer-sponsored coverage in that income range fared somewhat worse: a quarter (26%) spent that much of their income on out-of-pocket costs.

INCREASING SHARES OF PEOPLE WITH AND WITHOUT INSURANCE REPORT PROBLEMS GETTING NEEDED HEALTH CARE BECAUSE OF COST

The decline in the quality of private health benefits and the increasing instability of coverage may be making it harder for people to access health care. The Common-

wealth Fund survey asked respondents whether, in the last 12 months, they had not pursued medical care because of cost. Respondents were asked if they had not filled a prescription; had a medical problem but did not go to a doctor or clinic; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed. The share of people who reported any one of these problems increased from 29 percent in 2001 to 37 percent in 2003 (Chart 11). Those who were uninsured or who reported a gap in coverage were most at risk of encountering these access problems (Chart 12). Around 60 percent of this group reported that they did not get the care they needed because of cost. But those with insurance coverage also reported deteriorating access to care. Nearly three of 10 (29%) of those who were insured all year reported that they did not get the care they needed because of cost, up from 21 percent in 2001.[22]

Problems accessing the health care system also are related to income, even among those with health coverage. Nearly two of five (39%) adults who were insured all year with household incomes less than $35,000 said that they did not get the care they needed over the last 12 months because of cost. Obtaining prescription drugs appeared to be a particular problem in this income group (Table 4). But even a quarter (24%) of people with coverage in higher income brackets reported that they did not get needed health care because of cost.

MEDICAL BILLS AND LINGERING MEDICAL DEBT ARE UNDERMINING THE FINANCIAL SECURITY OF AMERICAN FAMILIES

Out-of-pocket costs for health care are negatively affecting the finances of those who have gaps in coverage as well as those who are continuously insured. The Commonwealth Fund survey asked people about their ability to pay their medical bills in the last 12 months, including whether there were times when they had difficulty or were unable to pay their bills, whether they had been contacted by a collection agency concerning outstanding medical bills, or whether they had to change their lives significantly in order to meet their obligations. People who reported no medical bill problems in the last 12 months were asked if they were currently paying off medical debt that they had incurred in the last three years.

The survey found that 41 percent of adults under age 65 either had medical bill problems in the last 12 months or were paying off accrued medical debt (Chart 13). The problem was most severe among those who were uninsured at the time of the survey or had experienced a time uninsured in the past year (Chart 14). Women were more likely to say that they were coping with medical bills or debt than men—70 percent of uninsured women reported medical bill problems or accrued debt (Chart 15).

But even those adults who were insured continuously over the last 12 months cited problems. More than a third (35%) reported that they had experienced problems with medical bills or were paying off accrued debt (Table 4). Moreover, among those with bill problems or past debt, three of five (62%) said the bills were incurred for themselves or a family member who had been insured at the time.

Among those who had medical bill problems or outstanding debt, 27 percent reported that they had been unable to pay for basic necessities, including food, heat, or rent because of medical bills (Chart 16). Two of five (44%) said that they used all or most of their savings in order to meet their obligations. One-fifth reported that they had run up large debts on their credit cards or had taken out loans against their homes in order to pay their bills. People who were uninsured for a time and/or had low incomes were the most severely affected (Table 4). More than half (51%) of those earning less than $35,000 a year—regardless of insurance status—said that they had used all or most of their savings to pay their bills. Forty-five percent of those who were uninsured in that income category had been unable to pay for basic living necessities.

CONCLUSION

The recent conflict between uninsured patients and hospitals over payment is a symptom of two underlying trends in the U.S. health care system: growing instability in health insurance coverage and rapid growth in health care costs. Health insurance has become both less available and more expensive to workers and their families, and health care itself continues to become more expensive. Indeed, health

[22] Increase statistically significant at $p < .05$.

care cost growth is expected to outpace the growth rate in the economy by a wide margin for the foreseeable future.[23] Against this backdrop, patients, providers, employers, workers, labor unions, and federal, state and local governments are struggling to solve serious problems that stem from a far greater crisis. The practice of hospitals billing uninsured patients more than negotiated rates with insurers is troublesome and will only increase access and medical debt problems experienced by uninsured families.[24] And some hospitals' methods to attempt to recover medical debt from patients—charging high interest rates, having collection agencies harass them, and placing liens on their homes—are simply deplorable. Developing policies that would discourage hospitals from either practice is necessary. But in the meantime, the pressures that gave rise to this conflict will continue to grow apace. In the end, small policy changes will need to be accompanied by broad policy solutions that address the root cause of the affordability crisis in U.S. health care—policies that would expand access to affordable health insurance and reduce the rate of health care cost inflation. Thank you for the opportunity to be here today.

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[23] B.C. Strunk and P.B. Ginsburg, "Tracking Health Care Costs: Trends Turn Downward in 2003," *Health Affairs* Web Exclusive (9 June 2004): W4-354—W4-362.

[24] R. Abelson and J.D. Glater, "Nonprofit Hospitals Said to Overcharge Uninsured," *New York Times,* June 17, 2004; L. Lagnado, "Dunned for Old Bills, Poor Find Some Hospitals Never Forget," *The Wall Street Journal,* June 8, 2004; C. Pryor et al., *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt* (New York: The Commonwealth Fund, June 2003); C. Pryor and B. Seifert, *Unintended Consequences: An Update on Consumer Medical Debt* (New York: The Commonwealth Fund, June 2004).

Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills

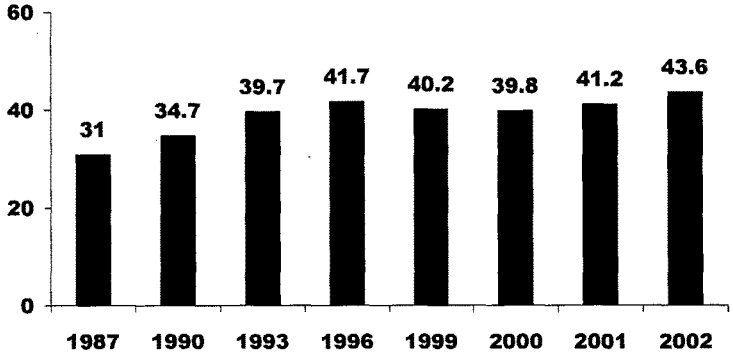
Sara R. Collins, Ph.D.
Senior Program Officer, The Commonwealth Fund
June 24, 2004

Hearing on "A Review of Hospital Billing and Collection Practices"
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Chart 1

Uninsured Up by Nearly 4 Million People in Past Two Years

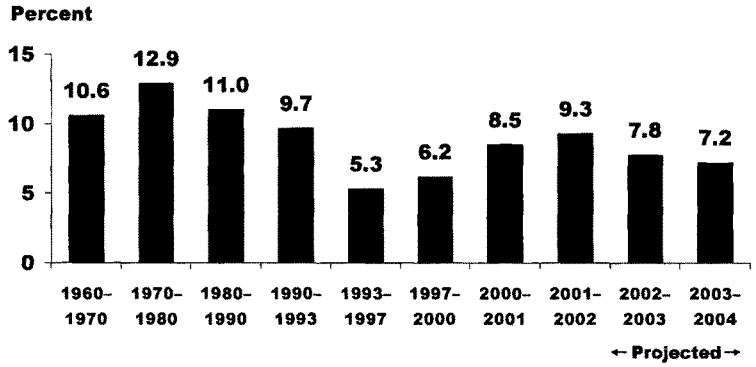
Millions uninsured, 1987–2002



Source: U.S. Census Bureau, March CPS Surveys March 1988 to March 2003. Years 1999 and on adjust for new question and for 2000 population weights.

Chart 2

National Health Expenditures' Average Annual Percentage Growth, Selected Calendar Years, 1960–2004

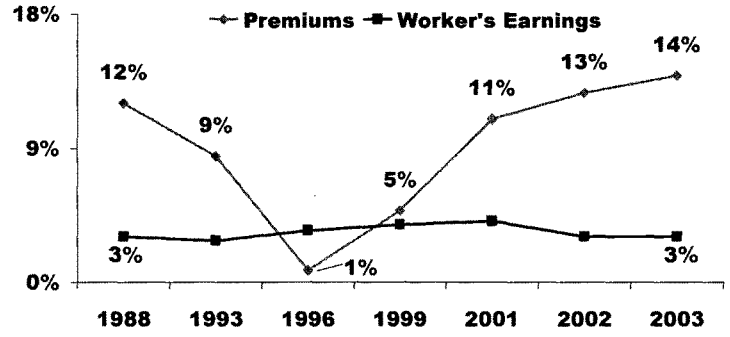


Source: The Commonwealth Fund, based on K. Levit et al., "Health Care Spending Rebound Continues in 2002," *Health Affairs* 23 (Jan./Feb. 2004): 147–59; and S. Heffler et al., "Health Spending Projections Through 2013," *Health Affairs* Web Exclusive (11 Feb. 2004): W4-79–W4-93.

Chart 3

Growth in Employment-Based Insurance Premiums

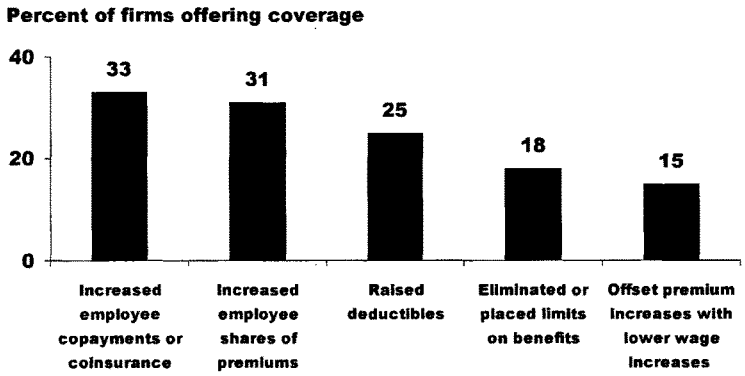
Percent change in health insurance premiums and workers' earnings from previous year



Source: J. Gabel et al., "Health Benefits in 2003: Premiums Reach Thirteen Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs* (Sept./Oct. 2003): 117–26.

Chart 4

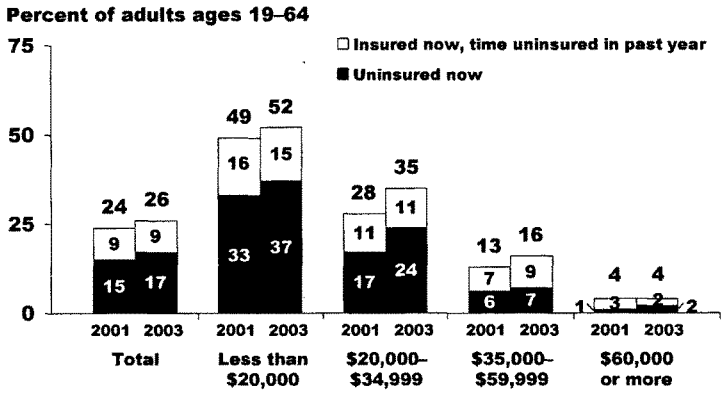
Percent of Employers with Increases in Cost-Sharing, Reductions in Benefits



Source: S.R. Collins et al., *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, March 2004).

Chart 5

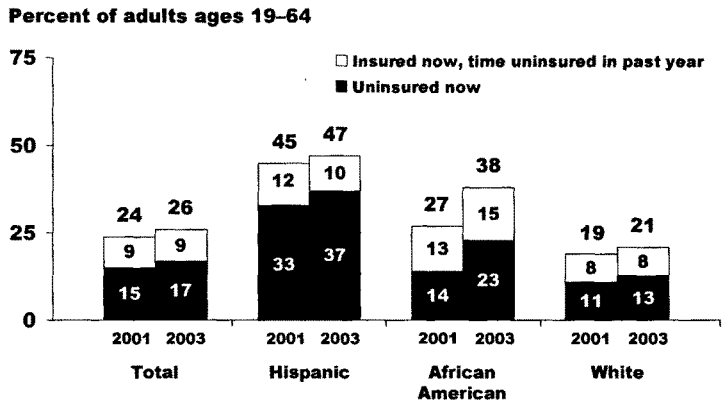
More than One-Quarter of Adults Uninsured: Rates Highest Among Adults with Low Incomes, 2001–2003



Note: Income groups based on 2002 household income.
Source: The Commonwealth Fund Health Insurance Surveys (2001 and 2003).

Chart 6

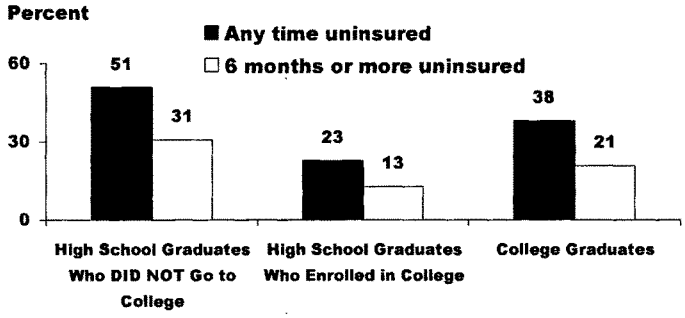
Uninsured Rates Highest Among Hispanics and African Americans, 2001–2003



Source: The Commonwealth Fund Health Insurance Surveys (2001 and 2003).

Chart 7

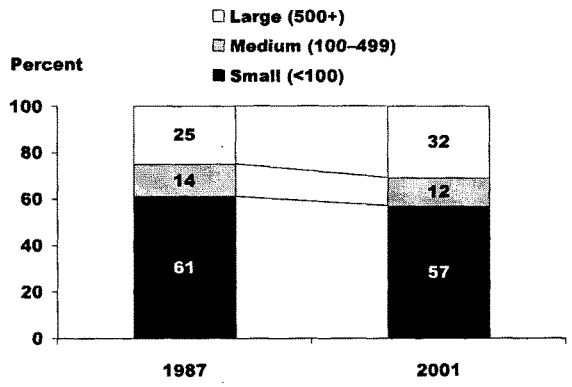
Percent of Graduates with Gaps in Insurance Coverage in Year Following Graduation, by Student Status 1996–2000*



* People who graduated from high school or college during 1996–2000.
Source: S.R. Collins et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, May 2004).

Chart 8

Share of Uninsured Workers by Firm Size, 1987–2001

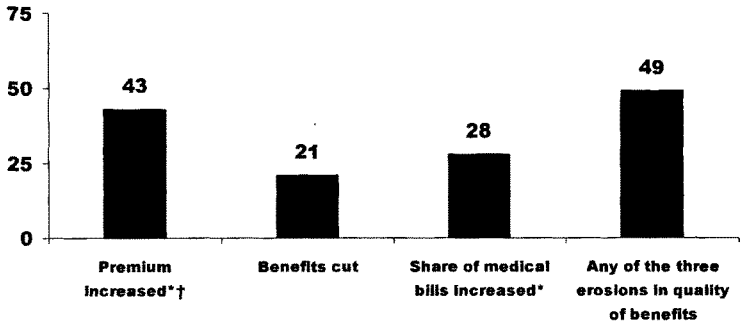


Source: S. Glied, J.M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms* (New York: The Commonwealth Fund, October 2003).

Chart 9

Nearly Half of Adults with Private Health Insurance Report Erosions in Their Benefits

Percent of adults 19–64 with continuous coverage throughout past year

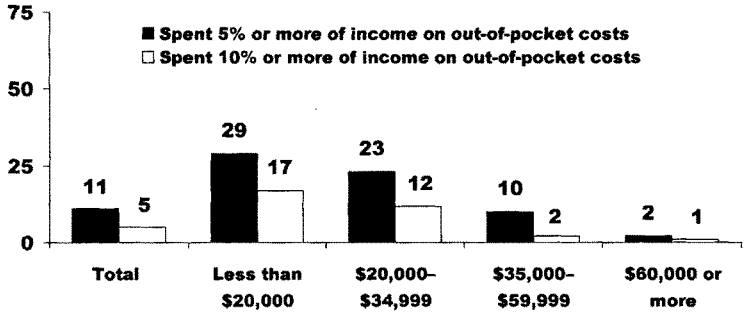


* Increased a lot or a moderate amount.
† Among those who pay any premium.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 10

Adults with Low and Moderate Incomes Spend Greatest Share of Income on Out-of-Pocket Costs

Percent of adults ages 19–64 insured all year with private insurance

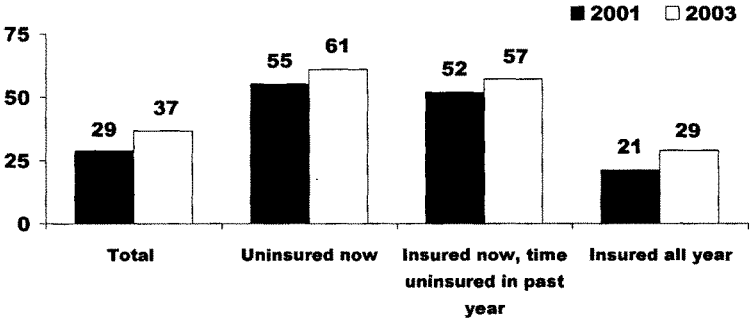


Note: Income groups based on 2002 household income.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 11

Cost-Related Access Problems Have Increased, 2001–2003

Percent of adults ages 19–64 who had any of four access problems* in past year because of cost

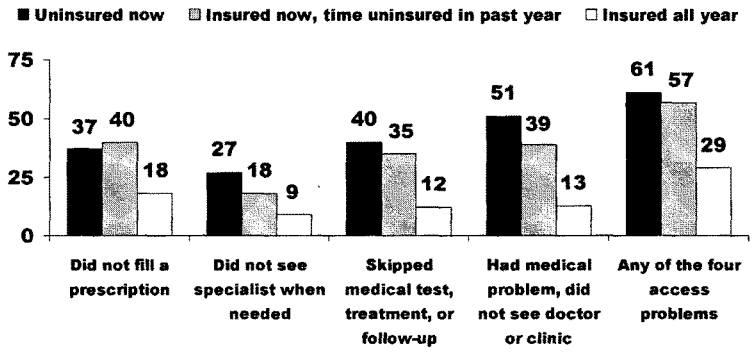


* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Source: The Commonwealth Fund Health Insurance Surveys (2001 and 2003).

Chart 12

Lacking Health Insurance for Any Period Threatens Access to Care

Percent of adults ages 19–64 reporting the following problems because of cost:

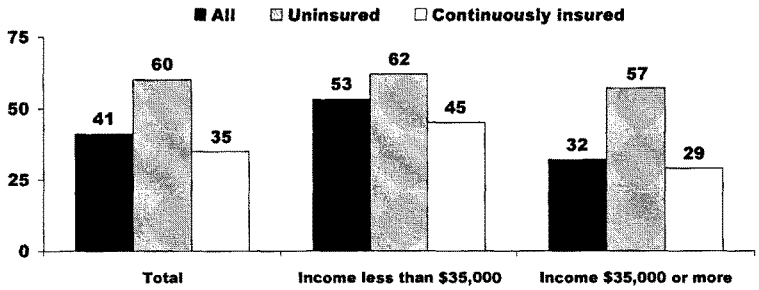


Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 13

Two of Five Adults Have Medical Bill Problems or Accrued Medical Debt:* Uninsured and Low Income Most at Risk

Percent of adults ages 19–64 with any medical bill problem or outstanding debt

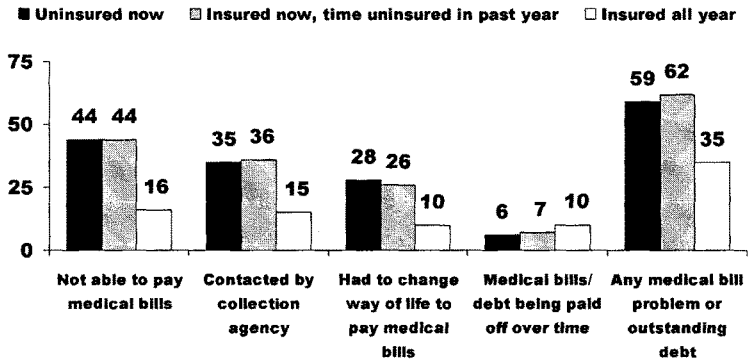


* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.
Note: Income groups based on 2002 household income.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 14

Adults with Any Time Uninsured Have High Rates of Medical Bill Problems

Percent of adults ages 19–64 who had the following problems in past year:

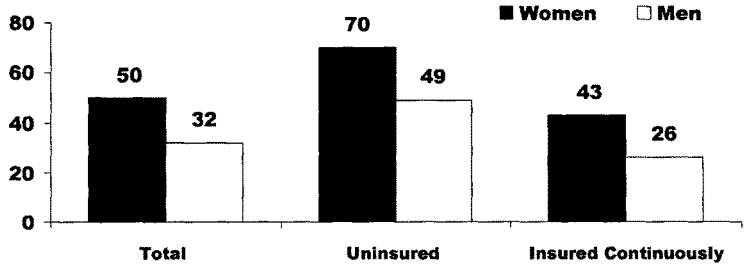


Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 15

Half of Adult Women Have Medical Bill Problems or Accrued Medical Debt,* Uninsured at Highest Risk

Percent of adults ages 19–64 with any medical bill problem or outstanding debt



* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Chart 16

More than Two of Five Adults with Medical Bill Burdens Used All or Most of Their Savings on Medical Bills

Percent of adults ages 19–64 with medical bill problems or accrued medical debt:

Percent of adults reporting:	Total	Uninsured now	Insured now, time uninsured during year	Insured all year
Unable to pay for basic necessities, such as food, heat, or rent	27%	39%	41%	18%
Used all or most of savings	44	53	46	39
Had large credit card debt, or had to take loan against home	20	21	30	18

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Table 1. Changes in Health Benefits Among Insured Adults, 2003
(base: adults ages 19–64, insured all year with private insurance)

	Insurance Source			Income Distribution* (base: employer-based insurance)			
	Total Private	Employer	Individual	Less than $20,000	$20,000-$34,999	$35,000-$59,999	$60,000 or more
Total in Millions (estimated)	108.4	100.8	7.6	9.7	13.6	30.8	36.3
Changes in Health Benefits in Past Year							
Cuts in benefits							
Yes	21%	22%	14%	14%	14%	22%	27%
No	75	75	84	77	81	75	70
Increases in paying share of medical bills							
None	56	55	66	61	67	54	48
Increased a lot	9	9	14	8	8	8	9
Increased a moderate amount	19	20	13	13	11	21	25
Increased only a little	15	16	6	17	13	15	18
Premium increases (base: respondents reporting paying any premiums)							
None	40	42	27	47	48	43	37
Increased a lot	19	18	34	19	15	15	21
Increased a moderate amount	24	24	24	21	21	22	25
Increased only a little	13	13	7	10	13	13	14
*One or more of the above changes in health benefits***	49	48	61	36	38	47	56

Note: Columns may not sum to 100% because of rounding and because "Don't know/Refused to answer" not shown.

* Among respondents reporting income.

** Respondents whose premiums increased a lot or a moderate amount, had cuts in benefits, or whose share of medical bills increased a lot or a moderate amount.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Table 2. Annual Deductibles and Insurance Premiums, 2003 (base: adults ages 19–64, insured by private insurance when surveyed)

Deductibles and Insurance Premiums by Plan Type	Current Insurance Source: Total Private	Employer	Individual
Total in Millions (estimated)	119.0	109.8	9.2
Annual Deductible Per Person			
No deductible	34%	35%	25%
Less than $100	6	7	6
$100-$499	27	28	11
$500-$999	10	10	14
$1,000 or more	7	5	30
Undesignated	15	15	15
Annual Premium Costs			
Type of Plan			
Single/Individual Plan	38	36	57
Family Plan	59	61	40
Single/Individual Plan			
None	22	24	8
$1-$499	10	10	12
$500-$999	18	20	9
$1,000-$1,499	15	15	13
$1,500-$2,499	9	8	13
$2,500 or more	13	10	34
Undesignated	13	13	12
Spent 5% or more of income	20	16	52
Spent 10% or more of income	7	5	26
Family Plan			
None	19	20	4
$1-$499	5	6	0
$500-$999	7	7	4
$1,000-$1,499	12	12	7
$1,500-$2,499	13	14	5
$2,500 or more	28	26	65
Undesignated	15	15	14
Spent 5% or more of income	19	18	36
Spent 10% or more of income	5	5	13

Note: Columns may not sum to 100% because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Table 3. Individual Out-of-Pocket Costs Among Uninsured, Insured, and Low-Income Adults, 2003 (base: adults ages 19–64)

		Continuity of Insurance			Continuously Insured*		
	Total Adults 19-64	Uninsured Now	Insured Now, Time Uninsured in Past Year	Continuously Insured	Employer	Individual	Public
Total Individual Out-of-Pocket Costs in Past 12 Months							
None	12%	23%	14%	10%	6%	6%	31%
$1-$499	33	27	37	34	35	23	34
$500-$999	18	16	12	19	21	23	7
$1,000-$1,999	13	10	8	14	15	15	8
$2,000 or more	14	17	16	13	13	23	9
Undesignated	10	7	12	10	10	10	11
Spent 5% or more of income	17	33	23	12	10	18	22
Spent 10% or more of income	9	18	14	6	4	10	15
INCOME BELOW 200% POVERTY							
Total in Millions	59.4	20.5	8.7	30.2	16.6	1.9	9.7
Total Individual Out-of-Pocket Costs in Past 12 Months							
None	19	23	16	17	8	14	30
$1-$499	34	28	40	37	40	37	37
$500-$999	14	16	12	13	17	11	7
$1,000-$1,999	9	9	8	10	11	8	9
$2,000 or more	14	18	13	12	13	20	7
Undesignated	9	6	11	11	11	10	10
Spent 5% or more of income	29	35	26	25	26	42	19
Spent 10% or more of income	17	20	19	14	15	23	12

* "Other" insurance category (including military or veteran's coverage) not shown.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Table 4. Access Barriers and Medical Bill Burdens by Insurance and Income, 2003
(base: adults ages 19–64)

	All Adults 19–64				Income Less than $35,000		Income $35,000 or More	
Access and Cost Indicators	Total	Continuously Insured	Insured Now, Time Uninsured in Past Year	Uninsured Now	Continuously Insured	Uninsured	Continuously Insured	Uninsured
Total in Millions (estimated)	171.9	126.5	15.6	29.8	40.0	33.8	77.7	8.7
Percent Distribution:	–	74%	9%	17%	34%	80%	66%	20%
Access Problems in Past Year								
Went without needed care in past year due to costs:								
Did not fill prescription	23	18	40	37	25	38	15	40
Did not get needed specialist care	13	9	18	27	13	24	7	24
Skipped recommended test or follow-up	19	12	35	40	17	38	10	42
Had a medical problem, did not visit doctor or clinic	22	13	39	51	20	50	10	39
At least one of four access problems due to inability to pay	37	29	57	61	39	61	24	58
Would have received better care if had been insured or had different insurance plan	38	30	58	61	34	61	28	53
Medical Bill Problems in Past Year								
Problems paying or not able to pay medical bills	23	16	44	44	26	46	11	40
Contacted by a collection agency for medical bills	21	15	36	35	23	37	12	33
Had to change way of life to pay bills	15	10	26	28	19	29	6	25
Any bill problem	32	25	55	53	37	56	19	49
Medical bills/debt being paid off over time	9	10	7	6	8	6	11	8
Base: Any bill problem or medical debt	41	35	62	59	45	62	29	57
Percent reporting that:								
Unable to pay for basic necessities (food, heat, or rent)	27	18	41	39	29	45	11	24

Used all or most of savings	44	39	46	53	51	51	30	52
Had large credit card debt/ Needed loan or debt against home	20	18	30	21	19	24	17	27
Insurance status of person/s at time care was provided								
Insured at time care was provided	62	83	42	20	74	24	92	41
Uninsured at time care was provided	32	11	52	73	17	69	5	52
Other insurance combination	3	2	4	4	2	4	2	2

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Mr. GREENWOOD. Thank you, Dr. Collins.

The Chair would notify the subcommittee that we will do one round with 10 minutes each for the members, and recognizes himself for 10 minutes. And let me begin by making my own personal stipulations about this issue.

No. 1, I believe that most hospitals treat most of the uninsured fairly most of the time. I believe that many hospitals treat many patients very unfairly many times. I would stipulate that people who have financial obligations that they can reasonably manage should be expected to meet those obligations, and I would stipulate that we haven't solved the issue of universal health coverage yet. We are not going to do that today. No one in this Congress has figured out how to develop an approach to that for which he or she can gain consensus among the stakeholders. That is why we haven't solved that problem yet.

Now, having said that, I have a question that I would like to pose to each of the panels, and that is, is there any reason for any hospital to charge any uninsured or self-pay patient its charges, ever? Dr. Anderson.

Mr. ANDERSON. No, I don't think so. I think when you are talking about the full-charge master file, which is anywhere from two to four times what everybody else pays, I don't think there is a reason to charge more than that.

Mr. GREENWOOD. More than——

Mr. ANDERSON. More than what the Medicare program, what the highest amount that a commercial insurer pays. I think that—and maybe just a little bit more than that.

Mr. GREENWOOD. Which seems to me to be a no-brainer.

Mr. ANDERSON. Exactly.

Mr. GREENWOOD. Seems to be obvious. Someone is already—unless Donald Trump decides to go bare and walk into a hospital and say, "I can just cover the charges," fine, that is not what we are talking about. We are talking about people who don't have insurance because either they have never had it, they can't afford it, they have lost it, that is what we are talking about for the most part—or the young people who don't think they need it, whatever the issue may be. But the fact of the matter is, it seems to be quite obvious to me that those people, they either go into the charity care portion, or the hospital should give them a bill that reflects something like what insurance companies pay.

Mr. ANDERSON. So, somebody who makes $50,000, $75,000, and has a heart attack in Pennsylvania, is going to have a $30,000 bill, and I think Medicare would have a $10,000 bill, Medicaid would have a $9,000 bill, Aetna might have an $11,000 bill. That seems like a reasonable amount that person who makes $50,000 or $75,000 should pay, not $30,000.

Mr. GREENWOOD. And to me, that is the whole point of this investigation and this hearing, and it isn't rocket science. Ms. Jacoby?

Ms. JACOBY. I have heard no such reason, but I do want to state the limitation that I come to this from a very different perspective from studying debt and bankruptcy, and therefore will defer to my colleagues on that.

Mr. GREENWOOD. That is okay. You agree with me, so you are probably right. Mr. Rukavina?

Mr. RUKAVINA. Well, we have concerns for uninsured, low-income uninsured patients, and believe that the fees should be set that they enjoy the benefits that insured patients do, also.

Mr. GREENWOOD. Right. So you are agreeing with the proposition that the uninsured shouldn't be charged significantly more than the insured.

Mr. RUKAVINA. Absolutely.

Mr. GREENWOOD. Okay. Dr. Collins?

Ms. COLLINS. I definitely agree that the uninsured shouldn't be charged more than the insured.

Mr. GREENWOOD. Next series of questions for everyone. How widespread do you think, if we know—and I think this is a difficult thing to get a handle on—is the practice by which hospitals, in fact, do charge uninsured patients their full charges?

Mr. ANDERSON. Well, I think they start out trying to get full charges from everybody.

Mr. GREENWOOD. Now, let us put a point on this. When you say "they," you mean you think that is the widespread in most hospitals?

Mr. ANDERSON. I think they, first of all, start out trying to get full charges. Then what they do is they have a series of discounts that they do if you are below a certain level of income.

Mr. GREENWOOD. And this is very important because this is our concern—and I don't know the answer to this question—and that is, if an uninsured person is about to be discharged, and in comes the billing clerk, I don't know whether most hospitals say, "Okay, you are uninsured, let us begin by seeing if you fit into our charity category, or let us begin by taking a look at what your earnings and assets are," or whether they usually begin by saying, "Do you have a VISA card?"

Mr. ANDERSON. I think it depends on the extent of the bill. If it is $1,000, I think they will go for the VISA card. I think if it is $30,000, they recognize that most people don't have $30,000, except for Donald Trump and a few others, and then they will start the negotiation process. But it is not over their charges, it is over a discount that they will do for charity care. But they will start with the charges, which are very high.

Mr. GREENWOOD. And you said, I think, is that based on some statistical evidence?

Mr. ANDERSON. We have looked at the hospital industry—and, again, every hospital is different and every system is different—but only about 1 in 20 people that walk out of the hospital have negotiated a charge that is lower than the full rack rate when they leave the hospital.

Mr. GREENWOOD. Does that include those that need to negotiate because they weren't asked to pay it all?

Mr. ANDERSON. That would not include those individuals. So, it is just the people that actually went through a negotiation process.

Mr. GREENWOOD. So you are already excluding the charity care.

Mr. ANDERSON. I am already excluding the people——

Mr. GREENWOOD. You are already excluding Medicaid/Medicare insurance.

Mr. ANDERSON. Certainly I am doing that.

Mr. GREENWOOD. You are saying that the uninsured who actually end up with some obligation because they are not charity care, only 5 percent of those folks ever really have an opportunity to negotiate.

Mr. ANDERSON. Only do negotiate.

Mr. GREENWOOD. Only do negotiate. Ms. Jacoby, do you feel competent to respond to the question of how widespread this problem is?

Ms. JACOBY. Well, I am under oath, so I should qualify that the limited data or evidence that I have seen makes me very concerned about the efforts to get money first and ask for eligibility information later. The prophecies that I am familiar with do seem to encourage charity care eligibility considerations to come way later in the process, or at least have the possibility of coming way later in the process, and allowing collection to go forward on presumably the full charge before considering that eligibility or having those two prophesies wound up with each other, and of course that is a very big concern to me.

Other data that I have seen suggests that most patients do not even think to negotiate their bills with their health care providers and especially at hospitals.

Mr. GREENWOOD. Mr. Rukavina?

Mr. RUKAVINA. Well, I would defer to the hospital panel in terms of how widespread the issue is.

Mr. GREENWOOD. You will take their word for it, will you?

Mr. RUKAVINA. Well, I would hope that——

Mr. GREENWOOD. They will be under oath as well.

Mr. RUKAVINA. [continuing] they will be under oath as well. But we do know, in working with groups across the country, that this problem is experienced by individuals in communities in many States across the country, and that hospitals appear to acknowledge that they are charging higher rates, and oftentimes stating—prior to Secretary Thompson's clarification, certainly—stating that they need to do that because of Federal Medicare rules and regulations.

Mr. GREENWOOD. Dr. Collins?

Ms. COLLINS. I can actually only point to anecdotal evidence, too. I don't know how widespread the problem is.

Mr. GREENWOOD. Fair enough. Dr. Anderson, I think it was in your opening statement that you made reference to—you were describing why the charge masters exist to begin with, and you talked about the Medicare formula, or formulae, that looked to outliers, saw the outlier issue, and that it is advantageous for them to have these higher charges when that calculation is occurring.

Mr. ANDERSON. Correct.

Mr. GREENWOOD. That leads me to think that if that is the only reason they have them—well, let me rephrase that. That leads me to think that the outlier issue should be resolved using a different number.

Mr. ANDERSON. I think it should, in fact, be, and it is only——

Mr. GREENWOOD. And using a different number for the charge. Let us say you told them to use the average of insurance com-

pensation rates. You could change the formula in a second way so that they could still wind up with the same number of dollars.

Mr. ANDERSON. You could do it that way, but it is one reason why the reasons are so high, because the Medicare program calculates outliers based upon full charges.

Mr. GREENWOOD. So, it would seem prudent to me to change that situation so you would give the hospitals at least one less reason to—so we wouldn't be skewing the system creating an incentive, having the Federal Government and the Medicare program create an incentive for hospitals to make up mythological charges.

Mr. ANDERSON. I agree.

Mr. GREENWOOD. Anyone else want to comment on that point?

[No response.]

Final question for each of you. The time can now be sort of demarked by as that before our investigation and before the communication with the Hospital Association and the Secretary, when there was this question about whether they were required to do that, and then the point at which the hospitals have taken, I think, some commendable steps to solving this problem. Have you noticed or had the opportunity to observe any difference?

Mr. ANDERSON. I have not.

Mr. GREENWOOD. Because it doesn't exist, or you just haven't had the chance?

Mr. ANDERSON. I just have not had the opportunity. It is just too recent to have a chance.

Mr. GREENWOOD. Anyone else want to comment on whether you think the world has changed in this regard since the hospitals have initiated their voluntary efforts?

Mr. RUKAVINA. I would like to comment, Mr. Chairman. I think that there is an openness on the part of the Association and many of the hospitals to try and address this problem. Many of the groups that we work with unfortunately have expressed some frustration with the lack of actual written policies that do explain the discount, that do explain the collection procedures used by the hospitals and, very importantly, a lack of information on the process for informing patients of these programs, the steps used to ask questions.

Mr. GREENWOOD. Do you think Congress should require that patients be given some kind of information, that the hospital give them some information upon admission, as to what their options are for payment?

Mr. RUKAVINA. We would hope that that information would be supplied to all self-pay patients, that the hospitals would in fact work with those patients to ensure that the information is given to them about existing programs, and assistance also provided to them to enroll in those programs. Again, we think it would be financially beneficial to the institutions, and helpful to these patients.

Mr. GREENWOOD. Dr. Collins, anything to add on this subject?

Ms. COLLINS. No. I do think that transparency would be very helpful in terms of people having access to information.

Mr. GREENWOOD. Thank you. My time has expired. The gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman. First of all, let me say that I agree with the chairman that charging the uninsured exorbitant rates compared to, say, the insurance companies, I disagree with that, too. But I want to explore with you how much reducing these fees would really help solve the problem.

I believe, Dr. Anderson, you testified there are a range of reasons why people are uninsured, but the primary reason people are uninsured or underinsured is because they can't afford to pay for insurance, correct?

Mr. ANDERSON. Correct.

Ms. DEGETTE. And most of those people tend to be lower-income individuals, that is all the anecdotal evidence we have read and testimony we have seen, is that correct?

Mr. ANDERSON. That is correct.

Ms. DEGETTE. Does anybody disagree with that?

[No response.]

So, here is my question. Let us say—and I don't believe that the chairman or anyone in the Majority would pass legislation like this, but let us say we passed a law that required hospitals to charge only a certain amount above Medicare or above their highest insurance rate, so we capped it. Would that really solve the problem of the uninsured being able to pay their hospital bill?

Mr. ANDERSON. I don't believe it would solve the problem, but it would mean that the collections would go down because instead of being responsible for a $30,000 bill, you would be responsible for a $10,000 bill.

Ms. DEGETTE. Okay, I understand that, but for most of these people—and I agree it should go down, but for most of these individuals, some I read about in the excellent series in the Wall Street Journal and other places, they can't even pay a $1,000 bill, correct? So that is not going to help them, is it?

Mr. ANDERSON. No, but if you are getting a 50 percent discount on $30,000, it is still $15,000. If you are getting a 50 percent discount on $10,000, now it is $5,000. We are starting to get to a range where at least some of the more affluent uninsured individuals can, in fact, pay.

Ms. DEGETTE. Do you have any statistics about how many more would be able to pay in that circumstance?

Mr. ANDERSON. I do not, but I think somebody making $50,000 or $75,000 might be able to pay a $5,000——

Ms. DEGETTE. What percentage of the uninsured are making $50,000, because you had just testified that most of the uninsured are lower income individuals. So, how many of the uninsured are the people that are making $50-75,000?

Mr. ANDERSON. About 10 percent.

Ms. DEGETTE. Ten percent. So the rest of them are making a lot less, aren't they? Mr. Rukavina, what do you think about that? I mean, again, I agree people shouldn't be charged these exorbitant rates, but I am not sure that most uninsured could even pay reduced rates.

Mr. RUKAVINA. I think that the discounts—we believe they are necessary, though not sufficient. It is a fairness issue in terms of the discounts being offered.

Ms. DEGETTE. Exactly right.

Mr. RUKAVINA. Many of the uninsured that we have interviewed—SEIU is here today, and they have interviewed a number of uninsured individuals, a lot of the groups we work with across the country—the uninsured are actually interested in paying something for their care. And it isn't until they actually receive the bills, that are oftentimes quite eyepopping, that they kind of throw their arms up in despair.

Ms. DEGETTE. And that is where we get back to the other component, that the hospitals should really work with folks from the front end to establish payment plans and to explain, so that some poor person is not sitting there recovering in their home and they get a $30,000 bill.

Mr. RUKAVINA. We believe that would be the fiscally prudent approach for both the hospital and the uninsured patient.

Ms. DEGETTE. Now, Edith just told me that half of the uninsured are below 200 percent of the poverty rate, does anybody disagree with that?

[No response.]

Okay. And my second question is that a lot of people think that the solution to this problem are the health savings accounts, that if we let people have a health savings accounts which would have high deductibles, that might solve the problem. What do you think about that, Dr. Anderson?

Mr. ANDERSON. I am not a fan of health savings accounts because I don't think that the American public—two things: One can frequently negotiate with doctors, with hospitals, whatever, one-on-one. You have got Aetna and everybody else negotiating hundreds on one, thousands on one, why should an individual be able to negotiate?

The second thing is, I think patients don't have the clinical information to make decisions as well, quite often. And so they are not the best informed, especially the Medicaid and Medicare recipient are not the best informed individuals to make a lot of their decisions.

Ms. DEGETTE. Anyone else have an opinion on the health savings accounts? Mr. Rukavina?

Mr. RUKAVINA. Well, we think that more exposure will not help the problem, that if people are more financially exposed——

Ms. DEGETTE. You mean if they have to pay, say, $1,000?

Mr. RUKAVINA. $1,000, $2500, that, in fact, it will be harmful to the individual, and also to the hospital.

Ms. DEGETTE. It will be much harder to collect and it makes the problem a lot bigger because you are not just trying to collect from a small percentage of uninsured.

Mr. RUKAVINA. Again, I was asked the question earlier about the hospitals and changes since earlier this year when some of this has come to the fore. We hope to work with some of the hospitals to better understand this problem as it affects insured patients, and actually are looking at the increase in these high deductible policies and whether they do contribute to the medical debt problem, and the uncompensated care problems of the hospitals in the country.

Ms. DEGETTE. Dr. Collins, what do you think about that?

Ms. COLLINS. I just wanted to cite some research by the Center for Study in Health System Change that found if all Americans had a $1,000 deductible health plan, a third would spend more than 10 percent of their income on their health care in the event that they were hospitalized. So, you are still looking at charges that could exceed large shares of people's income, particularly at the lower level income ladder.

Ms. DEGETTE. Even for some of those people, it might send them into bankruptcy and cause other severe financial problems just trying to pay their deductible, correct?

Ms. COLLINS. Yes.

Ms. DEGETTE. I didn't get to you with my last question. I am wondering if you think that the solutions which we all can agree are important short-term bandaid type fixes—charity care and discounting for the uninsured—are going to solve the financial problems with health care of the uninsured in America.

Ms. COLLINS. I think that they are short-term solves to this problem. They certainly will not solve the problem in the long-run, and there is no question that with the growing cost in health care, that employers are going to continue to have to shift more of their burden to their workers, raising the concerns that workers will become more underinsured or drop their coverage all together. So, now I think that there really needs to be a broader policy solution to increase coverage of the uninsured.

Ms. DEGETTE. Now, in your study, in fact, that you cited today, it seemed to me like everything is getting worse. There is more uninsured. Insurance is more expensive, it covers less. Public health care systems are being cut back, and people can't pay their medical bills. Do you see anything reversing those trends in the next 5 years?

Ms. COLLINS. Improving economy will certainly help, but research by Paul Ginsberg just recently on health care costs predicts that health care costs will continue to outpace the growth rate in the economy for the foreseeable future.

Ms. DEGETTE. One of the things I noticed also in your study was that the largest companies, the ones that employ 500 people or more, the ones who should be providing excellent insurance, now have 32 percent of their workers uninsured. This compares to the medium size companies which actually had a small decrease in the number of uninsured. What is happening with those larger employers, are they following sort of the Wal-Mart method of having temporary or part-time employees, or what is going on?

Ms. COLLINS. What really reflects broader changes in the economy away from manufacturing and toward the service industry is the larger firms are now firms that are like Wal-Mart that tend not to offer insurance coverage to all of their employees, or not any of their employees, so looking more like small employers. Small employers certainly—workers in small firms currently make up the largest share of the uninsured, but it certainly is growing in the large firm sector.

Ms. DEGETTE. Ms. Jacoby, getting to you with the questions I was asking, do you think that instituting this charity care and discounting are really going to help the uninsured that you looked at in your research?

Ms. JACOBY. I think that—do you mean in terms of discounts to a lower amount——

Ms. DEGETTE. Because of the population we are talking about here, is it really practically going to make them not have to take bankruptcy if they have the lower bills, and can you quantify how many people?

Ms. JACOBY. I am concerned that even smaller bills can be a big problem for the families that we are talking about. I think if we look at the bankruptcy data, credit report data, and even the published case law of hospital lawsuits against patients, we are finding a real range of bills.

Ms. DEGETTE. What are some of the average medical bills in these bankruptcies?

Ms. JACOBY. Well, in the average medical bills in bankruptcies, some of the latest data would suggest that they are well over $10,000, on average, since illness onset, at the time of filing. We need to be careful because that may not include amounts that are included on credit cards. I know that The Access Project has done other work on this finding that nearly half of all bankruptcy filers have medical debt in their bankruptcy files, and that is in addition to people who may have mortgages on their homes already from medical debt, who may have used credit cards and have higher interest payments on those as well. So, I do think there is a range of bill sizes, but the average is actually fairly high for families with the incomes that we are talking about.

Ms. DEGETTE. Thank you.

Mr. GREENWOOD. The time of the gentlelady has expired. The gentleman from Oregon, Mr. Walden, is recognized for 10 minutes.

Mr. WALDEN. Thank you very much, Mr. Chairman. I want to go to a comment you made, Dr. Collins, regarding insurance and the $1,000 deductible portion because I will tell you what I hear, having been a small employer for 18 years now, and we provide insurance for our employees, health insurance. As I talk to small employers in my district and around, it is the price of the premium that is driving them away from providing insurance. The annual increase is sometimes 30 or 40 percent. And they are having to make some really difficult and unwanted choices. And with the advent of the health savings accounts, I am finding a renewed interest and a new availability of policies where you could actually insure a family for catastrophic care at, say, $300 a month. Now, albeit the deductible can be high, but the employer can contribute to that, which then goes into the HSA. And they are saying, "Gee, maybe I can continue to provide health insurance for a while longer." Some are adding it for the first time.

And I am wondering in terms of your studies and others on the panel, do you look at that and what that means because, if I am a moderate to low-income person and my small employer—which is where most of us work and get our insurance—if they are able to continue to insure, they are preventing a catastrophic loss—because when you have a heart attack and you are on a gurney, you are not negotiating price at the door of the hospital, and it may be the only hospital within 20 miles. So, do you look at those data as well? Would the loss be higher if you are uninsured than if you have a catastrophic stop-loss?

Ms. COLLINS. Well, certainly, if you had a catastrophic stop-loss, your losses would be less if you had a catastrophic event. The problem is that you are going to be so underinsured for first-dollar event, so the preventive care. And so people are going to have similar access to care that the uninsured have simply because those dollars, preventive care dollars, are not available to them.

Mr. WALDEN. Right. But it seems to me that if I have got, let us say, a $1,000 deductible HSA policy, health savings account policy, I am out $1,000 up front, certainly. I may be out some form of copayment—and I don't know what that would be, 80-20, 90, whatever, to a stop-loss period—but once I am out that, then I am covered, right? So my heart attack that may be $11,000, I am paying $1,000. Without any insurance, I am getting hit for not $11,000, but $30,000, according to Dr. Anderson, which is outrageous.

So, I am looking at this—and I have worked on this issues as an employer, on a small community hospital board, in the State Legislature, I chaired the committees after my first session that implemented the Oregon Health Plan and expanded the high-risk pool, and did all these things. I haven't found a silver bullet yet that solves this problem, but what I find is there are a bunch of little things you can do that fit different pieces, and we try and get more people covered.

And so I look at HSAs and say, maybe this is one piece that works for a certain segment that can insure the uninsured that otherwise would be walking away from the table today, and are.

Ms. COLLINS. Yes. The concern, of course, is whether or not people have a comprehensive benefit package that leaves them covered when they need it. It gives them good access to the health care system and not underinsured. And whether or not there are other options for small employers buying into large group pools, for example, that might provide more affordable care for their employees.

Mr. WALDEN. Right.

Mr. ANDERSON. When people have first-dollar coverage, the things that they don't do are preventive services, so the women do not get mammograms, they do not get pap smears because they can defer those things until the next year and the year after that. Those are the things, when we have this lack of first-dollar coverage, are the things that we go without. I mean, that is just——

Mr. WALDEN. Right, but if your alternative is you have no coverage, how are you any better?

Mr. ANDERSON. You are clearly better off having coverage than no coverage, but the whole idea behind managed care, the whole idea behind——

Mr. WALDEN. Prevention.

Mr. ANDERSON. [continuing] is prevention.

Mr. WALDEN. Sure, and that was the whole idea behind the Oregon Health Plan, which for the Medicaid population said "we can immunize for preventive work for thousands where we can do one high-risk procedure for an 80, 90-year-old that wanted a liver transplant, is an alcoholic, diabetic, whatever.

Mr. ANDERSON. And that is what the health savings accounts will still pay for.

Mr. WALDEN. I understand that, but there is a certain amount of personal responsibility when it comes to health care, and people

do make decisions about whether or not they have satellite TV and a new car. I mean, there are other financial decisions. I am sure you see it in your bankruptcy work, don't you? Half of it is medical, certainly, and those are those out-of-the-blue charges like you are saying, $30,000 that shouldn't be $30,000, but there are other—and I guess that is what I wrestled with on the hospital board because we looked at the list of people who owed us money, and as community leaders we knew some of them. And you would say, "Wait a minute, I just saw them buying a new whatever, and they are driving in town, or they are in a business or something," and they should pay and they should be held accountable.

Mr. ANDERSON. But if they are being asked to pay $30,000 for something you know everybody else is buying for $10,000——

Mr. WALDEN. I don't disagree with that. But the issue, too, is, don't those who are insured—don't the insurance companies bring some efficiencies to the hospital? I mean, just like—well, in theory, Medicare does, but I think it just brings more regulation and cost, frankly—but, in theory, there is an advantage to having a third-party payer handle that, whether you are a doctor or a hospital. So, I can see a reason to be able to negotiate—have to have some room to negotiate some reductions for that opportunity, right?

Mr. ANDERSON. Sure. And the savings occur mostly in the billing and administrative side, they don't—once you get on the surgical table, it doesn't matter who is insuring you.

Mr. WALDEN. And it seems to me that part of the problem with this market is—I look again at my district, I have got 20 counties, three of whom don't have doctors or hospitals, and you drive 100 or 150 miles to the first one, literally. And so if you walk in with chest pains, you are not going to say, "Well, I am going to go to the Dow, it is 19 miles away, and I can get it for 100 bucks less." So, it isn't really a market process where you can negotiate that kind of price.

Mr. ANDERSON. Certainly if you just had a heart attack.

Mr. WALDEN. Right. Now, if you are doing cosmetic surgery or something—our colleague, Greg Ganske, used to talk about people got three prices before they came and made their decision. You look at lasik eye surgery and things, it is advertised based on price, and I am not sure I want the cheapest one, but—but it is a voluntary choice in that case. And what you are looking at is emergency care and others.

Mr. ANDERSON. Correct.

Mr. WALDEN. But does it make sense to, in effect, get into a price setting, say, 25 percent above Medicare. Does that work everywhere, and is that—what are they collecting now off the charge master?

Mr. ANDERSON. Most of them are collecting very little off the charge master.

Mr. WALDEN. So it raises the issue, why do we have a charge master?

Mr. ANDERSON. Exactly. Well, we had a charge master from 1900 on because people originally paid charges, and in 1960, 1965, and 1990, the charge master meant something. After about 1990, the charge master has no market forces to determine it at all, it is just raised two, three times faster than health care costs have risen.

Mr. WALDEN. How much of that is because of cost shift from lower, like Medicare and Medicaid, that don't always pay the full freight, and how much of that is just that those final folks left have no negotiator?

Mr. ANDERSON. I would say that it is mostly that those final folks have no negotiator.

Mr. WALDEN. And it seems to me, too, on debt—and maybe, Ms. Jacoby, you can address this—as a small business owner, when I have a client that is behind 30, 60, 90 days, I am much better off to sit down and cut a deal because I am never going to see anything—even if I go through bankruptcy, the opportunity to collect is pretty slim.

Ms. JACOBY. I think that is what has struck some of us on the debtor/creditor side about the situation about attempts to collect through the formal process, that it is a little unusual as compared to what institutional lenders are doing and how they are handling the situation.

Mr. WALDEN. It is not very effective. Okay. Then where in the process do you make this work? I am in the radio business, so I can negotiate a sales price when we go in the door and out the other side and all that. But if I am a patient coming into the hospital in need of emergency care, I don't want to wait around, I want somebody to look at me. Where do you make this thing work? Where should these hospitals make it fit?

Ms. JACOBY. Well, this is a big concern, as I tell my contract students, this is very different from even the other standard form contracts that patients and consumers enter into every day, that there really is no opportunity for negotiation when they need the care, and often their family members are signing agreements that have terms in them that they barely are reading because they have very important things on their mind and would sign them in any event. It is a very difficult situation to find the right time when people aren't involved in regular care. If they are involved in more regular and preventive care, they might have a better——

Mr. WALDEN. That is a different issue. One final point, because the census data I have here somewhere indicated that I think the figure was 43.3 percent of those who have no insurance for an entire year are not citizens of the United States. That means—and we saw it in our hospital, we have a very high Hispanic population. A lot of them are not legal citizens of the United States. How do we cope with that because they are not going to want to give data, and you know why. I mean, they don't want a free ride back to their country where they are citizens.

Ms. JACOBY. Even those who are citizens may not have the data that are necessary in order to process their charitable care eligibility in terms of pay stubs and the like, if that is what you are referring to.

Mr. WALDEN. Well, but when you are talking about signing up for charity care in this environment, some of them won't. Well, that means they are probably not paying taxes because you could always turn in a copy of your tax return, I would think. So, where do you help the hospitals here who are saying, "Okay, I do have a charity program, but you have got to work with me. You have

got to give me some data here". How do we address—what do you recommend? You are the certified smart lawyer here, I am not.

Ms. JACOBY. Well, I will wear that hat then today. I don't see a magic bullet to the situation, and I hope I was clear that I don't see the hospitals as being fully responsible for the situation. I think at every level of our legal system, from the county level to the State to the level to the Federal level, we do have a system where the charges are not known to the patient often until afterwards, and that we treat patients as debtors through our whole legal system and our whole health care system. And I think just as that has developed over a very long period of time, I don't think it can be solved overnight.

Mr. WALDEN. Okay. I have overrun my time here. Your comments have been very helpful, thank you very much.

Mr. GREENWOOD. The Chair thanks the gentleman and recognizes the gentlelady from Chicago, Ms. Schakowsky, for 10 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you, panel. This has been a very interesting conversation that we have been having. As someone who supports some kind of universal health care plan, I would like to see a national health care plan. One consensus that seems to be here is that the market doesn't work. People are talking about whether the uninsured should get the same rate as people who are insured, so we start talking about price setting and that kind of thing. The market in health care and in hospital care seems to have absolutely failed us.

I want to talk a little bit about people with insurance because I am looking at something from one of the hospitals, Quality Health Care For Those in Need, and the guidelines that they have. It begins with the charity care program, and basically it deals with people who are uninsured.

So I want to ask the witnesses to talk a little bit more about people who have insurance with very high deductibles, about what is happening to them in terms of their financial fragility.

Ms. JACOBY. Well, many medical bankruptcy filers have some insurers in their families at least at some point. One study that I was involved with originally found that 80 percent of bankruptcy filers with medical problems had some insurance at the time of filing.

Ms. SCHAKOWSKY. I want to underscore that because I think it is really important. When we think of these problems with medical bills, very often we talk about people who find themselves uninsured. But you are saying that bankruptcies due to medical bills involve people, 80 percent of whom are at least partially insured. That is a serious problem.

Ms. JACOBY. I agree. Follow-up research is trying to dig a little bit deeper and see what those numbers mean, and I think what we are finding is that many of those people have had gaps in coverage in the past, so they may have incurred some of these debts while they are insured at least for some family members. It also could go the other way, they are insured at the onset of their illness and later become uninsured, and then are facing some of these problems. So, I think it is more complex than just the label of insured

or not insured, it is the quality of their coverage, but also the continuity of their coverage that is showing up in bankruptcy.

Ms. SCHAKOWSKY. I wonder, Dr. Collins, if you could comment on that as well?

Ms. COLLINS. Yes. The survey conducted The Commonwealth Fund asked people about their medical debt, and 35 percent of people who were continuously insured said that they had had a medical bill problem or had accrued medical debt. Forty-five percent of those who were continuously insured, who earned less than $35,000 a year, said that they had had a medical bill problem or accrued medical debt. So, we are clearly seeing that people who are insured continuously are having problems paying their bills. In fact, when we asked people whether when the bill was incurred, if they had a medical bill problem or debt problem, if they were insured at the time of the bill problem or the time of the event, 60 percent said that they had been insured at the time. So, we are clearly seeing this is a problem of underinsurance as well as uninsurance.

Ms. SCHAKOWSKY. I don't know if anyone else——

Mr. RUKAVINA. I would like to comment on this as well. We worked with a nonprofit consumer credit counseling service and found similar figures. About 40 percent of the people seeking the services of this consumer credit counseling service were there because of a medical incident, and nearly I think it was 70 percent of those people that were there because of a medical incident were insured at the time of the medical incident.

Mr. ANDERSON. We also know the characteristics of these individuals, generally. A few of them have a catastrophic thing that was unexpected, but most of these people that have these debts are people with chronic conditions, with multiple chronic conditions. They are somebody who is going to the doctor repeatedly. They are going to the hospital repeatedly, year in and year out, and they are the ones that find—and the health system and the health insurance system doesn't cover them adequately. If you have got an acute care problem, the insurance takes care of it, generally. If you have a chronic problem, the health care system doesn't cover you as well, and you are the ones having most of the expenditures.

Ms. SCHAKOWSKY. The other thing about that is that it may be an accumulated debt over a period of time where the individual charges may seem manageable but, in fact, over time, are not.

Mr. ANDERSON. If you have diabetes and congestive heart failure and three other things wrong with you, you are seeing a lot of different doctors and you are incurring a lot of bills, and you are doing that not just 1 year, but year in and year out. And so those medical bills pile up. And a lot of times, with co-insurance and other things, you are paying 20 percent of the doctor bill, a portion of the hospital bill, and with 30 doctor visits and 50 prescriptions and all sorts of things that you fill in a year, that is a lot of money.

Ms. SCHAKOWSKY. I think it is important for us to paint a picture of the people who are facing this problem as most often having jobs, working, and in many, many cases, also have insurance. In fact, it sounds like in some cases having a job can be—I am looking at a document, "Collection Practices Prohibit Legal Action Against Unemployed Individuals." Well, if you are employed and still can't

pay, then that doesn't apply to you. It prohibits liens on a patient's residence if it is the sole real asset. Well, what if you don't have a house and you are a renter? So, you are employed, you have insurance, and you are a renter, then your wages could still be garnished and you can't pay your rent. It seems to me that there are just so many, many holes in here.

I am concerned about the women who traveled here from Chicago to talk about their situation. We hear about charity care being offered. The hospital did work to help her apply under the Victims Assistance Fund, but she was denied, and then she was sued.

If charity care doesn't work, do they then just turn these over to collection agencies? When do they start suing?

Ms. JACOBY. I guess we should let the next panel answer that in some measure, but my belief is that turning medical accounts over to collection is quite a routine matter, and it is happening earlier and earlier, perhaps earlier than it would happen with other types of debts that consumers and patients face.

Ms. SCHAKOWSKY. Then do the hospitals claim to no longer have—I guess we could ask the next panel.

Ms. JACOBY. Again, I stand to be corrected, but my understanding is that they are mostly not selling the debt outright, but assigning it to a primary and then perhaps a secondary collector, and therefore are taking the responsibility for overseeing that process.

Ms. SCHAKOWSKY. Is the rate of lawsuits increasing?

Ms. JACOBY. I don't have a way to measure that.

Ms. SCHAKOWSKY. Does anybody know if there are more lawsuits? Both of these instances ended up in a lawsuit. Even in the case of Ms. Perez working out a payment plan and with payments being made on time, she was sued. So my concern is that, after all is said and done, if you can't even work out a payment plan without getting sued, this sounds like an intractable problem. I don't know if anyone wants to comment on where we need to go with this.

Ms. JACOBY. Just looking at the trends in the health care system right now, rising costs, rising numbers of uninsured, there is no question that this problem will continue to grow. We probably will continue to see lawsuits and growing numbers of lawsuits, just because of the drivers in the system right now.

Ms. SCHAKOWSKY. My concern is the problem that the uninsured pay this premium price. It is also true, by the way, in the cost of prescription drugs where those who have a prescription drug plan that has been negotiated by their HMO or their insurance company pay less, and the people who can't afford it end up paying the premium price. Mr. Waxman's studies have shown that. So, that is one problem that the hospitals are charging premium prices. Nonetheless, hospitals need to recover some costs as well. We are not asking them to do complete charity care.

At some point, Mr. Chairman, it just seems to me that we need to get to the core issue. You said we are not going to solve the issue of universal health care today, but I just feel that we keep marching around the edges here. At some point we are going to have to jump right into the middle and deal with the core problem. I thank the witnesses.

Mr. GREENWOOD. The Chair thanks the gentlelady. The gentleman from New Hampshire, Mr. Bass, is recognized for 10 minutes.

Mr. BASS. I am going to pass, Mr. Chairman.

Mr. GREENWOOD. The gentleman from Michigan, Mr. Ferguson.

Mr. ROGERS. Rogers.

Mr. GREENWOOD. Rogers—I am sorry.

Mr. ROGERS. Wow. Has it been that long since I have been in committee, Mr. Chairman?

I do appreciate it. Thank you, Mr. Chairman, and I appreciate the panelists today, and I am adamantly opposed to national health care. We see it just north of our border. They ration, they have very few choices on prescriptions, and many places in the system they stop people from getting care determined by age and illness and other things that I just think is un-American.

I was curious, Dr. Anderson, something struck me that you said about the lack of first-dollar coverage would stop people from getting preventative care. Have you done any study on any of the new folks who have embraced HSAs—and I know it is a relatively new phenomenon, people are just getting into the system and getting started—but do you have any studies on the folks who have actually signed up within the last few months and are participating in these programs?

Mr. ANDERSON. I do not, but if you look at programs like the Rand Health Insurance experiment that ran in the 1970's and early 1980's. they in fact did have something very similar to the HSA type of thing. The services that people chose not to get were the preventive services. So we have a large national experiment that was done in the 1970's and 1980's, and maybe people are different now, but I don't think so.

Mr. ROGERS. You don't think people may be more price sensitive today than in the 1970's? Let me tell you why I ask you this. There was a group—and I am just trying to figure out if you are right or they are right—but there was a group of about 18 to 20 small businesses, under 500, who had gone to HSAs, and we assembled them in a room and said, "Tell us the good and the bad and the ugly about these things, are they working or are they not?"

And they had some interesting percentages on the people that were involved in those programs—and they could have been an anomaly, I suppose—but 45 percent of the membership in these agencies were brand new. They had never had health care before, which I thought was pretty staggering. And what they found is that they were 30 percent more likely to go into preventative care than the folks in the old system that had first-dollar coverage. And they were certainly more price sensitive, and most of them—and I forget the percentage—had engaged in negotiations for things like annual physicals where they went into the doctor and said, "I don't care what you are charging, this is what I am going to pay. Do you still want me as a patient?"

And to some degree I thought that was very encouraging news. That may have reverse in the trend, and if there is finally—and one of the things I think is broken about our health care system is the consumer is really never in charge. I am told what to do by everybody else—third-party administrators, your employers, the

hospital gets their say. At the end of the day, I end up with a collection agency, and I am not really sure what in the heck happened.

My theory is that if we had this sense of price sensitivity, maybe the $9 aspirin would have gone away a long time ago. Somebody would have said, "Hey, wait a minute, I am not paying nine bucks for this." I am encouraged by it, and I was just curious.

Mr. ANDERSON. Well, I think what you have got to look at is the 43 million uninsured who do have an incentive to negotiate with their hospital, negotiate with their physician, negotiate with anybody they can negotiate with over price, and very few of them are able to do it, and certainly cannot negotiate rates that are comparable to what Aetna can do, or what anybody else can do when they walk into a hospital.

Mr. ROGERS. Of course, under an HSA, you have leverage. If I have absolutely no insurance and nowhere to go, I have no leverage. At least I know I have got some money to pay, No. 1, and I have catastrophic coverage, No. 2, so I have got some leverage. You and I can work together because I have got some money to give you.

Mr. ANDERSON. Right. And the other thing is that many of the HSAs—not all of them, but many of the HSAs, in fact, negotiate for you, so that if the HSA is run by Aetna or is run by somebody else, they are actually negotiating the rates on your behalf, and you are essentially piggybacking on those rates.

Now, maybe you can even negotiate a better rate than Aetna is going to do for you, but I doubt it.

Mr. ROGERS. Interesting. I am actually fairly hopeful for it, so I hope you will get involved in some of those studies in the future with actual participants, and maybe we can see where those numbers—I was encouraged by that first batch of folks coming in.

This is a very difficult issue, in some cases very difficult to understand about what care is compensated and isn't, and I have a feeling at the end of the day we are going to find that there are several people that at fault for the problems that we found in the system, and one of those problem-makers is policymakers. The way we develop policy for uncompensated care creates some kind of really anomalies in the system that makes very compassionate, kindhearted people do some kind of things we all look at and scratch our head and say, "Why would we do that?"

So, I hope that through this that we can fix those kind of things. And I guess, Mr. Rukavina, I would ask, there are five systems joining us today, and they said—at least have told us—that they have taken steps to enhance and revisit their billing system. Have you found that to be true and, if so, what has that done for the patients?

Mr. RUKAVINA. Well, we are talking to several of those systems. They are, in fact, taking steps to address some of the problems that have been highlighted, and I think that frankly it is too early to tell.

I received a call from an attorney recently that had a patient in one of these systems that will be here today. We have addressed it with the system directly. A patient was identified as possibly having another source of payment, an uninsured patient possibly

having a source of payment. There were some problems, probably problems resulting from actions the hospital took and actions the patient took, but the end result was that the bill was sent to collection after 30 days, and the first call that this patient received after being released from the hospital was from a collection agent that she felt was fairly intimidating. And, again, we are hopeful. I think it is too early to tell. And I think that it has been raised earlier by others asking the question, the details of how these programs are implemented will be of utmost importance. How people are informed of the program, the kind of information that is actually shared with patients, when it is shared, and the whole series of questions that get asked regarding patients and their ability to pay will be very crucial, and we hope that these systems and others and the American Hospital Association and State associations will work hand-in-hand with community and consumer groups that we believe are resources that could help the hospitals and patients solve some of these problems.

Mr. ANDERSON. One of the problems is the charge master file. A charge master file has about 10,000 different items on it. You walk into the hospital, even in a nonemergency situation, you don't know which of these 10,000 items you should negotiate on the basis of. So, you can negotiate afterwards and try to lower your rates on a certain set of things, but you don't know a priori when you walk in what services you are going to need. Are you going to need an x-ray? How many x-rays are you going to need? What type? Are you going to need an MRI? What type are you going to need? Ten thousand items, you can't negotiate on that. You have got to have something for somebody that you can, in fact, negotiate on, and that is probably what is your day rate, what is your DRG rate, what is something simple that somebody can negotiate on, not 10,000 items, of which probably 9,950 of them you will never use.

Mr. ROGERS. Interesting. I know this problem is complex. I appreciate all you being involved in it. I hope we don't give up on probably one of the better health systems in the world—and it is not perfect. It has got bumps and bruises and warts and it is ugly, but if we want to remove compassion and care from a system, nationalize it. Ask the Canadians, ask the British, they are all having problems with the weight of these large, unmanageable, uncaring—intentions are great, the outcomes are awful, and I just don't think we ought to really hinder the innovation of our health care system that does miraculously well for a pretty unhealthy population, quite frankly, and that is America as a whole. Thank you, Mr. Chairman, I yield back.

Mr. GREENWOOD. The Chair thanks the gentleman. The gentleman from Maine is recognized.

Mr. ALLEN. Thank you, Mr. Chairman. Dr. Anderson, I would like to pursue some of this. I have a different view than my friend from Michigan, about how the Canadian health care system works. I think every country has its own unique system, and we are not going to adopt any other country's system, but whenever elections are held in Canada, it is pretty clear how the Canadians feel about their health care system. They know it has problems, but substantial majorities are very positive about it. In fact, all the polling

shows the Canadians like their health care system better than Americans like ours.

I was intrigued by one of your comments, and you were just pursuing it with Mr. Rogers. This notion of bargaining for your health care makes some sense to me when you are part of a very large group, which is essentially what happens with our insurance companies. They negotiate rates on behalf of their members, their beneficiaries, and then, without even knowing it, the beneficiaries get the benefit of that negotiated rate for a whole range of services, but they can do it simply because they are pooled in a large group. But I was struck by your testimony, your written testimony, about the constraints on the bargaining power of the uninsured.

You say perhaps the most important constraint on their bargaining power, however, is that they do not know what services they will ultimately need. They do not know how long they will remain in the hospital, what x-rays or lab tests they will need, and therefore they cannot know in advance what services they will require and which of the 10,000 prices they should negotiate. And if they could negotiate those prices, you would still have an individual trying to negotiate with a hospital, which doesn't work very well, except it works, as the testimony has shown, after the services have been rendered in terms of how much you are going to pay on a bill that has been rendered.

And so that point seems to me to be particularly compelling in terms of our expectations about what we really expect here. I don't know if you want to elaborate on that anymore, you already commented to the gentleman from Michigan, but do you have anything further you would like to say on that?

Mr. ANDERSON. I think to allow the marketplace to work, people have to have good information. And one of the key things you have got to know is what services are you going to need.

Mr. ALLEN. You touched on how to move ahead, and I was struck by your DRG+25 percent. Probably doesn't stand much of a chance in Congress because we prefer complexity to simplicity here, at least that is the trend. Give us as much complexity as we possibly can have, and I offer the Medicare law as the prime example. But it does seem to me that it highlights the tradeoff that we have here. If you are going to have stability and predictability and equity, and you come to this particular problem—and I take the testimony of the panel as a whole to be saying essentially we are really going to operate in the margins here. We are not going to fix the problem of the uninsured, we are trying to deal with what started out being the subject of this hearing, which is the fact that some people are charged way more—way more—than others, and that looks unfair. That looks abusive. But if you have—I guess this is probably for the other panelists.

You could say Medicare+25 percent, you could say Medicare+35 percent, you could say Medicare+10 percent. You could say almost anything. But if you did that system, it would be a simple system. You wouldn't be trying to figure out what insurers for a particular hospital get reimbursed or are charged for their beneficiaries.

So, if we remove—for all the other panelists—if you remove the element of how much above Medicare the reimbursement is—and Medicare is often under-reimbursed—how would you react to, say,

DRG-10 percent as opposed to DRG+—do you catch my drift—DRG+10 instead of DRG+25 percent? Is the concept of having a simpler system one that makes sense to the rest of you? I know it does to you, Dr. Anderson.

Ms. JACOBY. Well, I think simplicity would assist patients, and that could be done in a lot of different ways. But I think that one problem that they are experiencing is trying to figure out what they owe, if it is owed right away, if it is owed over installments, what their legal situation is. So, I am certainly in favor of simplicity. I don't have an opinion on any particular way to make the system more simplified, but from the patient's perspective, they already aren't—if they are not negotiating the rates in their care very much, then that is one way to at least let them know how they can handle their financial affairs.

Mr. RUKAVINA. I think that clearly a more simpler billing system would be helpful. Transparency would be helpful all around. Hospitals, as Secretary Thompson pointed out, are reimbursed by the Federal Government $22 billion per year to pay for the care of poor and uninsured patients. I think that it is oftentimes confusing to figure out what the gap is in terms of the services provided, the cost of those services, and what providers, hospital and other providers, are actually reimbursed for the cost of that care, reimbursed from the self-pay patient and from the various subsidies that come from Federal, State, and oftentimes local governments. So, clearly transparency would help. But, again, a system that is caring and compassionate on the finance side we believe would benefit the providers and the patient.

Mr. ALLEN. Dr. Collins?

Ms. COLLINS. I certainly think that that would be an improvement over the current situation. In the long-term, it might be helpful if people without insurance coverage could actually buy into a group insurance program like the Medicare program, so that could be sort of a long-term goal and this being a step to fixing the current problem on the way to getting to that.

Mr. ALLEN. We are doing an experiment in Maine, we call it Derigo Health. The State government is essentially contracting with an insurance company to cover a pool of people who are essentially working for small businesses and most likely be uninsured. That is another whole speech.

I want to ask one other question, maybe primarily for you, Dr. Anderson. Put yourself in the position of a hospital CFO. The change is needed. But any change that is made can easily lead to an increased cost-shifting. Unless we do something about Medicaid reimbursement, Medicaid and Medicare—unless we do something about those reimbursement systems, any loss of revenue anywhere in the system for a particular hospital can lead to more cost-shifting to the commercial side, and at least in my State, the small business community in particular, but even large businesses are really struggling.

Any thoughts about how to deal with that particular problem, if we basically laid down some ground rules for what hospitals could do with respect to the uninsured in terms of how they charge and how they collect from the uninsured? Any thoughts on how we deal

with the other side, the potential loss of revenue and the risk of more cost-shifting to commercial insurers?

Mr. ANDERSON. Well, essentially, most of the uninsured have difficulty paying these bills, most of them do not pay the bills. Only about 3, 4 percent of hospital revenue actually comes from the uninsured. So it is not a big number that we are talking about here in terms of loss of revenue for the hospital industry because many of these people don't pay.

So, as a result, I don't think that it is going to have a whopping big impact on the bottom line, and Medicaid and Medicare could do it more substantially by increasing the rates by 1 percent than all the hospitals tripling the rates on the uninsured. It would have a much bigger impact on the hospital's bottom line.

Mr. ALLEN. Thank you. Anyone else? I have 30 seconds left.

[No response.]

Thank you, Mr. Chairman, I yield back.

Mr. GREENWOOD. The Chair thanks the gentleman, and the Chair thanks our panel of witnesses for your help this afternoon. Happy birthday, Dr. Anderson, go and enjoy your birthday dinner. You are excused.

The Chair calls forward our second panel consisting of Anthony R. Tersigni, Chief Operating Officer and Interim CEO of Ascension Health; Kevin Lofton, President and Chief Executive Officer of Catholic Health Initiatives; Jack O. Bovender, Jr., Chairman and Chief Executive Officer, HCA, Nashville; Herbert Pardes, M.D., President and Chief Executive Officer, New York Presbyterian Hospital; and Mr. Trevor Fetter, President and Chief Executive Officer of the Tenet Healthcare Corporation.

Gentlemen, we welcome you, and let me begin by thanking all of you for being here. I know how difficult it was to arrange your schedule so that you could be with us this afternoon, and that is appreciated.

It is the practice of this committee to take testimony under oath, and so I need to ask if any of you gentlemen have objections to giving your testimony under oath this afternoon?

[No response.]

Seeing no such objection, I would advise you that under the rules of this committee and the House of Representatives, you are entitled to be represented by counsel. Do any of you wish to be represented by counsel this afternoon?

Mr. TERSIGNI. No.

Mr. GREENWOOD. Dr. Tersigni says no. Mr. Lofton, you are represented by counsel? Would you identify your attorney by name?

Mr. LOFTON. Mr. Paul Newman is seated directly behind me.

Mr. GREENWOOD. Mr. Bovender, are you represented by an attorney?

Mr. BOVENDER. No.

Mr. GREENWOOD. Dr. Pardes, are you represented by attorney?

Dr. PARDES. No.

Mr. GREENWOOD. Mr. Fetter?

Mr. FETTER. No.

Mr. GREENWOOD. Okay. Then I would ask if you would please stand and raise your right hands.

[Witnesses sworn.]

Mr. GREENWOOD. You are under oath and, Dr. Tersigni, we will begin with you. Again, welcome, and you are recognized for your opening statement, sir.

TESTIMONY OF ANTHONY R. TERSIGNI, FASCHE, CHIEF OPERATING OFFICER AND INTERIM CEO, ASCENSION HEALTH; KEVIN E. LOFTON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CATHOLIC HEALTH INITIATIVES; JACK O. BOVENDER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, HCA; HERBERT PARDES, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NEW YORK PRESBYTERIAN HOSPITAL; AND TREVOR FETTER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TENET HEALTHCARE CORPORATION

Mr. TERSIGNI. Thank you. Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear this afternoon. I am Anthony Tersigni, the new President and CEO of Ascension Health. This is my fourth day on the job, and I am pleased to be here.

Mr. GREENWOOD. You are under oath, Dr. Tersigni.

Mr. TERSIGNI. Ascension Health was formed just four and a half years ago when the Sisters of St. Joseph of Nazareth and four provinces of the Daughters of Charity united their health ministries to continue their ministries as one. I am grateful that three of our sponsors have joined me here today, and I ask that they stand to be recognized—Sister Bernice Corell, Sister Maureen McGuire, and Sister Mary Kate Terrell.

They are here today because we are as concerned as the subcommittee about the issues brought forth today. Ascension Health carries on our sponsors' strong commitment, which has been in place for over 400 years, to the healing ministry of Jesus. It is central to our mission to serve those who are poor and vulnerable. In 2003 alone, Ascension Health provided more than $500 million dollars in charity care and community benefits. In other words, for every dollar we made from our operations, we spent nearly $4 on charity care and community benefits.

Each day our hospitals—or as we call them, our health ministries—save the lives and relieve the suffering of hundreds of people without insurance. We receive letters every day from patients, thanking us for the care they received. I have several sample letters with me today, and there are thousands of stories just like them that go untold. I would respectfully request that these letters be made part of the record.

That Ascension Health gets many things right is not to say we get everything right. We are still a young system in the process of integrating many management and information systems. As a part of this effort, which began in early 2003, we re-examined our billing and collection policies and identified several areas for improvement. The subcommittee's work also prompted us to further review our policies more carefully.

We determined that, because Ascension seeks out the poor in our communities, we need more clarity and consistency in this area. Last December, our System Board approved a system-wide billing and collection policy for all uninsured patients. I call your attention to the chart above, which is Attachment 3 of my statement, de-

scribing the minimum guidelines which are clear and simple, and must be posted in our hospitals for patients to see. "We will write-off your bill if you are at or below the poverty line; we will provide you a sliding scale payment plan if you are financially needy; we will give you a discount based on our best paying payers regardless of your income if you have no insurance."

Under our policy, extended payment options must be offered to all uninsured patients. Every one of our CEOs, CFOs, and BPs of mission have committed in writing to carry out the letter and spirit of the policy. I respectfully ask that a sample be entered into the record.

Mr. GREENWOOD. Without objection, it will, sir.

Mr. TERSIGNI. Ascension Health will not take action to cause bench warrants. For those who qualify for charity care or financial assistance, we will not seek liens on personal residences, we will not authorize a collection effort that will result in a bankruptcy, we will require collection agencies to follow our system-wide policy for billing and collection. While we believe these limits generally were being followed in our Health Ministries, our new policy is unequivocal.

Let me address the claim that hospitals make money on uninsured care. Our mission is to care for the poor, not to make money on their suffering. As shown in our submission to the subcommittee, we collect between 5 and 10 percent of the total charges for uninsured patients. Each health ministry reported losses on uncompensated services to the uninsured. In the aggregate, Ascension Health lost $222 million on uncompensated care in 2003.

Mr. Chairman, Ascension Health does all it can to respond to the needs of the poor. We have committed 350 financial counselors and 1500 registrars to identify and assist those in financial need. Our Call to Action commits us to work for 100 percent access to healthcare in the communities we serve.

We urge Congress to support our efforts and those of many others to achieve access for all Americans.

I thank you, and I look forward to answering any questions.

[The prepared statement of Anthony R. Tersigni follows:]

PREPARED STATEMENT OF ANTHONY R. TERSIGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ASCENSION HEALTH

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to appear before you. Ascension Health commends the Subcommittee on Oversight and Investigations for its interest in uninsured patients.

I am Anthony R. Tersigni, Ed.D., FACHE, President and Chief Executive Officer of Ascension Health, one of the nation's largest nonprofit Catholic health systems. Ascension Health was formed in 1999 when sponsors of two Catholic hospital systems that shared a centuries-old commitment to care for the poor—the Sisters of St. Joseph of Nazareth and four provinces of the Daughters of Charity—agreed to unite their health systems and continue their ministries as one.

Today, Ascension Health carries on our sponsors' strong commitment to care for the poor and the uninsured. It continues to be central to our mission—and the work of the Catholic sponsors that remain active in the leadership and operation of Ascension Health. It is reflected in the principles and strategies that guide our operations [See attachment 1]. In 2003 alone, Ascension Health provided more than half a **billion** dollars in charity care and community benefits. In other words, for every dollar we made from our operations, we spent nearly four dollars on charity care and community benefits.

Because of our tradition of caring for the most vulnerable among us, our hospitals and clinics—or, as we call them, our health ministries—play a unique and extremely

important role in our society, serving as a healthcare safety net for millions of uninsured Americans. For the thousands of religious and lay persons who work in our hospitals, this is a calling. It is humbling to lead an organization whose origin, as well as its Mission moving forward, is due to women who have dedicated not just their careers, but their lives, to providing care to people who are poor.

Today, I want to address three points:

- What we do right
- How in the past we fell short in some areas and what we're doing to address these issues
- Our response to the Subcommittee's request for information

Later on in my statement I will also lay out in greater detail our *Call to Action* initiative. It is perhaps the best expression of our Mission, Vision and Values. Our *Call to Action* has as its goals the achievement of 100 percent access to healthcare for every person who lives in the communities we serve—certainly an ambitious goal, but one that speaks to our compassion for the poor and vulnerable.

What We Do Right

Every one of our health ministries has had charity care policies in place for years, if not decades. We publish and post our charity policies throughout our health ministries. Our financial counselors are dedicated professionals who share our values and who strive to do the right thing. They answer patient questions over the phone about our charges. They seek out patients who may be in need before they go home and make attempts to contact patients later on to discuss how their financial obligations could be eased. They help patients qualify for financial assistance so they can get the healthcare they need.

In addition, the men and women who work in our health ministries every day save the lives or relieve the suffering of hundreds of people who do not have health insurance. The Subcommittee need not take our word for it. Our patients are our toughest judges, and it is in their words that our success is revealed [See attachment 2].

For example, we received a letter from a woman who was a patient at SETON Southwest Healthcare Center in Austin, Texas:

> I am writing . . . today to tell you how thankful I am that your organization was able to assist me on 100% of the hospital bill I accumulated while a patient at Seton SW . . .
>
> Earlier this year, my world fell apart. I lost my job and my health insurance. Shortly there after, my fiancé left me for someone else. I lost my home and—pretty much the life that I had planned on. It was at that point, I thought I had lost everything and then I lost my health. Once that was gone, I grasped on to all that I had left which was my family, friends and faith . . . Being that sick, was one of the most humbling experiences of my life. I was unable to work and very worried about how I would pay my hospital bill. Stress doesn't help my medical condition at all. Please know that it was a wonderful surprise to hear that my bill was taken to a zero balance.
>
> It is said that everything happens for a reason. I would like you to know that I had a wonderful experience while in Seton. The nursing staff was excellent and they inspired me. I have decided that I want to be a nurse. I am feeling better now and plan to enroll in nursing school next year. I hope that I can offer the same compassion and inspiration to someone else in their time of pain and illness . . .

From another letter we received from a patient:

> I recently had an operation to remove my gall-bladder. The operation went well, and I am now in recovery. I don't know how to thank you. Words cannot express my gratitude. The cost of the operation had been a big burden to me. I had just started a new life in America and was financially unstable; in addition, I had no medical insurance.
>
> Thankfully, you heard of my situation . . . and funded my operation. Because of you, I was able to have the operation safely. I believe that all of this is due to your organization, which truly personifies the love and spirit of Christ. I thank you . . . with all my heart. I do not know how I will ever be able to repay you for all your help. Right now, all I can do is pray, and I will pray for you and your hospital continuously and diligently. I will also do my best to follow your example and help others with the love of Christ. Again, I thank you for the love you have shown me. I will always be praying for your hospital and your mission.

Mr. Chairman, for every letter like those two, there are hundreds, maybe thousands, of positive stories *just like it* that are *not* told. I have additional representative letters from patients from across the nation. I request that these letters be

made a part of the record [Attachment 2]. Each one is a very personal story, and each one thanks the health ministry that provided care—in some cases, life-saving emergency care. Each person expresses heartfelt gratitude to Ascension Health for reducing or eliminating his or her hospital bill or eliminating it entirely.

How We Fell Short in Some Areas and What We're Doing to Address These Issues

That Ascension Health gets many things right is not to say we get *everything* right. Formed just four and a half years ago, Ascension Health is a young system that is still in the process of integrating the many management and information systems used by our health ministries. As a part of that effort, which began in early 2003, we reviewed the billing and collection policies that existed throughout our system and determined that we, as a system, needed more clarity and consistency in this important area. The Subcommittee's work also prompted us to examine our policies more carefully, which led to our identifying a number of opportunities for improvement.

We learned, for example, that our policies were not always explicit and each health ministry did things a little differently. Consequently, we could not speak to an Ascension Health system-wide billing and collection policy. Nor did we have a process that could measure the effectiveness of our health ministries' charity care programs in reaching those in need. Our billing and collection practices were not receiving the level of attention or oversight by our senior management team that, in retrospect, they should have received. And we had no system-wide policy that addressed the level of charges for uninsured patients.

As a result, we believe too many patients, even if only one, had come to our emergency rooms and, in spite of the charity care and financial assistance programs our health ministries have had in place for years, they had returned home fearful and anxious about the bills they could not pay. Unfortunately, there are times when patients do not respond to our communications and their needs are not fully met.

Regrettably, it has on occasion become necessary for hospitals, even those such as ours that are dedicated to the poor, to refer cases to collection agencies. And the truth is, we have not wanted to be in the business of bill collecting. We have learned through this investigation that there have been instances, and I believe they are rare, when collection agencies have been more aggressive in their practices than our values would support. That there may only be a few instances does not excuse us.

We concluded from this review that the experience the poor and uninsured have when they come to us for care is too important to allow completely local variation. Although Ascension Health is newly formed and somewhat decentralized, we determined that we needed a level of consistency throughout Ascension Health regarding the care and billing of the uninsured. As a system, we needed assurances that our charity and financial assistance programs were meeting certain minimum standards and reflecting our values.

In December 2003, a single, system-wide policy was approved by our Board of Trustees, subject to approval by the Centers for Medicare and Medicaid Services (CMS). It is important to point out that this policy is a "floor"—it is the least that we require of our health ministries, many of which have been and will continue to be more generous in their care for the poor and uninsured than this new floor requires.

Ascension Health Policy Regarding Care for the Poor and Uninsured

The Ascension Health policy is premised on several core values and principles, including our commitment to, and reverence for, human dignity and the common good; our special concern for, and solidarity with, poor and vulnerable persons; and our dedication to distributive justice and stewardship.

The Ascension Health policy establishes minimum guidelines relating to the level of charges, if any, that would apply to an uninsured patient, depending upon his or her particular circumstances: those who are poor based on poverty guidelines; those who face special circumstances; and those who are determined or presumed (by not applying for financial assistance) to have the means to pay [See attachment 3]. The policy is as follows:

Charity Care. For the poorest patients, Ascension Health covers 100 percent of their hospital bills. To qualify, a patient must have household income at or below the federal poverty level (FPL). Those with household incomes between 101 and 200 percent of FPL will have their charges reduced on a sliding-scale basis. The poverty limits will be adjusted at each health ministry based on area wages.

Financial Assistance. Income is not the only determinant of need. So our Financial Assistance program considers a broader picture of a patient's financial resources and circumstances. Each health ministry must have a written policy that considers income as well as the patient's assets, size of the medical bill and other financial

obligations (e.g., for housing, transportation and childcare). For example, a married adult male with annual income of $14,500 a year is making 120 percent of FPL and, therefore, would be entitled to a sliding scale adjustment of his hospital bill, leaving him responsible for, say, 20 percent of it. However, if the bill is $30,000, he would still owe $6,000. If he had no assets or had other obligations, he could have problems paying his medical bill.

Finally, because of the complexity and subjectivity of its guidelines, our health ministries are required to have review boards that consider patient appeals of adverse determinations.

Uninsured Patients with Means to Pay. Not all uninsured patients are poor and even those who are don't always apply for financial assistance (out of reluctance to fully disclose finances, fear or embarrassment, or other reasons). In the interests of fairness and clarity, these patients are charged a rate comparable to the discounted rate each local health ministry has negotiated with its "best paying" insurers. This portion of the policy is subject to approval of CMS. (The commercial payers whose rates are used as the benchmark must account for at least 3 percent of that particular health ministry's patient volume.)

Mr. Chairman, I would like to reiterate that this policy represents the floor. It represents *the least* any of our health ministries will do. We are a system that believes in distributed leadership. Local health providers know more about local needs than those at the home office, so if an Ascension Health ministry wants to go above and beyond the policy I just explained to the Subcommittee, it may. In fact, many of our health ministries currently are going above and beyond what is required in our new policy.

The Ascension Health policy on discounts for the uninsured also addresses billing and collection practices. The policy requires that employees and agents of each health ministry treat patients and their families with dignity, respect and compassion. Patients must be provided prompt access to charge information and be advised of applicable policies, including charity care and financial assistance, in easily understood terms and in the language common to the community. Policies must also be posted in hospital reception and registration areas.

Patients qualifying for financial assistance are to be provided with both extended payment options that are appropriate for their financial status and access to financial counseling. Outstanding balances on accounts are to be pursued fairly and consistently.

With respect to collection practices, the system-wide policy adopts several key principles:

- Ascension Health will not take action to cause bench warrants to be issued.
- Liens on personal residences will not be sought against individuals who qualify for charity or financial assistance.
- Ascension Health will not authorize a collection effort that will result in a bankruptcy.
- Interest may only be charged to patients not qualifying for charity or financial assistance, and only if they are not complying with payment arrangements.
- Collection agencies must follow Ascension Health's system-wide policy for billing and collection.

Ascension Health's Response Highlights Our Charity Care & Values

In October of 2003, Ascension Health complied with a request from this Subcommittee for detailed information regarding four key areas: billing and collection policies and practices for the uninsured; collections from uninsured patients; operating incomes overall and from uninsured patients; and mark-ups for services. Ascension Health worked diligently with 44 health ministries to assemble the requested information at a cost of over $400,000 [See attachments 4 and 5]. A brief outline of our submission follows:

- Each of these health ministries has a billing and collection policy for the uninsured. Furthermore, all of our health ministries reported offering charity care to the poor, and all reported providing assistance to patients for enrolling in public health-insurance programs.
- The aggregate data collected from the 44 Ascension Health ministries shows that uninsured collections as a percent of uninsured charges ranged from only 5 to 10.0 percent for the various periods reported [See attachment 4, p. 14-17]. In fact, our health ministries lost $222 million on uncompensated services to the uninsured in 2003.
- Services provided to the uninsured had a negative impact on margins at every health ministry during the periods reported. Let me reiterate that point, because the claim has been made by some that hospitals "make money" from

these services: every Ascension Health hospital lost money on the services provided to the uninsured.

Mr. Chairman, I direct the Subcommittee's particular attention to the attached chart, entitled "Charges, Costs and Collections on a Per Equivalent Patient Day Basis" [Attachment 6]. As you can see, the collections from the uninsured represent the smallest portion of collected services. As I mentioned, some have suggested that hospitals are somehow "making money" by providing these services. However, we provide them because it is our mission to serve those most in need, and we are unsure, as experienced healthcare administrators, exactly how anyone could recoup 100 percent or more of the aggregate costs of services for uninsured patients.

Moving Forward: "Healthcare That Leaves No One Behind"

Although the purpose of this statement is to address issues raised by the Subcommittee relating to billing and collection practices, we believe a full understanding of our fundamental operating principles and some system-wide achievements in serving the uninsured will help inform the work of the Subcommittee. I will now describe several important and representative activities.

Our Mission, Vision and Values are reflected every day in our ministry to care for the poor and uninsured. Their best expression is found in our *Call to Action,* a strategic initiative that dedicates Ascension Health to achieving "Healthcare That Works; Healthcare That Is Safe; and Healthcare That Leaves No One Behind."

Our *Call to Action's* last component has as its goal 100 percent access to healthcare for everyone in the communities we serve. In furtherance of 100 percent access, Ascension Health is providing leadership at the national level to sustain and strengthen the safety net for the poor and uninsured throughout the United States. Ascension Health worked closely with Congress to help craft the Healthy Communities Access Program that provides infrastructure dollars to local communities to strengthen the local safety net. Ascension Health was then the only organization in the country that made a commitment to match first-year federal funds for expanding access.

Ultimately, Ascension Health contributed over $7 million, which was used to catalyze local leadership in eight communities to achieve 100 percent access. Dollars were invested to design and implement information systems to link all safety-net providers, hire case managers, screen uninsured individuals for insurance eligibility, design disease management programs for the uninsured, and facilitate a number of other critical activities to bring health services to uninsured persons. With four years of experience and results, we are now designing model programs that other communities can replicate in their efforts to achieve 100 percent access to healthcare.

For example, in Tawas City, Michigan this year, Ascension Health ministry leadership brought together all of the local safety-net providers in a public-private partnership that now provides healthcare to the uninsured. This safety net coalition has received close to $1 million of federal funding.

In Austin, Texas, our SETON Healthcare Network recently joined with the Travis County Medical Society in an effort to have every private primary care physician in the city voluntarily take ten uninsured patients into his or her practice, and every private specialist take 20 uninsured patients. Although still in its early stages, this combined, community-wide program has already provided "medical homes" to 250 individuals without insurance and has set its sights on doing the same for all of Austin's uninsured.

In Detroit, Michigan, a coalition of the city's three major health systems (Ascension Health's St. John Health, Henry Ford Health System and the Detroit Medical Center) are working in partnership with the Detroit Health Department and three local federally qualified health centers to enroll uninsured patients into a "virtual HMO" that case manages their care across multiple providers. The program also collaborates with several other safety net healthcare providers in the city.

In New Orleans, Louisiana, the Ascension Health primary clinic for the poor has joined forces with the public hospital and all other safety-net providers to expand access to healthcare. In some parishes, the number of uninsured exceeds 80 percent of the population. In Nashville, Tennessee, the health department is working with our Saint Thomas Health Services to provide free pharmaceuticals to the uninsured.

Our five-year goal for the "Healthcare That Leaves No One Behind" initiative is to achieve 100 percent access to healthcare in the communities we serve. Each of our hospital chief executive officers is charged with the responsibility to work towards 100 percent access within his or her own community and is held accountable for these efforts by me and our board.

In addition to our hospitals, Ascension Health owns and operates dozens of clinics for the uninsured throughout the country. Ascension Health is currently leading an

effort by the nation's major Catholic health systems to work with the federal government on ways to expand these services to the uninsured.

In furtherance of our *Call to Action,* Ascension Health was the only health system in the country last year to have 100 percent participation in "Cover the Uninsured Week," which was sponsored by numerous national organizations to raise awareness of the plight of the uninsured. At every Ascension Health hospital, activities were held during the week, enrolling thousands of eligible poor persons into insurance assistance programs offered by states and the federal government. Today, these thousands carry an insurance card when they seek healthcare services, thanks to the collective work of Ascension Health ministries.

Finally, our ministry to the poor extends beyond healthcare. The commitment our hospitals have made to pay a "living wage" is just one example. We believe that the people who work in our health ministries should have a decent standard of living and be able to live within our communities.

Conclusion

Mr. Chairman, Ascension Health and our original sponsors take our tradition and commitment to care for the poor and uninsured very seriously. For us it is both a social and solemn obligation. I have described for the Subcommittee how the men and women who staff our hospitals and clinics work tirelessly to care for individuals who are poor and uninsured. I have also presented the numerous efforts across the country in which Ascension Health employees, working closely with public and private partners, are striving to increase access to healthcare for everyone in their communities.

It is true that, throughout the nation, Ascension Health is responding to the needs of the poor and vulnerable. Our new billing policy will prevent some of the problems the uninsured have faced in the past. But the work of ten Ascension Health systems or 100 or 1,000 would still fall short and leave many of the health needs of the poor unmet. We as a nation can do better.

We therefore urge Congress to adopt policies and provide adequate funding to achieve universal healthcare access for all Americans. The change that is necessary to address the needs of the nation's 44 million uninsured will take a much greater collective effort than any one hospital system can undertake.

Thank you, Mr. Chairman. I look forward to answering any questions the Subcommittee may have.

Mr. GREENWOOD. Thank you, sir.

Mr. Lofton, you are recognized for 5 minutes for your opening statement. Welcome.

TESTIMONY OF KEVIN E. LOFTON

Mr. LOFTON. Thank you, Mr. Chairman and members of the subcommittee. Thank you for inviting Catholic Health Initiatives to participate in today's hearing. My name is Kevin Lofton, and I am President and CEO of Catholic Health Initiatives. I have committed my entire career to serving the needs of the poor, uninsured, and underinsured. I joined Catholic Health Initiatives in 1998, and became President and CEO last August.

I also want to acknowledge and ask to stand, Sister Elizabeth Windo, a Sister Charity who is a member of the CHI Board of Stewardship Trustees.

CHI hospitals take care of patients in need, regardless of ability to pay. We are proud of our policies and practices. I am pleased to update you on our improved billing and collection practices. These improvements are important, but they will not substitute for long-overdue structural reform in health care delivery and financing.

Catholic Health Initiatives believes the solution is universal health care coverage. The CHI health system includes 68 hospitals and 44 facilities offering health-related services such as long-term care. We serve 19 States, 68 rural and urban communities, and employ more than 67,000 dedicated men and women.

Care for the poor, uninsured, and underinsured has been the mission and tradition of CHI hospitals for more than 100 years. Last year, CHI's total measurable benefit for the poor and broader community was $644, or 10.6 percent of our total revenue. Community benefit includes things such as free clinic grants and mobile medical vans. CHI hospitals provided $108 million in direct charity care.

CHI does not consider its $326 million in bad debt expense as part of our community benefit or charity care commitment. In the last 3 years, our hospitals committed $1.9 billion to improve the overall health of our communities.

Chairman Greenwood, I commend you, the subcommittee and staff for your attention to hospital billing and collection issues. It prompted CHI to examine our billing and collection practices, and to aggressively seek clarification and guidance from HHS to ensure we were doing the right thing. As a result, we are proactively reforming our billing and collection policies.

All CHI hospitals have amended contracts with third-party collection agencies, to include the following standards: First, no collection agency will request bench or arrest warrants. Second, no collection agency will seek liens requiring the sale or foreclosure of a primary residence. And, third, no collection agency will seek court action without hospital approval. Several collection agencies refused these new standards, and the hospital terminated these contracts.

We also require collection agencies to be trained on our mission, core values, and standards of conduct, to make sure that all patients are treated with proper dignity and respect.

Mr. Chairman, we all share in the heartbreak of people who suffer under the current system of hospital billing and collection. However, we must acknowledge that hospitals have an obligation to seek payment so they can continue to provide services to the community.

The goal of providing fair and compassionate health care financial services requires that healers, policymakers, administrators, and regulators truly understand the complexity of hospital pricing.

Recent guidance from HHS allows greater flexibility in discounting for individuals in the case of medical indigence. As a result, our hospitals are expanding their definition of who qualifies for charity care so even more people qualify.

We met with Secretary Thompson and various representatives from HHS and CMS over the course of three meetings, to discuss other improvements and services to the uninsured such as presumptive eligibility. These changes will bring some overdue rationality to a small corner of the problems of the uninsured.

I respectfully suggest that it is impossible for any one hospital to solve the complex issue of financing care for the uninsured and underinsured. We must address it as a country. We must rationalize and simplify our payment system.

Our hospitals can provide charity care and discounted services and improve financial services, yet the biggest problem remains unsolved. There are too many people who are uninsured. There are too many people without access to health care in an appropriate

setting. The system is clearly broken. The solution is universal health care coverage.

Catholic Health Initiatives wants to work with Congress and other policymakers to achieve comprehensive reform. If coverage for all cannot be achieved immediately, we should adopt a phase-in plan, one that begins with coverage of the most vulnerable members of our society.

Mr. Chairman, we pledge our cooperation, and thank you for allowing us to testify today.

[The prepared statement of Kevin E. Lofton follow:]

PREPARED STATEMENT OF KEVIN E. LOFTON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CATHOLIC HEALTH INITIATIVES

Chairman Greenwood and members of the Subcommittee, thank you.

My name is Kevin Lofton. I am the President and Chief Executive Officer of Catholic Health Initiatives. Thank you for inviting us to join you today to discuss how we may all work together to achieve quality health care services AND fair, efficient and compassionate health care financing for all Americans, particularly persons who are poor, uninsured and underinsured.

Catholic Health Initiatives hospitals take care of patients in need, regardless of ability to pay. Providing charity and discounted care to persons who are poor, uninsured and underinsured is core to our mission. In that regard, we appreciate the opportunity to respond to the Subcommittee's invitation to testify on the subject of hospital billing and collection practices. I am proud of our policies and practices, and am pleased to provide you with an update on our improved billing and collections procedures. Further, we appreciate the assistance of these valuable hearings and the increased guidance from the Department of Health and Human Services (HHS).

Improved billing and collection practices—while important—will not substitute for the long-overdue structural reforms in health care delivery and financing. Catholic Health Initiatives is a strong advocate for universal health care coverage, and urges the Congress to consider meaningful expansion of health care coverage to all Americans.

That view is not only the view of Catholic Health Initiatives; it is my view as well. I have committed my entire professional career to working with public, inner city and faith-based health care organizations, all of which have been dedicated to serving the needs of poor, uninsured and underinsured persons. I joined Catholic Health Initiatives in 1998 as a Group President and was later promoted to Chief Operating Officer and Executive Vice President. In August 2003, I was appointed President and Chief Executive Officer.

Prior to joining Catholic Health Initiatives, I was Chief Executive Officer of the University of Alabama Hospital in Birmingham, a 908-bed university teaching hospital. I have also served as the Chief Executive Officer of Howard University Hospital in Washington, D.C., and Chief Operating Officer at the University Medical Center, the urban campus of the University of Florida Health Science Center in Jacksonville, Florida.

I received a master of health administration degree from Georgia State University in Atlanta and a bachelor of science degree in management from Boston University. A copy of my curriculum vitae is attached to this testimony.

Catholic Health Initiatives is a national non-profit corporation based in Denver, Colorado. The CHI health system, which is comprised of affiliated non-profit corporations located in 19 states, includes 68 hospitals, 44 long-term care, assisted and independent living and residential facilities and five community-based health organizations serving 68 rural and urban communities. CHI hospitals, facilities and community health organizations are non-profit health corporations in the states in which they operate and have fiduciary boards of directors, although Catholic Health Initiatives has some approval rights over these other non-profit entities. Collectively, these health providers employ more than 67,000 dedicated men and women. All of us are bound together by a common mission and vision.

Catholic Health Initiatives was formed to advance and strengthen the Catholic health ministry into the 21st century and is unique among health care systems in the United States. During the last decade, religious sponsors of Catholic health care ministries recognized that the changing health care environment meant greater resources would be needed to develop programs, structures and services in the next century. In early 1995, a group of visionary leaders in Catholic health care began to explore ways to preserve and strengthen the health ministry for the future. They

envisioned a national Catholic health care organization, sponsored by multiple congregations of women religious and governed by a religious-lay partnership whose mission was to transform health care delivery and create new ministries to promote healthy communities. The result was the formation of Catholic Health Initiatives through the consolidation of Catholic Health Corporation, Omaha, Nebraska; Franciscan Health System, Aston, Pennsylvania; the Sisters of Charity Health Care Systems, Cincinnati, Ohio; the Sisters of Charity of Nazareth Health System, Bardstown, Kentucky; and the Sisters of St. Francis of the Immaculate Health of Mary, Hankinson, North Dakota.

Catholic Health Initiatives is committed to creating new models of health care, based on collaborative relationships and partnerships with community groups, agencies and other health care organizations. Since 1997, the Catholic Health Initiatives Mission and Ministry Fund has awarded 123 grants, totaling more than $11 million, to improve the health of communities served by its facilities. Through this national healthy communities commitment, hospitals and health services throughout the organization are developing unique programs to address the root causes of serious social and health issues, such as domestic violence and the inability to access basic health care services, so we can create solutions for the long term.

In our testimony, we hope to provide a better understanding of how the Catholic Health Initiatives mission and vision motivates our deep commitment to charity and discounted health care services to persons who are poor, uninsured and underinsured; our resolve to proactively improve collections and billing for patients; and our strong advocacy commitment to national health care reform.

CATHOLIC HEALTH INITIATIVES: A COMMITMENT TO CHARITY AND DISCOUNTED HEALTH CARE FOR THE POOR, THE UNINSURED AND THE UNDERINSURED.

First and foremost, Catholic Health Initiatives cares for and cares about poor, uninsured and underinsured persons. Catholic Health Initiatives has designed charity care standards to meet the needs of the uninsured and the underinsured. This has been the mission and tradition of Catholic Health Initiatives hospitals for more than 100 years. As part of this commitment to persons who are poor, alienated and underserved, Catholic Health Initiatives uses financial resources to emphasize human dignity, social justice and the promotion of healthy communities. Several examples of CHI's commitment to the poor and underserved include: free clinics at many CHI hospitals; $24 million in direct community investments, which are no- or low-cost loans to institutions or projects that promote access to jobs, affordable housing, child care, education, environmental protection and health care for low-income and minority communities; and $11 million in Mission and Ministry grants.

When determining eligibility for charity and discounted health services, Catholic Health Initiatives facilities have considered income, family size, available assets and extenuating circumstances. CHI facilities use the Department of Housing and Urban Development (HUD) income guidelines because they are more inclusive than other poverty guidelines and more accurately reflect the economic differences of the 68 urban and rural communities in 19 states served by CHI hospitals and health care facilities. In 26 of those communities, a CHI hospital is the only hospital serving that community.

In an effort to be inclusive, CHI hospitals provide charity and discounted health care services on a sliding scale. For example, at St. Anthony Hospital in Denver, the community in which I live, a family of four with an income of up to $74,000 would qualify for assistance.

With the recent guidance from the Department of Health and Human Services, Catholic Health Initiatives hospitals are revising their charity care policies. For example, the policies will now cover more people and will further simplify the application process. If a patient is unable or unwilling to provide financial information, but that person has other evidence of indigence, such as a person who is homeless, he or she will be covered by the charity care policy.

Catholic Health Initiatives and its hospitals are responding to the needs of the poor and underserved and the broader community in very direct ways. In fiscal year 2003, CHI's total measurable benefit for the poor and the broader community was $644 million, which includes grants, free clinics, mobile medical and dental vans and educational programs. That was 10.6 percent of our total revenues.

As part of that, CHI hospitals provided $108 million in direct subsidization of charity care. This is the estimated cost of providing the care, not what was charged. Over the last three years, Catholic Health Initiatives-sponsored hospitals provided $1.9 billion in measurable benefits to improve the overall health of our communities.

Let me give you a few examples:

Good Samaritan Hospital in Kearney, Nebraska, has lowered the rate of mortality from heart disease by 34 percent in its rural Nebraska and Kansas communities through a program to make advanced cardiac care available and accessible to the people in these farming communities. Good Samaritan staff members have driven more than a half million miles to outreach sites since the program began.

St. Elizabeth Health Services in Baker City, Oregon, is a critical access hospital in an isolated, rural community in eastern Oregon. St. Elizabeth's provides prescription medications to persons who do not have the means to purchase them. These medications help the recipients recover more quickly from their illnesses, better manage chronic conditions and avoid costly hospitalizations and interventions.

St. Joseph Medical Center in Towson, Maryland, provides free or low-cost health care services to underserved residents of the greater Baltimore community through a mobile medical van staffed with bi-lingual health care providers. The van regularly stops at a soup kitchen, and the staff serves clients who face homelessness, mental illness and drug addiction.

Our Lady of the Way Hospital in Martin, Kentucky, handles more than 18,000 emergency department and urgent care visits each year. Nearly 60 percent of the 42,000 people living in Floyd County have a family income below 200 percent of the federal poverty level and nearly half of the adults in the county have less than a high school education. The hospital's outreach program provides care for more than 25,000 people. To combat the county's high teenage pregnancy rate, Our Lady of the Way Hospital initiated the RESPECT Program for girls in grades six through eight. RESPECT is a nine-week program designed to build self-esteem, develop career skills and encourage young teenage girls to postpone sexual activity. More than 400 girls have completed the program and there have been only three teen pregnancies among program participants.

Finally, Lakewood Health Center in Baudette, Minnesota, is a founding partner of Communities Caring for Children, a program involving 13 counties in northwestern Minnesota, that offers free care to pregnant women and children up to age five. The goals are to encourage healthy deliveries and to increase the number of children who receive well-child exams and immunizations.

CATHOLIC HEALTH INITIATIVES: PROACTIVELY IMPROVING BILLING AND COLLECTIONS

Chairman Greenwood, I would like to commend you, the Subcommittee and staff for your attention to this issue. It prompted Catholic Health Initiatives to examine our own billing and collections practices more closely, and to aggressively seek clarification and guidance from the Department of Health and Human Services to ensure we are doing what is right. As a result, Catholic Health Initiatives is proactively reforming its own billing and collection policies. Let me be specific:

All Catholic Health Initiatives hospitals have been asked to amend the contracts they hold with third party collection agencies to include the following standards: neither CHI hospitals nor their collection agencies will request bench or arrest warrants; neither CHI hospitals nor their collection agencies will seek liens that would require a sale or foreclosure of a primary residence; and no collection agency may seek court action without hospital approval. Several collection agencies refused to agree to these new standards and the hospitals terminated their contracts.

As of June 30, 2004, we will require that collection agencies be trained on the Catholic Health Initiatives Mission, Core Values and Standards of Conduct to make sure all patients are treated with dignity and respect. Catholic Health Initiatives will continue to work with the hospitals so that all patient financial services staff show respect for the individual, regardless of the source of payment for care.

Improving billing and collections—what we charge and how we collect—are important. Catholic Health Initiatives is committed to fair, efficient and compassionate billing and collection policies and practices.

To be fair to the community, patients in a hospital have an obligation to pay if they can or, if they cannot, to provide information so they can seek to be qualified for government or charity programs. Hospitals have an obligation to seek payment so they can continue to provide services to people in the community.

Some of our patients qualify for charity care and discounts based on income levels, but many others fall outside the charity care guidelines and cannot afford adequate insurance. It is for those uninsured and underinsured patients that we must do better as health care providers, as policy makers and as a nation.

However, the goal of providing fair and compassionate health care financial services requires that healers, policy makers, administrators and regulators truly understand the complexity of hospital pricing.

Catholic Health Initiatives appreciates the guidance given by the federal government regarding charges and discounting to better serve the community, including

people who are uninsured and underinsured. This guidance, provided by Secretary Tommy Thompson and HHS, allows greater flexibility in discounting for individuals in the case of medical indigency, and as a result, Catholic Health Initiatives hospitals are expanding their definition of who qualifies for charity care.

We have also been meeting with the Centers for Medicare and Medicaid Services to discuss other improvements to the provision of services to the uninsured, such as presumptive eligibility, so that people in any of several situations, such as those living in subsidized housing or migrant farm workers living in transient housing, are presumed to be eligible for charity care. I am convinced that these changes will bring some overdue rationality to at least a small corner of the problems of the uninsured.

But as CEO of Catholic Health Initiatives, I respectfully suggest that it is impossible for any hospital to solve the complex issue of financing care for persons who are uninsured and underinsured. We must address it as a country from the standpoint of day-to-day regulatory and operating reality.

We need to rationalize and simplify our payment systems. These systems are well-past complex and have evolved so that list prices (charges)—which are used in the formula for Medicare reimbursement, workers compensation plans and private insurance discounts—may or may not have a relationship to the actual cost of providing services—and also have nothing to do with what most hospitals are actually paid. An indirect and unintended consequence of these forces is that they have created hardship for uninsured patients. The system is clearly broken.

At Catholic Health Initiatives, we believe that quality health care and fair, efficient, compassionate billing and collection policies should not, and cannot, be separated.

Information about hospital charges may be useful in helping patients ask better questions. However, obtaining accurate charge information in advance is made difficult by the many uncertainties involved in predicting the course of treatment for any one individual. No two patients, diseases or injuries are alike.

Average charge information may be useful for a simple procedure—such as an x-ray—or for diagnoses that are common and have a great deal of standardization—such as the normal delivery of a baby. However, the average charge would be misleading for patients when the diagnosis is unclear—and so diagnostic tests are needed—or where there are greater ranges of possible treatments.

Charges will depend on the specific items and services ordered by the patient's physician and on complicating diseases the patient may have such as diabetes or hypertension. For example, in Colorado where charges are publicly available, the average statewide charge for hospitalization for simple pneumonia is about $6,000 for a patient without complications and more than $31,000 for a patient with extreme complications. One might question if publishing the overall average charge of $12,000 for pneumonia provides any useful information to a patient.

In the end, however, the bottom line for Catholic Health Initiatives is social justice. All Americans should have access to affordable care. The number of uninsured persons continues to grow. St. Anthony Hospital in Denver has seen the number of self-pay patients (who are typically uninsured) in the emergency department grow from 21 percent to 33 percent in two years.

Catholic Health Initiatives can provide charity care and discounted services and improve patient financial services. Yet, the biggest problem remains unsolved: too many uninsured people, too many persons without access to health care in an appropriate setting. Again, the system is broken.

The solution is universal health care coverage.

CATHOLIC HEALTH INITIATIVES: STRONG ADVOCACY COMMITMENT TO NATIONAL HEALTH CARE REFORM.

While incremental change that benefits patients is good . . . it is not the solution.

Catholic Health Initiatives believes all Americans should have health care coverage. All Americans should have access to quality health care services: the right care, at the right time, at the right place.

Uninsured Americans are up to three times more likely to have poor health outcomes. Studies show nearly 40 percent of uninsured adults skipped a recommended medical test and 20 percent say they have needed but have not gotten care because they did not have insurance. The Institute of Medicine recommends that the problems caused by uninsurance in the United States require a national and coherent strategy aimed at covering the entire population.

Further, as a matter of social justice, it is important that all people have access to routine, consistent primary care in accessible settings that will be less costly. Many persons without insurance come to the hospital through the emergency de-

partment. Often, an uninsured person does not have a primary care physician and as a result will have had no routine or preventive care. The emergency department does not have the medical background or history and physical from a primary care physician that an insured patient with access to primary care will have. More clinical and diagnostic tests are needed, and they must be done in this more expensive setting.

In addition, a patient without access to a primary care physician is more likely to have chronic diseases that have been untreated—diseases like diabetes and hypertension. The Institute of Medicine has found that people without health insurance have diminished health, poorer outcomes and are less likely to get preventive services or the care they need for chronic conditions. Simply put, patients least able and least likely to pay may be among the most expensive to treat.

Catholic Health Initiatives wants to work with Congress and other policy makers to achieve comprehensive reform. And, if coverage for all cannot be immediately achieved due to current budget and political constraints, we should adopt a phased-in plan that begins with coverage of the most vulnerable members of our society, including women and children.

We encourage Congress to start by enacting legislation that: removes the prohibition on legal immigrant children and pregnant women receiving Medicaid/SCHIP coverage during their first five years in this country; expands Medicaid/SCHIP programs to cover additional uninsured children from low-income families; and provides Medicaid/SCHIP coverage for family members of children covered by these programs.

Mr. Chairman, we pledge our cooperation. Thank you.

Mr. GREENWOOD. Thank you very much, sir.

Mr. Bovender, welcome.

TESTIMONY OF JACK O. BOVENDER, JR.

Mr. BOVENDER. Thank you, Mr. Chairman. My name is Jack Bovender, and I am the Chairman and CEO of the Hospital Corporation of America. We own and operate 190 hospitals and 82 outpatient surgery centers in 23 States and two foreign countries, with about 190,000 employees. Last year, we treated over 14 million patients in our facilities.

I appreciate this opportunity to share our company's insight into the issues surrounding the uninsured, hospital pricing and collection policies, our escalating bad debt problems and, in particular, our charity care discount policy, which has been used as a model by many other hospitals and hospital systems in the country.

In my 34 years in hospital administration, I have never seen another time in which the level of uninsured using hospital emergency departments has been as great, or the amounts we are writing off to bad debts and charity care have risen so high. The numbers are staggering.

Families, USA recently reported that nearly 82 million people went without health insurance at some point during the last 2 years. Specific to HCA, we have seen our bad debt expense rise from 8.5 percent of net revenue to about 11.7 percent. Put another way, HCA hospitals provided free or discounted care to over 1 million patients. For HCA, the cost—the cost, not charges—of providing this unreimbursed care was over half a billion dollars last year.

Hospitals in this country have become virtually the only safety net for the uninsured needing health care. The pharmaceutical companies do not give us free of charge their expensive antithrombolytic drugs for use with the uninsured heart patient. The medical device companies are not giving away free of charge the expensive cardiac stints we implant in the uninsured patients. And

the managed care companies are certainly not coming into our communities offering free or significantly discounted insurance policies to the uninsured. This unshared burden has driven hospital margins in this country down to 3.5 percent. These are historic lows, so low that even the short-term viability of many hospitals is now threatened. Compare this 3.5 percent margin to those in the pharmaceutical and medical device industries, which range between 13 and 15 percent.

While hospitals have been castigated recently in the press for charging and collection practices related to the uninsured, and in many cases with great justification, hospitals are not the problem. They are merely the symptom of a much bigger problem. The problem is how are we as a society going to guarantee that every American has some form of health insurance, health insurance that adequately reimburses hospitals and doctors for the health care they render?

Before I discuss HCA's charity discount policy, I would like to spend a minute on hospital charges. The charge master system on which hospitals rely to set pricing and billing codes have a 40-year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost-shifting to the private sector, and this was exacerbated in the 1990's by aggressive managed care discounting. I am not here to try to justify this, and it really needs to be fixed.

HCA has focused on developing a pricing structure for the uninsured that more closely mirrors pricing to managed care. We believe recent pronouncements by CMS allow us to do this without as much reliance on complicated indigence tests. In the interim, we believe our charity care and financial discount policy provides necessary relief to those in financial need.

Our charity care program offers free or discounted nonelective care for those not covered by private insurance or government health assistance programs. For individuals with income up to 200 percent of the Federal poverty level, care is free. For those between 200 and 400 percent of the Federal poverty level, a sliding scale of discounts is applied.

To give you an idea of who benefits from these discounts, a family of four with a gross income of $37,700 receives free care. At 400 percent above the poverty level, a family of four with a gross income of up to $75,400 would qualify for a discount as high as 65 percent. Such a discount places the pricing into the same zone as those negotiated with some of the Nation's largest health insurance providers.

Now, I will be the first to admit that we are not perfect. We have been criticized for the effectiveness of our implementation, and assertions have been made that every HCA patient who is eligible is not receiving free or discounted care. That is undoubtedly the case, but I assure you it is not for either a lack of effort or a lack of intent. We are making every effort to provide financial relief to those individuals who qualify. While we and other hospitals can improve pricing and collection practices, this will not solve the mushrooming problem of the uninsured. We need a comprehensive strategy that guarantees coverage for all Americans.

The problem is that we as a nation are actually going in the other direction. More and more businesses are dropping health insurance coverage, or shifting more and more of the burden to the employee with higher premium sharing and higher co-pays and deductibles. Many are pushing higher levels of part-time employment, thereby avoiding coverage of ever-larger segments of employees. About 60 percent of the uninsured are employed.

I believe we need to move to a system of employer-mandated health insurance in this country, a system that would require all businesses above a certain size to provide health insurance. Limits on premium-sharing, deductibles and co-pays should be defined, thereby leveling the playing field with regards to benefits across all businesses.

Small businesses should be allowed to form purchasing consortia, as has been advocated by the National Federation of Independent Businesses, in order to receive the best insurance rates.

Finally, some form of Federal and/or State coverage must be provided for the unemployed. This population needs regular access to routine and preventive care to reduce health care crises necessitating hospitalizations. Hospitals cannot long continue to incur ever greater increases in bad debt and charity. We need help from other segments of the health care industry. More importantly, we need a new paradigm that provides a reasonable level of health insurance coverage for all Americans. We will continue to do our part, but we cannot do this alone.

Thank you.

[The prepared statement of Jack O. Bovender, Jr. follows:]

PREPARED STATEMENT OF JACK O. BOVENDER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, HOSPITAL CORPORATION OF AMERICA

INTRODUCTION

Mr. Chairman, members of the Committee and staff—good morning. My name is Jack Bovender. I come before you today as a 34-year veteran of the healthcare industry and current Chairman and Chief Executive Officer of the Hospital Corporation of America ("HCA").

I grew up in hospitals, and I have spent my life around healthcare professionals. My mother was a nurse. My wife was a nurse. My first civilian job was in a hospital, and I began my career in hospital administration in the Navy, at the Naval Regional Medical Center in Portsmouth, Virginia. So I feel qualified to say the issue of the uninsured is one the healthcare industry has always faced—it has been with us for as long as I can remember, but at no other time in my life has this challenge been of the magnitude it is today.

The cost of providing healthcare services to the uninsured is the most significant issue currently facing hospitals and, I believe, one of the most important domestic concerns for our country. And the issue of the uninsured is the responsibility of every one of us—the business community, the government, and the individual, not just hospitals. We must all play a role if this situation is to be ameliorated.

I appreciate this opportunity to share my personal experience, and the experiences of HCA, working on behalf of this vulnerable and growing population. We welcome the invitation to work with members of the Congress to find a real solution to this escalating problem, and we are hopeful that with this Committee's help, Congress will reach beyond today's hearing to engage those groups and individuals who can also play a role in this process.

Let me tell you a little bit about our company and what we are doing to address this critical issue. Headquartered in Nashville, Tennessee, HCA affiliates operate nearly two-hundred hospitals and eighty-two outpatient surgery centers in twenty-three states, England, and Switzerland. Our facilities currently employ some 190,000 people. Certainly no organization has a greater interest in addressing the present crisis in health insurance coverage. In many cases and for many, many people, we are the nation's safety net for the uninsured. Last year alone, our hospitals

provided healthcare services to over one million uninsured patients—let me repeat that number—one million uninsured patients. Add to that the 1.6 million Medicaid patients we served last year, and you have an idea of the magnitude of the care we provide for the underserved.

Our hospitals are dedicated to delivering healthcare services to meet the needs of all Americans, regardless of whether they are or aren't the beneficiary of health insurance. The costs of providing medical services to the uninsured fall disproportionately upon the hospital industry, whose emergency rooms routinely function as the primary (and largely uncompensated) point of access to healthcare for this vulnerable population.

My testimony today will detail HCA's charity care plan and discount policy for uninsured patients receiving treatment at any of our hospitals nationwide, as well as recommendations for improved coordination of resources to decrease the number of uninsured Americans.

CARING FOR THE UNINSURED

While hospital management and medical personnel certainly can't solve the root causes for the vast numbers of uninsured individuals, every day our people are on the front lines in the struggle to care for this population's health and well-being. The Committee is undoubtedly aware that hospitals equipped with emergency rooms must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. This burden has grown even heavier in recent years, with the advent of physician-owned limited-care hospitals, which skim profitable service areas for low-risk patients, and leave larger, full-service facilities the task of handling uninsured patients within their community.

In addition, the uninsured cannot visit a pharmacy and expect to receive free or discounted drugs; they cannot visit a physician's office and expect to receive free or discounted medical services; they cannot visit a physical therapist and expect to receive free or discounted rehabilitation treatment; nor can they go to an insurance company and expect to receive a free or discounted insurance policy. But in every HCA hospital's emergency room, they are assured of receiving the critical medical care they need, without consideration for their financial condition or health insurance coverage.

America's hospital emergency rooms have become our *de facto* public healthcare system, the primary point of access to quality healthcare services for the nation's uninsured. For HCA hospitals, medical treatment of the uninsured has represented a substantial and growing segment of the patient population.

And contrary to a prevailing myth, the treatment of the uninsured is far from a profit center for hospitals. Last year, the one million uninsured patients we treated contributed less than one percent to our net revenues. On average, we received about $200 in payments from each of the one million uninsured patients we cared for, and many paid nothing at all. Said another way, we lost a staggering half billion dollars in un-reimbursed expenses for treating the uninsured. Again, I am not talking about un-reimbursed charges, I'm talking about real costs we incurred for which we were not paid. Our hospitals incur both the internal costs generated by the hospitals' own medical services, such as nursing salaries and utilities charges, and costs from outside vendors, like prescription drugs, over the counter medications, medical devices, and other supplies necessary for the patient's care and treatment.

In many instances, these goods and services are being provided to individuals whose needs are less acute and who would, were it not for their inability to pay, seek treatment at a physician's office. The cost of ensuring healthcare coverage of this nature is straining both the physical and financial capacity of the hospital industry; it cannot continue to be borne solely by hospitals, or medical services may not be available when Americans need them. The responsibility for the uninsured must be shared by all sectors of the healthcare industry, and by society at large.

The financial pressures facing hospitals today, including the growing non-reimbursed costs of providing care for the uninsured, are illustrated in declining hospital profit margins (See Chart I). It is this margin that makes capital available to insure hospitals will be here to serve future generations. It is this margin that provides funding to cover our wage increases for our nurses and other caregivers. The most recent estimates from the American Hospital Association show U.S. hospital margins at approximately 3.5%. Over the last five years, the net profit margins for U.S. hospital companies have been substantially below margins of both pharmaceutical and medical device companies, and in 2003, margins of health insurance companies were more than double that of public hospital companies (See Chart II). For the most recent year (2003), public hospital company margins were 1.5%, while health

insurance company margins were 4.3%, pharmaceutical companies margins were 13.8% and medical device companies margins were 15.6%.

The lower margins for hospitals reflect the disproportionate uninsured burden carried solely by hospitals. As illustrated in Chart III, hospitals' bad debt (primarily arising from uninsured) totaled 9.9% of net revenues in 2003, compared to bad debt levels of 0.1% for insurance companies and 0.3% for pharmaceutical and medical device companies. Further, the percentage growth in spending for hospital care between 1991 and 2002 was substantially below the growth in spending for prescription drugs (three times the growth in hospital spending) and private health insurance (two times the growth in hospital spending) (See Chart IV).

THE HCA CHARITY CARE AND DISCOUNT POLICY

Charity care has always been a part of our mission at HCA, and part of the service provided at our nearly two hundred hospitals nationwide. However, in order to respond to the recent growth of the uninsured population, last year we developed an enhanced, system-wide charity care and financial discount policy. In March 2003, we submitted our proposed discount program for uninsured patients to CMS for approval. In June 2003, we received a letter from CMS advising us while they "applauded HCA's efforts to improve access to quality healthcare to financially needy patients," we still needed to "pursue our proposal" with our (five) fiscal intermediaries (FI's) before implementation. After discussions with our FI's in the fall, we initiated our new policy nationwide, effective October 1, 2003.

Our standardized charity care programs offer free or discounted medical care to patients in financial need who come to our emergency rooms and are not covered under any private health insurance policy, and cannot qualify for any state or federal health payer assistance programs. For individuals whose income is up to two hundred percent of the federal poverty level, care is free; for those who make between two hundred and four hundred percent of the federal poverty level, a sliding scale of discounts is applied. To give you an idea of who benefits from these discounts, a family of four with a gross income of $37,700 receives free care. At four hundred percent above the federal poverty level, a family of four with a gross income of up to $75,400 would qualify for a discount as high as sixty-five percent. These uninsured individuals benefit from a pricing structure competitive with the reduced rates negotiated by the nation's largest health insurance providers.

Eligibility for charity care relates only to the patient's or responsible party's gross income and family size; the potential value of other available family assets and resources are not considered when determining the appropriate rate of reduction in hospital charges. Moreover, free or discounted benefits are available under these programs at any time after care is rendered and the account is in the process of being settled. This permits write-offs of outstanding charges or restructuring of payment plans for patients who lose their insurance or suffer a substantial change of income. In addition, patients may request consideration under the charity and discount programs for costs associated with previous hospital visits. Each of our hospitals employs a team of patient representatives available to discuss an individual's particular situation and develop an appropriate solution.

HCA's assistance is not just limited to providing medical care. We are also committed to helping patients who are eligible to receive the full range of government benefits. To that end, our hospitals employ a full-time staff of specially trained benefits counselors who are responsible for educating and enrolling patients in Medicaid or other state health benefit programs. Once enrolled in these federal and state medical benefit programs, patients can access physicians and other healthcare providers for critical preventive and follow-up care. Last year, HCA facilitated the enrollment in Medicaid of one in five of the uninsured patients who presented at our hospitals.

In summary, our philosophy is clear and simple. When a patient arrives at one of our hospitals in need of emergent care, we provide that care regardless of whether or not they are insured. And if they tell us they cannot afford to pay for that care, we will write off those costs or discount the charges. While these programs cannot be a long-term substitute for private health insurance or government health assistance programs, they may for now be the only recourse for a patient lacking insurance and unable to afford essential medical care.

HCA'S HOSPITAL BILLING AND COLLECTIONS PRACTICES

Like all hospitals, HCA relies upon a chargemaster as the central repository of charges and associated coding information used to develop claims. These charges are determined on a local hospital-by-hospital basis. To put it simply, the chargemaster system on which hospitals rely to set pricing and billing codes has a forty-year his-

tory of changes that has distorted the relationship between price and cost. It grew out of a time in our industry's history, during the advent of managed care, when the inadequate level of Medicare reimbursement prompted cost-shifting. Therefore, HCA is now seeking to develop a pricing structure for the uninsured that is more reflective of the actual cost of providing the care, and which will provide prices comparable to managed care pricing for all aspects of uninsured care. In the interim, we believe our charity care and financial discount policy provides necessary relief for those individuals who are in financial need.

With regard to collections, we have worked hard to develop a policy that strikes a careful balance between our fundamental belief that people who receive medical care should pay a fair price for those services, and an understanding that many in our nation lack the financial ability to do so. *But despite the substantial reduction of an individual's medical expenses through the discount policy, HCA appreciates that many patients will lack the readily available financial resources needed to meet what are often unanticipated health care costs. Medical debt is, and is likely to remain, a difficult issue for hospitals and patients across the country, and I believe will become an increasing concern for this nation as a whole. As a medical services provider, HCA recognizes its fundamental obligation to be a steward of public health in its local communities. The HCA charity care and discount policy ensure compassion and consideration for those among us who simply cannot afford to pay hospital bills.*

We feel the process we have in place is one that seeks to help patients who are needy and willing to work with us to resolve their debt with our facilities. HCA hospitals will provide individuals with payment plans that are interest-free and tailored to each patient's distinct needs and financial ability. One of our challenges in making these options available, however, is in communication with the patients themselves. We find some patients do not answer our phone calls and letters, discuss their financial status, talk about payment plans, receive assistance with public benefits coverage, or apply for a reduction under the charity care or discount policy. It is difficult to effect assistance or financial relief if a patient is unable, or in many cases, unwilling to give us information.

HCA does employ a collections process, but even then we do our best to work with our patients as individuals, with sensitivity to their personal and financial circumstances. If we receive no response to our phone calls and letters, we eventually place the account with an external collection agency, which continues to attempt to contact the patient to work out a reasonable and workable payment plan. In some instances, this collection effort still yields no response from the patient, and litigation is the remaining alternative to resolve the debt; however, we have no desire to compel payment from patients who have no ability to pay.

We believe our collection policies are reasonable and reflect an understanding of individual circumstances. Unfortunately, patients who are financially able yet choose not to pay affect the cost and availability of healthcare resources to the entire population. When an individual who is able to pay for medical care refuses to do so, the resulting debt is a cost of doing business that must be absorbed by the hospital; and, as with any business, that cost is partially passed on to the consumer. More importantly, the drain on hospital resources compromises its ability to continue providing everyone in the community with quality, affordable care. This situation is magnified at HCA, because we have nearly two hundred hospitals, but through our experience we know that every day, in cities all across America, hospitals are struggling to balance a community's healthcare needs with a way to pay for care given when the recipients either cannot or will not contribute financially to the effort.

SUMMARY AND RECOMMENDATIONS

As previously indicated, the cost of ensuring healthcare coverage for everyone cannot be borne solely by hospitals. I believe Congress, the Administration, the nation's employers, and all sectors of the healthcare industry—hospitals, pharmaceutical companies, medical device manufacturers, insurance carriers, and the physician community—must work cooperatively and with equal participation to solve this enormous problem. And if every participant in the process were to play a meaningful role—as hospitals already do—think how much greater the potential would be for finding a real solution.

Specifically, I recommend examination of appropriate discounts from all healthcare industry participants, not unlike the charity care discounts being provided by hospitals. And I strongly suggest working with the insurance industry to develop more affordable coverage for the self-employed, and for small business own-

ers and their employees. We advocate small business health plans or association health plans.

Let us not forget the individual as well. This country has been very good to me and to my family, and I believe in its strength and fundamental fairness; but I also believe each individual plays a part in his or her destiny. So whatever solution is devised, it must include an accountability for individuals to take part in the management of and payment for their healthcare needs. Ultimately, I believe all employers should be required to provide coverage for their employees.

Finally, I believe some universal healthcare coverage must be provided for the unemployed. Since the implementation of our charity care and financial discount policy, our statistics show that over 95% of those who qualify fall in the vastly lower income levels, and many, though ineligible for Medicaid, live just above the poverty level. These people must be given a means by which to receive regular and preventive medical care.

The bottom line is this: hospitals cannot continue to absorb more bad debt as they strive to maintain a quality healthcare system for Americans. As more insurance plans shift a greater burden of the cost of care to individuals, through higher copays and deductibles, the situation will only get worse. This financial picture will not improve without the intervention and support of other sectors of the healthcare industry, the greater business community, the assistance of the government, and the leadership of individuals such as the membership of this Committee.

Thank you, Mr. Chairman and members of the Committee for your time and attention. I will be happy to respond to your questions.

Mr. GREENWOOD. Thank you.

Dr. Pardes.

TESTIMONY OF HERBERT PARDES

Mr. PARDES. Mr. Chairman, distinguished members of the committee, and staff, good afternoon. Thank you for convening this hearing on hospital billing and collection practices related to the uninsured. The committee's inquiry into these matters has raised public awareness regarding a serious problem facing millions of Americans—the lack of health insurance coverage and ability to pay for necessary medical treatment. There are more than 43 million Americans living without health insurance, and millions of others lack coverage for catastrophic health care expenses. As a result, U.S. hospitals treat millions of patients each year who can make only minimal payment, or no payment at all for the medical services they receive.

My name is Dr. Herbert Pardes, President and Chief Executive Officer of the New York Presbyterian Hospital. I have served there for 4 years as CEO, and appreciate the opportunity to testify and share my insight into and experience with New York Presbyterian's charity care and collection policies. New York Presbyterian has always strived to treat each patient fairly when it comes to how charity care is provided and how uninsured patients are billed. Through my testimony, I hope to convey New York Presbyterian's commitment to these important issues.

After providing a brief description of the New York Presbyterian Hospital and the community it serves, my testimony will focus on our charity care efforts as well as our collection policies and charges.

New York Presbyterian Hospital is the largest single hospital and academic medical center in the New York Metropolitan Area. It is comprised of four separate campuses, collectively serving a large geographic area with many diverse communities. The vast majority of communities served by New York Presbyterian are ethnically diverse and economically distressed, with a large percentage

of Medicaid-eligible, uninsured and underinsured individuals and families, so we treat a high percentage of Medicaid and uninsured patients.

As a nonprofit, New York Presbyterian maintains strong and long-standing commitment to meeting the diverse medical and social needs of the communities it serves. It is especially committed to our obligation to provide care both to the uninsured and underinsured in our service area. Each year, we forego some $70 million in charity care, write off an additional $70 million in bad debt. We also expend significant resources in support of very expensive community benefit programs. Many of our initiatives are directed to the uninsured and underinsured populations, including a facilitated Medicaid enrollment program, prenatal assistance program, community outreach program, and a number of others.

New York Presbyterian is committed to enrolling patients who are eligible into Medicaid and other government programs We routinely screen patients for Medicaid eligibility, and assist them with the enrollment process. For those patients ineligible for Medicaid and otherwise not insured, we offer charity care and other financial aid.

New York Presbyterian has implemented a charity care policy that applies across its campuses. Under this policy, New York Presbyterian provides charity care and financial aid to patients with incomes up to 300 percent of the Federal poverty level, which equates to some $56,550 for a family of four. In addition, New York Presbyterian routinely assesses patients' eligibility for assistance from a philanthropic fund. The philanthropic fund is supported by private donations and used to pay the medical bills of patients experiencing financial hardship. To the extent that a patient is ineligible for either charity care or the philanthropic fund, New York Presbyterian makes every attempt to establish flexible payment arrangements based on the patient's individual circumstances. On average, we collect only 12 to 13 percent of the charges for services to uninsured patients. After making reasonable efforts to collect the balances, we must frequently write off some, if not all, of the uninsured patients' balances, and these write-offs approach nearly $70 million per year.

New York Presbyterian works to ensure the fair collection of outstanding patient debts. We have internal policies and procedures as well as written agreements with our outside collection agencies. Our collection agencies do not pursue income executions on a patient's spouse, and we do not permit foreclosure on a patient's primary residence.

New York Presbyterian must establish charges for thousands of different items and services. We review our charges periodically to ensure that they cover costs and are in line with charges in the New York Metropolitan Area. Inevitably, increases in health care costs lead to increases in charges. The increase in health care cost in recent years can be attributed to a variety of factors, including increased cost of technology, research, pharmaceuticals, employees, insurance, and facility expansion and improvement.

Third-party payers are frequently able to negotiate discounts on these charges based on factors such as volume of service providers, reduced transaction cost, assurance of timely payment. New York

Presbyterian understands that uninsured patients do not have the benefit of negotiated group rates, and so we offer free or reduced-charge care to uninsured and underinsured patients, and are flexible in establishing payment arrangements based on patient's individual circumstances.

At the end of the day, New York Presbyterian stands committed to meeting the medical and social needs of the communities we serve. We are also committed to the promotion of meaningful industry-wide change in how charity care is provided and the uninsured are billed. We welcome this opportunity to discuss our charity care and collection policies, and we will continue to buildupon them to further our commitment to patients' needs.

Thank you.

[The prepared statement of Herbert Pardes follows:]

PREPARED STATEMENT OF HERBERT PARDES, NEW YORK PRESBYTERIAN HOSPITAL

Mr. Chairman, distinguished members of the Committee and staff—good morning, and thank you for convening this hearing on hospital billing and collection practices related to the uninsured. The Committee's inquiry into these matters has raised public awareness regarding a serious problem facing millions of Americans—the lack of health insurance coverage and ability to pay for necessary medical treatment. There are more than 43 million Americans living without health insurance, and millions of others lack coverage for catastrophic healthcare costs. As a result, U.S. hospitals treat millions of patients each year who can make only minimal payment, or no payment at all for the medical services they receive.

My name is Dr. Herbert Pardes, and I am the President and Chief Executive Officer ("CEO") of the New York Presbyterian Hospital ("NYPH" or "NYP"). I have served as the CEO of NYPH for four years. I appreciate the opportunity to testify and share my insight into and experience with NYPH's charity care and collection policies. NYPH has worked to promote change in how charity care is provided and how uninsured patients are billed. Through my testimony, I hope to convey NYPH's commitment to these important issues.

I. OVERVIEW

New York Presbyterian Hospital ("NYPH") is the largest, single hospital and academic medical center in the New York Metropolitan area. NYPH is comprised of four separate campuses, which collectively serve a large geographic region with many diverse communities. The vast majority of communities served by NYPH are ethnically diverse and economically distressed, with a large percentage of Medicaid-eligible, uninsured and underinsured individuals and families. As a result, NYPH treats a high percentage of Medicaid and uninsured patients.

As a non-profit institution, NYPH maintains a sincere and longstanding commitment to meeting the diverse medical and social needs of the communities it serves. NYPH is especially committed to its obligation to provide care to both the uninsured and underinsured in its service areas. Each year, NYPH spends nearly $70 million in charity care, and writes off an additional $70 million in bad debt resulting from the unpaid balances of self-pay patients. NYPH also expends significant resources in support of its Community Benefit Initiatives, many of which are directed at the uninsured and underinsured populations.

NYPH is committed to enrolling eligible patients into Medicaid and other government programs. NYPH routinely screens patients for Medicaid eligibility and assists eligible patients with the enrollment process. For those patients who are ineligible for Medicaid and who are not otherwise insured, NYPH offers charity care and other financial aid. NYPH has implemented a charity care policy that applies across all of its campuses. Under this policy, NYPH provides charity care/financial aid for patients with incomes up to 300% of the federal poverty level, or $56,550 for a family of four. In addition, NYPH routinely assesses patients' eligibility for assistance from the Philanthropic Fund, a fund which is used to pay the medical bills of patients experiencing financial hardship. To the extent that a patient is ineligible for either charity care/financial aid or the Philanthropic Fund, NYPH makes every attempt to establish flexible payment arrangements based on the patient's individual circumstances.

NYPH also works to ensure the fair collection of outstanding patient debt. NYPH has internal policies and procedures, as well as written agreements with its outside collection agencies. NYPH's collection agencies do not pursue income executions on a patient's spouse, and do not force a foreclosure on a patient's primary residence. On average, NYPH collects only 12-13% of the charges for services to self-pay patients. After making reasonable efforts to collect the outstanding monies, NYPH must frequently write off some, if not all, of the uninsured balances. As noted above, these write-offs approach nearly $70 million per year. While a portion of this is reimbursed to NYPH through the New York State Bad Debt and Charity Care Pool, the write off of bad debt is still a substantial burden on NYPH.

II. NYPH'S CHARGES

NYPH recognizes that rising health care costs are a significant and growing concern. Increases in health care costs lead to increases in our charges. The increase in health care costs in recent years can be attributed to a variety of factors, including the increased costs of technology, research, pharmaceuticals, employees, insurance, and facility expansion and improvements. NYPH must absorb these increased costs, and must update its chargemaster accordingly. Generally speaking, NYPH's charge increases in recent years have been due to an overall increase in these types of operational expenses.

NYPH understands that uninsured patients do not have the benefit of negotiated group rates. As such, NYPH has been and remains committed to providing free or reduced charge services that are medically necessary to persons who are determined to be unable to pay for their care, in whole or in part, based on their financial situation. A description of NYPH's charity care efforts is set forth below.

III. NYPH'S PROVISION OF CHARITY CARE

As the largest hospital in the New York metropolitan area, NYPH is serious about its commitment to provide medical care to both the uninsured and underinsured in its community. NYPH is continually modifying and improving its charity care policies to meet the three-fold challenge of surviving in the face of burgeoning costs and cumbersome federal and state regulation, continuing to provide high-quality, innovative medical care, and serving the needs of the uninsured and underinsured patients in its community. To this end, NYPH has recently revised its charity care guidelines in order to implement a new Charity Care/Financial Aid Policy ("Charity Care Policy") across all four of its campuses. NYPH's Charity Care Policy allows NYPH staff to consistently and fairly assess each patient's ability to pay for medical services, and provides a level of assistance commensurate with their resources.

NYPH's provision of charity care/financial aid is not intended to be a substitute for existing government entitlement or other assistance programs. Based on the individual circumstances of each patient, NYPH makes every reasonable effort to explore appropriate, alternative sources of payment and coverage through Medicaid or other public and private programs. Eligibility for charity care/financial aid will be determined only after eligibility for Medicaid and other public and private programs has been assessed. This allows NYPH to provide charity care/financial aid to those patients that are most in need of assistance.

A. Charity Care/Financial Aid Policy

1. Eligibility and Application Process

NYPH's Charity Care Policy defines charity care/financial aid as "the provision of free or reduced charge services that are medically necessary to persons who are determined to be unable to pay for their care in whole or in part, based on their financial situation." While charity care/financial aid is aimed at NYPH's uninsured population, insured patients who face extraordinary medical costs, not covered by a third party payer, may be eligible for assistance. As a general rule, other than cases of medical emergency, NYPH offers charity care/financial aid to individuals who reside within the communities it serves.

In assessing a patient's eligibility for charity care/financial aid, NYPH asks applicants to provide certain information and/or documentation related to their financial resources. NYPH asks applicants to submit the following:

- Household income for the most recent three months;
- Household income for the most recent twelve-month period;
- Number of persons in the household and their relationship to the applicant;
- Net assets (e.g., value of personal and real property, insurance policies, bank accounts, and other investment accounts); and/or

- Form 1040 (U.S. Individual Income Tax Return) or, in the absence of a Form 1040, any other documentation that can be used to substantiate household income.

NYPH reviews the application and documentation in making a decision regarding the patient's ability to pay for the services provided, and eligibility for charity care/financial aid. NYPH will provide free or reduced care to uninsured applicants with incomes below 300% of the federal poverty level (i.e., $56,550 for a family of four), and who have no significant assets other than their primary residence. The federal poverty level is listed in the Federal Poverty Guidelines for Non-Farm Income, which is published on an annual basis. Exceptions to the income levels may be authorized by a designated hospital executive. If a patient is found to be ineligible for charity care/financial aid based on their available assets and income, the patient's eligibility may be re-evaluated at a later date. Regardless, NYPH attempts to establish flexible payment arrangements based on the patient's individual circumstances.

2. Communication of NYPH's Charity Care Policy to the Community

NYPH has made an effort to disseminate information about its Charity Care Policy to the communities it serves. NYPH has shared information about the policy with various community health agencies and other local organizations that assist individuals in financial need. NYPH also provides information about its charity care/financial aid programs in the Emergency and Admitting Departments of each of its facilities. In so doing, NYPH provides the information in the primary language spoken by the patients served by that facility. Finally, NYPH has trained the personnel who come in contact with uninsured and underinsured patients so they may educate such patients about the availability of, and process for obtaining charity care/financial aid.

B. The Philanthropic Fund

NYPH's Philanthropic Fund is used to provide aid to patients experiencing financial hardship. The Philanthropic Fund, which is supported by private donations, contains approximately three million dollars in available funding on an annual basis.

Both insured and uninsured patients may apply for financial aid from the Philanthropic Fund. In order to receive monies from the Fund, the patient must submit a letter of hardship which details their financial circumstances, and explains why the patient is unable to pay his or her medical bills. The patient may also be required to submit financial documentation, such as W-2 forms, Form 1040s and mortgage statements. Upon receipt of the patient's letter and documentation, NYPH will make a determination as to the eligibility of the patient. If the patient is deemed to be eligible, NYPH will forgive the patient's entire balance due to the hospital, subject to the availability of funds. Monies from the Philanthropic Fund are allocated on a first-come, first-served basis.

IV. NYPH'S COMMUNITY BENEFIT INITIATIVES

In addition to providing nearly $70 million in charity care per year, NYPH expends significant resources in support of its Community Benefit Initiatives. Through these initiatives, NYPH collaborates with various local health agencies to ascertain and respond to the myriad of health care needs of its communities. NYPH incorporates the outcome of these assessments into its strategic and program planning process in an effort to target needed services to residents of its communities. NYPH currently funds approximately twenty Community Benefit Initiatives. The following initiatives are directed at the uninsured and underinsured populations:

NYPH's *Facilitated Medicaid Enrollment Program* is aimed at enrolling the uninsured in the Medicaid Program. NYPH funds community-based organizations, throughout its five targeted neighborhoods, which hire bi-lingual community-based staff to serve as liaisons. These liaisons seek out the uninsured by visiting public housing, homeless shelters, churches, schools, health fairs and other community events. The liaisons pre-screen uninsured individuals to determine if they are eligible for Medicaid, assist them in completing the application and gathering required documentation, and provide referrals to Medicaid application offices located throughout the City. As a result of these efforts, approximately 6,500 uninsured individuals have been enrolled in the Medicaid Program in a single year.

NYPH's *Pharmacy Assistance Program* makes affordable pharmaceuticals available to the uninsured and underinsured patients who do not have a prescription drug benefit. The Pharmacy Assistance Program currently works with over 130 pharmaceutical manufacturers to offer more than 1100 legend drugs to eligible patients. Under this Program, patients pay a $5 co-payment for a three-month supply of medicine. Since its inception in August 2002, the Pharmacy Assistance Program

has assisted many uninsured and Medicare patients to obtain the prescriptions they need at an affordable cost.

NYPH's *Prenatal Care Assistance Program* seeks to enroll low-income pregnant women into the Medicaid Program. NYPH Medicaid counselors, at both the Columbia Presbyterian and Cornell campuses, pre-screen female outpatients in an effort to determine if they are eligible for participation in the Prenatal Care Assistance Program. The Prenatal Care Assistance Program is a State-sponsored initiative that expands the Medicaid eligibility criteria to include pregnant and postpartum women. NYPH maintains an electronic Medicaid application program that allows eligible pregnant women to receive Medicaid numbers within 48 hours.

In 1998, the Columbia University School of Dental and Oral Surgery, in partnership with NYPH, the Mailman School of Public Health, Harlem Hospital, and Alianza Dominicana, became one of thirteen sites nationwide to be awarded a Community Voices Health Care for the Underserved Initiative grant by the W.K. Kellogg Foundation. This led to the formation of *Northern Manhattan Community Voices Collaborative* ("NMCVC"). NMCVC is a partnership of over 35 community-based organizations, faith-based groups, health care providers, and institutions working to address the health care needs of the Central Harlem and Washington Heights/Inwood communities. Under the NMCVC Program, NYPH has worked collaboratively with its partners to increase Medicaid and Child Health Insurance Plus ("CHIP") enrollment in the targeted communities.

NYPH's *Community Outreach Program* is also aimed at enrolling the uninsured into health insurance programs. NYPH substantially expanded its Community Outreach Program in 2001, when the number of Outreach staff grew from 12 to 36. The increase in staffing allowed NYPH to develop a grassroots strategy aimed at the uninsured members of the community. Outreach staff approach individuals in schools, day care centers, supermarkets, check cashing centers, Department of Labor sites, consulates and many other community locations. The staff members educate the patients about health insurance options and attempt to enroll them into CHIP, Family Health Plus and Medicaid plans.

NYPH's *Breast Cancer Screening Partnership* is a program, directed by Columbia Presbyterian Hospital, which provides free breast and cervical cancer screening to uninsured and underinsured women. To be eligible for the program, a woman must be over the age of 40, and have either no insurance coverage or insurance that does not cover medical screenings. The Partnership conducts outreach, which includes education and recruitment of women, through community-based and faith-based institutions. The Partnership provides ease of access through its two mobile mammography units, and through formal referral linkages with Harlem Hospital and the Union Health Center.

The Community Benefit Initiatives, described above, clearly demonstrate NYPH's strong commitment to the economically disadvantaged communities that it serves. NYPH makes every effort to obtain health insurance for the uninsured and underinsured, as evidenced by the Facilitated Medicaid Enrollment Program, the Prenatal Care Assistance Program and the Community Outreach Program. To the extent that patients are not eligible for Medicaid programs, NYPH provides low cost prescription drugs and free preventative services through several of its Community Benefit Programs.

V. NYPH'S COLLECTION POLICIES

NYPH works to ensure the fair collection of all outstanding patient debt. NYPH's handling of outstanding patient bills differs depending on a variety of factors, including the amount of the balance, whether the services were performed in the outpatient or inpatient setting, and the age of the account. For example, outpatient balances under $1,000 are handled by NYPH's Patient Financial Services Department. Representatives in the Patient Financial Services Department may take varying approaches based on the particular patient's needs and circumstances. The patient representative may assess a patient's eligibility for Medicaid, settle the account for less than the full balance, negotiate flexible payment arrangements, or assess the patient's eligibility for charity care from the Philanthropic Fund. The patient representative's goal is to tailor the arrangement to the individual patient's ability to pay.

NYPH has internal policies and procedures, as well as written agreements with its outside collection agencies and law firms (hereinafter "outside collectors"). NYPH's outside collectors do not pursue income executions on a patient's spouse, and do not foreclose on a patient's primary residence. NYPH's outside collectors routinely assess patients' eligibility for Medicaid and other government programs. To the extent the patients are ineligible, the outside collectors provide the patient with

multiple opportunities to pay on the account. NYPH's outside collectors are expected to negotiate flexible payment arrangements based on the patient's individual circumstances, and to settle accounts for a percentage of the balance.

On average, NYPH collects only 12-13% of the charges for services to uninsured patients. After making reasonable efforts to collect the outstanding monies, as required under the Medicare program, NYPH must frequently write off some, if not all, of the uninsured or self-pay balances. NYPH's bad debt expense approaches nearly $70 million per year.

Mr. GREENWOOD. Thank you.

Mr. Fetter.

TESTIMONY OF TREVOR FETTER

Mr. FETTER. Thank you, Mr. Chairman. I appreciate this opportunity to address the subcommittee.

My name is Trevor Fetter. Last September, I was named Chief Executive Officer of Tenet Healthcare Corporation. Prior to that, I had served since November 2002 as President of Tenet. I have spent nearly 9 years as an executive in the health care field.

Tenet is America's second largest investor-owned hospital company. Last year, we treated more than 9.5 million patients at our 99 hospitals in 14 States across the Nation. We employ more than 100,000 people in our hospitals. Every one of us at Tent is very familiar with the growing uninsured crisis in our country. We deal with it every single day, and the burden is rapidly increasing.

Tenet, like most hospital operators, has always provided charity care to those truly indigent patients with no ability to pay. But in recent years, we have been forced to absorb the sharply rising cost of treating uninsured patients who are not indigent, but for a variety of reasons can't or won't pay for the services that we provide.

It is important to note that the uninsured crisis is definitely not confined just to the unemployed and to the indigent. In some communities that we serve, as many as a third of the uninsured patients have jobs, but no health insurance.

We estimate that the number of uninsured patients in Tenet hospitals has now risen to more than 500,000 per year. This has an enormous cost. So far this year, Tenet has incurred about $20 million a month in cost to provide care to uninsured patients. It costs us an additional $15 million per month to provide charity care to people whom we believe cannot afford to pay us anything.

As hospitals continue to absorb costs of that magnitude to provide free care to uninsured and indigent patients, their ability to invest in capital improvements, expanded services, and new technology becomes limited. My greatest objective is to improve the quality of care that is provided by our hospitals, but my greatest concern is that the uninsured crisis may compromise our ability to reinvest appropriately in our hospitals.

We know that Tenet alone cannot fix the uninsured problem. Only when the uninsured have insurance will we truly solve this challenge. But we have committed ourselves to do what we can to ease this burden until more fundamental solutions are developed.

That led us, in January 2003, approximately a month after I made the comment that the chairman referenced in his opening statement, to adopt what we call Tenet's Compact With Uninsured Patients. The Compact has radically changed many of the ways that Tenet hospitals interact with uninsured patients, including a

dramatic overhaul of some collection practices. Under our Compact, we do not sue uninsured patients to collect unpaid bills, if the patient is unemployed or lacks significant income. And we also do not impose liens on homes if they are a patient's only significant asset. These two changes in our collection practices have reduced by 90 percent our patient litigation and lien activity since 2002.

A key aspect of the Compact is our uninsured discount program which we are currently rolling out. Uninsured patients in Tenet hospitals who do not qualify charity care or government health coverage will be offered a substantial price discount similar to those negotiated by HMOs for their members.

Tenet's Compact provides uninsured patients with meaningful price discounts and less onerous collection practices, but I must emphasize that it is simply no substitute for health insurance.

As Congress continues its efforts to address this problem, I urge you to keep in mind that the most formidable challenge faced by uninsured patients, as well as their hospitals and other health care providers, is the lack of affordable health insurance. With our Compact, all of us at Tenet believe we are doing our part to ease the burden of this crisis on the patients who need that the most.

We welcome this opportunity to work collaboratively with Congress and others to find broader answers to this pressing challenge.

I applaud the subcommittee's leadership in evaluating the uninsured crisis and how our country can do a better job of providing health care for all Americans, and I would be happy to answer any questions that you might have.

[The prepared statement of Trevor Fetter follows:]

PREPARED STATEMENT OF TREVOR FETTER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TENET HEALTHCARE CORPORATION

Thank you, Mr. Chairman. I appreciate this opportunity to address the Subcommittee.

My name is Trevor Fetter. Last September, I was named Chief Executive Officer of Tenet Healthcare Corporation. Prior to that, I had served as President of Tenet since November 2002. I have spent nearly nine years as an executive in the health care field.

Tenet is America's second largest investor-owned hospital company. Last year, we treated more than 9.5 million patients at our 99 hospitals in 14 states across the nation. We employ more than 100,000 people in our hospitals. Tenet's largest regions are in California, Texas and Florida. We also operate hospitals in Alabama, Georgia, Louisiana, Massachusetts, Mississippi, Missouri, Nebraska, North and South Carolina, Pennsylvania and Tennessee.

This has been a challenging time for our company. Last year we reported a net loss of $1.4 billion. Tenet's challenges have galvanized our board of directors, our new management and our employees to make our company a model partner with federal and state payors and regulatory agencies. In the past 18 months, we have made enormous progress in the areas of compliance, quality and transparency, but all of us know that we have to regain the full trust of the government, our patients and our physicians if Tenet is to succeed in its mission.

The specific subject you have asked me to address is the growing challenge of providing health care to uninsured and under-insured Americans, and it has two parts. The first requires all of us to recognize that individuals without insurance are not represented by large payors and therefore do not benefit from negotiated pricing. The second part is the limited ability that these patients have to pay for health care, regardless of the price. Tenet has taken action we believe is appropriate on both fronts, but our company—and our hospitals—cannot solve this problem alone.

Every one of us at Tenet is very familiar with the growing uninsured crisis in our country. We deal with it every single day, and the burden is rapidly increasing. Tenet, like most hospital operators, has always provided charity care to truly indigent patients with no ability to pay. But in recent years, we have been forced to

absorb the sharply rising cost of treating uninsured patients who are not indigent but for a variety of reasons can't or won't pay for the care we provide. I think it's important to note that the uninsured crisis is definitely *not* confined just to the unemployed and the indigent. In some of our markets, as many as a third of our uninsured patients have jobs, but no health care insurance.

We estimate that the number of uninsured patients receiving care in Tenet hospitals has now risen to more than 500,000 per year. This has an enormous cost. So far this year, it has cost us about $100 million a month to provide care to patients where neither an insurance company nor the patient has paid us. About three-quarters of that total was from uninsured patients. In *addition,* Tenet provides $15 million per month in charity care to people who we believe can't afford to pay us anything.

What's most alarming is how the uninsured totals have grown just recently. While our charity care increased 15 percent from 2002 to 2003, our write-offs from unpaid patient bills—the vast majority of them uninsured—rose by 49 percent.

As hospitals continue to incur this significant and rapidly growing cost, their ability to invest in capital improvements, expanded services and new technology becomes limited. My greatest objective is to improve the quality of care provided by our hospitals. But my greatest concern is that the uninsured crisis may compromise our ability to do that.

When I was named President of Tenet in November 2002, this company faced many difficult issues. Our new management team set out to address each one. Among the things we faced were some very vocal complaints that our hospital charges and collection practices were unfair to uninsured patients. I knew that Tenet alone could not fix the uninsured challenge. Only when the uninsured have insurance will we truly solve this problem. But I was determined to see what Tenet *could* do to ease the burden until more fundamental solutions are developed.

In January 2003, we adopted our own approach to the uninsured crisis. We called it Tenet's *Compact With Uninsured Patients.*

The *Compact* has radically changed many of the ways Tenet hospitals interact with uninsured patients, including a dramatic overhaul of some collection measures. The paramount goal of the *Compact* is to treat all Tenet patients fairly and with respect, regardless of their ability to pay. We start by giving our uninsured patients extensive financial counseling to help them access all state and federal programs, such as Medicaid, that may help pay for their health care. As part of this process, we also determine if the patient is indigent and therefore eligible for Tenet's charity care program.

Under our *Compact,* we do not sue uninsured patients to collect unpaid bills if the patient is unemployed or lacks significant income. And we also do not impose liens on homes if they are a patient's only significant asset. These two changes in our collection practices have reduced by *90 percent* our patient litigation and lien activity since 2002.

One of the unique aspects of the *Compact* is our uninsured discount program. Every uninsured patient who does not qualify for charity care or government health coverage will be offered a substantial price discount similar to those negotiated by HMOs for their members.

Although our uninsured patients have benefited from all *other* features of the *Compact* since January 2003, Tenet has not implemented the uninsured price discount until very recently. That's because we wanted to be sure our program complied with all federal and state laws. Earlier this year we concluded that Tenet's discount program *is* in compliance with all federal laws, but there are two states where we have had to take interim measures. By the end of July, the discount will be available in virtually all of our hospitals, except those in Texas and California. We are still awaiting resolution of regulatory issues in those two states. In the interim, we are significantly expanding our charity care policy there to include many more uninsured patients until our discount is available.

As Congress continues its efforts to address this problem, I urge you to keep in mind that the most formidable challenge faced by uninsured patients—as well as their hospitals and other health care providers—is the lack of available and affordable health insurance.

Tenet's *Compact* provides uninsured patients with meaningful price discounts and less onerous collection practices. But it is no substitute for health insurance. Even with the price discount offered by our *Compact,* uninsured patients still must pay their own bills. Not many Americans *with* health insurance would find it easy to pay their own medical bills, even if they were discounted to HMO-style rates.

With our *Compact,* all of us at Tenet believe we're doing our part to help ease the burden of this crisis on the patients who need help the most. We welcome the

opportunity to work collaboratively with Congress and others to find broader answers to this pressing challenge.

I applaud the Subcommittee's leadership in evaluating the uninsured crisis and how our country can do a better job to address the health care of all Americans. I'd be happy to answer any questions the Subcommittee may have.

Mr. GREENWOOD. Thank you very much, Mr. Fetter. The Chair recognizes himself for 10 minutes for inquiry.

You all heard me quote Mr. Fetter's comments, and let me just refer back to them again. He said, "In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay. The problems that this creates are obvious. The bills are tremendous and incomprehensible to most people. The patient leaves the hospital presumably after some traumatic event, and the hospital ill adds to the trauma," and I think all of you have essentially recognized that this has been a problem. All of you have essentially testified that you have made changes in your billing practices in order to deal with this problem.

The thing that I am trying to ascertain is when did this occur to you, and why? In other words, this is a long-standing issue. Mr. Fetter said in his statement it is a long-standing issue. When did these issues first raise concerns in your mind, and what did you do about it? I would just like the panel go down from my left to right.

Mr. TERSIGNI. Mr. Chairman, we always had policies within our health ministries. What we didn't have was a uniform policy across all of Ascension Health. And so we began on the journey beginning in early 2003, actually before the subcommittee's investigation, and what we learned was that our policies weren't always explicit and each hospital did things differently. We really couldn't speak, as an Ascension Health policy, that there really wasn't a process to measure how well our charity care programs were doing, and then our billing and collection wasn't receiving the level of attention and oversight that we believe we needed to do from a systemwide perspective. And, therefore, we went about, as we are beginning to integrate our system, management systems, in creating a systemwide policy that I indicated that our board approved.

Mr. GREENWOOD. I am going to ask everyone to be brief because I have a series of questions and limited time, so just basically when did you start working specifically on the question of trying to make sure that the uninsured were not billed charges. I know that all hospitals, all of your systems have long-standing charity care procedures and so forth, but on the specific question that this committee is focused on, making sure that the uninsured aren't billed charges, when did you recognize this is a problem, and when did you take action to correct it?

Mr. LOFTON. Again, we have had policies in place to help them, so the assistance has been there. It has been done on an individual patient-by-patient basis. The investigation brought to light a serious problem that was there. We definitely could have been more purposeful in addressing it as a system.

CHI itself is still a relatively new system with a collection of hospitals, and each hospital had their own policies and practices. So, last year was when we began to look at it from a systemwide basis and looked to put systemwide policies in place.

Mr. GREENWOOD. Very well. Mr. Bovender.

Mr. BOVENDER. In late 2002, I asked my staff to start formulating a program where we could provide policy discounts to charity care discounts, as I enumerated in my testimony. I was told by both inside and outside legal counsel at the time that we had to get clearance for this through CMS, and so we, in March 2003, sent a letter detailing our plan to CMS. They responded in June 2003, saying that they thought the plan was good, fit within the regulations, but we would have to get individual permission from each of our five fiscal intermediaries in order to implement the plan.

Mr. GREENWOOD. What was the impetus for you to seek that legal advice? Was it this investigation? Was it the lawsuits that Tenet was experiencing? What was it?

Mr. BOVENDER. It was mainly seeing the growing problem and the attention both this committee as well as the problems that Tenet has alluded to earlier were seen, and I just said to our people very frankly, we need to fix this problem, it is not conscionable. This kind of disparity between what is actually being charged to the uninsured and what is appropriate given our managed care discounting and other rates, and it needed to be changed. But it took a process through CMS to get approval. We got approval in October. We have implemented the policy. And as I have said, it has not been perfect. And we have learned a lot. In fact, about 3 weeks ago, through the open forum that the Office of Inspector General did in HHS, they opened the doors a lot wider for discounting policies, and we are going to go back and actually, as I mentioned in my testimony, implement some new plans, which won't replace the charity discount, but I think will change the pricing to the uninsured based upon actually some of the things that Dr. Anderson was testifying about earlier.

Mr. GREENWOOD. Dr. Pardes.

Mr. PARDES. We have had policies trying to address the problems of the uninsured for some time, Mr. Chairman, and those have included developments like reducing the number of collection agencies, taking more of the collections under our control, and trying to interfere with inappropriate practices.

Your investigation I think has spurred that further, and I think you should be credited for it.

Mr. GREENWOOD. Thank you. Mr. Fetter.

Mr. FETTER. Well, those comments that you cited I made in December of 2002. In January 2003, we announced this Compact With the Uninsured, having those two features I mentioned, the different collection practices as well as the discounting.

We did immediately take action to seek an opinion from HHS with respect to the discounting, and it was almost a year later that the Secretary clarified HHS policy. We then took immediate action to roll out the discounting plan which we are doing now.

I would also, as Mr. Bovender just did, like to applaud HHS for holding those open forums. We found them to be exceedingly helpful in clarifying a variety of regulatory issues.

Mr. GREENWOOD. Thank you. And let me be clear. I am not interested in knowing whether this investigation was the inspiration for your change so we can take credit for it so much as I want to examine the question of whether the Congress feels a need to go on and do something legislatively, which I think you would probably,

to a person, prefer that we did not. And so we are interested in seeing the impact of all of these events on the hospitals across-the-board.

Let me ask this question now. What is the most—using standards like Medicaid, Medicare, the average third-party payment in your charges, what is the most highest price that an uninsured person now could pay at your facilities? Dr. Tersigni.

Mr. TERSIGNI. Our average patient cost per day for caring for an uninsured is about $1376, of which we collect an average of $155.

Mr. GREENWOOD. I am not sure that that exactly answered my question. The question is, when an uninsured person comes into your hospital, what is the most they could pay? Is it possible now, given the procedures that you have, for that person to be billed charges?

Mr. TERSIGNI. All of our patients presently are billed charges. In the case of the uninsured, as they enter one of our facilities, the financial counselors will begin working with them, and the first questions they ask are, do you have insurance, and then we begin the process of looking at the means to pay or the inability to pay.

Mr. GREENWOOD. But, again, someone says "I have no insurance." Is it possible, in your system, for that person to walk away from the hospital with an obligation equal to your charges?

Mr. TERSIGNI. Not if we have all of the financial information necessary to determine that they are in financial need.

Mr. GREENWOOD. Mr. Lofton.

Mr. LOFTON. One of the considerations that we have to look at is differences across the country. I have heard a lot of generalizations about charges and we have seen cost and average charges put up, so the answer to your question will vary based on where the location of the hospital is. We have some markets where there is very little discounting from charges, so the variation that was talked about earlier is very small between what a managed care patient will pay and what a full-charge patient will pay.

Mr. GREENWOOD. Is it still possible for an uninsured person to pay significantly more than, let us say, third-party payers pay at your hospital?

Mr. LOFTON. That scenario is possible, but again if the information is provided—one of the things that the advice and guidance that the Secretary issued allows us to do, if we have the proper information with that given patient, we are able to determine whether there is a medical indigency reason whether we can discount that bill. So a lot of it has to do with the patient providing adequate and proper information for us to make the proper determination as to what they should pay. There is no clearcut answer to your question.

Mr. GREENWOOD. Mr. Bovender.

Mr. BOVENDER. In our circumstances, assuming that we can qualify them under that 400 percent or below criteria, then the payment will range from anywhere near a managed care rate down to a 200 percent or below the Federal poverty guidelines, it would be free. Above that level, above 400 percent now, they are going to be charged charges. Under the plan that we are evaluating now, hopefully we can move everyone uninsured into a price point that

is essentially around probably the 95th percentile of all of our managed care contracts as a standard.

Mr. GREENWOOD. Now, that is the clearest answer I have had so far. That is quite straightforward. Dr. Pardes.

Mr. PARDES. I would say, Mr. Chairman, that about—the bulk of our patients either are either in Medicaid or Medicare programs, or are under plans. That least about 2 percent who are self-pay. We do have some people who are international patients and wealthy patients who will pay charges. We individually assess every other individual, and for those individuals who have financial distress, we work out individual arrangements so they will pay substantially below the charges.

Mr. GREENWOOD. Mr. Fetter.

Mr. FETTER. Once one of our hospitals has implemented our Compact With the Uninsured Discounts, uninsured patients would not be rendered a bill of charges. They would be rendered a bill that would approximate the 75th percentile of what we are paid in that market by managed care.

Prior to the implementation of the Compact, an uninsured patient could receive a bill at full charges, but I would like to point out——

Mr. GREENWOOD. When do you expect all of your hospitals to have that contract in place?

Mr. FETTER. By the end of July, with the exception of the States of California and Texas, where there are certain State laws that have presented us with difficulties in implementing that. But I would like to point out with respect to those patients who would receive a bill at full charges, that was represented by the Orange bar, I believe, on the graph that you showed in the beginning. The collection rate from those patients is actually less than 10 percent.

Mr. GREENWOOD. In the aggregate, I understand that. What we have been worried about in this committee is that disaggregated, that some individuals of limited means get hammered with charges, and that is the only thing that we think is unfair about it. Speaking for myself, that is the unfairness of the system.

The gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman. I would like to ask you gentlemen about something you keep referring to, which is about a year ago when you said you got clarification from CMS as to the policies, and that combined with these pending hearings were what caused you to really re-examine your policies that related to the uninsured, and to change them.

What policy was it from CMS that you thought had to be clarified? Mr. Fetter, we will just start with you, I think.

Mr. FETTER. Thank you. And I would point out I believe that HHS guidance was actually issued in April of this year, not a year ago. I referenced a year. That was more than a year ago.

Ms. DEGETTE. I am sorry. What policy was it that you thought needed to be clarified?

Mr. FETTER. The policy that required that charges be uniform for all patients, and that discounts could be negotiated with individual payers, but there must be a charge master, and the charge master must be the same, regardless of the——

Ms. DEGETTE. For all patients. Now, was that a written policy, or was that more of an understanding?

Mr. FETTER. You know, I am not an expert in——

Ms. DEGETTE. Does anybody know? Was that—Mr. Bovender?

Mr. BOVENDER. We were told by both our inside counsel and outside counsel, Medicare experts, attorneys who are experts on the Medicare law, that you could not arbitrarily, without reference to some indigence test, discount your charges to individual patients. And so that is what led us in March to send a letter of request detailing our discount program that I talked about before and, as I said, we got a letter back in June that said that CMS thought the program was fine, but it needed approval by each of our five fiscal intermediaries.

Ms. DEGETTE. And what Mr. Fetter just described about having to have the same charges for everyone, was that everyone else's understanding as well? Mr. Lofton?

Mr. LOFTON. Yes. Ours was we could not charge individual patients, there had to be consideration for discount.

Ms. DEGETTE. And was that also a basis of your previous understanding, that CMS was requiring that you aggressively pursue these collections as well?

Mr. LOFTON. Yes. In the past, OIG has been very forthright in making it clear about waiver of co-payments or reductions of patient bills for individual patients.

Ms. DEGETTE. Now, do all of you think that has now been cleared up by HHS?

Mr. LOFTON. Yes.

Mr. BOVENDER. Yes.

Ms. DEGETTE. Okay. And so that is why you are now instituting these policies, in addition with these pending hearings, correct?

Mr. FETTER. Yes.

Ms. DEGETTE. I want to ask about the collection process because you have all talked about how you are really making these efforts to make accommodations for the uninsured particularly, the less affluent uninsured, and so on, but I just said this actually in a different hearing in this committee on Tuesday of this week—the devil is really in the details.

So, I want to ask you when—and I guess I will start with you, Dr. Tersigni—what is your organization's policy when you send these cases to a collection agency?

Mr. TERSIGNI. Well, we have asked the collection agencies to comply with——

Ms. DEGETTE. Do you have a policy after a patient has been discharged from the hospital, how long is it before you will send it to a collection agency?

Mr. TERSIGNI. It depends on the circumstance.

Ms. DEGETTE. So you don't have a firm policy on that?

Mr. TERSIGNI. We don't have a firm policy of when it goes to collection.

Ms. DEGETTE. Mr. Lofton, do you have a firm policy on that?

Mr. LOFTON. I don't know if I can say policy. Our practice is that a bill will go to a collection agency 90 to 120 days following discharge. And during the course of the next 150 days, if that bill has not been acted on or been active during that time, we take it back

from the collection agency. So, 90 to 120 days we send it, and then another 150 days we take it back.

Ms. DEGETTE. And is there some discretion involved within that 90 to 120 days, or does every case go to a collection agency at that point?

Mr. LOFTON. It is discretion within that based on if they have already worked with a given patient or family and they think that they have a resolution, it does not have to go.

Ms. DEGETTE. Mr. Bovender?

Mr. BOVENDER. Our general policy is 180 days, but it does also have the exceptions that Kevin mentioned, which is that if we are working actively with a patient, either qualifying them for Medicaid or on charity care policy, obviously that doesn't happen.

Ms. DEGETTE. Dr. Pardes?

Mr. PARDES. We try to handle most internally, and then we don't send it out to collection agencies until at least 6 months have passed.

Ms. DEGETTE. Six months have passed? Is that for every bill, or certain kinds of bills?

Mr. PARDES. If there is an unpaid bill, then we would first have bills sent out over a 6-month period before it went to a collection agency.

Ms. DEGETTE. Mr. Fetter?

Mr. FETTER. Our policies are similar to what Mr. Bovender and Dr. Pardes described, with the exception that we use an internal staff, we do not generally send bills out to collection agencies.

Ms. DEGETTE. Do you put it on people's credit reports after a period of time, if you are using an internal——

Mr. FETTER. Yes.

Ms. DEGETTE. And how long is that?

Mr. FETTER. That would be also after about 180 days.

Ms. DEGETTE. Okay. I don't know if you heard the testimony—I think you were all here—the testimony of the previous panel. One of the panelists said that actually once it goes to a collection agency and is listed on someone's credit report, it may make it more difficult for them to get a job or find some other method of paying their bills. Did you hear that testimony? Mr. Bovender? What do you make of that?

Mr. BOVENDER. I think that is true, but I have been told by people who do credit scoring and are in this type of business, that hospital debt is not viewed at the same level as mortgages or car payments. You may know that if you were to rank how well people pay different portions of their debt, from first to last, mortgages being first, hospitals are ninth on that list. The only ones worse than us as far as payment are the student loan programs.

Ms. DEGETTE. Let me ask you this question. Do any of you utilize—this has been all over in the press, what they call body attachments. They don't have those in Colorado. I practiced law for a number of years, and they don't have that civil arrest or body attachments, but in some States they do, and of course those are some of the horror stories, people who can't or don't pay their hospital bill and end up in jail.

Dr. Tersigni, do you know if your organization uses body attachments?

Mr. TERSIGNI. I can't answer whether we have in the past used body attachments. I know that presently that is not part of our policy.

Ms. DEGETTE. And when you send something out to collection, do you tell them not to go for body attachment?

Mr. TERSIGNI. Yes. As a matter of fact, each of our collection agencies have to sign an agreement with us that comply with our policy.

Ms. DEGETTE. Would you mind supplementing your testimony today with a copy of that agreement?

Mr. TERSIGNI. Sure.

Ms. DEGETTE. That would be great. While I am asking questions, what about attaching people's homes? Dr. Tersigni?

Mr. TERSIGNI. Again, we want to make sure that we are not taking advantage of people's situation, so our financial counselors will work with them, and we do, in some cases, have liens, but it is very clear that we don't want to have any foreclosures or do anything that is deleterious to their homes or——

Ms. DEGETTE. Well, I am here to tell you, a lien on someone's home is deleterious. Is your policy with respect to liens on people's homes also in your agreement with the credit agencies?

Mr. TERSIGNI. Yes, it is.

Ms. DEGETTE. Mr. Lofton, I think you testified that your policies say no bench warrants, no court action without approval, and no liens, is that right?

Mr. LOFTON. That is correct. Every one of our contracts have been amended to state such, that we would not do that, on a primary residence.

Ms. DEGETTE. How long has that been your policy?

Mr. LOFTON. That has been in effect since April 1st.

Ms. DEGETTE. April 1st, 2004?

Mr. LOFTON. 2004.

Ms. DEGETTE. Why did you institute those policies, Mr. Lofton?

Mr. LOFTON. Well, again, we took this opportunity to look at our practices. CHI cares deeply about the poor uninsured and underinsured. And we have been working with those individuals on a case-by-case basis, but we felt that we would take a look at that from a system perspective, and the boards of every one of our local hospital systems adopted that contract change.

Ms. DEGETTE. Mr. Bovender, does your organization allow body attachment?

Mr. BOVENDER. No, ma'am.

Ms. DEGETTE. Is that in your written policies?

Mr. BOVENDER. Yes, I believe so.

Ms. DEGETTE. And what about liens on homes?

Mr. BOVENDER. Liens on homes are only permitted with homes of over $300,000 in value.

Ms. DEGETTE. That seems reasonable. What about you, Dr. Pardes?

Mr. PARDES. Body attachment is prohibited in New York State, Congresswoman.

Ms. DEGETTE. What about liens on homes?

Mr. PARDES. We have liens on homes in exceptional situations, do not have foreclosures on homes.

Ms. DEGETTE. Is that in your written policies?

Mr. PARDES. Yes.

Ms. DEGETTE. Would you mind supplementing your record?

Mr. PARDES. Happy to do so.

Ms. DEGETTE. What about you, Mr. Fetter?

Mr. FETTER. I do not believe we have body attachments as part of our policy, and also, as I mentioned earlier, under our Compact With Uninsured Patients, will not place liens on homes.

Ms. DEGETTE. I just want to ask one last question for all of you, under your new policies, do you intend to release any liens that you have already placed on primary residences? Just go real fast because my time is over.

Mr. GREENWOOD. Be very brief because the gentlelady's time has expired.

Mr. FETTER. As Congressman Walden pointed out earlier, you always attempt to work things out with patients who owe you money, so I am sure that we are releasing liens on homes where we have liens today.

Mr. PARDES. I would say we are reviewing all of our policies and issues, and we may well find that we will release additional ones of those.

Mr. BOVENDER. If we find any we have with value under $300,000, we will.

Mr. LOFTON. We are reviewing for all patients, and all of our patients can come back and we can review their record after the fact, and make appropriate changes.

Mr. TERSIGNI. Again, as well, we review all patients and, after the fact, can make the changes.

Ms. DEGETTE. Thank you.

Mr. GREENWOOD. The Chair thanks the gentlelady, and recognizes the gentleman from Oregon, Mr. Walden, for 10 minutes.

Mr. WALDEN. Thank you, Mr. Chairman.

I am curious, as you all work on getting payment situations set up for those who owe you money, do any of those folks end up getting a loan from a financial institution to pay you? Do you see that happening? Do they go to the bank or their credit union and get a loan, take out a loan so they can pay you? Anybody?

Mr. TERSIGNI. I don't know that.

Mr. WALDEN. You don't know.

Mr. LOFTON. I am not aware of any specific cases.

Mr. BOVENDER. Do not know.

Mr. WALDEN. So you are not seeing any of that sort of activity.

Mr. PARDES. Don't know.

Mr. WALDEN. Don't know. All right. I am just curious because it would seem to me if they went to a financial institution to get a loan to pay you back, that financial institution would probably require that loan to be secured by some asset, right? I mean, I was on a bank board for 5 years. You don't make uncreditworthy loans on purpose, and so I wonder how all that works.

Let me go to the charge master issue. Now that you all have taken a second look at your charity care, your billing and collection processes, and we have heard a lot today about charge master rates being significantly higher than those rates actually paid for by third-party payers, insurance companies, Medicaid, Medicare. What

have you done, if anything, to change and lower your charge master rates? Have you adjusted your charge master rate downward and, if so, by how much?

Mr. TERSIGNI. I don't know that the answer is we have adjusted the charge master downward as of this point in time, but we have asked all of our ministries to look at those charges from various factors—market factors, service cost, the competition within the little local area, as well as the impact to the uninsured.

Mr. WALDEN. Mr. Lofton?

Mr. LOFTON. We have looked at a number of ways of helping our constituents and patients, and CHI has adopted the HUD guideline for who would qualify for charity care. We feel that they are both more inclusive, as well as they take into account the geography differences.

Mr. WALDEN. But do the HUD guidelines—does that have anything to do with how you set your charge master rates?

Mr. LOFTON. No. We have not adjusted the charge master, but what we have done from the charity care side is to see that we can qualify more patients and then provide them discounts from the charge master.

Mr. WALDEN. Mr. Bovender?

Mr. BOVENDER. There are really two issues associated with this charge master problem. The first is the uninsured, and we have talked about that, and programs and plans to fix that by going to some discounted method that looks like managed care.

The more complicated problem is that many of our contracts—and at HCA we have over 5,000 contracts with managed care providers across the country. Many of those contracts are not on a per diem basis or case rate basis, but are really based on a discount off of charges.

It will take us probably two to two and a half years to renegotiate all of those contracts because many of them are multiple year contracts. It is our plan to get away from the charge master having any impact, or very little impact, if you will, even on the—not just on the uninsured, but on the issue of how we negotiate managed care.

Mr. WALDEN. Good to know. Doctor?

Mr. PARDES. Approximately 2 years ago, we engaged an outside consultant to examine our charges in relationship to other charges in the area, and adjusted them accordingly.

Mr. WALDEN. Okay. But if the other hospitals in the area had charge master rates that were high—I mean, we have heard testimony in the prior panel that in some cases you have got a $10,000 charge, $11,000 here, but if you are private pay, you are $30,000. If that is the situation among all the hospitals, is that really change anything, if yours is $30,000 and theirs is $29,000, and you know what I am saying?

Mr. PARDES. Yes. We found that we were somewhat lower actually than charges in many of the other areas. We found also that our cost-to-charge ratio in our urban setting is lower than urban settings in about 28 other States.

Mr. WALDEN. Maybe I will ask this question differently. How much different is your charge master rate for a given procedure compared to what you charge your managed care plans, your fee-

for-service plans, Medicare and Medicaid? What is that relationship?

Mr. LOFTON. Again, Representative Walden, for us, it is going to range. We have some markets where we are a sole community provider in rural north Nebraska, where there is only a 7 percent difference between the two. And examples were given about California rates. Well, we are not in California. So when we look at the markets that we are in, the rates and variation between charge master and the managed care contracts are going to vary, so there is no one answer for the entire system.

Mr. WALDEN. Well, one of the prior witnesses—whose name escapes me for the moment—suggested that the charge master rate should be Medicare+25 percent, which seems sort of arbitrary to me, but I guess that is what I am trying to get at. What is your charge master rate compared to Medicare? Is Medicare+25 percent far more than your charge master rate or private pays, or is 25 percent a pretty good deal?

Mr. BOVENDER. Well, in our case, I can tell you that 25 percent is significantly below our managed care—our overall average managed care rate. So it would put it significantly below what we are negotiating with managed care.

Mr. WALDEN. So, Medicare+25 percent is below your managed care rate.

Mr. BOVENDER. Right. I think the theory that he is putting forward is good, the price point, at least in our case, based upon what Medicare is paying us related to our total all end charges is well below what the rate would need to be to make that happen.

Mr. WALDEN. You see what I am trying to get at here, though, is—I mean, being in the radio business, we sell advertisements—I can set a rate at whatever per commercial, but that doesn't mean I get it. And, yet, in your situation it is a little different because my clients don't have to walk in my door half dead and have to have a radio ad. It would be easier to sell, but collections could still be a problem. But in your case, that literally is what happens, and they can't negotiate that price, and that is why we are having this hearing, is to say is this system working? Is it broken? And it sure seems like there are some problems. And you are addressing some of them, I think we have all given you credit for that, but what is that differential between charge master and actual cost of delivering the service? What is the right price point, Medicare+40 percent? Is that even a realistic way to do it?

Mr. BOVENDER. Well, it would be a realistic way, but I think a better way was the second suggestion, which is to peg the price for the uninsured and do it on possibly a DRG rate, or a case rate, a diagnostic rate, but peg it to a percentage of your average managed care contract either in a specific market or nationwide. And as I said, we are looking at a price point somewhere around the 95th percentile of all of our managed care contracts. You have got to be careful in setting that because, obviously, any managed care provider above that is going to want at least as good as what the uninsured is getting.

Mr. WALDEN. They are going to tell you that minus 3 percent.

Mr. BOVENDER. Well, it sounds easy to say, well, just fix your charge master. It has to be fixed for the uninsured, which it needs

to be done, but it has to be fixed also taking into account that we have got 5,000 managed care contracts to renegotiate over the next year to 2 years.

Mr. WALDEN. I understand that. Anybody else want to comment on that? Mr. Lofton?

Mr. LOFTON. That approach makes a lot more sense because it will allow the rate to be market-specific, and it will be on a market rate tied to something that is realistic, as opposed to picking numbers out of the air because when you have managed care contracts, as Jack says, then they don't want someone else coming in paying much lower than what they will be paying. So, it would allow for whatever the market rate is in a given community, it would be tied to what is the customary rate being paid.

Mr. WALDEN. What about in—you don't always have managed care contracts, though, in all communities, do you, in the really rural communities? Isn't there a lack of managed care in some cases?

Mr. LOFTON. Yes, for the most part. The word is generally used from a more generic standpoint.

Mr. WALDEN. Than traditional—okay. I guess the reason I am trying to probe and get at the bottom of this is, there is enough pressure built up that if you all don't figure it out, I am afraid we will, in a way that may not work, and that isn't good for the delivery of health care in my community or anywhere else. But it is also hard for us to go back and say, "Sorry, you don't have insurance and you are going to pay three times the amount and they are going to take your house." I mean, you are correcting some of those. I appreciate your comments, and I have used up my time. Thank you, Mr. Chairman.

Mr. GREENWOOD. Are you sure you want to yield back all 3 seconds of your time?

The gentleman from Los Angeles, Mr. Waxman, is recognized for 10 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman, from Bucks County. Gentlemen, the American Hospital Association has established a set of principles and guidelines regarding a more humane way to deal with this problem, and the way they will do billing and collection practices. And they have asked hospitals to adopt these. But it is one thing to ask for a pledge and another to be sure the pledge is carried out.

Will the American Hospital Association discipline members who don't follow the guidelines? How can we be sure they are enforced if we don't adopt legislation, but rely on the industry to police itself? Anybody want to respond to that?

Mr. LOFTON. Well, CHI's system supports the pledge that the American Hospital Association promulgated. One hundred percent of our hospitals approved the pledge, and that was done at a local level, gaining approval from their local board of directors.

The follow-up to that is such that we have to implement audit processes to ensure that the pledge is being carried out not just from an audit perspective, but we also are looking for our system to include patient billing into our patient satisfaction review. That had not been a component previously. So, there are ways that you can monitor this on an ongoing basis, and we plan to do that.

Mr. WAXMAN. Why don't we just go quickly down the line. Are all of you going to abide by the American Hospital Association guidelines?

Mr. TERSIGNI. Yes. As I indicated in my testimony, we have asked all of our CEOs, CFOs, and BP submission to sign an affidavit that will abide by our policy. We will then bring an audit process in to make sure that they are in compliance.

Mr. BOVENDER. Yes, we will comply with it.

Mr. WAXMAN. Dr. Pardes?

Mr. PARDES. Yes, Mr. Waxman, we will comply, and we will make sure it is implemented in our institutions.

Mr. WAXMAN. Mr. Fetter?

Mr. FETTER. Yes. I signed the pledge on behalf of our hospitals, due to the investor-owned nature of our company, I can ensure that it will be complied with, as well as our internal policies.

Mr. WAXMAN. Thank you. In our first panel, we heard from Mr. Rukavina, and he outlined the difficulties his organization had in attempting to get information about the billing practices for HCA and Tenet. He said it took him more than 6 months to get a copy of your policy. I would like to know why that took so long, and whether you have a policy in effect today, and how you are ensuring that it is being carried out. Mr. Fetter?

Mr. FETTER. Two clicks on our Web site leads you to our policy, so it is relatively easy and simple. It is also posted in our hospitals and the Compact With the Uninsured is distributed in leaflet form as well as poster form at points of service within our hospitals.

Mr. WAXMAN. Mr. Bovender?

Mr. BOVENDER. We are making wide dissemination of our discount policy. In fact, I have met with my staff within the last week to make sure that it is getting much wider dissemination than it has in the past. I think the problem, as I was told, with the 6-month lag in his being able to get our policy was that when it was first asked for, it still had not been approved and implemented.

Mr. WAXMAN. Do you know why, Mr. Fetter, it took so long? Six months he was asking for meetings, no one responded. In fact, this is what he said. He called Tenet and HCA Healthcare Systems, and he said both you had "announced with fanfare programs to help the uninsured with discounts and sliding scale." And he asked the company to give him a copy of this policy which they had announced. Made another request a month later. Finally, 6 months later, he went in to find out what was going on and asked for a community meeting, but the leaders—I think it was in Florida—do you have any idea about that?

Mr. FETTER. I really am not aware of that. Are you sure he is referring to Tenet, because it is quite available.

Mr. WAXMAN. Is there another Tenet?

Mr. FETTER. Well, I don't know the specifics of his——

Mr. WAXMAN. Mr. Fetter, you indicated in California that it is different because of regulatory problems. I hadn't heard from other California hospitals that this was a problem. What specifically is the issue in California?

Mr. FETTER. The problem—and I am repeating here legal advice that we received—but it relates to insurance regulations. I have been informed that the California Health Care Association, which

represents hospitals, has brought this to court to seek clarification, and we do expect that it will be resolved sometime relatively soon. As an interim measure, we have expanded our charity care policy within California.

Mr. WAXMAN. Would you submit that letter so that we can have it for the record?

Mr. FETTER. Yes.

Mr. WAXMAN. I wonder if any of you would comment on the issues you see for your institutions if HSAs and high deductible plans become a major way people are provided insurance coverage in this country. What will it mean for the financial viability of your institutions? Any of you want to comment on that?

[No response.]

Well, let me ask it this way. Is it fair to ask you to provide discounted rates for persons during their period of no coverage before the high deductible plans kick in? Any of you have any views on that?

Mr. BOVENDER. My view on HSAs is that if they bring more people in with insurance, even if it is catastrophic insurance, that is helpful. My big fear, though, is that the high deductibles and co-pays are going to increase the level of our bad debts, just said very simply and shortly.

Mr. WAXMAN. You are worried about it increasing the amount of bad debt?

Mr. BOVENDER. The higher levels of co-pays and deductibles is going to increase the level of our bad debts.

Mr. WAXMAN. And why is that the case?

Mr. BOVENDER. Because the first $2,000 has to be assumed by the patient, and assuming they haven't accumulated that amount in their savings account, then we are exposed to that whereas they may have been in a—some of them, at least—in a health insurance plan before that had a $250 deductible or $500 deductible.

Mr. WAXMAN. Do you think if you discount the bills during this period, you are helping the individual, or protecting the insurer by lengthening the time before their coverage kicks in? If you give a discounted rate to somebody who has a high deductible, are you helping the individual by giving him a discounted rate, or are you simply allowing the insurance company not to negotiate a price with you to ensure that you are going to actually be paid?

Mr. BOVENDER. I think the answer is that we absorb more and more of the cost of the care. The insurance company, nor the employer, nor the patient is absorbing it in those circumstances.

Mr. WAXMAN. You would absorb most of the cost of that.

Mr. BOVENDER. Yes.

Mr. WAXMAN. Well, this hearing clearly has identified several issues. One, people without insurance are charged the very highest rate for services. Two, the charge structure of hospitals no longer bears any sensible relationship to cost, if it ever did. And, three, people faced with high bills beyond what they can afford have been the victims of indefensible collection policies in too many instances.

I think all of you agree health insurance coverage is the best and probably only effective way to deal with this problem. Policies to assist people of limited income to forgive bills, to help arrange payment policies that are affordable can help, but I want to con-

centrate on another piece of the problem—billing the uninsured on the basis of a charge structure that makes little sense and that clearly means the uninsured are billed at the highest rate. Isn't it time to move away from bills based on charges that make little sense? How can we move to a billing that is more closely related to the cost of service? And whatever rate you set, if they are uninsured and they don't have the money, you are not going to be able to collect it. Any of you want to respond to those points?

Mr. TERSIGNI. We would support that premise from the standpoint that we need to move, and we have been moving in this industry from a cost-based to competition-based pricing, and I think that brings some reality to the present situation.

Mr. LOFTON. From the standpoint of the uninsured, it makes perfect sense. We generally, right now, only collect about 7 percent of our revenue comes from that population. So, the change in terms of the dollars would not be really substantial. And then when you look at this or HSAs, those are still slices of the whole pie, and we still have to come back to the 40 million people that are not insured.

Mr. WAXMAN. Anybody else want to comment?

[No response.]

So, in the ultimate sense, then, if you are going to get your money, it is far better to have somebody with insurance.

Mr. PARDES. Yes.

Mr. WAXMAN. And all the other things don't really account for much, it just tinkers with how much bad debt you are actually going to absorb.

Mr. PARDES. Not only is it better to have the insurance, but it also provides the individuals with dignity when they walk into the hospital.

Mr. WAXMAN. And for those who have these high deductibles, to you it makes no difference, it is just most likely going to be another bad debt.

Mr. BOVENDER. Could be.

Mr. WAXMAN. Unless they are higher income people.

Mr. BOVENDER. Right.

Mr. WAXMAN. Do you have trouble collecting from these higher income people?

Mr. BOVENDER. Sometimes.

Mr. PARDES. I think it is important to recognize that there are some high income people and some international patients who do pay full charges, and as a result of that, there is a certain amount of cost optimization. For hospitals like those of us in New York in which 90 percent of the hospitals are below 1 percent margin, that is very important.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. GREENWOOD. The Chair thanks the gentleman. The gentleman from New Jersey, Mr. Ferguson, is recognized for his inquiry.

Mr. FERGUSON. Thank you, Mr. Chairman. I have a few questions for Dr. Tersigni. Doctor, first of all, you said this is your fourth day on the job?

Mr. TERSIGNI. Yes, it is, Congressman.

Mr. FERGUSON. Congratulations to you. Clearly, you learn something quickly in your fourth day on the job, which is it is good to bring the Nun.

I went to Catholic school. It is always a good idea to bring the Nun.

Mr. TERSIGNI. I am still on probation, Congressman.

Mr. FERGUSON. Good decision. Dr. Tersigni, you talked about your new policies and some of the procedures you go through with some of the uninsured. Is one of the things you do when you are dealing—when your hospitals are dealing with the uninsured is, do you ever help them or walk through with them finding public assistance in other ways perhaps, if they don't have their own insurance?

Mr. TERSIGNI. Yes, Congressman. As a matter of fact, the whole process of identifying and meeting with the patient to determine whether they are uninsured, whether they are financially needy, or whether they are just working uninsured, and then we begin the process of trying to identify for them whatever public funds, private funds are available, and we continuously do that through our financial counselors and our registrars.

Mr. FERGUSON. So part of the process in determining or trying to figure out some sort of payment or reimbursement is helping them to look through and find what public assistance might be available.

Mr. TERSIGNI. That is correct.

Mr. FERGUSON. Now, your new policy—you kind of outlined your new policy, and I know it is in your written testimony. I am assuming this is going to cost you money. This is going to affect your bottom line—your revenues, and possibly your bottom line. Do you have any estimates on that yet? Have you determined what this is going to cost?

Mr. TERSIGNI. We don't have any estimates at this point. We know that the present situation, we lost $222 million in 2003. We expect that to go up, but our mission——

Mr. FERGUSON. Was that a good year?

Mr. TERSIGNI. As a matter of fact——

Mr. FERGUSON. This is a tough industry.

Mr. TERSIGNI. [continuing] it has been rising. But, again, our mission is to care for the poor and the vulnerable in this country, to actually seek them out. And so we actually incent our CEOs of the Health Ministries to continue to grow the charity care that we provide in our communities annually, and I think there is some information in the testimony or in the information that shows that charity care has grown.

Mr. FERGUSON. Let me get that straight. You incent your executives to try and grow your charity care each year.

Mr. TERSIGNI. Correct.

Mr. FERGUSON. You try and find ways of providing more free health care.

Mr. TERSIGNI. More free health care. We try to find ways to take care of those who need to be taken care of, that are falling through the cracks. We have invested millions of dollars in 40 clinics, 175 programs across the country, specifically to deal with preventative care, primary care, and targeted for the poor and vulnerable.

Mr. FERGUSON. And I don't imagine that is necessarily good for the bottom line.

Mr. TERSIGNI. That isn't good for the bottom line, but——

Mr. FERGUSON. It is part of your mission.

Mr. TERSIGNI. [continuing] it is part of our mission.

Mr. GREENWOOD. Would the gentleman yield just for a second. I just want to be clear. There is a portion of charitable care for which you get reimbursed. So, I want to be clear that we are not saying—are you saying that you incent your executives to actually lose money, or to be able to get as much money into a pot that gets reimbursed by the Federal Government?

Mr. TERSIGNI. Actually, it is for charity care. We exclude the bad debt out of that $500 million that we have provided in 2003 for charity care and uncompensated care. So, we continue to seek out the poor and to make sure that we can begin—or hopefully help address a problem that is mammoth in this country.

Mr. GREENWOOD. Thank the gentleman for yielding.

Mr. FERGUSON. Of course. How do you communicate your charity care and your financial assistance policies to your patients, obviously, particularly to your uninsured patients that you serve?

Mr. TERSIGNI. Well, several ways. No. 1, we have signs and materials in multiple languages in our presenting station areas, whether it is emergency room, whether it is the clinics, whether it is our waiting rooms of surgery centers. We train our administrative personnel to make sure that as the patient presents, that we have dialog with that patient and direct them to the paraphernalia that we have relative to identifying what the policy is.

Mr. FERGUSON. There is a theme that has been suggested by some today, and elsewhere, that hospitals can make money on their uninsured patients. Now, obviously, there are uninsured patients who have the ability to pay, and I could see how for that portion of the uninsured population it is possible for a hospital to make money, so to speak, on the uninsured patients. But I have got to believe that, in the aggregate, it is difficult for a hospital to make money on uninsured patients. Is that accurate?

Mr. TERSIGNI. That is correct. As I indicated earlier, our average patient cost for caring for the uninsured is about $1376, of which we collect about $155.

Mr. FERGUSON. Along these lines, I wanted to address another question to the entire panel. Tenet operates about 100 hospitals, HCA about 190 hospitals, Catholic Health 68 hospitals, New York Presbyterian a handful of large health campuses, and Ascension 75 hospitals. Across almost 40 States you five systems have hundreds of men and women working daily with patients to understand and address their hospital charges. Consistent application of these policies and procedures is clearly crucial to making sure that they work. If your policies are not properly communicated to people, the policy is not particularly relevant.

Can each of you, in a few minutes that we have left, can each of you tell me the specific steps that your system is taking to make sure that, in effect, possibly hundreds of front-line employees know about and are applying consistently and equitably your billing and collection polices and procedures? Why don't we start with Dr. Tersigni.

Mr. TERSIGNI. I am happy to say that, No. 1, 103,000 of our associates understand our mission is to care for the poor and vulnerable, and we are in the process of reinforcing that by communicating with them out new policy, and making sure that we hold them as responsible as we hold ourselves to adhering to that policy and making it work.

Mr. LOFTON. All of our associates know that CHI takes care of patients regardless of ability to pay. We have a very strong process to roll out our core values across our system, which are reverence, integrity, compassion and excellence. And we have training for financial counselors along this line, so that they know that all of our patients are treated with proper respect and dignity and, as I mentioned earlier, all of our collection agencies, by the end of this month, will have been trained on the core values of CHI as well.

Mr. BOVENDER. Obviously, the practical problems of rolling out any policy of any kind in 190 different hospitals is difficult. One of the programs that we implemented, began implementing 3 years ago, was to consolidate all of our business office operations into ten regional revenue service centers, patient account service centers. This makes rolling out policies like this, and fixing problems, easier to do. It is easier to do it in ten different sites because the people at the hospital in the billing cycles and front-end, when they receive patients into the emergency room and in the hospital, are actually tied into these revenue service centers. So it makes training easier for us, and it makes implementation of these policies—and it also creates a better feedback loop where we find where problems have been created and how we need to fix those problems.

Mr. PARDES. We have been communicating our policies to all staff involved in admissions intake, anything related to these issues, Congressman, and disseminated to all the campuses. We have also disseminated to community agencies. We have put information in our emergency rooms and admission offices, so we are trying to disseminate them as widely as possible to ensure full compliance.

Mr. FETTER. Congressman, you raise an important challenge, and we have undertaken this by virtue of a very extensive communications and training program involving printed materials, written materials, materials that are communicated by the Intranet as well as conference calls.

Mr. FERGUSON. Mr. Chairman, I have a question I would like to submit for the record and ask for a written response, if I could submit that for the record, please.

Mr. GREENWOOD. Without objection, that will be the order.

Mr. FERGUSON. And I just want to close by thanking our panelists for being here today. I understand the hospital business is about the toughest—has got to be one of the toughest, if not the toughest, business to be in in America today. We hear it from our hospitals in our district. I am sure ours are no different from many hospitals around the country, particularly with the care and treatment that you provide Americans all over the country. We appreciate that. We appreciate the actions that you have taken to change some of your policies and procedures, and certainly encourage you, as you continue to implement those and find new ways of treating and caring for those who you care for, and we certainly appreciate

you taking the time to be with us at a very long hearing today. Thank you for being here, and thank you, of course, to the Nuns for being here, too.

Mr. GREENWOOD. The gentleman from Florida, Mr. Stearns, is recognized for 10 minutes.

Mr. STEARNS. Thank you, Mr. Chairman.

I was wondering if staff could put this graph up, and you folks could probably see it on the screens. What we have here, the staff has taken four of the hospitals at the dais here, the panels. One of them we didn't use. We took the four, and we tried to nominalize it by Medicare net revenues. It appears the cost of Medicare net revenues. We have blue, we have black, we have green, we have yellow, and red. And the importance of this is that Medicaid and Medicare are not too far from what appears to be the actual cost by the hospitals in question.

The third-party payer is a little higher. Now, obviously, that would be understandable because hospitals have to recapture a profit so they can capitalize to expand or to change and renovate and get new equipment and to keep up. But then the last, which is the red, is the uninsured amount billed. And we have on the first graph, 2000, then 2001 and 2002. So we are looking at a trend. Maybe we could argue about these graphs, you might not agree what staff did, but I think we see a trend in the red, which is the uninsured amount billed.

So the question I have for you folks is, if we go to 2003 and 2004, will this trend continue like this? In other words, will the red continue to go up, in your opinion? I would be glad to start with Mr. Lofton, the Catholic Health Initiatives. Would it be reasonable for me and the American public to say that this red line, which is the uninsured amount billed, is going to continue to go up? Just yes or no.

Mr. LOFTON. If I understand the graph, it is yes. But if I also look at the graph, it says Revenue, Cost, Revenue, Revenue, and then you get to Bill. So, I don't think we are comparing the same thing up there. If we talk about what is billed, if we look at the cost column, I don't think that that Medicare cost——

Mr. STEARNS. Okay, I will grant you that. I would agree that the cost, we could argue about that. I agree. But I am concentrating on the red line because, really, this is all about how this uninsured amount being billed is growing—not geometrically, at least—it is going up for the last 3 years, and then we have 2003 and 2004, and your opinion is probably in 2003 it is going to be higher, and in 2004 it is going to be even higher.

Mr. LOFTON. I would say it will be higher, but the actual experience for our system is that that group of patients, we only collect 13 cents on a dollar for.

Mr. STEARNS. Dr. Pardes, would you agree?

Mr. PARDES. I think that that would be true. I think that the costs of health care keep going up. Of course, the people who pay the full charges, Congressman, are, as I said, the well-to-do patients or international patients. We work individually so that the bulk of people who are not in those categories would pay far less.

Mr. STEARNS. Is there anybody on the panel that does not think that this trend is going up?

Mr. BOVENDER. I may need some clarification of your question, but if you are talking about the charges actually to the uninsured, given what CMS came out with about 3 weeks ago and said that we are allowed to do now, as I testified earlier, it is possible for us to go back and try to construct a charge system for the uninsured possibly based on case rate or a DRG basis, but to peg it to possibly the 95th percentile average of all of our managed care contracting. If we are able to do that, then obviously that red will not go up as fast. In fact, it would actually probably come down.

Mr. STEARNS. But your charge master rate, you can still use that.

Mr. BOVENDER. But the charge—as I testified earlier, the issue with the charge master is also separate. There is a separate component from the uninsured part, which is the managed care contracts we have that are pegged as a percentage of charges, and we have committed ourselves, as a company, to move away from percentage of charge contracting, and actually move to case rate or other basis for managed care contracts. But that will take us, as I testified, two, two and a half years because we have got over 5,000 contracts.

Mr. STEARNS. Now, isn't it true, when you have uninsured costs that are going up so much like that, at the end of the year, don't you take those uninsured costs and write them off against revenue?

Mr. BOVENDER. Well, the uninsured——

Mr. STEARNS. In other words, you try to collect the debt, and if you can't collect the debt, it is considered a bad debt, right?

Mr. BOVENDER. Correct, it is an expense.

Mr. STEARNS. It is an expense. So, if this graph continues to go up higher and higher, technically, you are going to be able to write that off as expense on your revenue, is that correct?

Mr. BOVENDER. Yes. I mean, it is a bad debt.

Mr. STEARNS. So the incentive here is not necessarily to control this because—and it appears from this that you are charging so much more relative to your getting reimbursed from Medicaid and Medicare, or even your third-party. So, you have this master rate that you are using, and I guess the question I have, what considerations go into the charges that make up that red? And why does it keep going so much higher than the yellow? I mean, the yellow seems to be stabilized here. That is the third-party net revenue. And yet the red continues to go up in almost quantum jumps here.

So my question is for each of you, what considerations go into this for the costs that make up these uninsured? I mean, how do you go about setting a charge rate for these? Let me start here on the right.

Mr. FETTER. Congressman, at Tenet Healthcare, as I mentioned, we have implemented this Compact With the Uninsured. So, with reference to your graph, the first point I would make is that our charges have been frozen since November 2002, so the orange bar would not continue to go up.

Second, as we implement——

Mr. STEARNS. So, under your—you are freezing it. You are saying 2003 and 2004—it is a red bar, but I understand—you are saying that bar would stabilize, it would not continue to go up.

Mr. FETTER. Well, actually, more importantly, under our discount plan that is part of the Compact With the Uninsured, the red bar—orange it looks to me—would approximate the level of the yellow

bar. But I think it is very important—Mr. Lofton made a very important point—no pun intended—the bars are comparing apples to oranges because you have billed and a billed amount on the——

Mr. STEARNS. I anticipated that. I am trying to make my argument in terms of trend.

Mr. FETTER. Right. I will answer with respect to our own company, the trend will be that the red bar all the way on the far right will drop substantially to approximate the yellow bar.

Mr. STEARNS. And, Dr. Pardes, you would agree, is yours going to drop?

Mr. PARDES. I am not sure that ours will drop in the same way that——

Mr. STEARNS. Because what we are going to do now is we are going to compute 2003 and 2004, so I want you to realize we are going to take the same information and try to see, for each of your hospitals, because your hospitals are up here, and we are trying to determine that. Let me go to my far left here. Would you care to comment, too?

Mr. TERSIGNI. I believe with our new policy, we are going to have all uninsured at the same discount from charges on our best-paying payer, so I believe that we will begin seeing a difference in that red bar.

Mr. STEARNS. What is the tax consequences of setting very high billing levels for the uninsured amounts billed, then writing them down? I mean, I touched on this, but in your own words, what are the tax consequences? I mean, just tell us for the—your bottom line and your profit, how this affects it. I told you what I thought it was. I would like, in your own words, basically with this huge amount of uninsured amount billed, and you are not getting it back reimbursed, how does this affect the bottom line?

Mr. TERSIGNI. Well, I can tell you, if our data is in that red line, our bottom line for that particular year is 1.7 percent of margin.

Mr. STEARNS. Now, if you didn't have that red bar, basically, you would pay more taxes, wouldn't you?

Mr. TERSIGNI. We are not-for-profit.

Mr. STEARNS. But if you were for-profit?

Mr. TERSIGNI. That information I wouldn't know. We haven't calculated that.

Mr. STEARNS. But, basically—Mr. Bovender, let me ask you that question. If this was not there, wouldn't you pay higher taxes? Just yes or no.

Mr. BOVENDER. No, I don't believe so because, if you didn't put the charges on, they wouldn't appear on the bottom line, to begin with. If you put the charges on, then take them off as a bad debt, it has no impact. The change in the bottom line, there is no impact.

Mr. STEARNS. So you are not writing off the uninsured bad debt on your revenue?

Mr. BOVENDER. Yes, we are, but if that revenue—if I understand your question, you are asking if those charges were smaller instead of large like you see them on the red side, is it not beneficial for us to inflate the charges and then just write off the bad debts, and that is not the case because, if you never put the charges on, you wouldn't be paying taxes——

Mr. STEARNS. But these uninsured are charges that you put on.

Mr. BOVENDER. But it does not affect whether you do not have the charges before the net revenue line or after the net revenue line does not affect the actual profits at the end of the day.

Mr. FETTER. Our company is the other taxpayer on the panel, and Jack's answer is correct. There is no tax impact of this level——

Mr. STEARNS. So you are saying that because you have a large uninsured and you can't collect it, it doesn't affect your profit at all?

Mr. FETTER. Well, it affects book income, but your tax impact is no different, regardless of where you set the charges for the uninsured.

Mr. STEARNS. But if you had a $100 million revenue and you had $10 million of uninsured and you couldn't get it back, you could take that $10 million and put it to the revenue and pay less taxes. I mean, every small business knows that, and that is what you have here with these red graphs.

Mr. FETTER. You are incurring the expense anyway, regardless of the patients. That is determined by——

Mr. STEARNS. But if the cost is a lot less than the red line, then you have got a bigger spread that you can use to write down your revenue. Instead of it cost you $10 and you charge $100, then you can write the $100 off instead of the $10.

Mr. FETTER. Respectfully, I don't believe it works that way.

Mr. STEARNS. Let me ask you this. For nonprofits, how much does your hospital save each year on taxes by virtue of your 501(c)(3) status?

Mr. LOFTON. I am not in a position to give you an answer for the whole system. As you know, the tax base is based on a State rate, but we don't compute that. We are in 19 States, and the amount of the tax would vary. I can tell you that in one of our markets in Carne, Nebraska, where we have a very sophisticated way of computing our community benefits, they have calculated that the amount that they would have approximated that we would have paid in taxes there is about $3 million versus the community benefit which is about $28 million. So we submit that the kind of things that we do—free clinics and other mission-based health care—where we provide free care far outweighs the amount that the tax would be, but I can't give you the total for the whole system.

Mr. STEARNS. If I could conclude, Mr. Chairman, just a quick comment, and I would say that I am very respectful—you folks are trying to make a living and make a profit, and how difficult it is, particularly, you have to take anybody that comes into your emergency room. But I am saying if you want to prevent Congress from coming in with the Hefley bill or any price controls, that red line can't continue to get bigger and bigger and bigger relative to the real cost, and that is what you folks have got to come up with an answer for us. We are trying to help you and to point out what we see as amateurs here, and your CEOs, you have got to come back to me and say, "Congressman, this is going out of sight, I am going to stop it, and this is what I am going to do, and I am going to reprice my master rule, and I am going to make sure this doesn't go any higher, and in so doing, I don't need you as a Congressman

to come in and legislate with price controls," and that is where you folks better get, I think, on the ball here and start to make those arguments and articulate them, instead of just arguing whether the staff has got that right normalization with the cost or any of these others. I mean, our attempt to understand this—the staff I think has done an excellent job just trying to show trends, and that is what I was trying to show. Thank you, Mr. Chairman.

Mr. GREENWOOD. The Chair thanks the gentleman and recognizes himself for 10 minutes, and I want to follow right on the gentleman's comments.

When we look at the red line, we look at what your master charges are, and we try to figure out why do they seem so absurdly high compared to your costs, and why are they rising at such a rate? Now, we know—and Dr. Anderson commented on it in the beginning—that there is a formula that CMS uses to take care of outliers from the DRGs. So, when a patient comes to a hospital, you are reimbursed on the basis of a DRG, but if there are complications, if there are unanticipated costs, you can, as I understand it, put those cases into an outlier pool and then be reimbursed by Medicare on a formula that is basically a cost-to-charge ratio, which puts the cost as the numerator and the charge as the denominator.

Now, it seems to me that that, in and of itself, would create a tremendous incentive for hospitals to set the charges as high as possible so that when it comes time to submit their data to CMS on a cost-to-charge ratio for reimbursement for outliers, that the reimbursement is maximized. Am I correct about that? Dr. Tersigni?

Mr. TERSIGNI. Mr. Chairman, I am not sure I quite understood the last part of the question.

Mr. GREENWOOD. Okay. When you have outliers from your DRG—in other words, as I understand it, there are CMS regulations that say that when you have specific cases in the hospitals, the cost of which significantly exceed certain parameters in comparison to the DRG, that you then get reimbursed using a different methodology than the DRG. You get reimbursed on the basis of—that gets called an "outlier." It gets put into a dataset of outliers, and then you submit a bill to CMS for those cases, and the basis of reimbursement is a function of the cost-to-charge ratio. Is anybody with me, have I got this right? The Nuns are nodding their heads "yes."

Anybody with me on this?

Mr. FETTER. Yes.

Mr. GREENWOOD. Would somebody comment, please? Do I have that right?

Mr. FETTER. It is close enough, I think.

Mr. GREENWOOD. All right. Help me out.

Mr. FETTER. Largely because of an outlier issue with Tenet Healthcare in late 2002, CMS undertook a change in the rules. Now, Tenet voluntarily adopted the rules that CMS ultimately promulgated——

Mr. GREENWOOD. Let me interrupt you. We will give you plenty of time here. But am I correct that it has long been, or ever since this regulation has been in place, an incentive for hospitals to set

charges high so that when they bill CMS, Medicare, for outliers from the DRGs, that they maximize their revenues?

Mr. FETTER. I was leading to a direct answer to the question, which is that prior to August of 2003 when CMS changed these rules, the system—I am ignoring a tremendous amount of complexity—but the system was set up in a way where rapid increases in gross charges did increase outlier payment. CMS made two important changes in the regulation that have essentially eliminated that incentive, as you describe it, or a reward that would accrue to the hospital from that type of behavior.

Mr. GREENWOOD. Because a part of my concern is that what we had—let us at least talk about prior to that regulatory change—you had this significant incentive to raise the charge for purposes of Medicare reimbursement, and you had to be able to say with a straight face, "Yes, that is what we charge people," and the only people that got charged that were people who were uninsured. So the poor schmuck who is uninsured gets ground up in the gears created by the CMS system that creates an incentive for you to have high charges. Do I have that right or wrong?

Mr. FETTER. I believe that problem was fixed, though.

Mr. GREENWOOD. I understand, but wasn't that the way it was—isn't that what happened?

Mr. FETTER. I might not choose the same adjectives, but you essentially have it.

Mr. GREENWOOD. It wasn't an adjective, it was a noun, "schmuck."

Look it up. But the fact of the matter is that people got ground up in the system, I think, because of that. Now, the question then remains, do incentives remain for you to have charges that are quite high, from which you have to create a discount so you don't overcharge the poor uninsured person. For instance, if you have an automobile accident patient come into your emergency room, and you are going to have a settlement, and you are going to get a subrogation out of that, and then you can bill the auto insurance company charges. Is that an existing incentive to have high charges?

Mr. FETTER. I don't believe the incentives continue to exist, but as Mr. Bovender pointed out earlier, because so many managed care contracts are structured based on these charges, it is very difficult to reduce the charges or address the charges in that other type of way. There is no incentive to have, on an absolute basis, high charges.

Mr. PARDES. The one concern we would have, Mr. Chairman, is that we not necessarily decrease charges for international patients or well-to-do patients who can handle the charges.

Mr. GREENWOOD. Yield to the gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman. We are trying to avoid holding you here while we have our next series of votes. I just want to ask a couple questions of Dr. Pardes, and if you will take a look at Tab 21—there is a notebook over there, do you see that, Tab 21? Is that your policy on how you are going to deal with the uninsured?

Mr. PARDES. There is a whole lot of page here. I can tell you how we are going to deal with the uninsured.

Ms. DEGETTE. Well, take a look at this Tab 21, is this your policy? I can represent to you——

Mr. PARDES. These are policies that—yes.

Ms. DEGETTE. These are the policies you have currently in effect? Are they currently in effect?

Mr. PARDES. Not necessarily. I think they have been updated.

Ms. DEGETTE. They have been updated. The date on this at the bottom is 1995 to 2002. Have they been updated since then?

Mr. PARDES. Yes.

Ms. DEGETTE. All right. When were they updated?

Mr. PARDES. In early 2004.

Ms. DEGETTE. In early 2004. Did you provide this committee with the updates of the policy? You lawyer is nodding "yes."

Mr. PARDES. I believe we did.

Ms. DEGETTE. I don't believe we have those updates. Would you please, sir, supplement—we don't have those updates unless they are under Tab 21, so would you please supplement your response with that?

Mr. PARDES. Sure.

Ms. DEGETTE. I am going to ask you a couple of questions very quickly. In this policy which is in Tab 21, it says that—at the bottom, right-hand, NYPH0001520, it is sort of about two-thirds of the way back in the document, do you see that?

Mr. PARDES. Yes.

Ms. DEGETTE. Now, it says there, "Attempt to obtain payment in full and settle the account. The second priority of a representative"—first, they are supposed to get insurance. Then if there is not insurance, "The second priority of a representative dealing with self-pay accounts is to settle the account balance of the patient. First settlement offering is 100 percent of the estimated account balance at discharge." Is that still your policy, Dr. Pardes?

Mr. PARDES. Our policies have been reworked——

Ms. DEGETTE. So none of these policies in here are still your policies?

Mr. PARDES. The policies, as we said before, were updated as of the beginning of 2004.

Ms. DEGETTE. But are they all new? Is this still your policy and, if not, what is your policy?

Mr. PARDES. Our policy is, first of all, to try to get as many patients——

Ms. DEGETTE. No, no. Do they still offer them 100 percent of the estimated account balance at discharge?

Mr. PARDES. I am sorry, say again?

Ms. DEGETTE. You know what, Mr. Chairman, I am going to ask unanimous consent to ask this witness some written questions and to have him respond within 20 days of this hearing because I have a number of questions about New York Presbyterian and Columbia Presbyterian's policies that relate to patients, and we have not been given the current policy.

Mr. PARDES. We would be happy to respond to that.

Ms. DEGETTE. Thank you. Let me just ask a couple—is that all right?

Mr. GREENWOOD. Yes, the gentleman has agreed to respond to questions that you submit in writing. They will become a part of the record.

Ms. DEGETTE. All right. I will just do that, Mr. Chairman, given the time.

Mr. GREENWOOD. We will add that to the record. The Chair would note that we have 5 minutes and 13 seconds to go over to the Capitol and undertake a series of votes, which will take well more than a half an hour, and what we have tried to do, we have debated whether to make you sit here for half an hour and come back and grill you for another hour or so, and we have decided that you have been saved by the bell. So, we thank you for your testimony. WE thank you for your time this afternoon. We thank you for all of the voluntary reforms that you have done. We are going to continue our work, we are going to continue to work with you. We may even ask you to come back at another date, but for this evening you are dismissed. Thank you.

The committee will recess for 30 minutes.

[Brief recess.]

Mr. GREENWOOD. The Chair thanks the witnesses for their patience. I know it has been a long day for you, as it has for us. As you both know, the committee takes its testimony under oath. Do either of you have objection to giving your testimony under oath?

Mr. KUHN. No.

Mr. MORRIS. No.

Mr. GREENWOOD. You are entitled to be represented by counsel, pursuant to the rules of the House. Do either of you wish to?

Mr. KUHN. No.

Mr. MORRIS. No.

Mr. GREENWOOD. Would you please stand and raise your right hands?

[Witnesses sworn.]

Mr. GREENWOOD. You are under oath. Mr. Kuhn, you are recognized to make your opening statement. Welcome.

TESTIMONY OF HERB KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND LEWIS MORRIS, CHIEF COUNSEL, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUHN. Thank you, Chairman Greenwood and members of the committee. I appreciate you inviting me to speak today about the Centers for Medicare and Medicaid Services regulations and how they affect hospitals and the ability to bill patients who are underinsured or uninsured.

Medicare and Medicaid provide health insurance for more than 80 million Americans. I would like to state right from the start that the provider reimbursement rules for those programs in no way restrict the ability of hospitals and other providers to offer free or discounted care to patients who are either underinsured or uninsured. The Medicare program provides flexibility to those providers who choose to offer discounted care to patients.

CMS has been closely involved with hospital billing for the underinsured and uninsured. A year ago, we received a request from some hospitals for guidance on whether it was permissible to discount charges to low-income uninsured or underinsured patients. After providing guidance to these hospitals, CMS began discussions with your staff in the Fall of 2003. In December of 2003, Secretary Thompson received a letter from the American Hospital Association that alleged that Medicare program rules, as well as restrictions imposed by the HHS Office of Inspector General hindered the ability of hospitals to provide discounts to low-income patients or to patients who were medically indigent. Secretary Thompson responded to the AHA letter in February and subsequently responded to a letter and request for information from this subcommittee.

Earlier this month, we held an open-door forum to provide a detailed overview of our policy in this area, and to allow providers to raise any additional questions or concerns. Of course, providers and their representatives should feel free to contact us at any time should they need guidance in this area.

Mr. Chairman, when CMS provides guidance on this issue, we have found that there are three main areas of concern. The first area is discounts and how they may be used. Medicare billing requirements do not prevent discounts as long as full charges, not discounted charges, are reported on the Medicare cost report. To provide discounts, providers must maintain accounts and records in a manner that would be necessary for any business. The program's rules have attempted to prevent the Medicare program from subsidizing a service that should be paid for by another provider, or preventing another provider from subsidizing a service the Medicare program should be reimbursing.

The second area of concern is indigency. Medicare indigency requirements do not prevent discounting to uninsured patients provided a few requirements are met. Providers may make indigency determinations using their customary method, but to protect all patients in the Medicare program, the methods used in determining indigency for non-Medicare patients should be similar to those for Medicare patients. Any indigency determination should be supported by documentation and be determined on a patient-by-patient basis because financial need is specific to each and every patient.

Hospitals set their own indigency policy and have the discretion and flexibility to define eligibility, including income level. This makes sense because hospitals are in the best position to know what their community needs are.

The third area of concern is Medicare's rules regarding bad debt. These rules do not require providers to aggressively collect unpaid bills. The rules do require efforts to collect from non-Medicare patients to be similar to those efforts for Medicare patients. This is designed to protect the integrity of the program if hospitals are seeking Medicare bad debt reimbursement.

We often hear from hospitals that Medicare somehow requires aggressive collection efforts that include attaching a patient's home, use of a bill collector, or other similar tactics. This is simply not true. The program does require, however, that if the hospital wants to bill the Medicare program for bad debt related to unpaid

deductibles and co-insurance by Medicare beneficiaries, it must use the same level of collection activity to secure collection of those debts by Medicare patients as it does to secure collection of debts by non-Medicare patients. Simply stated, the collection of Medicare and non-Medicare debts need to be treated similarly.

Mr. Chairman, thank you for this invitation to testify this evening. I want to acknowledge the subcommittee for its efforts in bringing to the forefront the problem of providing quality health care for patients of limited means. I applaud you for making this important issue the focus of your hearing today, and I will be happy to answer any questions that you may have.

[The prepared statement of Herb Kuhn follows:]

PREPARED STATEMENT OF HERB KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Greenwood, Rep. Deutsch, thank you for inviting me to speak with you about the role the Centers for Medicare & Medicaid Services plays in how hospitals and other Medicare providers bill patients who are uninsured or under-insured. I want to acknowledge the Subcommittee for their efforts in bringing to the forefront the problem of providing quality health care for patients of limited means and I applaud you for making this important issue the focus of your hearing today.

Combined, the Medicare and Medicaid programs provide health insurance for over 80 million Americans. The provider reimbursement rules for those programs "should in no way restrict the ability of hospitals and other providers to offer free or discounted care to patients who do not have coverage under these two programs. I am here today to talk about how the Medicare program provides the flexibility for providers to do so if they choose.

Hospital billing for the uninsured and underinsured is a very timely issue and an issue in which CMS and, in particular, the Center for Medicare Management, which I direct, have been deeply involved for over a year. It was a year ago that we received a request from some hospitals in the country for guidance on whether it was permissible to discount charges to low income uninsured or under-insured patients. Some months later, after responding to numerous inquiries on the issue, CMS began discussions with your staff in the fall of 2003. In December of 2003, Secretary Thompson received a letter from the American Hospital Association that alleged that Medicare program rules, as well as restrictions imposed by the HHS Office of Inspector General, hindered the ability of hospitals to provide discounts to low-income patients or to patients who were medically indigent. Secretary Thompson responded to the AHA letter in February, and subsequently responded to a letter and request for information from this Subcommittee. CMS also briefed your staffs in preparation for this hearing.

There are three central topics that most commonly arise when providing guidance on this issue. I'd like to address those topics for you today. Then, to conclude, I'd like to say a few words about what the Medicare and Medicaid programs are currently doing to assist hospitals that treat the uninsured. Finally, I'd like to conclude by mentioning the many initiatives that the Administration has taken to reduce the number of uninsured.

Three Topics of Focus on Billing the Uninsured

- **Discounts:** Medicare billing requirements do not prevent discounts as long as:
  - Full charges, not discounted charges, are reported on the cost report.
  - Accounts and records are maintained in a manner that would be necessary for any business.

Indigency

- Medicare indigency requirements do not prevent discounting to uninsured patients.
  - Providers may make indigency (including medical indigency) determinations using their customary methods.
  - In order to protect all patients and the Medicare program, the methods used in determining indigency for non-Medicare patients should be similar to those used for Medicare patients.
  - Indigency should be supported by documentation (good business practices would dictate that).

- Indigence should be determined on a patient-by-patient basis because financial need is specific to each patient.
- Medicare does not reimburse the bad debts of non-Medicare patients.
- Once indigence is determined, collection is no longer undertaken with regard to the patient for the forgiven amount.

Bad Debt

Medicare does not require providers to be aggressive in their collection of accounts. Medicare rules state that:

- Efforts to collect from non-Medicare patients must be similar to the efforts to collect from Medicare patients. Medicare wants parity in the treatment of Medicare and non-Medicare patients to protect the program and all patients, not just our beneficiaries.
- Efforts to collect on accounts should be more than a token effort. Rather, they should be positive efforts that would be used in any business.

Since the enactment of the Medicare program in 1965, the program's rules have attempted to prevent "cross-subsidization"—in other words, preventing the Medicare program from subsidizing a service that should be paid for by another payor, or preventing another payor from subsidizing a service the Medicare program should be reimbursing. One way that Medicare's regulations do that is to require hospitals to list their stated charges for a service on their cost reports for a service and maintain a uniform charge for a service. To repeat, nothing in CMS regulations prevents a hospital from providing a discount off of that stated charge. But when filing its cost report, the hospital must list its full charges.

Without question, a hospital can provide free care or discount charges to uninsured or underinsured patients. As we noted in our response to the American Hospital Association, "[n]othing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from offering discounts to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals."

In reference to the ability of a hospital to develop an indigency policy, it may be overstating matters to say that the Medicare program imposes a "restriction" on this. Hospitals—not the federal government—set their own indigency policies and have the discretion and flexibility to define eligibility indicators including income level. This makes sense because a hospital, as a community institution, is in the best position to know what policy best suits the community that it serves.

As I have stated earlier, if a hospital wishes to provide a discount off of its customary charges as part of an indigency policy, it can do so, but it must report the **full charge** for that service on its Medicare cost report.

Turning to the issue of bad debt, we often hear from hospitals that Medicare somehow "requires" aggressive collection efforts that include attaching a patient's home, use of a bill collector, and other similar tactics. The reality is otherwise. The Medicare program does not require any particular level of collection activity. It does not require that collection activities be "aggressive." It does not require that hospitals seize patient's homes or bank accounts. What the program does require, however, is that if the hospital wants to bill the Medicare program for bad debt related to unpaid deductibles and coinsurance by Medicare beneficiaries, it must use the same level of collection activity to secure collection of those debts by Medicare patients as it does to secure collection of debts by non-Medicare patients. For example, if a hospital wants to use a bill collection agency for its bad debts, it cannot turn only non-Medicare patient bills over to that collection agency; rather, the hospital must treat all bad debts the same. The principle, again to prevent cross-subsidization, is that collection of Medicare and non-Medicare debts need to be treated similarly.

In addition, a hospital may make an individualized indigency determination for a particular Medicare patient and excuse that patient from any efforts to collect unpaid deductibles and coinsurance. Doing so would not prevent the hospital from collecting Medicare bad debt payments from other payors on those unpaid amounts, provided the hospital treats all indigent patients the same. This is also true if the patient is a dually-eligible Medicare and Medicaid beneficiary. In such a case, the hospital would submit a bill for the unpaid deductible and coinsurance amounts to the state Medicaid plan. If the state Medicaid plan was not liable and denied payment on the account, the hospital could bill the Medicare program for it as a bad debt.

It is also important to note that in very limited circumstances, Medicare reimbursement could be affected by the "lesser of cost-or-charges," or "LCC" principle. This principle was of significant importance in the early years of the program, but is admittedly less so now that most providers are reimbursed on the basis of a pro-

spective payment methodology rather than on the basis of costs. However, where the LCC principle is applicable, a Medicare provider is paid the **lesser** of its actual costs or its actual charges. Implementing a reduced charge program for uninsured patients could potentially trigger the LCC principle because if a hospital lowered charges for enough patients, a hospital's fiscal intermediary could take the position that a hospital's charges were not its posted, or stated, charges, but rather, the charges applicable to most of its patients who were receiving discounted services. If the FI did take that position, it could then invoke the LCC principle and pay the hospital that lower charge-based amount.

Few providers are subject to the principle at all. The only example I am aware of is a pediatric or cancer hospital in its first year of operation, before it becomes subject to the TEFRA methodology, because there are no base year costs upon which to calculate a TEFRA target rate limitation. Other providers, including critical access providers, are not subject to the LCC provision.

The Office of Inspector General Guidelines

I cannot speak for the Office of Inspector General (OIG), but I will note that shortly after we released our letter to the AHA, the OIG put on its website a document addressing the application of its fraud and abuse authorities to discounts for uninsured patients and cost-sharing waivers for financially needy Medicare beneficiaries.

Lewis Morris, the Chief Counsel to the Inspector General, is here with me today to address the OIG's perspective on these issues.

Funding Programs for Uninsured Individuals

CMS has done its share to reimburse hospitals for the treatment of uninsured individuals. Since 1986, select hospitals have received reimbursement under the Medicare disproportionate share (DSH) program. Hospitals qualify for Medicare DSH payments if they treat a "disproportionate share" of low-income patients—defined in the statute as the share of a hospital's total inpatient days attributable to Medicare patients who are also eligible for SSI compared to all Medicare patients plus days attributable to Medicaid patients compared to all patients. As I mentioned above, Medicare also reimburses hospitals for the bad debt that arises from treating low-income Medicare beneficiaries who are unable to pay their cost sharing and deductible amounts. Finally, the Medicaid program requires states to designate certain hospitals as disproportionate share under their state Medicaid plans, and make additional payments to those DSH hospitals. The Medicaid DSH program is also advantageous for states because DSH payments to a hospital under a state plan are not counted in determining whether or not the state has breached the Medicaid upper payment limit, thus enabling states to increase payments to other providers participating under their state plan.

Other Administration Initiatives for the Uninsured

In addition to providing the guidance to hospitals on the uninsured, this Administration has undertaken other initiatives to address the plight of individuals who otherwise lack access to health insurance or who may be under-insured. For example, the Administration has dramatically increased funding to federally qualified community health centers, the "front line" treatment option for low-income uninsured individuals. The Administration provides an advanceable health coverage tax credit to certain individuals who are receiving a pension from the Pension Benefits Guaranty Corporation or who have become unemployed due to the adverse effects of international trade and are eligible for Trade Adjustment Assistance. This tax credit pays 65% of the premium for qualifying health insurance, including either employer-sponsored "COBRA" coverage or a state-designated private health insurance plan. The Administration's Medicaid waivers, state plan amendments, and HIFA waivers have provided health insurance for 2.6 million people who would have otherwise lacked coverage, and enhanced existing benefits for nearly 7 million individuals.

Many of you in Congress voted for and deserve credit for the provisions in the Medicare Modernization Act that will revolutionize health savings accounts and help make insurance more affordable for millions of Americans. In addition to creating a Medicare prescription drug benefit and providing interim savings and subsidies through Medicare-approved discount cards, this historic legislation allows people to establish health savings accounts (HSAs) in conjunction with affordable, high-deductible major medical coverage. These new products will make health insurance more affordable to businesses large and small, as well as to individuals whose employers do not sponsor coverage. The President has proposed to provide further assistance to such individuals by allowing them to claim an above-the-line deduction of the major medical insurance premiums.

For working individuals and families who would not benefit from tax deductibility because their incomes are too low, the President has proposed $70 billion in refundable, advanceable tax credits. He also proposed allowing expanded use of association health plans that allow small businesses to more easily pool resources to purchase health insurance. Combined with the steps that we have already taken, enactment of these and other measures will further reduce the number of individuals without health insurance in the United States.

Mr. Chairman and Congressman Deutsch, thank you for your invitation to testify this morning. I am happy to answer any questions that you may have.

Mr. GREENWOOD. Thank you, Mr. Kuhn.

Mr. Morris.

TESTIMONY OF LEWIS MORRIS

Mr. MORRIS. Thank you. Good evening, Mr. Chairman. I am here today to discuss the Office of Inspector General's views on the discounts that hospitals offer to uninsured patients and to others who are unable to pay their hospital bills. Simply put, the fraud and abuse laws enforced by the OIG allow hospitals to offer discounts to patients who cannot afford to pay for their care. Indeed, our legal authorities have virtually no application to the discounts offered to uninsured patients.

When the patient's health care is covered under a Federal health care program, such as Medicare and Medicaid, our legal authorities have greater relevance. But even then the laws clearly establish that hospitals are able to help patients who are experiencing financial hardship. Today, I will begin by describing why the fraud and abuse laws have virtually no relevance to hospitals offering discounts to uninsured patients, and then I will describe how a hospital may reduce or waive cost-sharing amounts for Medicare or Medicaid beneficiaries experiencing financial hardship.

I would note that while today's presentation focuses on discounts that hospitals offer to uninsured and financially needy patients, the underlying principles apply equally to the rest of the health care industry.

It has been suggested that the fraud and abuse laws, particularly the anti-kickback statute, prevent hospitals from offering financial assistance to patients who do not have health care coverage. At best, this view reflects a misunderstanding of the law. For the millions of uninsured citizens who are not referral sources, the anti-kickback statute simply does not apply. In other words, giving something of value, such as a discount on hospital charges, to an uninsured patient does not implicate the anti-kickback statute except in the most unusual situation where the uninsured patient is in a position to generate Federal health care business, such as a physician. In short, no OIG authority or policy should deter hospitals or others from offering financial relief to uninsured patients.

I will now address a hospital's ability to offer discounts to financially needy Medicare and Medicaid beneficiaries. Simply put, the law allows hospitals significant flexibility to help financially needy Medicare and Medicaid beneficiaries. For these patients, a discount generally takes the form of some or all of a co-payment or deductible waiver—that is, the portion of the bill that the beneficiary owes.

In 1996, Congress passed a law that prohibits a provider from offering a Medicare or Medicaid patient anything of value, including

waivers of cost-sharing amounts, that is likely to influence the selection of a provider of Medicare or Medicaid services. This law was necessary to curb abusive arrangements under which providers would pay patients to obtain services, often services which were unnecessary, overpriced, or substandard. However, Congress recognized that some beneficiaries might not be able to afford their cost-sharing amounts. The statute does expressly allow providers to waive these amounts on the basis of financial need. The exception has three requirements. The waiver may not be routine, the waiver may not be offered as part of an advertisement or solicitation, and the waivers may only be made after determining in good faith that the individual is in financial need or that reasonable collection efforts have failed. This exception is available to hospitals and others that want to provide relief to Medicare and Medicaid patients who cannot afford their cost-sharing amounts.

The OIG also has a long-standing and well-publicized position supporting such financial hardship waivers. For example, the ability to forgive Medicare cost-sharing amounts is discussed in a 1992 OIG special fraud alert on this topic. That fraud alert, as well as a wealth of guidance and other information about these issues, is available on the OIG's Web site. In short, the fraud and abuse laws clearly allow hospitals to provide financial relief to Medicare and Medicaid patients who cannot afford their cost-sharing amounts.

In conclusion, the OIG fully supports efforts to assure that a patient's financial need is not a barrier to health care. Our laws allow hospitals to offer bona fide discounts to uninsured patients as well as Federal health care beneficiaries who cannot afford their health care bills. Frankly, we do not know why lawyers advising hospitals would tell them that the fraud and abuse laws are an impediment to discounts to the uninsured. Such discounts do not violate the fraud and abuse laws. We have never taken any enforcement action in this area. And, finally, we have issued guidance as early as 1992 suggesting otherwise.

Mr. Chairman, thank you for the opportunity to present the OIG's views on these issues.

[The prepared statement of Lewis Morris follows:]

PREPARED STATEMENT OF LEWIS MORRIS, CHIEF COUNSEL TO THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and Members of the Subcommittee. I am here today to discuss the Office of Inspector General's (OIG's) views on the discounts that hospitals offer to uninsured patients and to others who are unable to pay their hospital bills. We understand that there is widespread concern about hospitals' billing and collection practices as those practices affect patients who cannot afford to pay their hospital bills. I—want to assure the Committee that OIG fully supports efforts that hospitals have made to help financially needy patients. We appreciate the opportunity to address this issue and to discuss OIG's legal authorities in this area.

Simply put, the fraud and abuse laws enforced by OIG allow hospitals and other health care providers and suppliers to offer discounts to patients who cannot afford to pay for their care. Indeed, our legal authorities have extremely limited application to discounts offered to *uninsured* patients. When the patient's health care is covered under a Federal health care program, such as Medicare or Medicaid, our legal authorities have greater application. But even then, the laws and regulations clearly enable hospitals and others to help patients who are experiencing financial hardship. OIG has long-standing and clear guidance on this point.

While today's presentation focuses on discounts that hospitals offer to uninsured and financially needy patients, the underlying principles apply equally to the rest of the Medicare- and Medicaid-serving health care industry. Before I discuss OIG's

views, it is important to note that a thorough discussion of hospital discounts for patients with financial hardship also involves questions for the Centers for Medicare & Medicaid Services (CMS). CMS has programmatic responsibility for the Medicare program and has established the cost reporting and bad debt rules relevant to hospital discounting practices. A CMS witness is also testifying today and will address the CMS issues.

From OIG's perspective, discounts offered to *uninsured* patients are analyzed under two fraud and abuse laws: the Federal anti-kickback statute and the permissive exclusion authority prohibiting providers and suppliers from charging Medicare or Medicaid substantially more than they usually charge other customers. Discounts offered to financially needy Medicare or Medicaid beneficiaries also must be analyzed under the civil monetary penalty (CMP) statute that prohibits offering inducements to Medicare and Medicaid beneficiaries.

Today, I will begin by describing the limited application of OIG's legal authorities to discounts offered to uninsured patients. Next, I will describe how a hospital may reduce or waive cost-sharing amounts for Medicare or Medicaid beneficiaries experiencing financial hardship. Finally, I will explain how hospitals and other health care providers and suppliers can obtain further guidance from OIG on these issues.

DISCOUNTS FOR UNINSURED PATIENTS

OIG authorities allow hospitals to offer discounts to uninsured patients. It has been suggested that two fraud and abuse laws—the Federal anti-kickback statute and the exclusion authority prohibiting excessive charges to Medicare and Medicaid—prevent hospitals from offering discounted prices to patients who do not have health care coverage. This view reflects a misunderstanding of the law.

The Federal Anti-Kickback Statute

The Federal anti-kickback statute is a criminal statute that prohibits the purposeful offer, payment, solicitation, or receipt of anything of value in exchange for, or to induce, business payable by any Federal health care program, including Medicare and Medicaid. Congress was concerned that improper financial incentives often lead to abuses, such as overutilization, increased program costs, corruption of medical-decision making, and unfair competition. Accordingly, Congress banned kickbacks in the Federal health care programs.

Giving something of value (such as a discount on hospital charges) to an uninsured patient does not implicate the Federal anti-kickback statute, unless the patient is in a position to generate Federal health care program business. For example, a hospital asked OIG about the propriety of offering discounts to doctors who self-pay. Such discounts would implicate the statute if one purpose were to induce the doctors to refer Medicare or Medicaid business to the hospital. But those situations are not, in our view, typical of hospital policies for discounting to the uninsured. Rather, most need-based discounting policies are aimed at making health care more affordable for the millions of uninsured citizens who are not referral sources for the hospital. For discounts offered to these uninsured patients, the anti-kickback statute simply does not apply.

The Excessive Charges Exclusion Authority

By statute, OIG is authorized, but not required, to exclude from participation in the Federal health care programs any provider or supplier that charges Medicare or Medicaid substantially more than it usually charges other customers. This law is intended to protect the Medicare and Medicaid programs—and the taxpayers—from providers and suppliers that *routinely* charge the Medicare or Medicaid programs substantially more than they usually charge other customers.

Some providers have expressed concern that discounting to uninsured patients might skew their "usual charges" to other customers and possibly subject them to exclusion under this provision. Let me assure you that this is not the case. OIG has never excluded or even contemplated excluding any provider or supplier for offering discounts to uninsured patients or other patients who cannot afford their care.

OIG believes that the statute can be reasonably interpreted as allowing providers to exclude discounts to these patients when calculating their usual charges to other customers. To this end, when we proposed regulations in connection with this exclusion authority, we included a provision that would clarify that free or substantially reduced prices offered to uninsured patients do not need to be factored into a hospital's usual charges for purposes of the exclusion authority. Those proposed regulations are still under development.

To further assure the industry with respect to discounts to the uninsured, we issued guidance in February that, pending issuance of final regulations or a decision not to proceed with final regulations, we will continue our enforcement policy that,

when calculating their "usual charges," providers and suppliers need not consider free or substantially reduced charges to uninsured patients.

In sum, no OIG authority or policy should deter hospitals and others from offering financial relief to uninsured patients.

WAIVERS OF COST-SHARING AMOUNTS FOR FINANCIALLY NEEDY MEDICARE AND MEDICAID BENEFICIARIES

A discount offered to a Medicare or Medicaid beneficiary generally takes the form of a waiver of all or a portion of the Medicare or Medicaid program copayment or deductible, that is, the portion of the bill that the beneficiary owes. *Routine* waivers of Medicare or Medicaid cost-sharing amounts are problematic under the fraud and abuse laws because they may be used impermissibly to induce Federal health care program business. For example, many fraud schemes use the promise of "free" or "no out-of-pocket cost" medical items or services to attract Medicare or Medicaid beneficiaries.

However, the law also clearly permits health care providers to waive Medicare and Medicaid cost-sharing amounts for financially needy beneficiaries. OIG has a long-standing and well-publicized position supporting such financial hardship waivers. For example, the ability to forgive Medicare cost-sharing amounts in consideration of a patient's financial hardship is discussed in a 1992 OIG special fraud alert on the waiver of copayments and deductibles. The alert is available on our web site, along with other guidance on this subject, at http://oig.hhs.gov/fraud/fraud alerts.html.

The Civil Money Penalty Prohibiting Beneficiary Inducements

While the Federal anti-kickback statute may be implicated in some cases, the primary legal authority in the area of waivers of Medicare and Medicaid cost-sharing amounts is the CMP prohibiting inducements to beneficiaries. Enacted as part of HIPAA in 1996, the CMP prohibits offering a beneficiary anything of value, including waivers of cost-sharing amounts, that is likely to influence the beneficiary's selection of a provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Beneficiary inducements are of particular concern because vulnerable beneficiaries may be enticed to obtain services that are medically unnecessary, overpriced, or of substandard quality.

While generally banning routine cost-sharing waivers, such "insurance only" billing and the like, the Congress recognized that some beneficiaries might not be able to afford their cost-sharing amounts. The statute thus includes an express exception for waivers on the basis of financial need. The exception has three requirements:

- the waivers may not be routine;
- the waivers may not be offered as part of any advertisement or solicitation; and
- the waivers may only be made after determining in good faith that the individual is in financial need or that reasonable collection efforts have failed.

This exception is available to hospitals and others that want to provide relief to Medicare and Medicaid beneficiaries who cannot afford their cost-sharing amounts.

We recognize that what constitutes a good faith determination of financial need may vary depending on individual patient circumstances. We believe that hospitals should have flexibility to consider relevant variables. For example, hospitals may consider:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

A hospital's financial need guidelines should be reasonable, based on objective criteria, appropriate for the hospital's locality, and applied uniformly to all patients. Hospitals should take reasonable measures to document the financial need determination. We are mindful that there may be situations when patients are reluctant or unable to provide documentation of their financial status. In such cases, hospitals may be able to use other reasonable, documented methods for determining financial need, including, for example, patient interviews or questionnaires.

As discussed in our 1992 special fraud alert and elsewhere, it is OIG's position that the principles articulated in this CMP exception apply equally to financial need-based cost-sharing waivers under the Federal anti-kickback statute. There also is a safe harbor under the Federal anti-kickback statute that protects certain cost-sharing waivers for inpatient hospital services (waivers protected under this safe harbor are also protected under the CMP). The safe harbor contains a number of conditions designed to prevent abusive waiver practices, but does not require a determination of financial need.

In sum, the fraud and abuse laws clearly allow hospitals to provide relief to Medicare and Medicaid beneficiaries who cannot afford their cost-sharing amounts.

OBTAINING OIG GUIDANCE

As evidenced by the number and range of fraud alerts, bulletins, and other guidance we have issued, OIG has a strong commitment to providing guidance to the health care provider community. As previously noted, in February we issued specific guidance on OIG's fraud and abuse authorities and their application to hospital discounting practices. This guidance, titled "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills" ("Discounts Guidance"), is available on our website at www.oig.hhs.gov and is attached to this testimony.

In addition to these resources, OIG's advisory opinion process is available to hospitals or others that want to know how OIG views a particular discount arrangement. OIG advisory opinions are written legal opinions that are binding on OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a written description of its existing or proposed business arrangement. Further information about the process, including frequently asked questions, can be found on OIG's web site at: http://oig.hhs.gov/fraud/advisoryopinions.html

In addition, our web site contains the Discount Guidance, the proposed regulations on the excessive charges exclusion authority, and a special advisory bulletin discussing the CMP statute, as well as special fraud alerts and bulletins, safe harbor regulations, compliance program guidances, and advisory opinions that relate to the issues I have discussed today.

CONCLUSION

In conclusion, I want to assure the Committee that OIG fully supports efforts to ensure that a patient's financial need is not a barrier to health care. Furthermore, OIG legal authorities permit hospitals and others to offer bona fide discounts to uninsured patients and to Medicare or Medicaid beneficiaries who cannot afford their health care bills.

Mr. Chairman and Members of the Committee, thank you for inviting OIG to testify today. I would be happy to answer any questions you may have.

ATTACHMENTS

HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS

This document addresses the views of the Office of Inspector General ("OIG") on the following topics: (1) discounts provided by hospitals for uninsured patients who cannot afford to pay their hospital bills and (2) reductions or waivers of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. For the following reasons, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. The OIG fully supports hospitals' efforts in this area.

Discounts for Uninsured Patients Who Cannot Afford to Pay Their Hospital Bills

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. We disagree and address each law in turn.

- **The Federal Anti-Kickback Statute.**[1] The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid. *The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills.* However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to *underinsured* patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. As discussed below, the statute and regulations offer

[1] 42 U.S.C. § 1320a-7b(b).

means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.

- **Section 1128(b)(6)(A) of the Social Security Act.**[2] This law permits—but does not require—the OIG to exclude from participation in the Federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs—and taxpayers—from providers and suppliers that routinely charge the programs substantially more than their other customers.

  The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[3] Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. *Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that. when calculating their "usual charges" for purposes of section 1128&)(6)(A), individuals and entities do not need to consider free or substantiallv reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.*

  As noted in the preamble to the proposed regulations, the exclusion provision does *not* require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship

The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary.[4] Importantly, under the fraud and abuse laws, the "financial need" criterion is not limited to "indigence," but can include any reasonable measures of financial hardship.

Like many private insurance plans, the Medicare program includes a cost-sharing requirement. Cost-sharing is an important control on overutilization of items and services. If beneficiaries are required to pay for a portion of their care, they will be better health care consumers, selecting items or services because they are medically needed.

The routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute (discussed above) if one purpose of the waiver is to generate business payable by a Federal health care program.[5] In addition, a separate statutory provision prohibits offering inducements—including cost-sharing waivers—to a *Medicare* or *Medicaid* beneficiary that the offeror knows or should know are likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier.[6] (This prohibition against inducements offered to Medicare and Medicaid beneficiaries does not apply to uninsured patients.)

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[2] 42 U.S.C. § 1320a-7(b)(6)(A).

[3] 68 Fed. Reg. 53939 (Sept. 15, 2003).

[4] Hospitals still need to ensure that they comply with all relevant Medicare program rules.

[5] In certain circumstances, the *routine* waiver of coinsurance and deductible amounts can implicate the False Claims Act, 31 U.S.C. § 3729. *See* Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994), available on the OIG webpage at: http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

[6] 42 U.S.C. § 1320a-7a(a)(5). The statute includes several other exceptions. One exception permits the waiver of cost-sharing amounts for certain preventive care services without any re-

However, there are two important exceptions to the general prohibition against waiving Medicare coinsurance and deductibles applicable to hospitals, one for financial hardship situations and one for inpatient hospital services.

First, providers, practitioners, and suppliers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived so long as:

- the waiver is not offered as part of any advertisement or solicitation;
- the party offering the waiver does not routinely waive coinsurance or deductible amounts; *and*
- the party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need reasonable collection efforts have failed.[7]

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

Second, another exception to the general prohibition against Medicare cost-sharing waivers is contained in an OIG "safe harbor" regulation related to inpatient hospital services.[8] Compliance with a safe harbor regulation is voluntary, and failure to comply does not necessarily mean an arrangement is illegal. However, a hospital that complies fully with a safe harbor is assured that it will not be prosecuted under the Federal anti-kickback statute.[9]

The safe harbor for waivers of coinsurance and deductibles provides that a hospital may waive coinsurance and deductible amounts for inpatient hospital services for which Medicare pays under the prospective payment system if the hospital meets three conditions:

- the hospital cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other payers, or individuals;
- the waiver must be made without regard to the reason for admission, length of stay, or diagnostic related group; and
- the waiver may not be part of a price reduction agreement between the hospital and a third-party payer (other than a Medicare SELECT plan).

While the OIG is not concerned about bona fide cost-sharing waivers for beneficiaries with genuine financial need, we have a long-standing concern about providers and suppliers that use "insurance only billing" and similar schemes to entice Federal health care program beneficiaries to obtain items or services that may be medically unnecessary, overpriced, or of poor quality.

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quirement to determine financial need. 42 U.S.C. § 1320a-7a(i)(6)(D); 42 C.F.R. § 1003.101; *see also* 65 Fed. Reg. 24400, 24409 (April 26, 2000).

[7] 42 U.S.C. § 1320a-7a(i)(6)(A); Special Fraud Alert, *supra* note 5.

[8] 42 C.F.R. § 1001.952(k).

[9] Furthermore, 42 U.S.C. § 1320a-7a(i)(6)(B) provides that any waiver that fits in a safe harbor to the anti-kickback statute is similarly protected under the beneficiary inducements statute (discussed above).

OIG Advisory Opinion Process

The OIG has an advisory opinion process that is available to hospitals or others that want assurance that they will not run afoul of the fraud and abuse laws.[10] OIG advisory opinions are written opinions that are legally binding on the OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a detailed, written description of its existing or proposed business arrangement. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. Further information about the process, including frequently asked questions, can be found on the OIG webpage at http://oig.hhs.gov/fraud/advisoryopinions.html.

Conclusion

Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means.

Guidance about the anti-kickback statute and other fraud and abuse authorities is available on the OIG's webpage at http://oig.hhs.gov/. This guidance includes the Special Fraud Alert on Routine Waivers of Copayments and Deductibles under Medicare Part B; safe harbor regulations (and the "preamble" discussions that include explanatory information), the compliance program guidance for hospitals, and OIG advisory opinions.

Mr. GREENWOOD. Thank you very much. The Chair recognizes himself for questioning.

I am going to go through a list of questions here, but before I do, I think you were both here throughout the afternoon, and you heard the line of questioning I started as we were running out of time with the hospitals, and that is that it seems to me the part of the phenomena that has driven up the charges at hospitals has been the fact that hospitals are reimbursed for outlying cases, outlying from the DRG range, on a charges-to-cost ratio, and therefore it seems, since the costs are fairly constant, growing at a slight rate, that it was in the hospital's interest to have the charge set as high as possible to maximize the revenue. Am I correct that that was—at least prior to 2003, that that rather relatively perverse incentive existed?

Mr. KUHN. That is correct, Mr. Chairman. There was a phenomena in the Medicare law that allowed some hospitals—and they actually figured out this loophole—that by greatly accelerating their charges, they could take advantage of the outlier payment. And what was really happening is that charges could be current, but the data on which they based cost were about 2 or 3 years old. By increasing that spread, it triggered the outlier payment more quickly. And, again, some hospitals figured that out, some hospital systems—you heard Mr. Fetter speak about that—capitalized and moved on that very aggressively. When CMS discovered that, we moved new regulations, which were finalized last year, that include two things. One, to tighten the time period between costs and charges in terms of the most recent cost report so hospitals can't work on that spread. We also have a look-back provision, so we can go back and really audit these folks and take dollars back should

[10] Section 1128D(b) of the Social Security Act; 42 C.F.R. part 1008.

they be abusing that system. So, you are correct in your statement. There was an opportunity for hospitals to accelerate charges because of some incentives in the Medicare program, but that is now gone.

Mr. GREENWOOD. Was it the case that the higher the charge, the higher the reimbursement, assuming constant costs, or was it simply that the higher the charge, the more cases fit into the outlier program and were reimbursed on a basis that is unrelated to the charge itself?

Mr. KUHN. It was more the latter. It just created a quicker, easier opportunity to trigger the outlier payment and to improve cashflow.

Mr. GREENWOOD. But it still created incentive to raise the charges, and it seems to me that that, I suspect, was the driver for these charges going up, at least a significant driver for the charges to go up, and to some extent the uninsured patient just got caught in the crossfire because hospitals had to, if they were going to, in fact, claim that that was their charge, they had to charge it.

Mr. KUHN. That was certainly one of the triggers that was out there. There are other things, obviously, for charge movement forward. That incentive did exist, but it does not exist anymore.

Mr. GREENWOOD. It is your contention that since 2003 that incentive has been eliminated.

Mr. KUHN. That is correct.

Mr. GREENWOOD. Do hospitals still have incentives to keep their charges high in cases of automobile accidents, for instance, where there may be a settlement and they get to subrogate and get a piece of the settlement and they use charges, or is that outside of your area of expertise?

Mr. KUHN. That is outside of my area. I am just looking at the Medicare program. I would leave that to others to opine on that.

Mr. GREENWOOD. Is it HHS' responsibility to make sure that the uninsured self-pay patients are not adversely and unfairly treated by hospital billing and collection practices?

Mr. KUHN. What our policy is, and it is really reflected by the clarification Secretary Thompson issued in the Qs and As we provided for hospitals in February of this year, is that we really did encourage hospitals to use whatever authority they had to take care of the uninsured and work in that area.

Where our exact oversight applies, however, is if a hospital wants to collect Medicare bad debt. That is really where the indigency policy becomes critical, and that is where we come into play. If a hospital wants to forego the bad debt in that Medicare payment, we really don't have oversight authority.

Mr. GREENWOOD. But suppose that an uninsured patient goes to a hospital and gets billed for charges that are extraordinarily high, and that patient just sucks it up and puts it on a credit card and says, "Well, I will spend the rest of my life paying for this," there is no bad debt here. CMS has no responsibility under any statute or regulation to protect that patient from that effect?

Mr. KUHN. You are correct, we have no authority in that area.

Mr. GREENWOOD. In a February 2004 briefing to this committee, representatives of HHS claimed to have not known until the middle to late part of 2003 of hospitals' concerns with the impact of Medi-

care rules on their treatment of the uninsured. Today, we heard statements from Trevor Fetter of Tenet who said in 2002 that this was something that had concerned him for years.

Could you explain why something apparently known by some or many in the industry for years was not even on the radar of HHS until 2003?

Mr. KUHN. That misunderstanding or that discrepancy also troubles us as well because as we prepared for this hearing, I queried a lot of staff in terms of what was going on in 2001, 2002, even 2003, and, quite frankly, we heard from few, if any, hospitals asking questions. Likewise, we talked to our regional offices and our fiscal intermediaries, and they too were receiving little comment. So, it was our impression that hospitals had a pretty good understanding of our rules which have been out there for a long time in the Provider Reimbursement Manual, and it wasn't until recently that some concerns became known. And what we tried to do this year in Secretary Thompson's response to Dick Davidson of the American Hospital Association was to try a different format. Instead of giving them a copy of, for example, the Provider Reimbursement Manual, we decided to do it in a series of questions and answers, and since then I think that has really clarified things. I have heard from the American Hospital Association—I really salute them for this effort—that they have over 2,700 hospitals in the country now that have signed a pledge that says they understand the rules, they are going to move forward with policy——

Mr. GREENWOOD. What percentage is that of the hospitals in the United States?

Mr. KUHN. I believe there are about 5,000 acute care hospitals in the country, so it is well over half. So, I think that is a good number in a very short period of time, and I commend them for that effort.

Mr. GREENWOOD. Well, if they get to 5,000, we won't have to legislate.

Mr. KUHN. We can all hope.

Mr. GREENWOOD. As part of Medicare cost reporting, HHS was aware of steadily declining cost-to-charge ratios revealing in inverse steadily growing disparities between the cost to a hospital and charges given to patients. In California, for example, these markups rose, on average, from 174 percent in 1990 to 310 percent in 2003. These figures depict real bills to real people with all too real consequences. Did this slip through the cracks at HHS?

Mr. KUHN. Well, I think we have become aware of that, and obviously we were aware of it when we fixed the outlier policy last year, as I mentioned earlier. But, again, when we set Medicare payment policy, as you showed on your graphs earlier, Medicare payment policy is very close to cost. We use charges in a lot of different ways. We use it for apportionment. We use it to set DRG rates. We use it to trigger outlier payments. So, it is used importantly by us, but in terms of what we ultimately pay, that is set by the rates when Congress gives us the updates. So, it is part of the process, but it doesn't really trigger that much in terms of the overall payment scheme.

Mr. GREENWOOD. And aside from the outlier issue that we talked about in the beginning, are you aware of any other Medicare for-

mulae or processes that would still create an incentive for hospitals to have high charges?

Mr. KUHN. We are not aware of any kind of incentives or disincentives or perverse incentives that would be in the Medicare program that would drive that.

Mr. GREENWOOD. You wrote in your response to this committee, "If a hospital wants Medicare bad debt reimbursement, it must at the very least send non-indigent Medicare patients a bill for the debt, and must make some reasonable effort to collect from Medicare patients as it does for non-Medicare patients." Why is HHS unwilling to be more precise about what is a reasonable collection effort?

Mr. KUHN. We really want to leave that up to the hospitals and what works for them. Each hospital wants to design its own bad debt policy differently. We want to give them maximum flexibility. What we are really looking for in our manual is genuine and reasonable efforts and good business judgment on their part.

Mr. GREENWOOD. Do you think that that creates any incentive for them to err on the side of more aggressive collections, since there isn't perfect clarity?

Mr. KUHN. Well, sunshine is a good thing, and I think this hearing and some of the news reports have been a good thing to kind of help stabilize and try to create community standards out there.

Mr. GREENWOOD. And as you have said, you have never taken any action whatsoever against a hospital for not actively pursuing bad debt, isn't that what you said earlier?

Mr. KUHN. What we would do is if, indeed, a hospital did not have consistent policy—say, they were trying to collect Medicare bad debt and they didn't have consistent policy on either side—in an audit, we would go back and maybe take back some of those Medicare payments that they claimed, but that would be the only activity that we could take.

Mr. GREENWOOD. As part of the Medicare proscribed reasonable and consistent collection efforts, can a hospital consider bills of similar amounts differently, based on the circumstances of the debtor? For example, if you had a $50,000 bill for a low-income person who doesn't qualify for charity, and a $50,000 bill for a well off professional, must collections proceed similarly against both individuals?

Mr. KUHN. As long as they are pursuing similar collections and it is a part of their indigency policy and they want to collect Medicare bad debt, they need to be consistent on both sides. However, I would just say that there are ways that they could do their policy differently. For example, we all know if you legislate, if you set any rule, if you draw a line at, say, 300 percent of poverty or $50,000, but, say, the person with $50,000 is the young college student right out of school, and he has got a pretty good job, he is making $50,000, but he incurs a huge debt from a medical incident. A hospital could simply have a policy that says, "We have an indigence policy," but anything that falls outside of that, we are going to look at these on a case-by-case basis. We are going to have a special committee of the hospital that will include the CEO and other folks, and as long as they do that consistently for Medicare and non-Medicare patients, we are fine.

Mr. GREENWOOD. Do all determinations of indigency for the purpose of qualifying a patient for a charity program have to be through a means test?

Mr. KUHN. No, they don't have to be through a means test, although we would like to see—I think what works best for us is to see income levels, and if you mean by means test, assets test, et cetera, we don't require that. They could use just a straight income test.

Mr. GREENWOOD. Hospitals have suggested that the anti-kickback law could interfere with efforts to make widely available to patients notice of a hospital charity policy. Could posting a hospital's charity policy on a Web site or including information about the policy in billing mailings, for example, ever run contrary to any HHS rules?

Mr. MORRIS. Probably the anti-kickback statute would not even be of concern. As I noted in my testimony, discounts to the uninsured have very little relevance because they are not Medicare and Medicaid patients, and that is not within the scope of the anti-kickback statute.

I did reference a beneficiary inducement prohibition which, in order to meet the protections of it, one of the elements is not advertising the promotion of those routine waivers, by which we believe Congress meant a provider should not be out there saying, "No out-of-pocket for you. We don't bill anything but insurance." But the public service announcements, things that would let the community know that the hospital has an indigency policy? You should ask about it. Putting flyers up so people can be informed? We don't think that is what Congress intended by the bar on advertising. The concern was that people should not be encouraged to seek medical care where they are told there is no out-of-pocket, and it is being put on the side of buses and things.

Mr. GREENWOOD. Isn't it true that with very limited exception such as prompt pay discounts, for example, the only manner by which a discount might be offered to an uninsured patient is by means of a hospital's charity program?

Mr. MORRIS. Well, a discount can be offered to anyone that the hospital, based on its indigency program—and, as has been indicated, we believe there should be great flexibility provided so they can structure those as they see fit—so a prompt pay discount, if it is a bona fide prompt pay discount reflecting the fair market value of not having to pursue administrative action against the money to seek, that would be appropriate—you could construct your indigency policy with a great deal of flexibility. It would not need to be restricted to a prompt pay.

Mr. GREENWOOD. The problem some hospitals are having, I believe, is how broad can a charity policy be. The issue turns perhaps on the definition of "financial need" and what to do about the group who is above both Medicaid and the 200 to 400 percent of the Federal poverty line bracketing many hospital policies.

Mr. MORRIS. I think the way I would answer that is that a good faith determination of financial need resides with the hospital, and they can bring whatever community assessment they want to that.

Where I think the fraud and abuse laws could be implicated is if there was a blanket waiver of all cost-paying obligation to an en-

tire community—no one was expected to pay the co-pays and deductibles—which, frankly, would seem to be a rather dangerous business proposition, much less a——

Mr. GREENWOOD. Suppose they said anyone without insurance?

Mr. MORRIS. And they applied that across-the-board?

Mr. GREENWOOD. Is that too broad?

Mr. MORRIS. I think there would need to be an individualized determination; so a blanket statement to anyone who does not have insurance does not have to pay co-payments would be problematic. There would need to be an individualized determination, but the element——

Mr. GREENWOOD. Based on things like income and assets.

Mr. MORRIS. Income, assets, number of members in the family, size of the debt, all those would be variables that should be taken into account.

Mr. GREENWOOD. Is there some limit? If a hospital said that our charity applies to anyone who is above 500 percent, or 700 percent, or 800 percent of poverty, is there some point at which CMS would say, "Wait a minute, that is too high?"

Mr. KUHN. I would say, ultimately, there would be a community standard that the auditors could come and look at. For example, under Medicare right now, the deductible is $876, so if you set the income standard so high that you waive that deductible on a consistent basis, I think that would be a bit of a problem. One, as Lew said earlier, as a business sense, I don't think the hospital would be doing that. But if you set it so high to kind of write everything off and collect a Medicare bad debt, I think the auditors would have to look at that one a little bit differently because, when Congress had the idea that there ought to be deductibles and co-payments, for those that have the ability to pay, I think there was an intent that people should pay those things.

Mr. MORRIS. It is worth remembering, too, that when we talk about Medicare co-pays and deductibles, we are therefore talking about people who have insurance, they are covered by a program, as distinct from those who are uninsured, for which, from a fraud and abuse standpoint, we have no jurisdiction directly. So, if we are talking about waivers of co-pays and deductibles for those who have Medicare coverage, what we expect is some reasonable assessment of financial need with a great deal of flexibility.

Mr. GREENWOOD. If CMS reimburses a hospital for a bad debt and 10 years later, or 5 years later, some period later, the debt ends up being collected by an agency and remitted to the hospital, does the hospital have a legal duty to report that to Medicare?

[The following was received for the record:

Yes. Medicare regulations at 42 CFR § 413.80(f) state, 11In some cases an amount previously written off as bad debt and allocated to the program may be recovered in a subsequent accounting period: in such cases the income from there must be used to reduce the cost of beneficiary services for the period in which the collection is made." Unfortunately, there is no way to quantify these offset amounts. There is a line on Worksheet E, part A of the Medicare cost report for offset adjustments, but that is an aggregate amount and a myriad of things is combined in the total.

Mr. KUHN. In 10 years, I am not sure, but within a reasonable amount of time. There is a part of the cost report where there is a place to report income. I remember looking at this recently, and I can't tell you exactly where, but we could follow up in writing to

make sure. But there is a way for that to be reported back and to indicate it that was once claimed as a bad debt but then reported back as income in the cost report.

Mr. GREENWOOD. What is the current process by which a hospital can seek an advisory opinion on matters such as this.

Mr. MORRIS. The advisory opinion process, as set forth on our Web site, allows any provider to write in with a proposed or actual arrangement if they would like to know whether it violates any of our anti-fraud and abuse provisions. Generally, the process takes a great deal of give-and-take. Sometimes the initial solicitation isn't clear, or in an effort to try to get an affirmative response, we may make suggestions to improve or reshape the proposal so it will not trigger concerns.

We have a team of attorneys who work on those. We have a substantial backlog because of the size of our staff.

Mr. GREENWOOD. Well, that gets me to the next question, which is what are the timeframes involved?

Mr. MORRIS. It depends a lot on the complexity of the request. The timeframes can be anywhere from the 60-day statutory obligation, provided that it is a clean request and doesn't require any sort of feedback. Some of our requests have been pending for over a year. In many cases, it is because we ask additional information of the requestor and we have not gotten information back for those, we are still waiting for additional information.

Mr. KUHN. And if I may, Mr. Chairman, if I could just reference that as well. This is for the OIG's advisory opinion process. But for hospital indigency policies, in order to go forward, they need not request an advisory opinion from CMS. In fact, we don't give advisory opinions. Hospitals are empowered to go out and set their own policies and move forward. And as I referenced earlier, the AHA said that 2700 hospitals have already signed a pledge that they have already done it. There is no way we could do 2700 advisory opinions that fast. They are empowered to do it, as they always have been. And so earlier there was testimony where people say they were waiting 6 months for these opinions, et cetera. That is not the case. They are empowered to go forward, set their policies, and move forward. We are not holding them up. Go do it.

Mr. MORRIS. And if I could add one other point germane to advisory opinions in this area, we have not seen a great deal of requests for advisory opinions on the application of our statutes to the uninsured because they don't apply. I am aware of only one formal request, for an advisory opinion, and before we were able to finalize our response, the request was withdrawn in light of the information that the Secretary provided earlier this year.

Mr. GREENWOOD. What is a UB92 form?

[The following was submitted for the record:]

The UB92 was developed over many years by the National Uniform Billing Committee to serve as a single simplified billing form that is used nationwide by institutional providers and payers for handling health care claims. The data elements included on the form are identified as being necessary for claims processing and meet the requirements for preparing Medicare, Medicaid, OCHAMPUS, BCBS, and commercial insurance claims. (A copy of the UB92 form and instructions is attached for the record.)

APPROVED OMB NO. 0938-0279

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D | 8 N-C D | 9 C-I D | 10 L-R D | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | 17 DATE | ADMISSION 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P REL | 60 CERT. - SSN - HIC - ID NO. | 61 GR OUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLO YER LOCATION

67 PRIN. DIAG CD | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD | 77 E CODE | 78

79 P C | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 | OCR/ORIGINAL | I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face hereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitorium's, certifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative, on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts, and;

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent, but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS combined with the cost-share amount and deductible amount, if any, paid by, or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Form CMS-1450

3604. REVIEW OF FORM CMS-1450 FOR INPATIENT AND OUTPATIENT BILLS

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form CMS-1450 are described, but detailed information is given only for items required for Medicare claims. The National Uniform Billing Committee (NUBC) maintains a complete list of allowable data elements and codes. You must be able to capture all NUBC-approved input data for audit trail purposes and be able to pass all data to other payers with whom you have a coordination of benefits agreement. Items listed as "Not Required" need not be reviewed although providers may complete them when billing multiple payers. All Medicare claims you process must be billed on Form CMS-1450 billing form or billed using related electronic billing record formats.

If required data is omitted, obtain it from the provider or other sources and maintain it on your history record. It is not necessary to search paper files to annotate missing data unless you do not have an electronic history record. You need not obtain data not needed to process the bill.

Data elements in the CMS uniform electronic billing specifications are consistent with Form CMS-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system for both Form CMS-1450 and the electronic specifications are identical.

Effective June 5, 2000, CMS extended the claim size to 450 lines. For the hard copy UB-92 or Form CMS-1450, this simply means you will accept claims of up to 9 pages. For the electronic format, the new requirements are described in Addendum A.

Effective October 16, 2003, all state fields will be discontinued and reclassified as reserved for national assignment.

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit - Type of Facility
1 - Hospital
2 - Skilled Nursing
3 - Home Health

4 - Religious Non- Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special Facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit - Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients", and referred diagnostic services).
5 - Intermediate Care - Level I
6 - Intermediate Care - Level II
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement.)
9 - Reserved for National Assignment

2nd Digit - Classification (Clinics Only)
1 - Rural Health Clinic (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free-Standing Provider-Based Federally Qualified Health Centers (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit - Classification (Special Facilities Only)
1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6 - Residential Facility (not used for Medicare)
7-8 Reserved for National Assignment
9 - OTHER

3rd Digit - Frequency	Definition
A - Admission/Election Notice	This code is used when a hospice or religious non-medical health care institution is submitting the Form CMS-1450 as an admission notice.
B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/ Revocation Notice	Use when the UB-92 is used as a Termination/ Revocation of a hospice, Medicare coordinated care demonstration, or religious non-medical health care institution election.
C - Hospice Change of Provider	This code is used when the Form CMS-1450 is used as a Notice of Change to the hospice provider.
D - Hospice/Medicare Coordinated Care Demonstration/Religious	This code is used when the UB-92 is used as a Notice of a Void/Cancel of a hospice, Medicare Coordinated

Non-Medical Health Care Institution-Void/Cancel	Care Demonstration Entity, or Religious Non-medical Health Care Institution election.
E - Hospice Change of Ownership	This code is used when the Form CMS-1450 is used a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	This code is used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	This code is used to identify adjustments initiated by CWF. For intermediary use only.
H - CMS Initiated Adjustment Claim	This code is used to identify adjustments initiated by CMS. For intermediary use only.
I - Int. Adjustment Claim (Other Than PRO or Provider)	This code is used to identify adjustments initiated by you. For intermediary use only.
J - Initiated Adjustment Claim-Other	This code is used to identify adjustments initiated by other entities. For intermediary use only.
K - OIG Initiated Adjustment Claim	This code is used to identify adjustments initiated by OIG. For intermediary use only.
M - MSP Initiated Adjustment Claim	This code is used to identify adjustments initiated by MSP. For intermediary use only.

NOTE: MSP takes precedence over other adjustment sources.

P - PRO Adjustment Claim	This code is used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
0 - Nonpayment/zero claims	This code is used when the provider does not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to the provider.
1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2 - Interim - First Claim	This code is used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment.
3 - Interim - Continuing Claims (Not valid for PPS Bills)	This code is used when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.

4 - Interim - Last Claim (Not valid for PPS bills)	This code is used for a bill for which utilization is chargeable and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this confinement or course of treatment.
5 - Late Charge Only	This code is used only for outpatient claims. Late charge bills are not accepted for Medicare inpatient or ASC claims.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or new bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also submitted by the provider showing corrected information.
9 - Final Claim for a Home Health PPS Episode	This code indicates the HH bill should be processed as a debit or credit adjustment to the request for anticipated payment.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period included on this bill are shown in numeric fields (MMDDYY). Days before the patient's entitlement are not shown. Use the "From" date to determine timely filing. (See §§3307ff.)

FL 7. Covered Days
Required. The total number of covered days during the billing period applicable to the cost report including lifetime reserve days elected for which Medicare payment is requested, is entered. This should be the total of accommodation units reported in FL 46. Covered days exclude any days classified as noncovered, as defined in FL 8, leave of absence days, and the day of discharge or death.

If you made an adverse coverage decision, enter the number of covered days through the last date for which program payment can be made. If waiver of liability provisions apply, see §3441.

The provider does not deduct any days for payment made in the following instances:

- o WC;
- o Automobile medical, no-fault, liability insurance;
- o An EGHP for an ESRD beneficiary;
- o Employed beneficiaries and spouses age 65 or over; or
- o An LGHP for disabled beneficiaries.

Enter the number of days shown in this FL in the cost report days field on the UB-92 CWF RECORD. However, when the other insurer has paid in full (see §§3682, and 3685), enter zero days in utilization days on the UB-92 CWF RECORD. For MSP cases only, calculate utilization based

upon the amount Medicare will pay and enter the utilization days chargeable to the beneficiary in the utilization days on the UB-92 CWF RECORD. (See §§3682 and 3685.)

For discussion of how to determine whether part of a day is covered, see §§3620ff.

If the provider reported an incorrect number of days, report the correct number when you submit the CWF RECORD.

FL 8. Noncovered Days
Required. The total number of noncovered days during the billing period within the "From" and "Through" date that are not claimable as Medicare patient days on the cost report.

FL 9. Coinsurance Days
Required. The number of covered inpatient hospital days occurring after the 60th day and before the 91st day or the number of covered inpatient SNF days occurring after the 20th day and before the 101st day of the benefit period are shown for this billing period.

FL 10. Lifetime Reserve Days
Required. The provider enters the number of lifetime reserve days applicable. Change this entry, if necessary, based on data developed by your claims processing system. (See §3106.2 for special considerations in election of lifetime reserve days.)

FL 11. (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 12. Patient's Name
Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address
Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, City, State, and ZIP code. A valid ZIP code is required for PRO purposes on inpatient bills.

FL 14. Patient's Birthdate
Required. The month, day, and year of birth is shown numerically as MMDDYYYY. If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.

FL 15. Patient Sex
Required. A "M" for male or a "F" for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Patient's Marital Status
Not Required.

FL 17. Admission Date
Required. The month, day, and year of admission for inpatient care is shown numerically as MMDDYY. When using Form HCFA-1450 as a hospice admission notice, the facility shows the date the beneficiary elected hospice care.

FL 18. Admission Hour
Not Required.

FL 19. Type of Admission/Visit
Required on inpatient bills only. This is the code indicating priority of this admission/visit.

Code Structure:

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	Newborn	Use of this code necessitates the use of a Special Source of Admission codes.
5	Trauma Center	Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
9	Information Not Available	The hospital cannot classify the type of admission. This code is used only on rare occasions.

FL 20. Source of Admission
Required. This is the code indicating the source of this admission or outpatient registration.

Code Structure (for Emergency, Elective or Other Type of Admission):

1	Physician Referral	Inpatient: The patient was admitted upon the recommendation of a personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted upon the recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3	HMO Referral	Inpatient: The patient was admitted upon the recommendation of an HMO physician.

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.
4	Transfer from a Hospital	Inpatient: The patient was admitted as a transfer from an acute care facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5	Transfer from a SNF	Inpatient: The patient was admitted as a transfer from a SNF where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she is an inpatient.
6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a SNF. This includes transfers from nursing homes, long-term care facilities, and SNF patients that are at a nonskilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where he or she is an inpatient.
7	Emergency Room	Inpatient: The patient was admitted upon the recommendation of this facility's emergency room physician. Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's representative. Outpatient: The patient was referred to this facility upon the direction of a `court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	Inpatient: The means by which the patient was admitted is not known. Outpatient: For Medicare outpatient bills this is not a valid code.
A	Transfer from a Critical Access Hospital	Inpatient: The patient was admitted to this facility as a transfer from a critical access hospital where he or she was an inpatient.

		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the critical access hospital where he or she is an inpatient.
B	Transfer From Another Home Health Agency	The patient was admitted to this home health agency as a transfer from another home health agency.
C	Readmission to Same Home Health Agency	The patient was readmitted to this home health agency within the same home health episode period.
D-Z		Reserved for national assignment.

FL 21. Discharge Hour
Not Required.

FL 22. Patient Status
Required. (For all Part A inpatient, SNF, hospice, HHA and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04-ICF.)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
*09	Admitted as an inpatient to this hospital
20	Expired (or did not recover - Christian Science Patient)
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility, (e.g., hospital, SNF, ICF or freestanding hospice)
42	Expired - place unknown (hospice claims only)
43	Discharged/transferred to a federal hospital. (Effective 10/1/03)
44-49	Reserved for national assignment
50	Hospice - home
51	Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
62-70	Reserved for national assignment
73-99	Reserved for national assignment

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier, such as observation following outpatient surgery, which results in admission.

FL 23. Medical Record Number
Required. This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect processing.

Code structure (only codes affecting Medicare payment/processing are shown).

Code	Title	Definition
02	Condition is Employment Related	Code indicates patient alleges that the medical condition in this episode of care is due to environment/events resulting from employment. (See §§3415.2ff. for WC and §§3415.3ff. for BL.)
04	Patient is HMO Enrollee	Code indicates bill is submitted for information only and the Medicare beneficiary is enrolled in a risk-based HMO and the hospital expects to receive payment from the HMO.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the first 30 months of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Code indicates the beneficiary would not provide information concerning other insurance coverage. Develop to determine the proper payer. (See §3686 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	Code indicates that in response to development questions, the patient and spouse have denied employment.

Code	Title	Definition
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Code indicates that in response to development questions, the patient and/ or spouse indicated that one or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance that covers the patient.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.
15	Clean Claim Delayed in HCFA's Processing System (Payer Only Code)	Code indicates that the claim is a clean claim in which payment was delayed due to a HCFA processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See §3600.1A.3.)
16	SNF Transition Exemption (Medicare Payer Only Code)	Code indicates an exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Code indicates patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole community hospitals only). Code indicates the patient was referred for a diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.

Code	Title	Definition
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees; or, (2) the EGHP is a multi- or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance coverage from a LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and that the employer has fewer than 100 full and part-time employees; or, (2), the LGHP is a multi- or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she enrolled in a cooperative/ work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that he/she is enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.
ACCOMMODATIONS		
35		Reserved for National Assignment.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Code indicates the hospital temporarily placed the patient in a special care unit because no general care beds were available.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) Code indicates that the patient was assigned to ward

Code	Title	Definition
		accommodations at his own request. This code must be supported by a written request in the provider's files. (See §3101.1F.)
38	Semi-Private Room Not Available	(Not used by hospitals under PPS.) Code indicates that the patient's assignment to a ward or private room was because there were no semi-private rooms available at admission.

NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 or 38 apply, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, pay semi-private costs.

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Code indicates patient's assignment to a private room was for medical reasons.
40	Same Day Transfer	Code indicates patient was transferred from one participating provider to another before midnight on the day of admission.
41	Partial Hospitalization	Code indicates claim is for partial hospitalization services. For outpatients this includes a variety of psychiatric programs. (See §§3112.7C and D for a description of coverage.)
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Postdischarge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the postdischarge window.
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Code indicates the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Medicare+Choice Organization Enrollee	Code indicates that patient is a terminated enrollee in a Medicare+Choice Organization plan whose three-day inpatient hospital stay was waived.
59		Reserved for national assignment

Code	Title	Definition
60	Operating Cost Day Outlier	(Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. Indicate the operating cost outlier portion paid in value code 17.
61	Operating Cost Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. Indicate the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Code indicates bill was paid under PIP. Record this from your system.
63	Payer Only Code	Code reserved for internal use only. CMS assigns as needed. Providers do not report this code.
64	Other Than Clean Claim	(Not reported by providers.) Code indicates the claim is not "clean." Record this from your system.
65	Non-PPS Bill	(Not reported by providers.) Code indicates bill is not a PPS bill. Record this from your system for non-PPS hospital bills.
66	Provider Does Not Wish Cost Outlier Payment	Code indicates a hospital paid under PPS is not requesting additional payment as a cost outlier for this stay.
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	Code indicates beneficiary has elected to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/DGME/N&A Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/ Nursing and Allied Health).
70	Self-Administered EPO	Code indicates the billing is for a dialysis patient who self-administers EPO.
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care In Unit	Code indicates the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where the patient and his/her helper (if necessary) were learning to perform dialysis.

Code	Title	Definition
74	Home	Code indicates the billing is for a patient who received dialysis services at home.
75	Home 100 percent Payment	(Not to be used for services furnished 4/16/90 or later.) Code indicates the billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100 percent program.
76	Back-up In-facility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Code indicates the provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	Code indicates this bill is for a Medicare newly covered service for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off Site	Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

Special Program Indicator Codes

Code	Title	Definition
A0	Special ZIP Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A3	Special Federal Funding	This code is designed for uniform use by State uniform billing committees.
A5	Disability	This code is designated for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumonia/ Influenza 100% Payment	This code identifies that pneumococcal/influenza vaccine (PPV) services given that are to be paid under a special Medicare program provision.
A7	Induced Abortion-Danger to Life	Code indicates an abortion was performed to avoid danger to woman's life.
A8	Induced Abortion- Victim of Rape/Incest	Self-explanatory. Discontinued 10/01/02
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.

Code	Title	Definition	
AA	Abortion Performed due to Rape	Self-explanatory.	Effective 10/1/02
AB	Abortion Performed due to Incest	Self-explanatory.	Effective 10/1/02
AC	Abortion Performed due to Serious Fetal Genetic Defect. Deformity. or Abnormality	Self-explanatory.	Effective 10/1/02
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by. Arising From or Exacerbated by the Pregnancy Itself	Self-explanatory.	Effective 10/1/02
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory.	Effective 10/1/02
AF	Abortion Performed due to Emotional/psychological Health of the Mother	Self-explanatory.	Effective 10/1/02
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory.	Effective 10/1/02
AH	Elective Abortion	Self-explanatory.	Effective 10/1/02
AI	Sterilization	Self-explanatory.	Effective 10/1/02
AJ	Payer Responsible for Copayment	Self-explanatory.	Effective 4/1/03
AK	Air Ambulance Required	For ambulance claims. Air ambulance required -time needed to transport poses a threat. Effective 10/16/03	
AL	Specialized Treatment/bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate alternate facility. Effective 10/16/03	
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03	
AN-AZ		Reserved for national assignment	
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.	
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending	

Code	Title	Definition
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the ambulance fee Schedule.
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when Mandated by law. The determination of pregnancy Should be completed in compliance with applicable Law. Effective 10/16/03
B4-BZ		Reserved for national assignment
M0-M9	Payer Only Codes	
M0	All-Inclusive Rate for Outpatient	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV)	Code indicates the influenza virus vaccine or Pneumococcal Pneumonia Vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payment to an HHA is significantly in excess of covered billed charges.
PRO Approval Indicator Codes		
C1	Approved as Billed	Code indicates claim has been reviewed by the PRO and is fully approved including any day or cost outlier.
C3	Partial Approval	Code indicates the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "M0" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	Code indicates patient's need for inpatient services was reviewed by the PRO and none of the stay was medically necessary.
C5	Postpayment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/ Preprocedure	Code indicates that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	Code indicates the PRO authorized these services for an extended length of time, but has not reviewed the services provided.

Claim Change Reasons

Code	Title	Definition
D0	Changes to Service Dates	Self-explanatory.
D1	Changes to Charges	Self-explanatory.
D2	Changes to Revenue Codes/HCPCs/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/ HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory.
D4	Change in ICD-9-CM Diagnosis and/or Procedure Codes	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in diagnosis (FL67-77) and procedure codes (FL80-81)
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
E0	Change in Patient Status	Self-explanatory.
E1-E9		Reserved for national assignment
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue the visits were distinct and constituted independent visits.
G1-G9		Reserved for national assignment
H0	Delayed Filing, Statement Of Intent Submitted specifically	Code indicates that Statement of Intent was submitted within the qualifying period to identify the existence of another third party liability situation.

Code	Title	Definition
M0	All-Inclusive Rate for Outpatient Services (Payer only code)	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

FL 31. (Untitled)
Not Required. This is one of four fields which are not assigned. Use of the field, if any, is assigned by the NUBC.

FLs 32, 33, 34 and 35. Occurrence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MMDDYY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

When FLs 36 A and B are fully used with occurrence span codes, FLs 34A and B and 35A and B may be used to contain the "From" and "Through" dates of other occurrence span codes. In this case, the code in FL 34 is the occurrence span code and the occurrence span "From" date is in the date field. FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "Through" date is in the date field.

Code Structure (only codes affecting Medicare payment/processing are shown).

01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
02	No-Fault Insurance Involved - Including Auto Accident/Other	Code indicates the date of an accident, including auto or other, where the State has applicable no-fault or liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicates the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicates the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Accident/No Medical or or Liability Coverage	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury.
11	Onset of Symptoms/Illness	Code indicates the date patient first became aware of symptoms/illness.
12	Date of Onset for a Chronically Dependent Individual	(HHA claims only) Code indicates the date the patient/beneficiary became a chronically dependent

Code	Title	Definition
		individual (CDI). This is the first month of the 3 month period immediately prior to eligibility under respite care benefit
16	Date of Last Therapy	Code indicates the last day of therapy services(e.g. physical, occupational or speech therapy).
17	Date Occupational Therapy Plan Established or Reviewed	Code indicates the date a plan was established or last reviewed for occupational therapy.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A claims only.) Code indicates date on which the provider began claiming payment under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF and hospital of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)
22	Date Active Care Ended	Code indicates date on which a covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital or date on which patient was released on a trial basis from a residential facility. Code is not required if code "21" is used.
23	Date of Cancellation of Hospice Election Period	For Intermediary Use Only. Providers Do Not Report. Code is not required if code "21" is used.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
25	Date Benefits Terminated by Primary Payer	Code indicates the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is not longer available to the patient.
26	Date SNF Bed Available	Code indicates the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods.

Code	Title	Definition
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care. (See §3350.)
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT. (See §3350.)
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology. (See §3350.)
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) may not be reasonable or necessary under Medicare.
33	First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP	Code indicates the first day of the Medicare coordination period during which Medicare benefits are secondary to benefits payable under an EGHP. This is required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services	Code indicates the date the guest elected to receive extended care services (used by Religious Non-medical Health Care Institution only)
35	Date Treatment Started For Physical Therapy	Code indicates the date the billing provider initiated services for physical therapy.
36	Date of Inpatient Hospital Discharge For Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay during which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
37	Date of Inpatient Hospital Discharge Non-covered Transplant Patient	Code indicates the date of discharge for inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
41	Date of First Test for Pre-admission Testing	The date on which the first outpatient diagnostic test, was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the tests (s).
42	Date of Discharge	(Hospice claims only.) Code indicates date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill. (See §3648, FLS 32-35, code 42.) The frequency digit (3rd digit, FL 4, Type of Bill) should be 1 or 4.

Code	Title	Definition
43	Scheduled Date of Canceled Surgery	The date for which ambulatory surgery was scheduled.
44	Date Treatment Started For Occupational Therapy	Code indicates the date the billing provider initiated services for occupational therapy.
45	Date Treatment Started for Speech Therapy	Code indicates the date the billing provider initiated services for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	Code indicates the date the billing provider initiated services for cardiac rehabilitation.
47	Date Cost Outlier Status Begins	Code indicates that this is the first day the inpatient cost outlier threshold is reached. For Medicare purposes, a beneficiary must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments.
48-49	Payer Codes	Codes reserved for internal use only by third party payers. CMS assigns as needed for your use. Providers do not report them.
A1	Birthdate-Insured A	Code indicates the birth date of the insured in whose name the insurance is carried.
A2	Effective Date- Insured A Policy	Code indicates the first date the insurance is in force.
A3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer A.
A4	Split Bill Date	Date patient became Medicaid eligible due to medically needy spend down (sometimes referred to as "Split Bill Date"). Effective 10/16/03.
B1	Birthdate- Insured B	Code indicates the birth date of the individual in whose name the insurance is carried.
B2	Effective Date- Insured B Policy	Code indicates the first date the insurance is in force.
B3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer B.
C1	Birthdate- Insured C	Code indicates the birth date of the individual in whose name the insurance is carried.
C2	Effective Date- Insured C policy	Code indicates the first date the insurance is in force.

Code	Title	Definition
C3	Benefits Exhausted	Code indicates the last date for which benefits are available and after which no payment can be made to payer C.
C4-C9		Reserved for national assignment.
D0-D9		Reserved for national assignment.

FL 36. Occurrence Span Code and Dates.
Required. Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

Code Structure (only the codes used for Medicare are shown).

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) Code indicates the dates shown are for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on this claim.
70	Nonutilizaton Dates (For Payer Use On Hospital Bills Only)	Code indicates a period of time during a PPS inlier stay for which the beneficiary had exhausted all regular days and/or coinsurance days, but which is covered on the cost report.
71	Prior Stay Dates	(Part A claims only.) Code indicates from/through dates given by the patient for any hospital stay that ended within 60 days of this hospital or SNF admission.

Code	Title	Definition
72	First/Last Visit	Code indicates the actual dates of the first and last visits occurring in this billing period where these dates are different from those in FL 6, Statement Covers Period.
74	Noncovered Level of Care	Code indicates the From/Through dates for a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span code 76, 77, or 79. Codes 76 and 77 apply to most noncovered care. Used for leave of absence. This code is also used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Also used for HHA or hospice services billed under Part A.
75	SNF Level of Care	Code indicates the From/Through dates for a period of SNF level of care during an inpatient hospital stay. Since Pros no longer routinely review inpatient hospital bills for hospitals under PPS, this code is needed only in length of stay outlier cases (code "60" in FLS 24-30). It is not applicable to swing-bed hospitals which transfer patients from the hospital to a SNF level of care.
76	Patient Liability	Code indicates the From/Through dates for a period of noncovered care for which the hospital is permitted to charge the beneficiary. Code is to be used only where you or the PRO approve such charges in advance and the patient is notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability--Utilization Charged	Code indicates the From/Through dates for a period of noncovered care for which the provider is liable (other than for lack of medical necessity or as custodial care.) The beneficiary's record is charged with Part A days, Part A or Part B deductible, and Part B coinsurance. The provider may collect Part A or Part B deductible and coinsurance from the beneficiary.
78	SNF Prior Stay Dates	(Part A claims only.) Code indicates the From/Through dates given by the patient for a SNF stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified or licensed by the State solely below a SNF level of care does not continue a spell of illness and is not shown in FL 36. (See §3035.B.2.)
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.

Code	Title	Definition
M0	PRO/UR Stay Dates	If a code "C3" is in FLS 24-30, the "From" and "Through" dates of the approved billing period are here.
M1	Provider Liability-No Utilization	Code indicates the From/Through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance from the beneficiary.
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients.
M3	ICF Level of Care	The From/Through dates of a period of intermediate level of care during an inpatient hospital stay.
M4	Residential Level of Care	The From/Through dates of a period of residential level of care during an inpatient hospital stay.
M5-WZ		Reserved for national assignment.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)
Required. Providers enter the control number assigned to the original bill here. Utilized by all provider types on adjustment requests (Bill Type, FL4 = XX7). All providers requesting an adjustment to a previously processed claim insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

FL 38. (Untitled Except on Patient Copy of the Bill) Responsible Party Name and Address
Not Required. (For Hospice claims only, the name, address, and provider number of a transferring Hospice is shown by the new Hospice on its Form CMS-1450 admission notice. (See §3648, FL 38.) For claims which involve payers of higher priority than Medicare as defined in FL 58, the address of the other payer may be shown here or in FL 84 (Remarks).

FLS 39, 40, and 41. Value Codes and Amounts
Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "A" through line "D." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used before the second line is used and so on).

04	Inpatient Professional Component Charges Which are Combined Billed	Code indicates the amount shown is the sum of the inpatient professional component charges which are combined billed. Medicare uses this information in internal processes and also in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)

Code	Title	Definition
05	Professional Component Included in Charges and Also Billed Separately to Carrier	Code indicates the charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the bill for physician's services is processed by the carrier. These charges are also deducted when computing interim payment.
06	Medicare Part A and Part B Blood Deductible	Code indicates the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not used. When the provider gives a discount for unreplaced deductible blood, charges after the discount is applied are shown.
08	Medicare Lifetime Reserve Amount for First Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. (See §§3206 and 3211.) These are days used in the year of admission.
09	Medicare Coinsurance Amount for First Calendar Year in Billing Period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the first calendar year of the billing period times the applicable coinsurance rate. These are days used in the year of admission. (See §§3206 and 3211.) This code is not used on Part B bills.
10	Medicare Lifetime Reserve Amount for Second Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the 2nd calendar year of the billing period times the applicable lifetime reserve rate. The code is used only for stays spanning two calendar years when lifetime reserve days were used in the year of discharge.

Code	Title	Definition
11	Medicare Coinsurance Amount for Second Calendar Year in Billing Period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the second calendar year of the billing period the applicable coinsurance rate. This code is used times only for stays spanning two calendar years when coinsurance days were used in the year of discharge. This code is not used on Part B bills.
12	Working Aged Beneficiary/ Spouse With an EGHP	Code indicates the amount shown is the that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage. (See §3491.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
13	ESRD Beneficiary in a Medicare Coordination Period With an EGHP	Code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD beneficiary that the provider is applying to covered Medicare charges on the bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage. (See §§3490ff.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
14	No-Fault, Including Auto/Other Insurance	Code indicates the amount shown is that portion of a higher priority no-fault, including auto/other, insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the other insurance has denied coverage, or there has been a substantial delay in its payment. (See §§3419-3489.) Where the provider received no payment or a

Code	Title	Definition
		reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
15	Worker's Compensation (WC)	Code indicates the amount shown is that portion of a higher priority WC payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See §§3407-3416.4.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
16	PHS, Other Federal Agency	Code indicates the amount shown is that portion of a higher priority PHS or other Federal Agency's payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges. (See §§3153ff.)
17	Operating Outlier Amount	(Not reported by providers.) Report the amount of operating outlier payment made (either cost or day) in CWF with this code. (Do not include any capital outlier payment in this entry.)
18	Operating Disproportionate Share Amount	(Not reported by providers.) Report the operating disproportionate share amount applicable with this code. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry.)
19	Operating Indirect Medical Education Amount	(Not reported by providers.) Report operating indirect medical education amount applicable with this code. Use the amount provided by the indirect medical education field in PRICER. (Do not include any PPS capital IME adjustment in this entry.)
31	Patient Liability Amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
32	Multiple Patient Ambulance Transport	If more than one patient is transported in a single ambulance trip, report the total number of patients transported.

Code	Title	Definition
37	Pints of Blood Furnished	Code indicates the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced, is shown. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	Code indicates the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.
39	Pints of Blood Replaced	Code indicates the total number of pints of blood which were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. (See §3235.4A.) Where the provider charges only for the blood processing and administration, (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	(For inpatient service only.) Code indicates the amount shown for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Condition Codes 04 and 78 must also be reported.
41	Black Lung	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment. (See §§3415ff.) Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)

Code	Title	Definition
42	Veterans Affairs	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. (See §3153.1A.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim. (See §3497.6.)
44	Amount Provider Agreed Accept From Primary Payer When this Amount is Less Than Charges But Higher than Payment Received	Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due. (See §3682.1.B.6 for an explanation.)
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, (Condition Code) indicating that the PRO has denied all or a portion of this billing period, the number of days determined by the PRO to be covered while arrangements are made for the patient's post discharge are shown. The field contains one numeric digit.
47	Any Liability Insurance	Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. (See §§3419ff.) If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.
48	Hemoglobin Reading	Code indicates the latest hemoglobin reading taken during this billing cycle. This is usually reported in three positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.
49	Hematocrit Reading	Code indicates the latest hematocrit reading taken during this billing cycle. This is usually reported in two positions(a percentage) to the left of the dollar cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Code	Title	Definition
50	Physical Therapy Visits	Code indicates the number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	Code indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	Code indicates the number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	Code indicates the number of cardiac rehabilitation visits from onset (at the billing provider) through this billing period.
54	Newborn birth weight in grams	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of 4 and on other claims as required by state law.
55	Eligibility Threshold for Charity Care	Code identifies the corresponding value amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse- Home Visit Hours (HHA only)	Code indicates the number of hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour.)
57	Home Health Aide- Home Visit Hours (HHA only)	Code indicates the number of hours of home health aide services provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour).

NOTE: Codes 50-57 and 60 are not money amounts but represent the number of visits. Entries for the number of visits are right justified to the left of the dollars/cents delimiter as shown.

					1	3		

Accept zero or blanks in cents position. Convert blanks to zero for CWF.

58	Arterial Blood Gas (PO2/PA2)	Code indicates arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the fourth month's bill. Report right justified in the cents area. (See note following code 59 for an example.)
59	Oxygen Saturation (02 Sat/Oximetry)	Code indicates oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill.

Code	Title	Definition
		Report right justified in the cents area. (See note following this code for an example.)

NOTE: Codes 58 and 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels. Round to two decimals or to the nearest whole percent. For example, a reading of 56.5 is shown as:

							5	7

A reading of 100 percent is shown as:

						1	0	0

60	HHA Branch MSA	Code indicates MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's - Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.)
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
62-65	Payer Codes	THESE CODES ARE SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
66	Medicaid Spenddown Amount	The dollar amount that was used to meet the recipient's spenddown liability for this claim.
67	Peritoneal Dialysis	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justify to the left of the dollar/cent delimiter. (Round to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Code indicates the number of units of EPO administered and/or supplied relating to the billing period and is reported in whole units to the left of the dollar/cents delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows:

				3	1	0	6	0

69	State Charity Care Percent	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollar/cents delimiter and fractional amounts to the right.

Code	Title	Definition
70	Interest Amount	(For internal use by third party payers only.) Report the amount of interest applied to this claim.
71	Funding of ESRD Networks	(For internal use by third party payers only.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72	Flat Rate Surgery Charge	Code indicates the amount of the standard charge for outpatient surgery where the hospital has such a charging structure.
75	Gramm/Rudman/Hollings	(For internal use by third party payers only.) Report the amount of sequestration.
76	Provider's Interim Rate	(For internal use by third party payers only.) Report the provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. Report to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows:

					5	0	0	0

77-79	Payer Codes	Codes reserved for internal use only by third party payers. CMS assigns as needed. Providers do not report payer codes.
A0	Special Zip Code Reporting	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1	Deductible Payer A	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	The amount assumed by the provider to be applied to the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	The amount estimated by the provider to be paid by by the indicated payer.
A4	Covered Self-Administrable Drugs-Emergency	The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation (e.g., diabetic coma). For use with Revenue Code 0637.
A5	Covered Self-Administrable Drugs – Not Self-Administrable In Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.

Code	Title	Definition
A6	Covered Self-Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reason (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
A7	Co-payment A	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A8-A9		Reserved for national assignment
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
AC-AZ		Reserved for national assignment
B1	Deductible Payer B	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
B2	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11
B3	Estimated Responsibility Payer B	The amount estimated by the provider to be paid by the indicated payer.
B5-B6		Reserved for national assignment
B7	Co-insurance Payer B	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9		Reserved for national assignment
BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
BC-C0		Reserved for national assignment

Code	Title	Definition
C1	Deductible Payer C	The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
C2	Coinsurance Payer C	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11
C3	Estimated Responsibility Payer C	The amount estimated by the provider to be paid by the indicated payer.
C4-C6		Reserved for national assignment
C7	Co-payment Payer C	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
C8-C9		Reserved for national assignment
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
CC-CZ		Reserved for national assignment
D0-D2		Reserved for national assignment
D3	Estimated Responsibility Patient	The amount estimated by the provider to be paid by the indicated patient.
D4-DZ		Reserved for national assignment
E0		Reserved for national assignment
E1	Deductible Payer D	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
E2	Coinsurance Payer D	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
E3	Estimated Responsibility Payer D	The amount estimated by the provider to be paid by the indicated payer.

Code	Title	Definition
E4-E6		Reserved for national assignment
E7	Co-payment Payer D	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
E8-E9		Reserved for national assignment
EA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer D	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
EB	Other Assessments or Allowances (e.g., Medical Education) Payer D	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
EC-EZ		Reserved for national assignment
F0		Reserved for national assignment
F1	Deductible Payer E	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
F2	Coinsurance Payer E	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
F3	Estimated Responsibility Payer E	The amount estimated by the provider to be paid by the indicated payer.
F4-F6		Reserved for national assignment
F7	Co-payment Payer E	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
F8-F9		Reserved for national assignment
FA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer E	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
FB	Other Assessments or Allowances (e.g., Medical Education) Payer E	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
FC-FZ		Reserved for national use

Code	Title	Definition
G0		Reserved for national assignment
G1	Deductible Payer F	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
G2	Coinsurance Payer F	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Vale Codes 8-11.
G3	Estimated Responsibility Payer F	The amount estimated by the provider to be paid by the indicated payer.
G4-G6		Reserved for national assignment
G7	Co-payment Payer F	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
G8-G9		Reserved for national assignment
GA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer F	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. Effective 10/16/03
GB	Other Assessments or Allowances (e.g., Medical Education) Payer F	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer. Effective 10/16/03
GC-GZ		Reserved for national use
H0-WZ		Reserved for national use
X0-ZZ		Reserved for national use

FL 42. Revenue Code
Required. For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered on the adjacent line in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry in FL 47 is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48 are summed.

To assist in bill review, revenue codes are listed in ascending numeric sequence to the extent possible. To limit the number of line items on each bill, revenue codes are summed at the "zero" level to the extent possible.

Providers have been instructed to provide detailed level coding for the following revenue code series:

0290s - rental/purchase of DME
0304 - rental and dialysis/laboratory
0330s - radiology therapeutic
0367 - kidney transplant
0420s - therapies
0520s - type of clinic visit (RHC or other)
0550s-0590s - home health services
0624 - Investigational Device Exemption (IDE)
0636 - hemophilia blood clotting factors
0800s-0850s - ESRD services
9000 - 9044 - Medicare SNF demonstration project

Zero level billing is encouraged for all services which do not require HCPC codes.

0001 Total Charge
For use on paper or paper facsimile (e.g., "print images") claims only. For electronic transactions, report the total charge in the appropriate data segment/field.

001X Reserved for Internal Payer Use

002X Health Insurance Prospective Payment System (HIPPS)

Subcategory	Standard Abbreviation
0 - Reserved	
1 - Reserved	
2 - Skilled Nursing Facility Prospective Payment System	SNF PPS (RUG)
3 - Home Health Prospective Payment System	HH PPS (HRG)
4 - Inpatient Rehabilitation Facility Prospective Payment System	IRF PPS (CMG)
5 - Reserved	
6 - Reserved	
7 - Reserved	
8 - Reserved	
9 - Reserved	

003X to 006X Reserved for National Assignment

007X to 009X Reserved for State Use To be discontinued effective October 16, 2003.
009X effective October 16, 2003 Reserved for National Assignment

ACCOMMODATION REVENUE CODES (010X - 021X)

010X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

Subcategory		Abbreviations	Standard
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC	
1	All-Inclusive Room and Board	ALL INCL R&B	

011X Room & Board - Private (Medical or General)

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Abbreviation	Standard
0 - General Classification	ROOM-BOARD/PVT	
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT	

2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
8 - Rehabilitation	REHAB/PVT
9 - Other	OTHER/PVT

| 012X Room & Board - Semi-private Two Bed (Medical or General)

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Subcategory Abbreviation	Standard
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
8 - Rehabilitation	REHAB/2BED
9 - Other	OTHER/2BED

| 013X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

Subcategory Abbreviation	Standard
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED
6 - Detoxification	DETOX/3&4BED
7 - Oncology	ONCOLOGY/3&4BED
8 - Rehabilitation	REHAB/3&4 BED
9 - Other	OTHER/3&4BED

| 014X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory Abbreviation	Standard
0 - General Classification	ROOM-BOARD/PVT/DLX

1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX

3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
8 - Rehabilitation	REHAB/DLX
9 - Other	OTHER/DLX

015X Room & Board Ward
(Medical or General)

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
8 - Rehabilitation	REHAB/WARD
9 - Other	OTHER/WARD

016X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

017X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Subcategories 1-4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under state regulations or other statutes supersede the following guidelines. For example, some states may have fewer than four levels of care or may have multiple levels within a category such as intensive

care.

Level I - Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).

Level II - Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (Continuing Care).

Level III - Sick neonates who do not require intensive care, but require 6-12 hours of nursing care each day (Intermediate Care).

Level IV - Constant nursing and continuous cardiopulmonary and other support for severely ill infants (Intensive Care).

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn - Level I	NURSERY/LEVEL I
2 - Newborn - Level II	NURSERY/LEVELII
3 - Newborn - Level III	NURSERY/LEVELIII
4 - Newborn - Level IV	NURSERY/LEVELIV
9 - Other	NURSERY/OTHER

018X Leave of Absence

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

NOTE: Charges are billable for codes 2 - 5

0 - General Classification	LEAVE OF ABSENCE OR LOA
1 - Reserved	
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Therapeutic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

019X Subacute Care

Accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Level I - Skilled Care: Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II - Comprehensive Care: Moderate to extensive nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III - Complex Care: Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV - Intensive Care: Extensive nursing and technical intervention. Active medical

care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

Subcategory	Abbreviation	Standard
0 - General Classification	SUBACUTE	
1 - Subacute Care - Level I	SUBACUTE/LEVEL I	
2 - Subacute Care - Level II	SUBACUTE/LEVEL II	
3 - Subacute Care - Level III	SUBACUTE/LEVEL III	
4 - Subacute Care - Level IV	SUBACUTE/LEVEL IV	
9 - Other Subacute Care	SUBACUTE/OTHER	

020X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are identified.

Subcategory	Abbreviation	Standard
0 - General Classification	INTENSIVE CARE or (ICU)	
1 - Surgical	ICU/SURGICAL	
2 - Medical	ICU/MEDICAL	
3 - Pediatric	ICU/PEDS	
4 - Psychiatric	ICU/PSTAY	
6 - Intermediate ICU	ICU/INTERMEDIATE	
7 - Burn Care	ICU/BURN CARE	
8 - Trauma	ICU/TRAMA	
9 - Other Intensive Care	ICU/OTHER	

021X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for furnishing such services, the hospital or third party may wish to identify the service.

Subcategory	Abbreviation	Standard
0 - General Classification	CORONARY CARE or (CCU)	
1 - Myocardial Infarction	CCU/MYO INFARC	
2 - Pulmonary Care	CCU/PULMONARY	
3 - Heart Transplant	CCU/TRANSPLANT	
4 - Intermediate CCU	CCU/INTERMEDIATE	
9 - Other Coronary Care	CCU/OTHER	

ANCILLARY REVENUE CODES (022X -099X)

022X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services furnished in greater detail and break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

| 023X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

| 024X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0 - General Classification	ALL INCL ANCIL
1 - Basic	ALL INCL BASIC
2 - Comprehensive	ALL INCL COMP
3 - Specialty	ALL INCL SPECIAL
9 - Other All Inclusive Ancillary	ALL INCL ANCIL/OTHER

| 025X Pharmacy

Code indicates the charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements.

Subcode 4 is for providers that do not bill drugs used for other diagnostic services as part of the charge for the diagnostic service. Subcode 5 is for providers that do not bill for drugs used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	Abbreviation	Standard
0 - General Classification	PHARMACY	
1 - Generic Drugs	DRUGS/GENERIC	

2 - Nongeneric Drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT ODX
5 - Drugs Incident to Radiology	DRUGS/INCIDENT RAD
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Nonprescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

026X IV Therapy

Code indicates the administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem rate.

Subcategory	Abbreviation	Standard
0 - General Classification	IV THERAPY	
1 - Infusion Pump	IV THER/INFSN PUMP	
2 - IV Therapy/Pharmacy Services	IV THER/PHARM/SVC	
3 - IV Therapy/Drug/Supply/Delivery	IV THER/DRUG/SUPPLY DELV	
4 - IV Therapy/Supplies	IV THER/SUPPLIES	
9 - Other IV Therapy	IV THERAPY/OTHER	

027X Medical/Surgical Supplies. (Also see 062X, an extension of 027X.)

Code indicates the charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Abbreviation	Standard
0 - General Classification	MED-SUR SUPPLIES	
1 - Nonsterile Supply	NONSTER SUPPLY	
2 - Sterile Supply	STERILE SUPPLY	
3 - Take Home Supplies	TAKEHOME SUPPLY	
4 - Prosthetic/Orthotic Devices	PROSTH/ORTH DEV	
5 - Pace maker	PACE MAKER	
6 - Intraocular Lens	INTR OC LENS	
7 - Oxygen-Take Home	02/TAKEHOME	
8 - Other Implants	SUPPLY/IMPLANTS	

9 - Other Supplies/Devices	SUPPLY/OTHER

028X Oncology

Code indicates the charges for treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

029X Durable Medical Equipment (DME) (Other Than Renal)

Code indicates the charges for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
4 - Supplies/Drugs for DME Effectiveness (HHAs Only)	MED EQUIP/SUPPLIES/DRUGS
9 - Other Equipment	MED EQUIP/OTHER

030X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - ImmunologyLAB/IMMUNOLOGY	
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Nonroutine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMATOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

031X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided for the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
1 - Angiocardiography	DX X-RAY/ANGIO
2 - Arthrography	DX X-RAY/ARTH
3 - Arteriography	DX X-RAY/ARTER
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

033X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided for the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of the State of Ohio.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

034X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service furnished.

Subcategory	Standard Abbreviation
0 - General Classification	NUCLEAR MEDICINE or (NUC MED)
1 - Diagnostic	NUC MED/DX
2 - Therapeutic	NUC MED/RX
9 - Other	NUC MED/OTHER

035X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	CT SCAN
1 - Head Scan	CT SCAN/HEAD
2 - Body Scan	CT SCAN/BODY
9 - Other CT Scans	CT SCAN/OTHER

036X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

037X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including

Medicare. Subcode 1 is for providers that do not bill anesthesia used for other diagnostic services as part of the charge for the diagnostic service. Subcode 2 is for providers that do not bill anesthesia used for radiology under radiology revenue codes as part of the radiology procedure charge.

Subcategory	Standard Abbreviation
0 - General Classification	ANESTHESIA
1 - Anesthesia Incident to RAD	ANESTHE/INCIDENT RAD
2 - Anesthesia Incident to Other Diagnostic Services	ANESTHE/INCIDENT ODX
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

038X Blood

Rationale: Charges for blood must be separately identified for private payers purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PALTELETES
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives (Cryopricipitates)	BLOOD/DERIVATIVES
9 - Other Blood BLOOD/OTHER	

039X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration (e.g.. Transfusions)	BLOOD/ADMIN.
9 - Other Processing & Storage	BLOOD/OTHER STOR

040X Other Imaging Services

Subcategory	Standard Abbreviation
0 - General Classification	IMAGE SERVICE
1 - Diagnostic Mammography	MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
3 - Screening Mammography	SCR MAMMOGRAPHY/GEN MAMMO
4 - Positron Emission Tomography	PET SCAN
9 - Other Imaging Services	OTHER IMAG SVS

NOTE: Medicare will require the hospitals to report the ICD-9 diagnosis codes (FL 67) to substantiate those beneficiaries considered high risks. These high risk codes are as follows:

ICD-9 Codes	Definitions	High Risk Indicator
V10.3	Personal History- Malignant neoplasm breast cancer	A personal history of breast cancer
V16.3	Family History- Malignant neoplasm breast cancer	A mother, sister, or daughter who has had breast cancer
V15.89	Other specified personal history representing hazards to health	Not given birth prior to 30 or a personal history of biopsy-proven benign breast disease

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

042X Physical Therapy

Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

043X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosethic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

044X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

045X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers. Under the provisions of EMTALA (Emergency Medical Treatment and Active Labor Act), a hospital with an emergency department must provide upon request and within the capabilities of the hospital an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

Subcategory	Standard Abbreviation
0 - General Classification	EMERG ROOM
1 - EMTALA Emergency Medical screening services	ER/EMTALA
2 - ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6 - Urgent Care	URGENT CARE
9 - Other Emergency Room	OTHER EMER ROOM

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Observation Room."

Usage Notes
An "X" in the matrix below indicates an acceptable coding combination.

	450 (a)	451 (b)	452 (c)	456	459
450					
451		X	X	X	
452		X			
456		X			X
459		X		X	

(a) General Classification code 450 should not be used in conjunction with any subcategory. The sum of codes 451 and 452 is equivalent to code 450. Payers

that do not require a breakdown should roll up codes 451 and 452 into code 450.

(b) Stand alone usage of code 451 is acceptable when no services beyond an initial screening/assessment are rendered.

(c) Stand alone usage of code 452 is not acceptable.

046X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviation
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

047X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

048X Cardiology

Charges for cardiac procedures furnished in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
3 - Echocardiology	ECHOCARDIOLOGY
9 - Other Cardiology	OTHER CARDIOL

049X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Observation Room."

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
3 - Echocardiology	ECHOCARDIOLOGY
9 - Other Cardiology	OTHER CARDIOL

049X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 762, "Observation Room."

050X Outpatient Services

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This revenue code is no longer used for Medicare.

Subcategory	Standard Abbreviation
0 - General Classification	OUTPATIENT SVS
9 - Other Outpatient Services	OUTPATIENT/OTHER

051X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers

may require.

Subcategory	Standard Abbreviation
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL

2 - Dental Clinic	DENTAL CLINIC
3 - Psychiatric Clinic	PSYCH CLINIC
4 - OB-GYN Clinic	OB-GYN CLINIC
5 - Pediatric Clinic	PEDS CLINIC
6 - Urgent Care Clinic	URGENT CLINIC
7 - Family Practice Clinic	FAMILY CLINIC
9 - Other Clinic	OTHER CLINIC

052X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice Clinic	FR/STD FAMILY CLINIC
6 - Urgent Care Clinic	FR/STD URGENT CLINIC
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

053X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: This is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviations
0 - General Classification	OSTEOPATH SVS
1 - Osteopathic Therapy	OSTEOPATH RX
9 - Other Osteopathic Services	OTHER OSTEOPATH

054X Ambulance

Charges for ambulance service usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 - General Classification	AMBULANCE

1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/0XY
5 - Air Ambulance	AIR AMBULANCE
6 - Neo-natal Ambulance	AMBUL/NEO-NATAL
7 - Pharmacy	AMBUL/PHARMACY
8 - Telephone Transmission EKG	AMBUL/TELEPHONIC EKG
9 - Other Ambulance	OTHER AMBULANCE

055X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

056X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

057X Home Health Aide (Home Health)

Charges made by an HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

058X Other Visits (Home Health)

Code indicates the charges by an HHA for visits other than physical therapy,

occupational therapy, or speech therapy, which must be specifically identified.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory Abbreviation	Standard
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT

2 - Hourly Charge	VISIT/HOME HLTH/HOUR
3 - Assessment	VISIT/HOME HLTH/ASSES
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

059X Units of Service (Home Health)

This revenue code is used by an HHA that bills on the basis of units of service.

Rationale: This breakdown is necessary for Medicare home health billing requirements.

Subcategory Abbreviation	Standard
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

060X Oxygen (Home Health)

Charges by an HHA for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary had purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 292 or 293 apply. DME (other than oxygen systems) is billed under current revenue codes 291, 292, or 293.

Rationale: Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory Abbreviation	Standard
0 - General Classification	02/HOME HEALTH
1 - Oxygen - State/Equip/Suppl or Cont	02/EQUIP/SUPPL/CONT
2 - Oxygen - Stat/Equip/Suppl Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
3 - Oxygen - Stat/Equip/Over 4 LPM	02/STAT EQUIP/OVER 4 LPM
4 - Oxygen - Portable Add-on	02/STAT EQUIP/PORT ADD-ON

061X Magnetic Resonance Technology (MRT)

Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.

Rationale: Due to coverage limitations, some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	MRI
1 - Brain (including Brainstem)	MRI - BRAIN
2 - Spinal Cord (including Spine)	MRI - SPINE
3 - Reserved	
4 - MRI – Other	MRI - OTHER
5 - MRA - Head and Neck	MRA - HEAD AND NECK
6 - MRA - Lower Extremities	MRA - LOWER EXT

7 - Reserved	
8 - MRA - Other	MRA - OTHER
9 - Other MRI	MRI - OTHER

062X Medical/Surgical Supplies - Extension of 027X

Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that do not bill supplies used under radiology revenue codes as part of the radiology procedure charges. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategory	Standard Abbreviation
1 - Supplies Incident to Radiology	MED-SUR SUPP/INCIDNT RAD
2 - Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCIDNT ODX
3 - Surgical Dressings	SURG DRESSING
4 - Investigational Device	IDE

063X Pharmacy-Extension of 025X

Code indicates charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in FL 44.

Subcategory	Standard Abbreviation
0 - RESERVED (Effective 1/1/98)	
1 - Single Source Drug	DRUG/SNGLE
2 - Multiple Source Drug	DRUG/MULT
3 - Restrictive Prescription	DRUG/RSTR
4 - Erythroepoetin (EPO) less than 10,000 units	DRUG/EPO/≤10,000 units
5 - Erythroepoetin (EPO) 10,000 or more units	DRUG/EPO/≥10,000 units
6 - Drugs Requiring Detailed Coding*	DRUGS/DETAIL CODE
7 - Self-administrable Drugs	DRUGS/SELFADMIN

NOTE: *Revenue code 636 relates to HCPCS code, so HCPCS is the recommended code to be used in FL 44. The specified units of service to be reported are to be in hundreds (100s) rounded to the nearest hundred (no decimal).

NOTE: Value code A4 used in conjunction with Revenue Code 637 indicates the amount included for covered charges for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. This is the only ordinarily non-covered, self-administered drug covered under Medicare with this value code.

064X Home IV Therapy Services

Charge for intravenous drug therapy services which are performed in the patient's residence. For home IV providers, the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY SVC
1 - Nonroutine Nursing, Central Line	NON RT NURSING/CENTRAL
2 - IV Site Care, Central Line	IV SITE CARE/CENTRAL
3 - IV Start/Change Peripheral Line	IV STRT/CHNG/PERIPHAL
4 - Nonroutine Nursing, Peripheral Line	NONRT NURSING/PERIPHRL
5 - Training Patient/Caregiver, Central Line	TRNG/PT/CARGVR/CENTRAL
6 - Training, Disabled Patient, Central Line	TRNG DSBLPT/CENTRAL
7 - Training Patient/Caregiver, Peripheral Line	TRNG/PT/CARGVR/PERIPHRL
8 - Training, Disabled Patient, Peripheral Line	TRNG/DSBLPAT/PERIPHRL
9 - Other IV Therapy Services	OTHER IV THERAPY SVC

NOTE: Units need to be reported in 1 hour increments. Revenue code 642 relates to the HCPCS code.

065X Hospice Services

Code indicates the charges for hospice care services for a terminally ill patient if he/she elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care	HOSPICE/CTNS HOME
3 - RESERVED	
4 - RESERVED	
5 - Inpatient Respite Care	HOSPICE/IP RESPITE
6 - General Inpatient Care	HOSPICE/IP NON RESPITE

(nonrespite)	
7 - Physician Services	HOSPICE/PHYSICIAN
8 – Hospice Room & Board-Nursing Facility	HOSPICE/R&B/NURS FAC
9 - Other Hospice	HOSPICE/OTHER

066X Respite Care (HHA only)

Charges for hours of care under the respite care benefit for services of a homemaker or home health aide, personal care services, and nursing care provided by a license professional nurse.

Subcategory	Abbreviation	Standard
0 - General Classification	RESPITE CARE	
1 - Hourly Charge/ Nursing	RESPITE/NURSE	
2 - Hourly Charge/Aide/ Homemaker/Companion	RESPITE/AID/HMEMKE/COMP	
3 - Daily Respite Charge	RESPITE DAILY	

Subcategory	Abbreviation	Standard
9 - Other Respite Care	RESPITE/CARE	

067X Outpatient Special Residence Charges

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	Abbreviation	Standard
0 - General Classification	OP SPEC RES	
1 - Hospital Based	OP SPEC RES/HOSP BASED	
2 - Contracted	OP SPEC RES/CONTRACTED	
9 - Other Special Residence Charges	OP SPEC RES/OTHER	

068X Trauma Response

Charges for a trauma team activation.

Subcategory	Abbreviation	Standard
0 – Not Used		
1 – Level I	TRAUMA LEVEL I	
2 – Level II	TRAUMA LEVEL II	
3 – Level III	TRAUMA LEVEL III	
4 – Level IV	TRAUMA LEVEL IV	
9 – Other Trauma Response	TRAUMA OTHER	

069X Not Assigned

007X Cast Room

Charges for services related to the application, maintenance, and removal of casts.

Rationale: Permits identification of this service, if necessary.

Subcategory Standard

Abbreviation	
0 - General Classification	CAST ROOM
9 - Other Cast Room	OTHER CAST ROOM

071X Recovery Room

Rationale: Permits identification of particular services, if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

072X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

073X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

074X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

075X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviation
0 - General Classification	GASTR-INTS SVS
9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

076X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services. Only 762 should be used for observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services.

The reason for observation must be stated in the orders for observation. Payer should establish written guidelines which identify coverage of observation services.

Subcategory	Standard Abbreviation
0 - General Classification	TREATMENT/OBSERVATION RM
1 - Treatment Room	TREATMENT RM
2 - Observation Room	OBSERVATION RM
9 - Other Treatment Room	OTHER TREATMENT RM

077X Preventative Care Services

Charges for the administration of vaccines.

Subcategory	Standard Abbreviation
0 - General Classification	PREVENT CARE SVS
1 - Vaccine Administration	VACCINE ADMIN
9 - Other	OTHER PREVENT

078X Telemedicine

Future use to be announced - Medicare Demonstration Project.

Subcategory	Standard Abbreviation
0 - General Classification	TELEMEDICINE
9 - Other Telemedicine	TELEMEDICINE/OTHER

079X Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)

Charges related to Extra-Corporeal Shock Wave Therapy (ESWT).

Subcategory	Standard Abbreviation
0 - General Classification	ESWT
9 - Other ESWT	ESWT/OTHER

080X Inpatient Renal Dialysis

A waste removal process, performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD

Subcategory	Standard Abbreviation
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

081X Organ Acquisition

The acquisition and storage costs of body tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

Rationale: Living donor is a living person from whom various organs are obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom various organs are obtained for transplantation.

Medicare requires detailed revenue coding. Therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	ORGAN ACQUISIT
1 - Living Donor	LIVING/DONOR
2 - Cadaver Donor	CADAVER/DONOR
3 - Unknown Donor	UNKNOWN/DONOR

4 - Unsuccessful Organ Search Donor Bank Charge*	UNSUCCESSFUL SEARCH
9 - Other Organ Donor	OTHER/DONOR

NOTE: Revenue code 814 is used only when costs incurred for an organ search does not result in an eventual organ acquisition and transplantation.

082X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X Peritoneal Dialysis - Outpatient or Home

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 - Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 - Other CAPD Dialysis	CAPD/HOME/OTHER

085X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient

A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other CCPD Dialysis	CCPD/HOME/OTHER

086X Reserved for Dialysis (National Assignment)

087X Reserved for Dialysis (State Assignment)

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultra filtration	DIALY/ULTRAFILT
2 - Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
9 - Misc. Dialysis Other	DIALY/MISC/OTHER

089X Reserved for National Assignment

090X Behavior Health Treatments/Services (also see 091X, and extension of 090X)

Subcategory	Standard Abbreviation
0 - General Classification	BH
1 - Electroshock Treatment	BH/ELECTRO SHOCK
2 - Milieu Therapy	BH/MILIEU THERAPY
3 - Play Therapy	BH/PLAY THERAPY
4 - Activity Therapy	BH/ACTIVITY THERAPY
5 – Intensive Outpatient Services-Psychiatric	BH/INTENS OP/PSYCH
6 – Intensive Outpatient Services-Chemical Dependency	BH/INTENS OP/CHEM DEP
7 – Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY
8 – Reserved for National Use	
9 – Reserved for National Use	

091X Behavioral Health Treatment/Services-Extension of 090X

Code indicates charges for providing nursing care and professional services for emotionally disturbed patients. This includes patients admitted for diagnosis and those admitted for treatment.

Subcategories 0912 and 0913 are designed as zero-billed revenue codes (no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.

Subcategory	Standard Abbreviation
0 - Reserved for National Use	
1 - Rehabilitation	BH/REHAB
2 - Partial Hospitalization* - Less Intensive	BH/PARTIAL HOSP
3 - Partial Hospitalization - Intensive	BH /PARTIAL INTENSIVE
4 - Individual Therapy	BH /INDIV RX
5 - Group Therapy	BH /GROUP RX
6 - Family Therapy	BH/FAMILY RX
7 - Bio Feedback	BH /BIOFEED
8 - Testing	BH /TESTING
9 – Other Behavior Health Treatments/Services	BH /OTHER

NOTE: Medicare does not recognize codes 912 and 913 services under its partial hospitalization program.

092X Other Diagnostic Services

Code indicates charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

093X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the State. Services may include physical therapy, occupational therapy, and speech therapy. The subcategories of 93X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

Subcategory	Standard Abbreviation
1-Half Day	HALF DAY
2-Full Day	FULL DAY

094X Other Therapeutic Services (Also see 095X an extension of 094X)

Code indicates charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Complex Medical Equipment Routine	RTN COMPLX MED EQUIP-ROUT
7 - Complex Medical Equipment Ancillary	COMPLX MED EQUIP-ANC
9 - Other Therapeutic Services	ADDITIONAL RX SVS

095X Other Therapeutic Services-Extension of 094X

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0-Reserved	

1-Athletic Training	ATHLETIC TRAINING
2-Kinesiotherapy	KINESIOTHERAPY

096X Professional Fees

Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSYCH
2 - Ophthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

097X Professional Fees-Extension of 096X

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

098X Professional Fees-Extension of 096X & 097X

Subcategory	Standard Abbreviation
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

099X Patient Convenience Items

Charges for items that are generally considered by the third party payers as strictly convenience items and are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE

4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

100X Behavioral Health Accommodations

Routine service charges incurred for accommodations at specified behavior health facilities.

Subcategory	Standard Abbreviation
0 – General Classification	BH R&B
1 – Residential Treatment – Psychiatric	BH R&B RES/PSYCH
2 – Residential Treatment – Chemical Dependency	BH R&B RES/CHEM DEP
3 – Supervised Living	BH R&B SUP LIVING
4 – Halfway House	BH R&B HALFWAY HOUSE
5 – Group Home	BH R&B GROUP HOME

101X to 209X Reserved for National Assignment

210X Alternative Therapy Services

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094X, 095X) or services such as anesthesia or clinic (0374, 0511).

Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue codes(s) would be used to report services in a separately designated alternative inpatient/outpatient unit.

Subcategory	Standard Abbreviation
0 - General Classification	ALTTHERAPY
1 – Acupuncture	ACUPUNCTURE
2 – Accupressure	ACCUPRESSURE
3 - Massage	MASSAGE
4 – Reflexology	REFLEXOLOGY
5 – Biofeedback	BIOFEEDBACK
6 – Hypnosis	HYPNOSIS
9 – Other Alternative Therapy Services	OTHER ALTTHERAPY

211X to 300X Reserved for National Assignment

310X Adult Care Effective April 1, 2003

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs).

Subcategory	Standard Abbreviation
0 – Note Used	
1 – Adult Day care, Medical and Social – Hourly	ADULT MED/SOC HR

2 – Adult Day Care, Social – Hourly	ADULT SOC HR
3 – Adult Day Care, Medical and Social – Day	ADULT MED/SOC DAY
4 – Adult Day Care, Social – Daily	ADULT SOC DAY
5 – Adult Foster Care – Daily	ADULT FOSTER DAY
9 – Other Adult Care	OTHER ADULT

311X to 899X Reserved for National Assignment

9000 to 9044 Reserved for Medicare Skilled Nursing Facility Demonstration Project

9045 to 9099 Reserved for National Assignment

FL 43. Revenue Description
Not Required. A narrative description or standard abbreviation for each revenue code in FL 42 is shown on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories descriptions are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here.

On inpatient hospital or SNF bills, the accommodation rate or HIPPS code is shown here.

FL 45. Service Date
Required. Effective June 5, 2000, CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service wherever a HCPCS code is required. This includes claims where the from and through dates are equal.

FL 46. Service Units
Required. Generally, the entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed. Providers have been instructed to provide the number of covered days, visits, treatments, procedures, tests, etc., as applicable, for the following:

Accommodations - 100s - 150s, 200s, 210s (days)
Blood - 380s (pints)
DME - 290s (rental months)
Emergency room - 450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic - 510s and 520s (HCPCS code definition for visit or procedure)
Dialysis treatments - 800s (sessions or days)
Orthotic/prosthetic devices - 274 (items)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (Units are equal to the number of times the procedure/service being reported was performed.)
Outpatient clinical diagnostic laboratory tests - 30X - 31X (tests)
Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
Oxygen - 600s (rental months, feet or pounds)
Hemophilia blood clotting factors - 636

Up to seven numeric digits may be entered. Charges for non-covered services are shown as noncovered or are omitted.

FL 47. Total Charges
Required. The total charges for the billing period are summed by revenue code (FL 42) or in the case of revenue codes requiring HCPCS by procedure code and entered on the adjacent line in FL 47. The last revenue code entered in FL 42 is "0001" which represents the grand total of all covered and non-covered charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional component is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement reports (PS&R) that you derive from the bill.

All revenue codes requiring HCPC codes and paid under a fee schedule are billed as net.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled)
Not Required. This is one of the four fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLS 50A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered, the provider has developed for other insurance and has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on lines B or C, as appropriate. (See §§3407-3415, §§3419, and §§3489-3492 to determine when Medicare is not the primary payer.)

FLs 51A, B, and C. Provider Number
Required. This is the six-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C. Release of Information
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

NOTE: The back of Form HCFA-1450 contains a certification that all necessary release statements are on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

FLs 54A, B, and C. Prior Payments
Required. For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.

Part A home health DME cost sharing amounts collected from the patient are reported in this item. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as noncovered by Medicare. Thus, for example, if total inpatient hospital charges are $350 including $50 for a deductible pint of blood, $300 is to be apportioned to the Part A deductible and $50 to the blood deductible. Blood is treated the same way in both Part A and Part B.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56 (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 57. (Untitled)
Not Required. This is one of the seven fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLs 58A, B, and C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in "3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- o EGHPs for employed beneficiaries and their spouses. (See §3491.);
- o EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to 30 months. (See §3490.);
- o LGHPs for disabled beneficiaries;
- o Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490.); or
- o WC, including BL. (See §§3407-3416.)

FLs 59A, B, and C. Patient's Relationship to Insured
Required. If the provider is claiming a payment under any of the circumstances described in the second paragraph of FLs 58A, B, or C, it may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

I. Effective Until October 16, 2003

Code	Title	Description	Map to List II
01	Patient Is Insured	Self-explanatory	18
02	Spouse	Self-explanatory	01
03	Natural Child/Insured Financial Responsibility	Self-explanatory	19
04	Natural Child/Insured Does not Have Financial Responsibility	Self-explanatory	43
05	Step Child	Self-explanatory	17
06	Foster Child	Self-explanatory	10
07	Ward of the Court	Patient is ward of the insured as a result of a court order.	15
08	Employee	Patient is employed by the insured.	20
09	Unknown	Patient's relationship to the insured is unknown.	None
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as	22

Code	Title	Description	Map to List II
		result of laws or agreements extending coverage.	
11	Organ Donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.	39
12	Cadaver Donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.	40
13	Grandchild	Self-explanatory	05
14	Niece/Nephew	Self-explanatory	07
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.	41
16	Sponsored Dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.	23
17	Minor Dependent of a Minor Dependent	Code is used where patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.	24
18	Parent	Self-explanatory	None
19	Grandparent	Self-explanatory	04
20	Life Partner	Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other)	29*, 53*
21-99		Reserved for national assignment	None

II. Effective October 16, 2003

Code	Title	Description	Map to List I
01	Spouse		02
04	Grandfather or Grandmother		19
05	Grandson or Granddaughter		13
07	Nephew or Niece		14
10	Foster Child		06
15	Ward	Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order.	07
17	Stepson or Stepdaughter		05
18	Self		01

Code	Title	Description	Map to List I
19	Child		03
20	Employee		08
21	Unknown		09
22	Handicapped Dependent		10
23	Sponsored Dependent		16
24	Dependent of Minor Dependent		17
29	Significant Other		None*
32	Mother		None
33	Father		None
36	Emancipated Minor		None
39	Organ Donor		11
40	Cadaver Donor		12
41	Injured Plaintiff		15
43	Child Where Insured Has No Financial Responsibility		04
53	Life Partner		None*
G8	Other Relationship		None

* No 1:1 map for Significant Other and Life Partner.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required. The provider enters the patient's Medicare HIC number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, EOMB, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the SSO. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the provider enters the patient's HICN, i.e., if Medicare is the primary payer, this information is entered in FL 60A.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP coverage for the patient or the spouse or during the first year of ESRD entitlement), the involved claim number for that coverage is shown on the appropriate line.

FLs 61A, B, and C. Group Name
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the name of the insurance group or plan.

FLs 62A, B, and C. Insurance Group Number
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the identification number, control number, or code assigned by such health insurance carrier.

FL 63. Treatment Authorization Code
Required. Whenever PRO review is performed for outpatient preadmission, preprocedure, or inpatient preadmission, the authorization number is required for all approved admissions or services.

FL 64. Employment Status Code
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, it enters the code which defines the employment status of the individual identified on the same line in FL 58, if the information is readily available.

Code	Title Definition	
1	Employed Full-Time	Individual stated that he or she is employed full-time
2	Employed Part-Time	Individual stated that he or she is employed part-time
3	Not Employed	Individual states that he or she is not employed full-time or part time
4	Self-employed	Self-explanatory
5	Retired	Self-explanatory
6	On Active Military Duty	Self-explanatory
7-8		Reserved for National Assignment
9	Unknown	Individual's Employment Status is unknown

FL 65. Employer Name
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66. Employer Location
Required. Where the provider is claiming a payment under the circumstances described in the second paragraph of FLs 58A, B, or C, and there is WC involvement or an EGHP, it enters the specific location of the employer of the individual identified on the same line in FL 58. A specific location is the city, plant, etc., in which the employer is located.

FL 67. Principal Diagnosis Code
CMS only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Inpatient--Required. The provider reports the principal diagnosis in this field. The principal diagnosis is the condition established after study to be chiefly responsible for this admission.

Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

Outpatient--Required. Hospitals report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. Hospitals report the diagnosis to their highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0).

If the patient arrives at the hospital for examination or testing without a referring diagnosis and

cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- Examination of ears and hearing (V72.1).

FLs 68-75. Other Diagnoses Codes
Inpatient--Required. The provider reports the full ICD-9-CM codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis entered in FL 67 should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, eliminate it before GROUPER. Proper installation of MCE identifies situations where the principal diagnosis is duplicated.

Outpatient--Required. Hospitals report the full ICD-9-CM codes in FLs 68-75 for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67. For instance, if the patient is referred to the hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported here.

FL 76. Admitting Diagnosis/Patient's Reason for Visit
Required. For inpatient hospital claims subject to PRO review, the admitting diagnosis is required. (See §3770.1.) Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 76 is a dual use field, Patient's Reason for Visit is not required by Medicare but may be used by providers for non scheduled visits for outpatient bills.

FL 77. E-Code
Not Required.

FL 78. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 79. Procedure Coding Method
Not Required.

FL 80. Principal Procedure Code and Date
Required for Inpatient Only.. The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (FL 67).

For this item, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation. Review this item against FLs 42-47. It may alert you to noncovered services or omissions.

The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all four digit codes where applicable. See first paragraph under FL 67 for acceptable ICD-9-CM codes.

The date applicable to the principal procedure is shown numerically as MM-DD-YY in the "date" portion.

Transmit to CMS the original codes reported by the provider, unless in the course of the claims development process you restore contradictory correct codes.

FL 81. Other Procedure Codes and Dates
Required for Inpatient Only. The full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 80). The date of each procedure is shown in the date portion of Item 81, as applicable, numerically as MMDDYY.

Transmit to CMS the original codes reported by the provider, unless in the course of the claims development process you restore contradictory correct codes.

FL 82. Attending/Referring Physician ID
Required. Effective January 1, 1992, providers must enter the unique physician identification number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services. Paper bill specifications are listed below. See Addendum A, record type 80 for electronic tape specifications. Accept data on paper bills that does not strictly adhere to the following, i.e., commas instead of spaces between subfields, or other minor variances if you can process it at no extra cost.

Inpatient Part A.--Hospitals and SNFs must enter the UPIN and name of the attending/referring physician. For hospital services, the Uniform Hospital Discharge Data Set definition for attending physician is used. This is the clinician primarily responsible for the care of the patient from the beginning of the hospital episode. For SNF services, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Home Health and Hospice.--HHAs and hospices must enter the UPIN and name of the physician that signs the home health or hospice plan of care. Enter the UPIN in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial.

Outpatient and Other Part B.--All providers must enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space and middle initial. If the patient is self-referred (e.g., emergency room or clinic visit), SLF000 is entered in the first six positions, and no name is shown.

Claims Where Physician Not Assigned a UPIN.--Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs, or Public Health Services. Providers must use the following UPINs to report these physicians:

- INT000 for each intern
- RES000 for each resident
- PHS000 for Public Health Service physicians, includes Indian Health Services

- VAD000 for Department of Veterans Affairs physicians
- RET000 for retired physicians
- SLF000 for providers to report that the patient is self-referred
- OTH000 for all other unspecified entities not included above

Accept the SLF entry unless the revenue code or HCPCS code indicates the service can be provided only as a result of physician referral. Accumulate and analyze information on providers that report SLF or OTH. Investigate the five provider types that report the highest percentage of SLF or OTH from January 1, 1992-June 30, 1992. Report your findings on the validity of their use of SLF and OTH to the RO.

If more than one referring physician is involved, the provider enters the UPIN of the physician requesting the service with the highest charge.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

FL 83. Other Physician ID.

Inpatient Part A Hospital.--Required if a procedure is performed. Hospitals must enter the UPIN and name of the physician who performed the principal procedure. If there is no principal procedure, the hospital enters the UPIN and name of the physician who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, the hospital leaves this item blank. See FL 82 (inpatient) for specifications.

Outpatient Hospital.--Required where the HCPCS code reported is subject to the Ambulatory Surgical Center (ASC) payment limitation or a reported HCPCS code is on the list of codes the PRO furnishes that require approval. Hospitals enter the UPIN and name of the operating physician. They use the format for inpatient reporting.

Other Bills
Not Required.

FL 84. Remarks
Required. For DME billings by HHAs, the rental rate, cost and anticipated months of usage are shown so that you may determine whether to approve the rental or purchase of equipment. In addition, special annotations may be entered where Medicare is not the primary payer because WC, an automobile medical or no-fault insurer, any liability insurer or an EGHP/LGHP is primary to Medicare. (See §§3679, 3680, 3681, and 3682.)

This space is also available to report overflow from other items.

FL 85. Provider Representative Signature.
Not Required. No signature is required for a general care hospital unless a certification is required. (See §3315.2.) A provider representative's signature or facsimile is required on the bill of a psychiatric or tuberculosis hospital.

FL 86. Date
Not Required. This is the date of the provider representative's signature.

Mr. KUHN. Uniform bill. UB92, and it is a bill that is used by hospitals in order to bill insurers, Medicare, everybody else, and it is an attempt to try to consolidate the information so there is standardization in terms of the information that moves forward, one, for standardization, but hopefully to help hospitals save cost by not having to add a lot of different things for this payer or that payer, et cetera.

Mr. GREENWOOD. Should these be available to any patient, Medicaid or otherwise—anyone who wants one, at least?

Mr. KUHN. That is a good question. In terms of transparency on the bill, I wouldn't see that there would be any barriers on that, but I would like to check with staff, and if we could get back to you on that one, that would be helpful for me, if I could.

[The following was submitted for the record:]

No. As previously stated, the UB92 is a claim form used to bill insurers for services provided to a patient they cover. Providers use many different codes on this claim form to identify services and reimbursement for different insurers. These codes are meaningless to the patient. Furthermore, these forms would not apply to uninsured patients.

Mr. GREENWOOD. Okay. Seeing no other colleagues with questions—in fact, seeing no other colleagues—we thank you for your help this afternoon. We apologize for the length of time you have had to spend here, but it is helpful.

Without objection, the binder of documents will be added to the record. The record will be kept open for 30 days, and the subcommittee is adjourned.

[Whereupon, at 7:40 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

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Tab	Document Description	Date
1	AHA Member Advisory	6/10/2003
2	AHA Letter to HHS	12/16/2003
3	HHS Response to AHA Letter	2/19/2004
4	HHS OIG Response to AHA Letter	2/2/2004
5	Energy and Commerce Committee Letter to HHS	1/22/2004
6	HHS Response to E&C Letter	No Date
7	HHS OIG Response to E&C Letter	3/1/2004
8	Ascension Proposed Policy for Discounts for the Uninsured	12/2003
9	Ascension Draft Billing and Collection for the Uninsured	4/30/2004
10	CHI - St. Francis Medical Center Financial Assistance Application	No Date
11	CHI - Central Kansas Medical Center Charity Care Policy	5/31/1991
12	CHI - Memorial Health System Financial Assistance Application	No Date
13	CHI - Charity Care/Extended Monthly Payment Checklist	No Date
14	CHI - Charity Care Standards and Guidelines	7/8/2003
15	CHI Proposed Discount Plan	1/27/2004
16	HCA Patient/Responsible Party Questionnaire Letter	No Date
17	HCA Income Attestation Long Form	No Date
18	HCA Uninsured Charity Policy and Procedures (Effective 10/1/03)	9/8/2003
19	HCA Income Attestation Short Form	No Date
20	NYPH Customer Service Reference Guide	© 2001
21	NYPH Customer Service Situation Response Training	© 1995-2002
22	NYPH Financial Screening Form	© 1995-2001
23	NYPH Columbia Presbyterian Medical Center Financial Screening Form	No Date
24	NYPH Charity Care/Financial Aid Policy	No Date
25	NYPH Billing and Collection Services Agreement	5/24/2004
26	Tenet Patient Financial Services Early Out Discounts	11/1/1999
27	Tenet Central Financial Control Policy and Procedure Manual - Litigation of Self-Pay Accounts	2/6/2004
28	Tenet Business Office Procedure Manual - General Guidelines for Financial Agreements	3/1/2000
29	Tenet Central Financial Control Policy and Procedure Manual - Interim Uninsured Settlement/Discount and Payment Plan Procedure	4/8/2002
30	Tenet Central Financial Control Policy and Procedure Manual - Charging of Interest on Bad Debt Accounts	2/6/2004
31	Tenet Central Financial Control Policy and Procedure Manual - Settlement Policy	12/6/2002
32	Tenet Central Financial Control Policy and Procedure Manual - Urgency Payment Tracking Policy and Procedure	12/2/2002
33	Tenet Central Financial Control Policy and Procedure Manual - Self-Pay and Time Pay Processing	10/28/2002
34	Tenet Business Office Procedure Manual - Patient Registration/Charity Care Policy	8/22/2003
35	Tenet Business Office Procedure Manual - Patient Registration/Charity Care Policy	1/20/2004
36	Tenet's Compact with Uninsured Patients	No Date
37	Business Week Article - U.S. Health Care System	5/24/2004
38	Business Week Article - U.S. Problem of Uninsured	5/31/2004
39	A Failing Mission: The Decline of Charity Care at Resurrection Hospitals	No Date
40	Health Care for the Uninsured - Preliminary Report from the Social Action Committee	No Date

Member A

TAB 1

AHA
Advancing Health in America

June 10, 2003

ALERT
Four Related Issues Drawing Media and Congressional Attention - Know your Organization's Policies

- **Hospital Charges**
- **Public Disclosure of Your Charges**
- **Hospital Charity Care Policies**
- **Hospital Debt Collection Practices**

A series of high-profile media stories have raised public and congressional concern about these four related issues. Significant news coverage already has occurred in California, Chicago and Denver. The New York Times and the Wall Street Journal have done major articles. Several other newspapers have indicated they are looking at stories with new angles, and congressional interest has been sparked, with staffers investigating. Every hospital leader should be aware of these issues, familiar with their own internal policies and prepared to discuss them publicly.

Background

Late last year, a "consumer advocacy" organization in California filed suit against a major health care system, alleging that the system was inappropriately billing uninsured Latino patients full hospital charges while at the same time granting discounts against those charges to government, HMOs and private insurers.

The suit arose from the standard practice of a hospital charging all patients it serves the same amount for the same service, regardless of the type of insurance a patient has or whether the patient is uninsured. Generally, federal law and regulations seek to ensure that a hospital charges all patients receiving the same services the same price.

The lawsuit was settled and the system announced a new policy, pending regulatory approval, of discounting charges to the uninsured.

While a hospital charges all patients receiving the same service the same price, what varies dramatically is how much a hospital is actually paid for the care it provides. The Medicare and Medicaid programs set payments that are not only less than charges, but also often less than the actual cost of caring for these patients. Private insurers negotiate discounts from charges on behalf of the enrollees they cover. As pressure increases from private insurers and managed care

companies for deeper discounts, charges have increased, as hospitals struggle to balance government under-funding and find the resources to care for those without insurance. But in the absence of health care coverage for all in America, people without insurance face bills reflecting these higher charges, with no one to negotiate on their behalf. They are victims of America's fragmented and inconsistent health care payment system.

Hospitals are on the front lines of care and serve millions of patients each year, regardless of ability to pay. Last year, hospitals provided more than $20 billion in uncompensated care – care to the uninsured and care for other patients who did not pay.

Media Attention Grows

The suit and the subsequent stories triggered similar reporting in other newspapers, most notably the Wall Street Journal. The scope of the stories widened to include hospitals across the country, covering not only the issue of high charges, but also the reluctance of many hospitals to make charge information public. They also delved into precisely what policies hospitals apply in determining if patients qualify for charity care.

The stories focused on debt collection practices. As hospital leaders are aware, federal agencies have publicly criticized hospitals for not aggressively attempting to collect money owed to them. But stories have chronicled cases of some hospitals seizing bank accounts, putting liens on homes, and continuing to charge interest on uncollected sums owed by patients who reportedly had made some effort to settle their debt.

The American Hospital Association (AHA) is aware of several other reporters working on similar stories in a variety of communities. In some cases, unions have been trying to fuel public attention in support of their efforts. Some reporters have begun linking some of these issues to hospitals' tax-exempt status.

In addition, legislation cracking down on debt collection practices and hospital charges to the uninsured has appeared in at least two states and a key congressional committee has expressed a high level of concern, with an investigation apparently in the works.

Because these issues are bound to get increased public attention and because they threaten to fuel public distrust of our nation's hospitals, the AHA recommends the following to its members.

RECOMMENDATIONS

Sharing Charge Information with the Public

- Consider a detailed review of the gross charges set for services provided by your organization or health care system.
- Understand how those charges relate to both costs incurred and payments made by payer type (e.g., Medicare, Medicaid, privately insured, state or local indigent care programs, uninsured).
- Review the methods used by your organization to set charges for various services.
- Develop a way for the public to promptly access charge information for any item or service provided by your hospital or health system.
- Working with your public relations department, be prepared to educate your local media about hospital charges.

- Educate patients about the potential financial obligation they may incur and any options that may be available to assist them with that obligation.

Policies for Identifying and Assisting Low-income Patients

- Review your organization's policy for identifying patients who may be eligible for public programs and charity care programs.
- Consider revisions to your current practices, if necessary, to ensure that the analysis of charity care eligibility is conducted consistently within your organization or health care system.
- Make your policy available to consumers in easy-to-understand language, as well as in languages commonly used by patients in your community.
- In relevant areas of your organization, post a notice advising patients and consumers that your organization provides charity care. Make your charity care policy available to consumers upon request and consider posting the policy itself in appropriate places.
- Refresh training for relevant staff who need to be able to answer consumers' charity care questions accurately, and ensure that they reflect the values of your organization in working with those in need of financial assistance.

Collection Practices

- Fear of a hospital bill should never get in the way of essential health services. Encourage all patients to ask questions about their hospital bill and to discuss with your staff any need for financial assistance.
- For patients who do not qualify for charity care but are in need of financial help, consider offering revised or extended payment terms or other payment options.
- In determining a payment schedule, take into account, among other factors, the amount of the charge and the income and financial assets available to patients.
- Know the resources and assets protected under your state and federal bankruptcy laws and encourage your organization to adopt similar protection policies.
- If your hospital or health system retains an agency to handle debt collection, make sure that the agency's behavior reflects the policies and values of your organization.
- Ask your collection agencies to use their contact with your patients as an opportunity to again encourage them to discuss their bill and any need for financial assistance directly with your hospital or health system.
- Demand that the individuals or agencies involved in billing or debt collection on behalf of your hospital or health system treat your patients with dignity and respect.

Discounted prices for hospital care

Generally, federal law and regulations seek to ensure that a hospital charges all patients receiving the same services the same price. These regulations and severe penalties for non-compliance have generally encouraged adherence to uniform charge schedules within the hospital field. We believe these regulations need to be clarified and possibly changed in order to allow hospitals to adjust bills for uninsured individuals without compliance concerns.

The AHA will work with federal regulators to seek clarification and explore ways in which hospitals and health systems might be allowed to adjust bills for those without health insurance coverage based on a variety of factors, such as a patient's income, overall debt, ability to continue to produce income and future medical needs. We'll keep you posted on our progress.

TAB 2

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December 16, 2003

The Honorable Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

The nation's hospitals seek your help in navigating federal regulations that make it far too difficult and frustrating to give uninsured Americans and others of limited means the same reduced rates for hospital care that state and federal governments, health plans and private insurers ultimately pay.

As you know, federal regulation makes it a practical requirement that a hospital bill all patients according to the same schedule of charges, regardless of who provides their coverage. But the amount the hospital actually is reimbursed by the various payors is quite a different story. Medicare pays under its own system, often less than the actual cost of hospital care. State Medicaid programs pay according to a variety of methods, again less than actual costs. Private insurers and health plans negotiate aggressively for the biggest payment discounts they can extract from hospitals.

In the end, one group of patients is left behind. With no one to negotiate on their behalf, uninsured Americans and others of limited means are often billed and required to pay full charges. This unfair situation is the unfortunate result of the fragmented and contradictory way health care in America is paid for and America's inability to find some way to get affordable coverage to the 44 million people who don't have it today. It is one aspect of health care in America that truly is broken.

Hospitals believe that patients of limited means should not have to pay full charges simply because they have no coverage. But federal Medicare regulations as written today contain a string of barriers that discourage hospitals from reducing charges or forgiving debt for these patients without potentially running afoul of the law. And our members tell us that past experience with federal regulation enforcement makes them extremely reluctant to risk it.

And the bill for full charges is only the beginning of what can be a long and sometimes confusing process patients must navigate. The vast majority of America's hospitals try to have fair and clear policies to help patients find financial assistance or to find out if they qualify for charity care – assistance for the truly indigent. And they try to administer those policies well. For patients who have some ability to pay, hospitals try to work out a fair way for them to pay their bills. But all of this often can be complicated and filled with anxiety and sometimes communication is poor and the practices of hospitals inconsistent.

I think you will agree that this is a situation that clearly is in need of attention, particularly in a time when so many Americans are uninsured, underinsured or worried that their coverage may erode or vanish altogether. There are opportunities for action by both the hospital field and the federal government to assure the public that we are doing all we can to help those of limited means.

At its November meeting and after extensive consultation with hospital leaders from across the nation, the American Hospital Association's Board of Trustees approved a set of principles and guidelines which they are asking the Association's nearly 5,000 members to use as a standard for assuring that all of their policies and actions in this area are open, fair and appropriate. Those principles and guidelines have been communicated to our members and we are developing educational materials and other resources to help them use them effectively.

But your help is essential in clearing away the underbrush of federal regulation cited earlier in this letter that would make it clear that hospitals have the ability to do what they can to respond to the needs of these patients.

We are enclosing an analysis of the regulatory environment that hones in on the actions we believe are needed. But specifically, we ask that the Department of Health and Human Services:

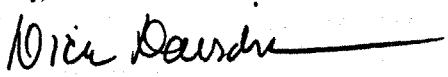
- Work through the Centers for Medicare and Medicaid Services and the Office of the Inspector General to develop safe harbor protection for discounting or waiving charges for collections for patients of limited means who are unable to pay their hospital bills. Such protection does not currently exist to guide hospitals in this area. Hospital programs that fall within the safe harbor would be protected from challenges to their payments and from the OIG under its enforcement authority.

- Institute an advisory opinion process that would allow hospitals to seek and receive binding regulatory guidance on a timely basis. This would augment the safe harbor protection and encourage hospitals to continue to develop policies and programs to assist patients of limited means.

- Create a panel of hospitals and others involved in this issue to explore solutions to the existing regulatory barriers described in the enclosed analysis and prevent new ones from cropping up. The panel would also develop other processes, tools and resources that would enable hospitals to create new and innovative programs to meet the needs of patients of limited means who are unable to pay their hospital bills.

You have our pledge to work closely and productively with you on this important issue. American Hospital Association staff members are ready to meet with whomever you designate to discuss these issues in detail and go to work with the mutual goal of doing more to help those in need.

Sincerely,



Enclosure

Am r. Hospital Assn. 12/18/2003 12:47 PAGE 002/018 Fax Server

(Embargoed until noon on Dec. 17, 2003)

Hospital Billing and Collection Practices

Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure. America's hospitals are united in providing care based on the following principles:

- Treat all patients equitably, with dignity, with respect and with compassion.
- Serve the emergency health care needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all of the care they receive.
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care in a community.

Hospitals' work is made more difficult by America's fragmented health care system ... a system that leaves *millions* of people unable to afford the health care services they need ... a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid or privately insured patients ... a system in which payments do not recognize the unreimbursed services provided by hospitals ... a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients. Today's fragmented health care system does not serve Americans well in many ways. It is in need of significant change as each day leaves more and more hospitals unable to make ends meet.

While most Americans have insurance coverage for their unexpected health care needs, more than 43 million people do not. Some of these people can pay for the health care they may

need, but America's hospitals treat millions of patients each year who can make only minimal payment, or no payment at all. In the absence of adequate insurance coverage for all, America's hospitals must find ways to both serve and survive.

Unfortunately, a vast and confusing array of federal laws, rules and regulations make it much more difficult than it should be for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills. Government must commit to removing these regulatory barriers to allow hospitals to do even more to make care affordable for patients who cannot pay for part or all of the care they receive.

The following guidelines outline how hospitals can better serve their patients. Hospitals have been following some of these guidelines for years as they work each day to find new ways to best meet their patients' needs.

Guidelines

Helping Patients with Payment for Hospital Care

Communicating Effectively

- Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.
- Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance.
- Hospitals should use a billing process that is clear, concise, correct and patient friendly.
- Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services.

Helping Patients Qualify for Coverage

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

Making Care More Affordable for Patients with Limited Means

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts (pending needed federal regulatory clarification). Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf, and should obtain agreement to these standards in writing from such agencies.
- Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection.

Hospitals in some states may need to modify the use of these guidelines to comply with state laws and regulations.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. These guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring.

Amer. Hospital Assn. 12/16/2003 12:47 PAGE 005/018 Fax Server

(Embargoed until noon on Dec. 17, 2003)

Federal Regulations Hamper Hospitals' Efforts to Assist Patients of Limited Means

Introduction and Executive Summary

The difficulties faced by patients who cannot pay their hospital bills are but one troubling element of a health care system badly in need of repair. This white paper explores a key part of this nationwide problem: the vast and confusing array of federal laws, rules, regulations, interpretive manuals, guidelines and audits that make it much more difficult than it should be for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills.

America's hospitals and the communities that built them have a longstanding bond, and part of that bond is an inherent promise: That people will get the care they need when they need it. Nowhere does this promise carry more human power than when it affects the poor of America's communities. Hospitals have a long tradition of caring for the poor: those who are unable to pay for their care through private resources, employer support or public aid. For these patients, hospitals provide billions of dollars in free or reduced-cost care every year ... $21 billion in 2001 alone.

Unfortunately, the situation is more complicated for patients who do not qualify as poor but are unable to pay their hospital bills because their resources are too limited and they lack adequate health insurance. That is because vast and confusing federal regulations make it more difficult than it should be to extend the same free or reduced-cost care that is routinely provided to the poor. The Commonwealth Fund, a private foundation that supports independent research on health and social issues, reached similar conclusions in its June 2003 report on barriers to care for the uninsured:

Federal fraud and abuse laws and Medicare regulations and guidelines designed to prevent overbilling and provision of unnecessary care may inadvertently inhibit providers from offering reduced-cost or free care and encourage providers to aggressively attempt to collect on both Medicare and uninsured patients' outstanding bills.

The complexity of the rules and the difficulty in interpreting them may also lead some providers to standardize their fee-setting and collections practices across all payer groups to the unintended detriment of the uninsured.[1]

The federal rules that hospitals must navigate in order to assist patients of limited means govern both billing and collections practices for hospital services. While technically these rules apply only to the beneficiaries of the Medicare program, their practical effect, due to Medicare's huge influence on health care in America and certain requirements for uniformity, is to shape policies for all hospital patients.

Billing

The difficulties created by the Medicare billing rules are related to the practical requirement that each hospital maintain a uniform charge structure that applies to all patients. In other words, each patient must be charged the same amount for identical services. Such uniformity remains crucial to determining payments for some hospitals, such as critical access hospitals, and also to the submission of accurate cost reports for all hospitals.

There are two limited exceptions to this practical requirement. The first exception, which is rarely used, allows hospitals to lower charges to patients if private Medicare contractors approve them to do so. To gain approval, hospitals must demonstrate that they can comply with complicated and burdensome record-keeping requirements. The second exception allows hospitals to lower their charges or provide free care to patients who meet the hospital's standards for indigence.

Collections

The difficulties created by the collections rules are related to the requirements that hospitals must meet under the Medicare bad debt rules. Those rules require hospitals to demonstrate that they made reasonable collection efforts that were comparable for all types of patients. According to the federal interpretive manuals for these rules, reasonable collection efforts include issuing bills, sending collection letters, making telephone calls and personal contacts, and initiating court action to obtain payment.

Through a series of reviews and audits, the U.S. Department of Health and Human Services Office of Inspector General (OIG) has helped to shape the definition of reasonable efforts and created an

[1] C. Pryor, R. Seifert, D. Gurewich, L. Oblak, B. Rosman, J. Prottas, "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt," (June 2003). http://www.cmwf.org/programs/insurance/pryor_unintendedconsequences_653.pdf, at p. vi. For purposes of this white paper, the above document will be referred to as the "Commonwealth Fund Report."

expectation that hospitals must be aggressive in their collection efforts or risk losing Medicare reimbursement for bad debt. Hospitals' attempts to respond to these pressures are at the core of the criticism that hospitals are now facing in the media and before Congress.

Similar to billing, there is an exemption from Medicare collections requirements for indigent payments. However, unlike billing, extending this exemption to indigent patients requires hospitals to comply with a complicated verification process that includes an independent and fully documented assessment of the patient's resources. If a patient is unable or unwilling to work with the hospital to document that he or she meets its indigence standards, the hospital must make reasonable collections efforts.

Antikickback Laws

As noted in the Commonwealth Fund Report, federal and state antikickback laws also contribute to the regulatory confusion. Those laws prohibit hospitals from offering inducements to patients. In a Special Fraud Alert, the OIG added forgiving a patient's debt for reasons other than genuine financial hardship to the list of prohibited inducements. To date, there has been a lack of guidance from federal or state authorities on how a hospital can forgive or reduce debts for all types of patients within the antikickback laws' restrictions.

Recommendations for Change

To address the problems created by vast and confusing federal regulations, the Department of Health and Human Services (HHS), through its constituent agencies, should take a number of important steps, including:

- Develop safe harbor protection for discounting charges and waiving or reducing payments owed by patients of limited means.
- Institute a timely advisory opinion process that allows hospitals to receive binding guidance on programs for discounting charges, waiving or reducing payments owed, or otherwise assisting patients of limited means.
- Work with a panel of stakeholders, including hospitals, to further address regulatory impediments to assisting patients of limited means and prevent the development of new ones, and to develop processes, tools and resources for hospitals to use in their efforts to assist patients of limited means.

Billing: Medicare Uniform Charge Requirement

As a practical matter, each hospital needs to establish a uniform charge structure that applies to all patients. Part of the rationale for this requirement was to prevent cross-subsidization between Medicare and non-Medicare patients. As discussed below, a uniform charge structure is crucial to the proper determination of payments under the "reasonable cost" system that dominated Medicare payments to hospitals for many years and still applies to some hospitals. It also remains crucial to the submission of accurate cost reports from hospitals, which the Centers for Medicare & Medicaid Services (CMS) relies on for various purposes. CMS has issued thousands of pages of regulations governing the reasonable cost reimbursement system and related interpretive guidances.[2] The practical result of CMS' insistence on uniform charges is that hospitals have been discouraged from lowering their charges to patients of limited means.

In General

At its inception, the Medicare program made payments to hospitals on a "reasonable cost" basis, under which the hospital cost report played a crucial role in determining payments.[3] The accuracy of the cost report, in turn, depends upon hospitals maintaining uniform charges for all patients. Without such uniformity, the cost report cannot properly determine Medicare payments to hospitals.[4]

The requirement appears in section 2203 of the Provider Reimbursement Manual ("PRM"), which states, in part:

"So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs."

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[2] *See* Shalala v. Guernsey Memorial Hosp., 514 U.S. 87, 96 (noting that as of 1993, the Medicare reimbursement regulations "consumed some 620 pages of the Code of Federal Regulations").

[3] Social Security Act ("SSA") § 1861(v)(1)(A). The statute defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" and determined in accordance with regulations. Id. The regulations are supposed to ensure that cross-subsidization (Medicare bearing the costs of non-Medicare patients and vice-versa) does not occur. Id.

[4] The cost report determines Medicare reimbursement by first compiling hospital incurred costs and allocating overhead costs ("cost finding") and then determining the allocation of such allowable costs to Medicare patients and non-Medicare patients ("cost apportionment"). *See* 42 C.F.R. §§ 413.24, 413.50.

(Emphasis added.)

CMS has been active in ensuring that hospitals maintain uniform charges and frequently used the principle to defend Medicare reimbursement disallowances.[5] Indeed, one court noted, "the regulations require that charges are reported at their pre-discount rates for Medicare apportionment purposes because the charge figure affects the amount of cost reimbursement."[6] Thus, as a practical matter, hospitals must levy uniform charges for all patients to ensure compliance with Medicare cost report requirements.

Medicare rules also clearly indicate that the uniform charge is what hospitals are supposed to levy to *all* patients, including Medicare patients. When a hospital provides a non-covered service to a Medicare patient, the charge for the service should be the customary charge.[7] Likewise, if a Medicare beneficiary insists on a private room, the hospital may collect the difference between the customary charge for the room and the most common charge for a semi-private room.[8] In these situations, the Medicare program expects that hospitals will use their uniform charges in billing Medicare beneficiaries for non-covered services, just as hospitals use the uniform charges when billing patients who have third party insurance or who have no insurance.

A recent proposed rule by the OIG illustrates the confusion created by the involvement of multiple federal agencies in hospital charging practices. That proposed rule, which would penalize hospitals for bills or requests for payments "substantially in excess" of "usual charges," appears to have the effect of reinforcing the practical requirement for uniform charges.[9] While CMS rules say that Medicare cannot dictate what a provider charges, the OIG rule appears to propose doing just that and in a manner that encourages uniformity in order to avoid exclusion from the Medicare program.[10]

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[5] *E.g.* St. Mary's Hosp. Medical Ctr. v. Heckler, 753 F.2d 1362, 1364 (7th Cir. 1985), *cert. denied* 472 U.S. 1028 (1986) (without uniformity of charges Medicare could bear a heavier burden for the cost of laboratory services); Baptist Memorial Hosp. v. Sullivan, 1992 WL 314081 (W.D. Tenn. 1992) (Secretary requires uniformity of reported price charged to ensure proper cost apportionment)

[6] Lake Region Hosp. Corp. v. Heckler, 602 F. Supp. 109, 111 (D. Minn. 1983).

[7] Hospital Manual § 415.3(D). "Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement." PRM § 2604.3.

[8] Id. at §§ 210.1, 415.3(G).

[9] *See* 68 Fed. Reg. 53939, 53940 (Sept. 15, 2003).

[10] *Compare* PRM §2203 *with* 68 Fed. Reg. 53940-42.

Limited Exceptions

There are two limited exceptions to the uniformity requirement. As explained below, one exception imposes considerable administrative burdens on hospitals and must be approved by the CMS private contractors (known as fiscal intermediaries), and the other applies only to Medicare beneficiaries meeting certain indigence standards.

"Grossing-up": The "gross-up" exception allows hospitals to bill lower charge levels to selected patients without jeopardizing the integrity of the cost apportionment process.[11] A provider is permitted to deviate from the uniformity requirement by having different charge levels as long as it first obtains the permission of its fiscal intermediary, having demonstrated to the intermediary that the provider has the accounting and record-keeping ability to track the lower charges and to gross them up to customary levels for the cost report. When permission is granted, the hospital may bill charges for some patients at levels that are different from those for other patients, although for cost report purposes the lower charges must be increased to the full charge level before cost apportionment is done. While the "grossing-up" technique does allow for a variance of charges with the fiscal intermediary's approval, there are significant risks and administrative and accounting burdens associated.[12]

Sliding Scale Charge Structure: Medicare rules allow providers to offer free care or care at a reduced charge to patients who are determined to be financially indigent. It is not clear whether indigence needs to be determined and verified by the same standards that govern debt collection. The charge assessed to the patient is typically based on the patient's ability to pay, and the hospital must meet certain conditions for the practice to be permissible.[13] While this provision allows hospitals to provide free or reduced-charge care to people who qualify as indigent, it does not expressly permit hospitals to lower their charge levels to patients of limited means who do not meet the hospital's indigence standards.

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[11] PRM §2314(B). This exception has been found to be an appropriate means to ensure proper cost apportionment when a provider charges patients different amounts for the same services. *E.g.* Tri-County Hosp. and Nursing Home v. Blue Cross and Blue Shield Assoc., HCFA Administrator Decision (Jul. 1, 1983), *reprinted in* Medicare & Medicaid Guide [CCH] ¶33,013. The decision of the HCFA Administrator was upheld in federal court. Tri-County Hosp. and Nursing Home v. Heckler, 1985 WL 56545 (D.D.C. Apr. 18, 1985). "HCFA" stands for the Health Care Financing Administration, which was the prior name of CMS.

[12] *See* Commonwealth Fund Report at p. 10 ("implementing multiple fee schedules can put providers at risk of violating the law"). *See generally* Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, *reprinted in* Medicare & Medicaid Guide [CCH] ¶ 44,591 (HCFA Administrator Decision Jun. 24, 1996) (dispute over how to gross-up charges); St. Mary's Hosp. and Medical Ctr. v. Blue Cross and Blue Shield Association/Blue Cross of California, *reprinted in* Medicare & Medicaid Guide [CCH] ¶ 80,656 (Provider Reimbursement Review Board Decision Apr. 25, 2001) (Board majority and dissent disagreed on gross-up methodology).

[13] PRM § 2608.2(D).

Why It Is Important

While it may be tempting to dismiss the uniform charge rule as a relic of the "old" reasonable cost reimbursement system, in fact, a significant portion of the Medicare program has only recently been converted to a system that does not base payments on "reasonable cost." Indeed, it was only three years ago that CMS discontinued determining payments for all hospital outpatient services on a reasonable cost basis. Moreover, reasonable cost remains the basis for determining Medicare payment levels for a number of hospitals, such as critical access, cancer and children's hospitals. Finally, information from the Medicare cost report continues to play a role in establishing Medicare payment levels for hospitals that are paid under the inpatient and outpatient prospective payment systems and hospitals remain obligated to file accurate cost reports at the risk of criminal sanctions.[14]

Effect on Patients of Limited Means

Because of the Medicare rules described above and the lengths to which CMS has gone to enforce the rules, hospitals continue to believe that the Medicare cost reporting rules require them, in practice, to develop and maintain uniform charges for all patients. There is no guidance from CMS that would lead hospitals to a different conclusion. While the rules countenance mechanisms by which charges can vary, the mechanisms either are extremely burdensome and risky for hospitals, or they would not allow hospitals to provide relief to all patients of limited means. In the absence of clear guidance allowing them to lower their charges to patients with limited means, hospitals are understandably reluctant to deviate from what they see as a longstanding requirement imposed by CMS.

Collections: Medicare Bad Debt Rules

Although Medicare bad debt policy provides payments to hospitals for uncollectible copayments and deductibles from beneficiaries, the rules governing such payments require uniformity in hospital collection efforts for all patients, not just Medicare patients. CMS has created an extensive set of rules regarding Medicare bad debt payments that are both difficult to navigate and incomplete. With the extensive review of hospital bad debt payments from Medicare fiscal intermediaries and the OIG and the insistence of these entities that hospitals make vigorous collection efforts, hospitals have been discouraged from making accommodations for patients of limited means who do not meet indigence standards.

[14] *See* 42 C.F.R. §§ 412.87-88 (inpatient new technology payments), 419.66 (Outpatient PPS pass-through payments for medical devices); 67 Fed. Reg. 66718, 66746 (Nov. 1, 2002) (use of charges for establishing outpatient prospective payment system rates).

What They Are

Medicare's bad debt policy is grounded in the same principle as the uniform charge requirement – minimizing cross-subsidization between Medicare and non-Medicare patients. As noted in a 1997 decision by the CMS administrator, "the program acknowledges that the inability of providers to collect deductibles and coinsurance amounts from Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. To minimize such cross-subsidization, Medicare pays providers for allowable bad debts."[15]

The bad debt policy is implemented by CMS through regulations and manual provisions. The regulations (42 C.F.R. § 413.80(e)) set forth four criteria for bad debts to be allowable:

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery in the future.

Further guidance appears in the Provider Reimbursement Manual. For example, PRM § 310 explains what constitutes a "reasonable collection effort." It requires a provider to use similar efforts to collect from Medicare beneficiaries as those that are made to collect comparable amounts from non-Medicare patients.[16] According to CMS, "[w]here a provider expends less effort to collect from some patients than from others . . . it has an inconsistent collection effort contrary to Medicare policy."[17]

Providers must issue a bill at, or shortly after, discharge to the party responsible for the patient's personal financial obligations, issue subsequent bills, issue collection letters, make telephone calls or initiate personal contacts. These actions must constitute a genuine collection effort. As part of that effort, the provider "may us[e] or threaten[] to use court action to obtain payment."[18] In addition, a provider may use a collection agency in addition to, or in lieu of, its collection efforts, and if it does so, must use that collection agency for all classes of patients. On the whole, these rules, as read by

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[15] Hennepin County Medical Center v. Blue Cross and Blue Shield Association, HCFA Administrator Decision (Jan. 13, 1997), *reprinted in* Medicare & Medicaid Guide [CCH], ¶ 45,182.

[16] That collection efforts must be the same for Medicare and non-Medicare patients under the bad debt rules has been confirmed by federal courts and the CMS Administrator. *E.g.*, id.; Mt. Sinai Hospital Medical Center v. Shalala, 196 F. 3d 703 (7th Cir. 1999). *See* Letter to Mark Rukavina from Laurence D. Wilson, Director Chronic Care Policy Group, CMS, Sept. 11, 2003 (hereinafter, CMS Letter on Hospital Charges).

[17] CMS Letter on Hospital Charges.

[18] PRM § 310.

hospitals, create a very strong presumption that hospitals must use aggressive efforts to collect from all patients.

The manual also sets forth a complicated independent verification system for indigent patients that, in effect, exempts them from "reasonable collection efforts." Providers are not required to undertake reasonable collection efforts when they determine that the Medicare beneficiary is indigent. Quite recently, confusion has arisen surrounding whether "Medicare policy requires a provider to apply . . . consistent methods for determining indigence[.]" to all patients.[19] In a letter responding to a general inquiry on the subject sent on September 11, CMS suggested that such a requirement might apply, although the manual provision does not contain such a requirement.[20] Providers may deem patients who are dually eligible for Medicare and Medicaid as indigent, for other beneficiaries, providers must determine indigence using the following guidelines:

- Providers must make an independent indigence determination – a signed declaration by the patient that he or she is unable to pay his or her medical bills will not suffice.
- A provider must take into account total resources including, but not limited to assets, liabilities, income and expenses.
- A provider must determine that the patient is not eligible for Medicaid or that another individual or program is not legally responsible for the patient's medical bills.
- The patient's file must include documentation of the method by which indigence was determined, including all backup information to substantiate the determination.[21]

According to the Commonwealth Fund Report, federal officials expect a patient's indigence to be determined anew at each visit, unless those visits were within days of one another.[22] Obviously, this requirement poses significant administrative burdens on the hospital.

Unless *all* of the above requirements are met, a hospital must undertake "reasonable collection efforts." Provided that a hospital adheres to this web of regulatory and manual provisions, it is eligible for Medicare bad debt payments.

Why They Are Important

CMS and the OIG have been vigorous in their enforcement of the Medicare bad debt rules. For instance, in 2002 the OIG reported the results of its review of inpatient bad debts at Jackson

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19 CMS Letter on Hospital Charges.

20 Id.

21 PRM § 312.

Memorial Hospital over three cost years. The OIG concluded "[m]any of the unallowable bad debts in our review of FY 1999 resulted from the hospital's not making collection efforts on patients who were not indigent."[23] After noting that efforts to collect from patients may be waived if the patient is determined to be indigent by the hospital, the OIG found that the hospital did not make reasonable collection efforts for patients that did not meet the hospital's indigence guidelines and recommended a disallowance of $157,179 because of this finding.[24] Although it is unclear whether the OIG reviewed bad debts for non-Medicare patients, the OIG appears to have faulted the hospital for not undertaking sufficient collection efforts for *the very patients that hospitals are now being criticized for demanding payment from too strenuously*.

The OIG's oversight of the bad debt rules also prompted the creation of additional requirements for hospitals to follow in making "reasonable collection efforts." In one recent audit, the OIG defined "reasonable collection efforts" as making genuine efforts on a monthly basis for 120 days from the initial billing, with the collection efforts thereafter to be frequent enough to constitute more than a token effort.[25] These requirements have never been included in the Medicare manuals. Moreover, the OIG has been active in exercising its oversight authority with regard to Medicare bad debts, particularly on the question of reasonable collection efforts.[26] These added (and unstated until the issuance of an audit report) requirements, combined with the OIG's extensive review of hospital bad debt payments, put even more pressure on hospitals to be aggressive in their collection efforts.

The length and the complexity of the appeals process for disallowed payments further deter hospitals from curtailing collection efforts from low-income patients. In University Health Services, the dispute involved whether the hospital was permitted to treat non-Medicare debts differently than Medicare debts. The district court determined that the PRM provisions could be interpreted either way, and thus found that the hospital was entitled to the $524,800 in Medicare bad debt payments in question from the 1986 cost report.[27] The appellate court, however, reversed the district court's decision two years later, deferring to CMS' interpretation of the PRM. The hospital had to fight the issue administratively and in federal court for more than 10 years to receive definitive guidance on the question from a

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[22] Commonwealth Fund at 7.

[23] *See* http://oig.hhs.gov/oas/reports/region4/40202015.pdf, OIG Report A-04-02-02015, Review of Medicare Bad Debts for Jackson Memorial Hospital for the Fiscal Year Ended September 30, 1999 (October 2002), at p. 1.

[24] *See* id. at p. 4.

[25] *See* http://oig.hhs.gov/oas/reports/region6/6020027.pdf, OIG Report A-06-02-0027, Audit of Inpatient Bad Debts Claimed by Hermann Hospital in its Medicare Cost Report Hospital for the Fiscal Year Ended June 30, 2000 (October 2002), at pp. 10-11.

[26] *E.g.* id.; http://oig.hhs.gov/oas/reports/region4/40202011.pdf, OIG Report A-04-02-02011, Review of Medicare Bad Debts for Florida Hospital for the Fiscal Year Ended December 31, 1999 (October 2002) (recommending a $131,698 Medicare disallowance because of a failure to undertake reasonable collection efforts).

[27] University Health Servs., Inc. v. Shalala, 1995 WL 842005 at *5 (S.D. Ga. 1995).

federal appeals court. Thus, when the Medicare policies on bad debts are unclear, it takes years to settle the disputes, at substantial cost and with substantial sums of Medicare reimbursement at stake.[28]

Effect on Patients of Limited Means

Complex regulatory requirements for bad debt payments, strict enforcement of these provisions, and the lack of clear guidance from regulators lead hospitals to presume that anything less than aggressive collection efforts run the risk of violating Medicare bad debt rules and jeopardizing payments that they are entitled to under the Medicare statute and regulations. These risks are far less for insured patients.

For patients insured by private health insurance, the insurer typically negotiates payments for services that are less than the hospital's charges, which are then reflected in a contract with the hospital. These contracts usually prohibit the hospital from collecting from the insured anything other than deductible or coinsurance amounts for covered services. This is a very typical arrangement between a hospital and an insurer, and the government has never questioned whether this constitutes a "reasonable collection effort" under the bad debt rules.That is because it would be quite difficult to demonstrate that the hospital's acceptance of payment that is less than the uniform charge, after arm's length negotiations with insurers, does not constitute a reasonable effort to collect billed charges.

Indeed, this private insurance scenario mirrors what occurs with Medicare beneficiaries, only without any negotiations between Medicare and the hospital. Medicare will establish a payment rate and assess a copayment. The Medicare statute requires that hospitals accept the Medicare payment rate and the copayment amount as payment in full for the service.[29] The hospital is prohibited from seeking the difference between its charge and the amount it collects from Medicare and the beneficiary. No one would suggest that, in abiding by the law, the hospital has failed to undertake reasonable collection efforts, just as no one should suggest that the hospital fails to undertake reasonable collection efforts when it abides by its contract with the private insurance company and seeks no further collections from private insurance patients.

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[28] University Health Servs., Inc. v. Health and Human Servs., 120 F.3d 1145 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998). Similarly, in Shalala v. St. Paul-Ramsey Medical Ctr., 50 F.3d 522 (8th Cir. 1995), the agency defended a denial of Medicare bad debt costs because the hospital relied on financial information from the patient in assessing whether the patient met its standards for indigence up to the United States Court of Appeals for the Eighth Circuit. The final decision was rendered more than eight years after the costs in question were reported by the hospital.

[29] SSA § 1866(a)(1).

The same, however, cannot be said for hospitals' decisions to discontinue collections for uninsured patients who are not indigent. No entity negotiates on behalf of these individuals, forcing hospitals to make case-by-case determinations with no clearly articulated Medicare policy that permits hospitals to take into account an individual patient's true ability to pay for services received. At most, the Medicare rules allow hospitals to determine that "the debt was actually uncollectible when claimed as worthless" or to exercise "sound business judgment" as to whether there is no likelihood of recovery at any time in the future. In practice, the patients in this category have some ability to pay, so the debt is neither worthless nor is there no likelihood of recovery. These provisions, thus, provide no assurance that a hospital wanting to accept $200 as payment in full for a $1,000 service from a patient of limited means would not bear the brunt of an OIG investigation or an audit by the hospital's fiscal intermediary regarding whether it has undertaken reasonable collection efforts.[30] The effect of the entire regulatory scheme is to pressure hospitals in these circumstances to be conservative in following the standard collection agency course, rather than negotiate a lower payment amount with patients of limited means who are not considered indigent.

Fraud and Abuse: Anti-kickback Laws

State and federal antikickback laws also create incentives for hospitals to aggressively seek repayment from uninsured patients of limited means. These laws generally prohibit entities such as hospitals from offering remuneration to induce individuals to obtain services at the hospital. For example, Rhode Island law prohibits offering remuneration to a person to induce him or her to purchase any health care item or service, regardless of the payer involved.[31] Under such state laws, a hospital that forgives patient debts could be accused of offering remuneration to induce patients to obtain services at the hospital.

While federal antikickback law applies only when the induced services are payable by a federal health care program (*e.g.*, Medicare or Medicaid), it is relevant to hospital efforts to collect less than full copayments from a Medicare beneficiary.[32] The OIG issued a Special Fraud Alert regarding waiver of Medicare deductibles and copayments and stated that when health care providers "forgive financial

[30] Indeed, when the authors of the Commonwealth Fund Report quoted a CMS official about using less aggressive collection efforts for the uninsured, the official could not provide assurance that such action would be found consistent with Medicare rules. *See* Commonwealth Fund Report at p. 9. That the government agency that enforces the bad debt rules cannot sanction such action underscores the complexity of these rules.

[31] R.I. Gen. Laws § 5-48.1-3(b). Other state laws follow the federal antikickback law explicitly but extend it to all persons. *See* Minn. Stat. § 62J.23 (making the federal law "apply to all persons in the state, regardless of whether the person participates" in a particular health care program).

obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them."[33] While the Special Fraud Alert suggests that hospitals can make determinations about financial hardship on a patient-by-patient basis, it offers no guidance on how hospitals can make these assessments consistent with the antikickback law.

Why They Are Important

Federal and state antikickback laws carry severe civil and criminal penalties, causing hospitals to consider very carefully whether their actions are consistent with these authorities. Penalties for violating the federal antikickback law consist of substantial criminal fines and up to five years of imprisonment, exclusion from participation in the federal health care programs, and the imposition of civil monetary penalties.[34] State laws also can carry significant penalties; the penalties for violating the Rhode Island law include up to a year in prison.[35]

Effect on Patients of Limited Means

Because the penalties for violating federal and state antikickback laws can be severe, hospitals are very reluctant to establish programs that may implicate these laws in the absence of clear guidance. Moreover, hospitals that serve patients residing in different states, or hospital systems operating in different states that want to have a uniform program, may have difficulty navigating the various state antikickback laws. States typically offer little guidance in this area. To the extent that federal antikickback law is applicable, the OIG has offered no guidance on programs for patients of limited means who are not indigent. As a result of this lack of guidance, hospitals are reluctant to proceed with these programs.

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[32] SSA § 1128B(b). Because patients that report they have no insurance later could be found to be covered by a federal health care program, the federal antikickback law also could be implicated in a hospital's consideration of collection forgiveness for uninsured patients.

[33] *See* 59 Fed. Reg. 65372, 65375 (Dec. 19, 1994). While this fraud alert pertains to routine waivers of Medicare Part B deductibles, the OIG stated that the focus should not be interpreted as legitimizing similar waivers under Medicare Part A. Id. at 65374. Further, OIG advisory opinions make clear that its concerns about waivers of deductibles and coinsurance extend to Medicare Part A. *See* OIG Advisory Opinion 01-07 (Jul.2, 2001), http://oig.hhs.gov/fraud/docs/advisoryopinions/2001/ao01-07.pdf.

[34] *See* SSA §§ 1128B(b)(criminal fine of $25,000 per violation and imprisonment for not more than five years; SSA §1128A(a)(7) (imposing civil monetary penalty of up to $50,000 per act plus three times the remuneration offered); SSA §§ 1128(b)(7), 1128A(a)(7) (exclusion from participation in a federal health care program).

[35] R.I. Gen. Laws § 5-48 1-3(b)

Recommendations for Change

There is no single panacea to solve the problems created by the vast and confusing array of federal laws, rules, regulations, interpretive manuals, guidelines and audits. However, there are certain important steps that the federal government can take to eliminate much of the regulatory uncertainty that hampers hospitals' efforts to develop programs or undertake other activities to assist patients of limited means with their hospital bills.

- HHS, working through its constituent agencies CMS and OIG, should develop safe harbor protection for discounting and waiving charges or collections for patients of limited means who are unable to pay their hospital bills. Currently there is no safe harbor that hospitals can look to for guidance in order to develop and operate programs that discount or waive charges or collections for these patients. Hospital programs that fall within the safe harbor would be protected from a challenge to their payments under the Medicare program and from the OIG under its enforcement authority.

- To augment safe harbor protection and encourage hospitals to continue developing programs to assist patients of limited means, HHS also should institute an advisory opinion process that allows hospitals to seek and receive binding regulatory guidance on a timely basis. Certain aspects of the OIG's current advisory opinion process could serve as a model. However, to be effective, there must be a high level of assurance that the process will be a timely one and that the guidance received will be binding on both CMS and the OIG. With regard to timeliness, the commitment of the federal antitrust agencies to respond to requests for guidance on most health care matters on an expedited basis — within 90 days of receiving the necessary information — should be incorporated into this advisory opinion process.

- To assist hospitals and their patients at the broadest level, CMS should work with a panel of stakeholders, including hospitals, to:

  - ✓ further explore solutions to the existing regulatory impediments described in this white paper and prevent the development of new ones, and
  - ✓ develop other processes, tools and resources that hospitals can use to facilitate the development of new and innovative programs to respond to the needs of patients of limited means who are unable to pay their hospital bills.

TAB 3

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 19 2004

Richard J. Davidson
President
American Hospital Association
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802

Dear Mr. Davidson:

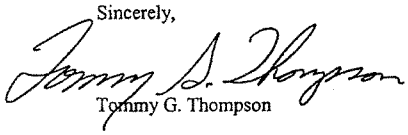
I received your letter regarding the issue of hospitals charging uninsured Americans more than individuals who have health insurance coverage. Hospitals' charging the uninsured the highest rates is a serious issue that demands all of our attention.

As I am sure you are aware, Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals provisions to help hospitals bear the cost of caring for the poor and uninsured. In addition, although Medicare beneficiaries are not uninsured, Medicare pays hospitals approximately $1 billion a year to compensate them for bad debt associated with serving Medicare clients.

Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay "full price" for their care. That suggestion is not correct and certainly does not accurately reflect my policy. The advice you have been given regarding this issue is not consistent with my understanding of Medicare's billing rules. To be sure that there will be no further confusion on this matter, at my direction, the Centers for Medicare & Medicaid Services and the Office of Inspector General have prepared summaries of our policy that hospitals can use to assist the uninsured and underinsured. This guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts. In addition, the Office of Inspector General informs me that hospitals have the ability to offer discounts to uninsured and underinsured individuals and cost-sharing waivers to financially needy Medicare beneficiaries.

With this guidance as a tool, I strongly encourage you to work with AHA member hospitals to take action to assist the uninsured and underinsured and therefore, end the situation where, as you said in your own words, "uninsured Americans and others of limited means are often billed and required to pay higher charges."

Sincerely,



Tommy G. Thompson

Enclosure

Questions On Charges For The Uninsured

Q1: Can a hospital waive collection of charges to an indigent, uninsured individual?

A1: Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.

In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Q2: What if a hospital wants to discount charges to patients with large medical bills?

A2: In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies. The separate issue of how Medicare reimburses for the uncollectible deductibles and coinsurance of Medicare beneficiaries will be discussed in answers below.

The OIG advises that discounts to underinsured patients can raise concerns under the Federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other Federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG webpage.

Q3: Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A3: No, a hospital does not need permission before offering discounts. However, the Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

Q4: Does offering discounts to the uninsured/underinsured affect a hospital's cost to charge ratio or Medicare cost apportionment?

A4: No, as long as the provider properly reports full charges on the Medicare cost report. This is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system.

Q5: How is the above any different than a hospital giving a discount to Blue Cross or any other insurer?

A5: For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances. The Medicare program sees no complications where a provider offers discounts or allowances to uninsured or underinsured patients versus allowing discounts or allowances to third-party payers.

Q6: Does the Medicare program's lesser of costs or charges (LCC) principle alter any of the above advice or prohibit hospitals from offering discounts to the uninsured or the underinsured?

A6: The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced.

The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But the vast majority of services provided in hospitals in America today are not subject to the LCC principle.

In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC. And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Q7: Will Medicare pay a hospital's bad debts for non-Medicare patients who don't pay their bills?

A7: No. Medicare does not pay the bad debts of non-Medicare patients.

Q8: Does Medicare provide any special compensation to hospitals that treat a large number of uninsured patients – especially those hospitals that have to write off a large number of bills for the uninsured?

A8: Yes. CMS makes payments – significant payments – to hospitals that treat a large number of low-income and uninsured patients. For example, the Medicare and Medicaid disproportionate share provisions paid $22 billion to hospitals last year. And under the rules we explain in Question 9, Medicare pays over $1 billion per year to hospitals for the bad debts of Medicare patients.

Q9: Can a hospital be reimbursed by Medicare for a Medicare patient's unpaid deductibles or coinsurance? Are there special rules for this "bad debt" if the patient meets the hospital's indigency guidelines?

A9: Yes. In the case of Medicare patients generally, the program reimburses a hospital for a percentage of the "bad debt" of a Medicare beneficiary (i.e., unpaid deductibles or coinsurance) as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts.

However, if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent (as we used that term in question 1), the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts.

Hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to their income). In the case of a Medicare patient that is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance.

Q10: Can a hospital determine its own individual indigency criteria?

A10: Yes. It must, however, apply the criteria to Medicare and non-Medicare patients uniformly.

Q11: Does CMS have any requirements as to what documentation a hospital must secure in order to make an indigency determination? If so, what are those requirements?

A11: For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

Q12: Are hospitals required to take low-income patients to court, or seize their homes, or send claims out to a collection agency when those patients don't pay their hospital bills?

A12: No. Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients.

However, as we noted and explained more fully above in question 9, the Medicare program does contain a special feature that allows a hospital to be paid for its Medicare bad debts. If a hospital wants this special reimbursement adjustment, it must, at the very least, send the Medicare patient a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Q13: Can a hospital write off a Medicare patient's bill but take aggressive collection action against a non-Medicare patient who doesn't pay his/her bill?

A13: Again, this is a decision to be made by the hospital. If a hospital decides that it wants the special Medicare reimbursement allowing for payment of Medicare bad debts, however, then it must engage in uniform collection efforts for all patients, both Medicare and non-Medicare.

Q14: Can a hospital be subject to criminal sanctions or penalties if it writes off a patient's bill?

A14: As explained more fully on its webpage, the OIG advises that offering a discount to an uninsured patient will not implicate the Federal anti-kickback statute, so long as the discount is not linked in any way to referrals of Federal health care program business.

Q15: What if the hospital wants to write off a Medicare patient's deductible and coinsurance regardless of their income level? Is that permissible?

A15: Yes. If a hospital does not want to collect, but wants to write off the uncollected debt regardless of income level, as "charity care" or as a "courtesy allowance," Medicare rules don't prohibit that, but Medicare will also not reimburse these amounts. Furthermore, a hospital may also forgo collection of deductible and coinsurance amounts using its customary methods for determining indigency, according to the bad debt policy stated in the Provider Reimbursement Manual. Bad debt reimbursement policies are governed by Medicare, but, as we note in the answers to Questions 12 and 13, these apply only where a hospital which has unpaid Medicare coinsurance and deductibles wants Medicare reimbursement for them.

Moreover, as explained in detail on its webpage, the OIG advises that under the Federal anti-kickback statute, there is an available safe harbor for waivers of Part A deductible and coinsurance amounts without regard to financial need. In addition, hospitals have the ability to provide relief to Medicare beneficiaries who cannot afford to pay their hospital bills by waiving all or part of a Medicare cost-sharing amount, so long as the waiver is not advertised, not routine, and made after there has been a good faith, individualized determination of financial need or failure of reasonable collection efforts. Advertised cost-sharing waivers, routine waivers, or waivers not based on good faith, individualized determinations of financial need or failed collection efforts potentially implicate both the anti-kickback statute and the civil monetary penalties provision barring the offering of inducements to Medicare and Medicaid beneficiaries.

Q16: What steps can hospitals take to assist the uninsured? The underinsured?

A16: The Department of Health and Human Services notes with interest the many steps that state hospital associations such as the Hospital Association of New York State and the Florida Hospital Association, and community hospitals across the country, have taken recently to address the issue of charges to the indigent and medically indigent. As these hospitals have already discovered, they can take several steps to assist patients with payment for hospital care. For example, hospitals can ensure that all written policies for

assisting low-income patients are applied consistently. In addition, hospitals can review their current charge structures and ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. Finally, hospitals could also implement written policies about when and under whose authority patient debt is advanced for collection. For example, a hospital could decide that only the CEO of the hospital can authorize collection action for a patient debt. As we have noted, this is a decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement for Medicare bad debts.

DEPARTMENT OF HEALTH & HUMAN SERVICES

TAB 4

Washington, D.C. 20201

HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS

This document addresses the views of the Office of Inspector General ("OIG") on the following topics: (1) discounts provided by hospitals for uninsured patients who cannot afford to pay their hospital bills and (2) reductions or waivers of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. For the following reasons, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. The OIG fully supports hospitals' efforts in this area.

Discounts for Uninsured Patients Who Cannot Afford to Pay Their Hospital Bills

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. We disagree and address each law in turn.

- **The Federal Anti-Kickback Statute.**[1] The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid. The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.

- **Section 1128(b)(6)(A) of the Social Security Act.**[2] This law permits – but does not require – the OIG to exclude from participation in the Federal health care

[1] 42 U.S.C. § 1320a-7b(b).

[2] 42 U.S.C. § 1320a-7(b)(6)(A).

> programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs – and taxpayers – from providers and suppliers that routinely charge the programs substantially more than their other customers.
>
> The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[3] Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that, when calculating their "usual charges" for purposes of section 1128(b)(6)(A), individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.
>
> As noted in the preamble to the proposed regulations, the exclusion provision does not require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

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[3] 68 Fed. Reg. 53939 (Sept. 15, 2003).

Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship

The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary.[4] Importantly, under the fraud and abuse laws, the "financial need" criterion is not limited to "indigence," but can include any reasonable measures of financial hardship.

Like many private insurance plans, the Medicare program includes a cost-sharing requirement. Cost-sharing is an important control on overutilization of items and services. If beneficiaries are required to pay for a portion of their care, they will be better health care consumers, selecting items or services because they are medically needed.

The routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute (discussed above) if one purpose of the waiver is to generate business payable by a Federal health care program.[5] In addition, a separate statutory provision prohibits offering inducements – including cost-sharing waivers – to a Medicare or Medicaid beneficiary that the offeror knows or should know are likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier.[6] (This prohibition against inducements offered to Medicare and Medicaid beneficiaries does not apply to uninsured patients.)

However, there are two important exceptions to the general prohibition against waiving Medicare coinsurance and deductibles applicable to hospitals, one for financial hardship situations and one for inpatient hospital services.

First, providers, practitioners, and suppliers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived so long as:

- the waiver is not offered as part of any advertisement or solicitation;

---

[4]Hospitals still need to ensure that they comply with all relevant Medicare program rules.

[5]In certain circumstances, the routine waiver of coinsurance and deductible amounts can implicate the False Claims Act, 31 U.S.C. § 3729. See Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994), available on the OIG webpage at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

[6]42 U.S.C. § 1320a-7a(a)(5). The statute includes several other exceptions. One exception permits the waiver of cost-sharing amounts for certain preventive care services without any requirement to determine financial need. 42 U.S.C. § 1320a-7a(i)(6)(D); 42 C.F.R. § 1003.101; see also 65 Fed. Reg. 24400, 24409 (April 26, 2000).

- the party offering the waiver does not routinely waive coinsurance or deductible amounts; and

- the party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.[7]

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

Second, another exception to the general prohibition against Medicare cost-sharing waivers is contained in an OIG "safe harbor" regulation related to inpatient hospital services.[8] Compliance with a safe harbor regulation is voluntary, and failure to comply does not necessarily mean an arrangement is illegal. However, a hospital that complies fully with a safe harbor is assured that it will not be prosecuted under the Federal anti-kickback statute.[9]

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[7] 42 U.S.C. § 1320a-7a(i)(6)(A); Special Fraud Alert, supra note 5.

[8] 42 C.F.R. § 1001.952(k).

[9] Furthermore, 42 U.S.C. § 1320a-7a(i)(6)(B) provides that any waiver that fits in a safe harbor to the anti-kickback statute is similarly protected under the beneficiary inducements statute (discussed above).

The safe harbor for waivers of coinsurance and deductibles provides that a hospital may waive coinsurance and deductible amounts for inpatient hospital services for which Medicare pays under the prospective payment system if the hospital meets three conditions:

- the hospital cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other payers, or individuals;
- the waiver must be made without regard to the reason for admission, length of stay, or diagnostic related group; and
- the waiver may not be part of a price reduction agreement between the hospital and a third-party payer (other than a Medicare SELECT plan).

While the OIG is not concerned about bona fide cost-sharing waivers for beneficiaries with genuine financial need, we have a long-standing concern about providers and suppliers that use "insurance only billing" and similar schemes to entice Federal health care program beneficiaries to obtain items or services that may be medically unnecessary, overpriced, or of poor quality.

OIG Advisory Opinion Process

The OIG has an advisory opinion process that is available to hospitals or others that want assurance that they will not run afoul of the fraud and abuse laws.[10] OIG advisory opinions are written opinions that are legally binding on the OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a detailed, written description of its existing or proposed business arrangement. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. Further information about the process, including frequently asked questions, can be found on the OIG webpage at http://oig.hhs.gov/fraud/advisoryopinions.html.

[10]Section 1128D(b) of the Social Security Act; 42 C.F.R. part 1008.

Conclusion

Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means.

Guidance about the anti-kickback statute and other fraud and abuse authorities is available on the OIG's webpage at http://oig.hhs.gov/. This guidance includes the Special Fraud Alert on Routine Waivers of Copayments and Deductibles under Medicare Part B; safe harbor regulations (and the "preamble" discussions that include explanatory information), the compliance program guidance for hospitals, and OIG advisory opinions.

February 2, 2004

TAB 5

MICHAEL BURGESS, FLORIDA
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FRED UPTON, MICHIGAN
CLIFF STEARNS, FLORIDA
PAUL E. GILLMOR, OHIO
JAMES C. GREENWOOD, PENNSYLVANIA
CHRISTOPHER COX, CALIFORNIA
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MIKE PENCE, INDIANA
DARRELL ISSA, CALIFORNIA
C. L. "BUTCH" OTTER, IDAHO

ONE HUNDRED EIGHTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

W. J. "BILLY" TAUZIN, LOUISIANA,
CHAIRMAN

DAVID V. MARVENTANO, STAFF DIRECTOR

January 22, 2004

The Honorable Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Thompson:

As you may know, the Committee on Energy and Commerce is conducting an investigation into the billing practices of certain medical providers for uninsured patients. Such individuals, we have learned, are often expected to pay substantially higher amounts for medical services than third-party health plans (such as medical insurers, health maintenance organizations and preferred provider organizations) or government health care programs. The uninsured appear caught in the middle of the sophisticated and complicated forces driving health care financing including managed care, government entitlements, rising costs and shrinking public funds. These practices raise significant public health and consumer protection issues.

Medical providers have pointed to certain federal regulations as principal impediments to addressing these problems. On December 16, 2003, the American Hospital Association sent you a letter asking for help with the "federal regulations that make it far too difficult and frustrating to give uninsured Americans and others of limited means the same reduced rates for hospital care that state and federal governments, health plans and private insurers ultimately pay." The AHA issued this letter in concert with a "white paper" outlining a number of specific regulations which they claim hamper their efforts to help uninsured patients in terms of charges and collections.

In this regard, pursuant to Rules X and XI of the U.S. House of Representatives, please provide the Committee with the following information and documents by February 6, 2004.

1. Do any federal regulations prohibit, complicate or otherwise impact a hospital's ability to offer discounted rates to uninsured patients?

2. Do any federal regulations make a "practical requirement that a hospital bill all patients according to the same schedule of charges, regardless of who provides their coverage," as the AHA claims?

   a. Do providers risk, in any way, reduction or suspension of payments under either the inpatient or outpatient prospective payment system of Medicare if they reduce, in any manner, their "schedule of charges" or "charge master" rates?

3. Do any federal regulations, including, but not limited to, those concerning Medicare bad debt, expect or encourage hospitals to be "aggressive in their collection efforts," as the AHA claims?

   a. Are such collection efforts required for all patients for whom adequate documentation is not available, or cannot be obtained, to demonstrate and establish proof of indigence?
   b. Do reasonable collection efforts under such federal regulations include:
      i. phone calls or letters threatening lawsuits or referral to a collection agent;
      ii. use of debt collection agents;
      iii. wage garnishment;
      iv. contacting employers;
      v. property and/or home liens;
      vi. lawsuits; or
      vii. credit reporting?
   c. What program memoranda or other such guidance has HHS provided in this regard? Please provide copies of all such program memoranda or guidance.

4. Does HHS dispute any statements or claims made in the AHA's December 16, 2003 letter or related white paper and, if so, please explain all such disputes?

5. Is HHS conducting, or has it ever conducted, any studies, reports or investigations on these issues and, if so, please produce copies of all such studies, reports or investigations?

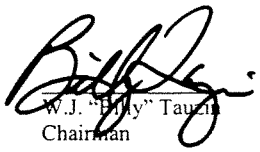
6. Is HHS considering providing, or has it ever provided, any statements or guidance on these issues to patients or any entity in the health care industry and, if so, please produce copies of all such statements or guidance?

7. Is HHS considering any rule changes relating to these issues and, if so, please provide the status of all such rule changes and please produce copies thereof?

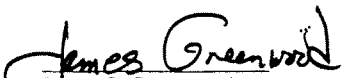
8. Does HHS have any recommendations to Congress relating to these issues?

If you have any questions, please contact Mark Paoletta, Chief Counsel for Oversight and Investigations, at (202) 225-2927 or Anthony M. Cooke, Majority Counsel for Oversight and Investigations, at (202) 226-2424.

Sincerely,



W.J. "Billy" Tauzin
Chairman



James C. Greenwood
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable John D. Dingell, Ranking Member
The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations
Dennis G. Smith, Acting Administrator
Centers for Medicare and Medicaid Services
Dara Corrigan, Acting Principal Deputy Inspector General
U.S. Department of Health and Human Services

TAB 6

RESPONSE TO QUESTIONS TO THE U.S. HOUSE OF REPRESENTATIVES ENERGY AND COMMERCE COMMITTEE

Question (1): Do any federal regulations prohibit, complicate, or otherwise impact a hospital's ability to offer discounted rates to uninsured patients?

Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibits a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy.

Similarly, with regard to discounted rates for uninsured patients (as opposed to a waiver of all collection of charges to patients), a hospital may offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies.

In our response to question two below, we discuss the "lesser of cost or charges" (LCC) principle. Although this LCC principle is not a prohibition on offering discounted rates to the uninsured, in very limited circumstances, the principle may affect a hospital's reimbursement under the Medicare program if the hospital has provided a discounted charge for uninsured patients.

Question (2): Do any federal regulations make a "practical requirement that a hospital bill all patients according to the same schedule of charges, regardless of who provides their coverage," as the AHA claims?

Although federal Medicare regulations do not generally require a hospital to bill all patients according to the same schedule of charges, a hospital's Medicare cost report should reflect full uniform charges rather than any discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report. For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances (see attachment 1).

Additionally, a hospital's decision to reduce its charges is unlikely to impact reimbursement for those few hospitals that are subject to Medicare's lesser of cost-or-charges (LCC) principle. The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced.

The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But aside from those limited examples, services provided in hospitals in America today are largely unaffected by the LCC principle.

In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC (see attachment 1). And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Question (2)(a): Do providers risk, in any way, reduction or suspension of payments under either the inpatient or outpatient prospective payment system of Medicare if they reduce, in any manner, their "schedule of charges" or "charge master" rates?

As long as the provider properly reports full charges on the Medicare cost report, a provider may reduce or discount charges to uninsured or underinsured patients without risking reduction or suspension of payments. Reporting full charges on the Medicare cost report is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system (OPPS). Under OPPS, if a provider should reduce its schedule of charges, as opposed to discounting charges to certain patients, it could risk a reduction of payment as a result of the overall reduction of charges. OPPS reductions might affect payments for devices under the pass-through, interim transitional outpatient payments, and outlier payments.

Question (3): Do any federal regulations, including, but not limited to, those concerning Medicare bad debt, expect or encourage hospitals to be "aggressive in their collection efforts," as the AHA claims?

No. Nothing in the Medicare regulations or instructions requires or encourages the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients unless they are seeking bad debt reimbursement under the Medicare program. If a hospital wants this reimbursement, however, it must, at the very least, send non-indigent Medicare patients a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Question (3)(a): Are such collection efforts required for all patients for whom adequate documentation is not available, or cannot be obtained, to demonstrate and establish proof of indigence?

For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement, CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual (see attachment 1). A hospital should examine a patient's total resources, which could include, but is not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

Question (3)(b)(i)-(vii): Do reasonable collection efforts under such federal regulations include listed collection steps (phone calls or letters threatening lawsuits or referral to a collection agent, use of debt collection agents, wage garnishment, contacting employers, property and/or home liens, lawsuits, or credit reporting)?

For non-indigent Medicare patients, the hospital must, at minimum, issue a bill if the hospital wants Medicare reimbursement for bad debts. If a hospital intends to bill the Medicare program for the bad debts of Medicare patients, the hospital must apply its collection policies to Medicare and non-Medicare patients consistently. Section 310 of the Provider Reimbursement Manual (see attachment 1) contains a list of illustrative examples of possible steps, but it does not require any particular steps. Furthermore, if a hospital makes a determination that a Medicare patient is indigent, then no collection effort of the amount that is otherwise owed by the Medicare patient is required.

Question (3)(c): What program memoranda or other such guidance has HHS provided in this regard? Please provide copies of all such program memoranda and guidance.

CMS provides formal guidance in the Provider Reimbursement Manual, Part I (PRM-I), Chapter 3 (see attachment 1). "Questions On Charges For The Uninsured" is available at the following web site: *http://www.cms.hhs.gov/FAQ_Uninsured.doc*.

Question (4): Does HHS dispute any statements or claims made in the AHA's December 16, 2003 letter or related white paper and, if so, please explain all such disputes.

Yes, HHS does dispute a number of claims made by the AHA in its December 16, 2003 letter and in the white paper submitted with the letter.

- **Billing: Medicare Uniform Charge Requirements**

  -HHS disputes the claim by the AHA that Medicare regulations bar or prohibit a provider from discounting charges to certain patients, including uninsured patients. Medicare does not prohibit a provider from discounting charges to certain patients, including uninsured patients, but it does require the provider to follow Medicare rules in reporting charges on its cost report where its charges are not uniform to all patients. In some limited situations, discounts of charges to charge-paying patients may result in adjustment to Medicare charges and Medicare payment under Medicare's lesser of costs or charges policy. However, even in these limited situations, if the provider uses a sliding-scale charge structure and reports the pre-discounted charges to Medicare, the reduced charges do not affect its Medicare payment.

- **Collections: Medicare Bad Debt Rules**

  -HHS disputes the claim by the AHA that hospitals must be aggressive in their collection efforts or risk losing Medicare reimbursement for bad debt. In order to recognize a provider's Medicare bad debts, Medicare requires that the provider:

  1) Make a "reasonable", "genuine" effort to collect Medicare coinsurance and deductibles (including billing a patient), as it would any patient's outstanding debt. This consistent effort should be applied to like unpaid amounts. For example, if a provider decides to utilize a collection agency unpaid accounts of $100 or more, but not lesser amounts, they should follow the same policy for Medicare accounts as they do for non-Medicare; or,
  2) Determine indigence and the amount the patient is unable to pay as it would for any non-Medicare patient, following Medicare's general guidelines in PRM section 312 (see attachment 1).

  Medicare does not require providers to use aggressive collection efforts. Medicare also does not specify a particular level of income in determining indigence, nor does it expect or require providers to bill patients for offered discounts or when the patient is determined to be indigent.

  -HHS disputes the claim that Medicare's bad debt policy requires a complicated verification system in determining indigence. For indigent patients who are not Medicare patients, the Medicare program does not prescribe any

specific rules for providers to make indigence determinations; rather, the provider is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. However, if a provider wants to claim Medicare bad debt reimbursement for the unpaid coinsurance and deductible amounts for Medicare patients, CMS expects the provider to provide documentation to support the indigency determination.

Hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to his or her income). In the case of a Medicare patient that is determined to be indigent using this method, the amount (or portion of amount) the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance. Examples of what might be included in a reasonable collection effort are illustrated in Chapter 3 of the Provider Reimbursement Manual (see attachment 1). In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the provider should forgo billing the patient, but must bill the State Medicaid program and receive a denial of payment from the State in order to receive bad debt reimbursement from Medicare.

-HHS disputes the statement in the Commonwealth Fund Report cited in the AHA paper that Medicare expects a patient's indigence to be determined anew at each visit. Medicare policy does not specifically address a provider's actions in determining indigence where there are multiple occasions of service in succession. However, in the case of successive admissions, if a patient returns for service in a short time period following the initial service and the provider has no reason to believe the patient's circumstances have changed, it may reasonably consider that its previous indigence determination remains valid.

- **HHS disputes the claim by the AHA that safe harbor protection is necessary.**

-For Medicare payment purposes, CMS does not believe that safe harbor protection is necessary. As we said in our initial response to question (1), we do not believe that Medicare policy prohibits or discourages providers from offering discounts to uninsured patients. For the same reasons, CMS does not believe that there is a need to institute an advisory opinion process or that CMS needs to work with a panel of stakeholders on this issue.

Question (5): Is HHS conducting, or has it ever conducted, any studies, reports, or investigations on these issues and, if so, please produce copies of all such studies, reports and investigations.

HHS is not conducting, nor has it ever conducted, any studies or reports on these issues. It is within the purview of the OIG to provide copies of its reports or investigations.

Question (6): Is HHS considering providing, or has it ever provided, any statements or guidance on these issues to patients or any entity in the health care industry and, if so, please produce copies of all such statements and guidance.

We have already shared with the Committee our response to the December 16, 2003 AHA letter and the associated Questions and Answers. We have also responded to HCA, Tenet, Triad and others on the issue of discounting to the uninsured. We have attached these responses (see attachment 2).

Question (7): Is HHS considering any rule changes relating to these issues and, if so, please provide the status of all such rule changes and please produce copies thereof.

CMS issued a Notice of Proposed Rulemaking (NPRM) articulating the agency's proposed changes with respect to non-hospital providers' Medicare bad debt reimbursement. This proposed rule was published in the February 10, 2003 Federal Register, and a copy of the NPRM is attached (see attachment 3).

On the other hand, we do not believe that the guidance that we have articulated here and in our response to the AHA constitutes a change in the agency's policy. The AHA guidance was posted on the CMS/HHS website and relayed in correspondence to the Committee on February 19, 2004.

Question (8): Do you have any recommendations to Congress relating to these issues?

No. The Department does not believe that with our policy, as it has been articulated, further statutory changes are necessary.

DEPARTMENT OI

TAB 7

Office of Inspector General

Washington, D.C. 20201

MAR 1 2004

OFFICE OF INSPECTOR GENERAL RESPONSE TO REQUEST FOR INFORMATION AND DOCUMENTS FROM THE COMMITTEE ON ENERGY AND COMMERCE

1. **Do any federal regulations prohibit, complicate or otherwise impact a hospital's ability to offer discounted rates to uninsured patients?**

   For the reasons explained in the statement attached at Tab A, the OIG does not believe that any OIG regulations prohibit, complicate, or otherwise impact a hospital's ability to offer discounted rates to uninsured patients.

2. **Do any federal regulations make a "practical requirement that a hospital bill all patients according to the same schedule of charges, regardless of who provides their coverage," as the AHA claims?**

   a. Do providers risk, in any way, reduction or suspension of payments under either the inpatient or outpatient prospective payment system of Medicare if they reduce, in any manner, their "schedule of charges" or "charge master" rates?

   No OIG regulations require hospitals to bill patients according to the same schedule of charges. The OIG does not have authority to reduce or suspend Medicare payments.

3. **Do any federal regulations, including, but not limited to, those concerning Medicare bad debt, expect or encourage hospitals to "be aggressive in their collection efforts", as the AHA claims?**

   a. Are such collection efforts required for all patients for whom adequate documentation is not available, or cannot be obtained, to demonstrate and establish proof of indigence?

   b. Do reasonable collection efforts under such federal regulations include:

   i. phone calls or letters threatening lawsuits or referral to a collection agent;

   ii. use of debt collection agents;

   iii. wage garnishment;

   iv. contacting employers;

   v. property and/or home liens;

   vi. lawsuits; or

   vii. credit reporting?

c. What program memoranda or other guidance has HHS provided in this regard? Please provide copies of all such program memoranda or guidance.

No OIG regulations require or encourage hospitals to be aggressive in their collection efforts. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). As further explained in the statement attached at Tab A, hospitals have the ability to waive Medicare cost-sharing amounts for financially needy Medicare beneficiaries under the fraud and abuse statutes, if the waivers are not advertised, not routine, and made after a good faith, individualized determination of financial need or the failure of "reasonable collection efforts." 42 U.S.C. § 1320a-7a(A)(5); 42 C.F.R. § 1003.101; 65 Fed. Reg. 24400, 24404 (April 26,2000) (a copy of this Federal Register notice is included at Tab D). There are no particular procedural or documentation requirements, although some documentation would be prudent. The OIG is aware that some patients may not be able to provide financial documentation; other reasonable means of determining financial need may be used.

4. **Does HHS dispute any statements or claims made in the AHA's December 16, 2003 letter or related white paper and, if so, please explain all such disputes?**

As fully explained in the statement attached at Tab A, the OIG disagrees with the AHA's assessment of the effect of the OIG's legal authorities on programs that offer discounts to uninsured patients. No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. In addition, under the fraud and abuse laws, hospitals have the ability to reduce all or part of a cost-sharing amount for a Medicare beneficiary who cannot afford to pay his or her hospital bill.

5. **Is HHS conducting, or has it ever conducted, any studies, reports or investigations on these issues and, if so, please produce copies of all such studies, reports or investigations?**

As part of its oversight obligation to detect and prevent fraud and abuse in the Medicare program, the OIG has audited a limited number of individual hospitals' compliance with CMS's bad debt rules. Copies of those audits are attached at Tab B. As reflected by the OIG's most recent work plan, the OIG currently has no audit initiatives in this area, nor are there any studies in this area. We are aware of no OIG investigations involving these issues.

6. **Is HHS considering providing, or has it ever provided, any statements or guidance on these issues to patients or any entity in the health care industry, and, if so, please produce copies of all such statements or guidance?**

Because no OIG rule or regulation prohibits discounts to uninsured patients, the OIG had not issued specific guidance on this issue until it recently issued the paper attached at Tab

A (which is available on the OIG webpage). Questions have been raised about the effect of discounts offered to uninsured patients on the calculation of a provider's "usual charges" under the OIG's permissive exclusion authority at section 1128(b)(6)(A). The OIG issued a notice of proposed rulemaking (NPRM) on September 15, 2003, that proposed definitions of key terms in the exclusion statute. (The NPRM is discussed in greater detail in the next response.) The OIG has issued some publicly available guidance on the permissive exclusion authority that is not specifically related to discounts for uninsured patients. The guidance includes four advisory opinions and three informal letters. These materials are available on the OIG webpage and are attached at Tab C.

As reported by Tenet Healthcare Corporation in the press, Tenet has filed a request for an advisory opinion with the OIG regarding its specific proposed discount program. We have very recently been informed that Tenet is considering withdrawing its request in light of the publication of the OIG's guidance at Tab A. The OIG has been working with Tenet to obtain certain supplemental information necessary to render an informed opinion.

The OIG has promulgated substantial public guidance on waivers of Medicare and Medicaid cost-sharing amounts. This guidance is available on our webpage, and includes a special fraud alert, a special advisory bulletin, safe harbor regulation preamble language, advisory opinions, and a statement addressing certain contractual waivers. Copies of these materials are attached at Tab D (in some cases we have attached only the relevant portions of longer documents).

In addition, our voluntary compliance program guidances discuss some of these issues, particularly the exclusion authority and waivers of copayments. These documents are on our webpage; we have attached copies at Tab E.

In addition, from time to time, the OIG may have responded informally to inquiries from specific providers, either by mail or email, particularly in the area of waivers of Medicare cost-sharing amounts. The guidance provided in this correspondence would be consistent with the publicly available guidance. A representative sample is attached at Tab F. To our knowledge, we have not responded substantively to any inquiries on the issue of hospital discounts to uninsured patients.

7. **Is HHS considering any rule changes relating to these issues and, if so, please provide the status of all such rule changes and please produce copies thereof?**

On September 15, 2003, the OIG published a notice of proposed rulemaking (NPRM) related to the permissive exclusion authority at section 1128(b)(6)(A) of the Social Security Act. Section 1128(b)(6)(A) permits the OIG to exclude from participation in the Federal health care programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The proposed

regulations touch tangentially on the issues raised by the AHA insofar as the proposed rules would clarify that free or substantially reduced services offered to uninsured persons need not be included in a provider's calculation of "usual charges" for purposes of the exclusion authority. As indicated in the statement attached at Tab A, until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that, when calculating their "usual charges" for purposes of section 1128(b)(6)(A), providers and suppliers do not need to consider free or substantially reduced charges to uninsured patients or underinsured self-pay patients.

The OIG received over 300 public comments to the NPRM and is in the process of reviewing them.

8. **Does HHS have any recommendation to Congress relating to these issues?**

The OIG has no recommendations at this time.

PROPOSED POLICY FOR DISCOUNTS FOR THE UNINSURED

DECEMBER, 2003

INTRODUCTION

As a society, we have chosen to insure people primarily through the workplace. This approach to providing health care insurance is inherently restrictive. Recent census information indicates that at any given time, 43.6 million Americans are without health insurance. This population includes individuals not eligible for government sponsored or other funded healthcare programs such as Medicaid, retired individuals living on fixed incomes not yet eligible for Medicare, families who do not have access to health insurance coverage through their employer, self-employed individuals who cannot afford health insurance coverage, and those recently unemployed who cannot afford COBRA payments, or their COBRA payments have expired. These individuals constitute by far the majority of the uninsured, of particular concern for Ascension Health, whose mission it is to serve all persons with special attention to those who are poor and vulnerable, and to be advocates for a compassionate and just society through our actions and our words. In the absence of national health care reform that appropriately addresses the plight of these millions of Americans, and in order to promote more just and equitable access to health care within our own service areas, Ascension Health adopts this *Policy for Discounts for the Uninsured.*

FOUNDATIONAL VALUES AND PRINCIPLES

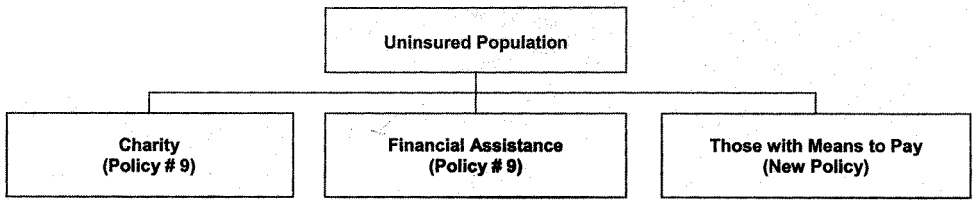
Our *Policy for Discounts for the Uninsured* is premised on several core values and principles, including: our commitment to and reverence for human dignity and the common good; our special concern for and solidarity with poor and vulnerable persons; and our commitment to distributive justice and stewardship. Human dignity and the common good are the foundational values for any consideration of the social good. We believe every person is created in the image of God. In accord with this inherent value, they should have access to those goods and services that are necessary for living a genuinely human life in community. The common good presupposes this view of the human person, calling on us all to ensure that individuals have access to those conditions of social life by which they can truly promote their human dignity, and so that they can more fully participate in and contribute to the communities in which they live. The poor and vulnerable include all those whose human or economic condition places them at grave risk or at the margins of society, where they do not have easy access to those goods and services that secure their human dignity and that make life in community possible. They must be a priority concern for our efforts - not just for their sakes, but for the sake of us all. For, we seek a social reality where everyone belongs, where everyone is welcome. We seek to model this solidarity in the way

we treat every vulnerable person who comes to us for care. Distributive justice demands that society and its institutions work together to ensure that people have ready access to health care, in such a way that genuinely accounts for their needs, resources and responsibilities, and in proportion to our societal and institutional resources. Finally, we seek to promote the value of stewardship, recognizing that we have an obligation to use our resources wisely: on the one hand, being genuinely concerned with promoting equity of care and good health in our communities; on the other hand, recognizing that there are many social goods that compete for the limited resources of society and our institutions. Taken together, these values, principles and considerations provide the ethical framework for a "socially just practice" of discounts for the uninsured.

POLICY SCOPE: THE UNINSURED POPULATION

The uninsured population can be sorted into three categories:

- Those qualifying for charity;
- Those not qualifying for charity but qualify for some discount of their bill based on a means tests, such as total income, total medical bills, assets, mortgage payments, utilities, number of family members, disability considerations, etc.
- Those with some means to pay, to be given a discount on full charges.



POLICY OBJECTIVE:

The objective of these two system-wide policies is to ensure a socially just practice for each of the three components of this population including eligibility criteria, discounts and maximum obligations or "caps" to be charged, under the overall framework of distributive justice (i.e. in proportion to an individual's overall needs and responsibilities, as well as financial resources), and where special consideration is given to those whose social and/or physical condition makes them particularly vulnerable.

The financial relief related to charity care and financial assistance will be administered as a procedures related to Policy #9. The discounts for the uninsured population with means, and collection practices will be addressed in a new Policy with procedures. This document is to explain how the two work together to address the needs of the uninsured.
This policy is meant to apply to acute care services (including behavioral health), and non-elective procedures. Out of state patients would be covered by this policy.

The policy does not apply to:

- Payment arrangements for elective procedures.
- Payment arrangements with providers of Medical Savings Accounts
- International patients
- Patients' amounts due for deductibles and coinsurance

I. CHARITY CARE (PROCEDURES FOR POLICY # 9)

Policy # 9 governs Ascension Health charity care and community benefit policies. Policy # 9 currently provides guidelines regarding how hospitals should determine who qualifies for charity care. Procedures for Policy # 9 will be amended to include the following minimum standards for charity care:

Eligibility for Charity Care (Minimum)	Charity Care Adjustment (Minimum)
Up to 100% of Federal Poverty Limits	100% write-off of accounts
100 to 200% of Federal Poverty Limits	A sliding scale of write-offs to be determined by the Health Ministry

Adjustments to the Federal Poverty Limits:

The Health Ministry may adjust the percentage of the Federal Poverty Limits based on the local wage index compared to the national average wage index.

Sliding Scale Guidelines:

Sliding scale guidelines should be defined by each Health Ministry as deemed appropriate. The sliding scales must provide some level of discount for any individual between 100% and 200% of Federal Poverty Limits.

Other Acceptable Requirements and Exceptions:

Health Ministries may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance programs to qualify for charity.

Other programs that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured. This is encouraged and will continue.

A nominal charge may be charged to patients qualifying for charity. The participation of individuals in the financial obligation of their health care is recommended by those who work with the poor since it helps their dignity as well as their sense of responsibility.

II. FINANCIAL ASSISTANCE (PROCEDURES FOR POLICY # 9)

The following minimum standards for Financial Assistance are required of each Health Ministry:

- Each Health Ministry must determine and document a policy that provides for financial assistance.
- The financial assistance policy must address a patient's eligible income and assets.
- The policy may allow the determination to be made on a case-by-case basis, but in this circumstance, a review panel must be formed to ensure a patient has the right to appeal a decision.
- Requiring a patient to apply for public financial assistance programs is permissible.

The minimum standards above are designed to ensure each Health Ministry designs a methodology to determine qualifying incomes and/or assets available to satisfy the patient's obligation to the hospital.

III. THE UNINSURED WITH MEANS TO PAY (NEW POLICY)

Financial obligations from the uninsured with means to pay are provided the following MINIMUM discounts:

- A discount based on the best-paying payor for that hospital
- The discount may be adjusted to reflect that there are not prompt pay or volume commitments that are typically provided for in managed care contracting.
- The best-paying insurance contract must account for at least 3% of the hospital's population. If a single contract cannot account for this much volume, more than one contract should be averaged.
- A prompt pay discount must be provided to all patients.

It is understood that this population (those with the means to pay) accounts for the minority of uninsured patients. However, the majority of dollars collected from the uninsured comes from this population.

IV. BILLING AND COLLECTION PRACTICES FOR THE UNINSURED

The following billing and collection procedures will be implemented:

- Each Hospital shall ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
- Each Hospital shall ensure that patients receive prompt access to charge information for any item or service provided.
- Each Hospital has a duty and responsibility to advise patients and their families of the hospital's applicable policies, including charity care policies, and the availability of need-based financial assistance in easily understood terms, as well as in the languages commonly used by patients in the community.
- Each hospital shall offer patients who do not qualify for charity care, but are in need of financial assistance, appropriate extended payment terms or other payment options that take into account the patient's financial status.
- Each hospital shall ensure that outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic sponsored facility in the community it serves.
- Financial counselors must be available to all patients
- Information must be posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies
- Liens on personal residences will be permitted only under certain conditions:
  - If the patient does not qualify for charity or financial assistance and
  - Patient is not complying with payment arrangements
  - The lien will not cause a foreclosure on a personal residence
  - Collection agencies must have hospital approval
- Garnishments should be permitted only if:

- Patient does not qualify for charity or financial assistance, and
- A court determines financial income is sufficient
- Collection agencies must have hospital approval

- The collection of a bill will not cause the uninsured patient to have to file for personal bankruptcy

- Eligibility can be determined at any point in the revenue cycle
- No bench warrants (also called body attachments, writ of capias)

- Interest can be charged only if:
  - Patient does not qualify for charity or financial assistance, and
  - Patient is not complying with payment arrangements
  - No add-on to minimum discount has been applied

- Collection agency policies must follow Fair Debt & Collection Guidelines

V. CONCLUSION AND NEXT STEPS

Procedures related to charity care and financial assistance will be implemented as soon as possible. The policy for the uninsured and the collection practices will require CMS and/or OIG approval before implementing.

TAB 9

Draft 4/30/04

SYSTEM POLICY#: 16	SUBJECT: Billing and Collection for the Uninsured	
BOARD APPROVAL DATE:	12/10/03	
EFFECTIVE DATE:	~~7/1/04~~	
REVISION DATE:		President/CEO, Ascension Health

POLICY

It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
    f. Financial counselors are available to all Patients.
    g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care(Minimum Standards)
    a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
    b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
    a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. The

Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, <u>and</u> a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

Ascension Health

Proposed Billing and Collection Policy for the Uninsured

Subject to CMS Approval

Uninsured Population

Charity

Eligibility up to 200% of FPL

MINIMUM to be OFFERED

1 100% write-off for those at 100% of Federal Poverty Limits or below

2 Sliding Scale for anyone 101% to 200% of Federal Poverty Limits

3 Federal Poverty Limits may be adjusted for geographic inflation as measured by local vs national wage index

Financial Assistance

Eligibility (> 200% of FPL)

MINIMUM to be OFFERED

1 Eligibility based on income tests and asset tests that consider for example:
- Medical bills
- Housing allowance
- Food, clothing, transportation costs

2 Can be done on a case by case basis, But a patient advocacy board must be available to which a patient can appeal

Those with Means to Pay

Income and Assets Sufficient to Pay

MINIMUM to be OFFERED

1 Discount based on what highest paying payor is willing to pay in market

2 Payor used as basis must account for at least 3% of patient volume

All Patients

1 Prompt pay discounts must be offered

2 No liens for patients qualifying for charity care or financial assistance

3 No garnishments for patients qualifying for charity care or financial assistance

4 No body attachments (bench warrants) for any patient

5 Patients to receive prompt access to charge information for any item or service

6 Financial counselors must be available to all patients

7 Interest on unpaid balances will not be charged to those qualifying for charity care or financial assistance

8 Fair Debt and Collection Guidelines must be followed

9 Policy must be posted publicly

10 All collection agencies must agree to Ascension Health Billing and Collection Policy for the Uninsured

TAB 10

Exhibit IV

Saint Francis Medical Center

2620 W. Faidley Ave. Grand Island, NE 68803

FINANCIAL ASISTANCE APPLICATION

Please complete and return with requested verification of income by _____. If you have any questions regarding this form, please contact your Financial Counselor. If your last name starts with: "A thru G" contact Rose at 308/398-5610, "H thru O" contact Diana at 308/398-5616, "P thru Z" contact Susan at 308/398-5553 or call 800/353-4893 and choose option #1, Monday through Friday from 8:00 a.m. to 4:30 p.m

Patient Name:_____ Patient Account Number:_____

Address :_____ Social Security Number :_____

_____ TelephoneNumber:_____

Employer :_____ Work Number:_____

Guarantor Name:_____ Phone Number:_____

THE FOLLOWING INFORMATION MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS IT FOR CONSIDERATION

Annual Gross Income for Household:_____Number of Dependents including yourself:____

Please provide copies of the following for each household member currently employed (excluding minors):

Current W2 Form **Current Pay Stub** **Copy of Last Two Years Income Tax Returns**

Other Income Verification:

____Social Security Insurance ____VA Assistance ____Railroad Retirement ____Child Support
____Disability ____Life Insurance ____Pension ____Alimony
____Unemployment ____Workman's Comp ____Other: Please List:
____Public Assistance ____Tuition/Grants

If you are receiving any of the above items for monthly income, please provide the following items:

1) **Copy of monthly check; OR**
2) **Copy of monthly bank statement showing direct deposit of the check; OR**
3) **Copy of Social Security Verification (received once a year from Social Security)**

Fixed Monthly Expenses:

House Payment/Rent:_____ Medical Bills :_____ Child Support:_____
Utilities :_____ Prescription Drugs:_____ Child Care :_____
Telephone :_____ Groceries :_____ Other:_____
Cable TV :_____ Insurance :_____ _____

Total Monthly Expenses:_____

ASSISTANCE PENDING

Are you currently an applicant for any Federal, State, or private financial assistance programs? (Medicaid, Food Stamps, Social Security Insurance, WIC, etc.)

Name	Case Manager	Telephone #

(Continue on Back)

Exhibit IV

FS-30 (9-98)

REASON FOR REQUEST: (In your own words, describe your need for financial assistance.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Client's Signature Date

For Hospital Use Only

Current Pay Stub Y / N Original Bill $_____ Adjusted Gross Income:$_____
W2 Y / N Ins Pmts Rec'd $_____ Less Medical Bills :$_____
Taxes Y / N Personal Pmts $_____ Total :$_____
Other Govt Assist Y / N
Previous BD_____ CAP_____ Balance SFMC $_____

Comments:_____

CAP Guideline $_____/$_____Actual Total Income

_____% HAS MET CAP INCOME GUIDELINES

Submitted by:_____ Date:_____

Recommendation:
Community Assistance $_____
Patient Responsibility $_____
Project Care $_____ Approved by_____

Rationale: _____% CAP APPROVED

_____

_____

_____

Approved by_____ Date_____
Approved by_____ Date_____
Approved by_____ Date_____

TAB 11

CATHOLIC HEALTH INITIATIVES

Central Kansas Medical Center

A spirit of innovation, a legacy of care.

POLICY NUMBER: 950.402
910.555

DEPARTMENT: Administration
Patient Financial Services

EFFECTIVE DATE: May 31, 1991

TITLE: **Charity Care (Indigent)**

POLICY: Central Kansas Medical Center will provide health care services to all persons who are in need, regardless of age, race, religion, national origin, gender, handicap, sexual orientation or ability to pay.

PURPOSE: This statement of policy reflects our mission to be a leader in addressing the areas of greatest need in our communities.

SPECIAL INSTRUCTIONS:

1. All patients of CKMC and its subsidiaries will have the option to make an application for the CHARITY CARE PROGRAM. The determination to provide charitable services should be made before the actual provision of services preformed.

   In the event a patient is not immediately able to declare an inability to pay he/she, or a responsible party, will be contacted within 24 hours regarding payment for the services rendered.

   If complete information on the patient's insurance or financial situation is unavailable or if the patient's financial circumstances change, the designation of Charity Care may be made after rendering service, and in some circumstances even after the rendering of the bill.

2. An application for Charity Care determination may be given to an interested patient by any employee of Central Kansas Medical Center, Great Bend Internists, Golden Belt Home Health and Hospice, and Central Kansas Health Equipment and Supply.

3. The application process consists of:

   a. Completion of the Financial Disclosure statement (Attachment A)
   b. Proof of income from two sources, e.g. the previous year's tax return, a recent bank statement, two recent paycheck stubs, or other income documentation. Charity application will not be processed until information is received, specific circumstances will be reviewed individually if documentation cannot be obtained.

4. ***Evaluation of the application will include a review of the income within the household and a review of the assets of the patient. Charity may be denied if a patient has excessive assets, or assets above the average living needs.*** Hardship cases will be reviewed individually by the Patient Financial Services Manager and the Chief Financial Officer for approval of Charity. The Patient Financial Services Manager may pull a credit report on the patient to verify information. ***If a patient's account has been sent to collection and subsequently is determined to be eligible for charity, the account will be reclassifed from bad debt to charity.***

   The amount of the charges eligible for Charity Care adjustment will be based on the poverty guidelines established by the United States Department of Health and Human Services. Patients with family income below the poverty guidelines are eligible to receive free care. Patient with family income between the poverty guidelines and a multiple of two times the poverty guidelines are eligible for reduced-price care:

Percent of Federal Poverty Level	Percentage of Discount
0 – 150%	100%
151 – 175%	75%
176 – 200%	50%

   The Income Eligibility amounts (Attachment B) shall be updated annually, upon publication of the updated federal poverty guidelines.

5. Normal charging procedures will be followed for charity care patients.

6. Once the need for health care payment assistance is substantiated, a Financial Counselor will refer the account to Midland Professional associates to assist patients with the Medicaid application process in order to obtain a determination of eligibility for Medicaid coverage. Patients must follow through with all assistance offered to them for other means of payment, which may be possible before charity assistance will be approved.

   If no other programs for assistance are available, the account will be classified as Charity Care.

7. The application packet shall be forwarded to the Patient Financial Services Manager for approval, with amounts of $5,000 and over shall be approved by the Chief Financial Officer.

8. The applicant shall be notified of approval or denial within a week of the completed application and documentation.

   If a patient does not qualify for charity care the packet is annotated and forwarded to the Financial Counselor to send a letter of denial to the patient. The account is then reviewed by the Financial Counselor to contact the patient and set payment arrangements. If a patient qualifies for charity, a letter of approval is sent, the financial disclosure and worksheet receive approval signature and the patient and all family members are listed on the Master

Charity Care List and amounts (s) allowed as charity care are adjusted off. Employees of CKMC who receive charity assistance, will not be on the master list, the Patient Financial Services Manager will maintain the financial information and adjust accounts accordingly.

9. Charity Care status shall remain in effect for four (4) months from the date of approval. After four (4) months, a new application is then required.

10. Central Kansas Medical Center and each of the subsidiaries listed in item 2 shall maintain a monthly log identifying charity care discounts extended during that period.

    The report will include inpatients and outpatients and contain the following data:

    - Name of the patient
    - Date of service
    - Total charges
    - Amount paid by the patient
    - Amount paid by the third party
    - Charitable discount amount
    - Date of application
    - Date of acceptance or rejection by CKMC

Approved by: Patient Financial Services Manager, Vice President/CFO, Administration
Developed: 05/30/91
Revised: 04/10/95; 10/1/98; 10/1/00; 10/1/01

CATHOLIC HEALTH INITIATIVES

Central Kansas Medical Center

Attachment A (Policy 950.402; 910.555)

Financial Information

Please return this completed form with appropriate attachments by _____
Date _____

Guarantor (Responsible Party) Information: *Telephone:* _____

Name	*Mailing Address, City, State, Zip*	
Date of Birth	*Social Security Number*	
Employer	*Years Employed*	*Gross Salary*

Spouse Information:

Name	*Mailing Address, City, State, Zip*	
Date of Birth	*Social Security Number*	
Employer	*Years Employed*	*Gross Salary*

Patient Information:

Name	*Mailing Address, City, State, Zip (if different than above)*	
Date of Birth	*Social Security Number*	
Employer	*Years Employed*	*Gross Salary*

Other Income:

Source (Rentals, 2nd Job, Farm, Social Security, Alimony, Pension)	*Dollar Amount*

A. Total Gross Income (add all Gross Salaries and Other Income): $_____

Dependents Information:

Total Number	*please list name-birthday-age*

Monthly Expenses (Please indicate the average monthly expense for each of the following items):

Item	*Amount*	*Item*	*Amount*
Groceries		Auto (Gas)	
Utilities		Telephone	
Child Care		Cable	
Medications		Other:	

Other:		Other:	
Monthly Insurance Cost: Auto		Monthly Insurance Cost: Life	
Monthly Insurance Cost: Health		Monthly Insurance Cost: Other	

B. Total Monthly Expenses: $

Credit Cards

Card Name	*Balance*	*Monthly Payment*	*Past Due (Y/N)*

C. Total Monthly Credit Card Payments: $

Hospital Accounts/Other Creditors

Type of Debt/Creditor	*Balance*	*Monthly Payment*	*Past Due (Y/N)*

D. Total Monthly Hospital/Other Payments: $

Summary of Income and Expenses/Payments:

Total Monthly Income (from line A): $_____

Total Monthly Payments (add lines B, C, D) $_____

Income Minus Payments $_____

Assets

Bank Name	*Checking Balance*	*Savings Balance*	*IRA or Retirement*	*Other*

Bank Name	*Checking Balance*	*Savings Balance*	*IRA or Retirement*	*Other*

Investment Name	*Value*	*Investment Name*	*Value*

Property Owned

	Mortgage/Lien Holder	*Payment*
Residence		
Rental Property		
Farmland		
Auto (Model/Year)		
Auto (Model/Year)		
Boat, etc.		
Other:		

The above is true and accurate to the best of my knowledge and I authorize Central Kansas Medical Center to verify the information.

Signature _____ Date _____

Please make sure to include the following with the completed application:

1. **Copy of last year's tax return**
2. **Two (2) current pay stubs (proof of income)**
3. **Copy of Bank Statement**

TAB 12

EXHIBIT VI

Memorial Health System
2525 de Sales Avenue, Chattanooga, TN 37404
(423) 495-8641

Financial Assistance Application

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
Guarantor's Address	City, State, Zip	Home Phone #	Length of Residence
Previous Address (if less than 2 years at above)	City, State, Zip	Marital Status	# of Dependents in Household
List Names and Ages of Dependents in Household:			

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address		
Job Title/Length of Employment		
Business Telephone #		
Hourly Rate		
Monthly Income Gross		
Monthly Income Net		
Other Income Source/Amount	Total Family Monthly Income	Total Family Income last 12 months

Have you applied for Medicaid or any other State/County Assistance? (check one)	Yes	No
Application Date	Caseworker Name/Telephone Number	

Have you filed Bankruptcy? Yes No	Chapter 7	Chapter 13	Date Filed	Date of Discharge
Are you a Homeowner? Yes No	Approximate $ Value	Approximate Balance on Loan		Years left on Loan

Bank Name	Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance

AUTOMOBILE(S)				
1. Make:	Model:	Year:	Pymt Amount:	Balance Due:
2. Make:	Model:	Year:	Pymt Amount:	Balance Due:

Other Assets (Stocks Bonds, Property, Boat, Business, etc.)

Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	$			$	$
Charge Cards	$			$	$
	$			$	$
	$			$	$
Bank Loans	$			$	$
	$			$	$
School Loans	$			$	$

List Other Expenses Below:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$	MEDICATION	$	AUTO INS	$
UTILITIES	$	LIFE INSURANCE	$	OTHER	$
GAS (CAR)	$	MEDICAL BILLS	$	OTHER	$
TOTAL MONTHLY EXPENSE	$				

Note: Attach additional sheet if necessary. Important: income verification must be attached – W2, Pay Stub, Tax Return, etc.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this hospital bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Memorial Health System information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Memorial Health System to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)	Date	Witness	Date
[illegible]	Date	Witness	Date

EXHIBIT VI

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

.NE 1: **Complete** the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.

LINE 2: Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "same" in this field.

LINE 3: Complete the guarantor's address, home telephone number and length of residence at this address.

LINE 4: Complete the guarantor's previous address (if residence on line three is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark 0 in the dependent field.

LINE 5: List the names and ages of those dependents counted above.

LINE 6: Complete the employer information. This is for the guarantor or patient – whomever is responsible for the balance. In this section, please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income both gross and net. If there is no employment, please note how expenses are being met.

LINE 7: Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark N/A.

LINE 8: Complete the income information of the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark N/A.

INE 9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the guarantor/patient net income). Then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.

LINE 10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance and on what date. Also in this section, we as for the Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.

LINE 11: Please complete this are if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark No. Please verify all questions are complete. Attach additional paper if needed for explanation.

LINE 12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark No.

LINE 13: Please complete the banking information as requested. Please list the bank name. Then complete the checking account number, and the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place N/A in the savings field.

LINE 14: This area is requesting automobile information. Please list the make, model, and year of your vehicle. Please also list the monthly payment amount and the current balance.

LINE 15: Please complete this section listing other assets you may have. This may include stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark N/A.

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Note whom the payment is made to, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment, or if you live with relatives. Use additional paper if needed.

CHARGE CARDS: Please note any charge card payments you are currently making. Please note the monthly payment amount, who the payment is going to, the account number and the current balance due. Please also add the credit limit for each card. Use additional paper if you needed to ensure this field is complete. If you have no charge cards please note N/A.

EXHIBIT VI

BANK LOANS: Please note any bank loans you may be paying. Note the monthly payment amount, who the payment is being made the account number, and the current balance due. Use additional paper if needed to completely explain this field. If you have no .nk loans, please mark N/A.

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not limited to college loans, private school loans (or tuition), day care expenses or any other loan that applies to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this area does not apply to you, please mark N/A.

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount used for food on a monthly basis.

UTILITIES: Please list the amount paid monthly for electricity, gas, water, trash, and any other utility you may pay. You may total these and place the total for all of them in the utilities field. If there are no monthly utilities paid, please mark N/A in this field and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid monthly for transportation in your vehicle. If there is no payment made monthly for gas, please mark the field N/A.

MEDICATION: Please add the amount you pay monthly in medication. If there are several prescriptions or medications you may take, please add them together and place the total amount in this field. If there are no monthly medication payments, please place NA in this field.

LIFE INSURANCE: If you have life insurance policy, please note the monthly amount you pay. If there is no payment, please place N/A in this field.

MEDICAL BILLS: Please add any medical bills you may be paying monthly. This may include, but not limited to Doctor bills, copays, deductibles, other hospital bills, radiology bills, and ambulance bills. Please use a separate sheet of paper to list these. Add 'hem together and place the total amount paid monthly towards these accounts. If there are no monthly medical payments being made, please place N/A in this field.

AUTO INSURANCE: Please place the total amount you pay monthly for auto insurance. If you pay quarterly, please divide the quarterly payment by three and place this amount in this field. If there is no monthly payment being made, please mark N/A in this field.

OTHER: This will include any monthly payments you are currently making that are not listed above. Please give details of what you are paying, to whom, and the balance due. Please use a separate sheet of paper if needed. If this field does not apply to you, mark N/A.

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this field.

PLEASE READ THE FINE PRINT!!!!!!!

DOCUMENTATION: Please notice you're signature agrees to attach all income verification. In addition to what is listed on the application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. Please explain lack on income completely for full consideration of this application. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:
NUMBER 1 is stating that the guarantor/patient has completed this form accurately.
NUMBER 2 is stating that the guarantor/patient will apply for any assistance to pay this bill. This may include getting a bank loan or putting the balance on the credit card.
NUMBER 3 authorizes Memorial Health System to obtain credit information and perform a credit check.

TAB 13

EXHIBIT VII

Charity Care/Extended Monthly Payment Checklist

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION
	Demographic information complete for patient and guarantor – address, telephone number, etc
	Dependent information complete - # in household, names and ages
	Employment and income information complete for patient/guarantor and spouse
	Copy of most recent year's Tax Return attached
	Copy of most current pay stub attached
	If no income documented – explanation for how expenses are being met attached
	If patient/guarantor has filed bankruptcy – all questions answered
	If patient/guarantor is a homeowner – all questions answered
	Information complete for banking information – checking and savings
	Information complete for automobile
	Information complete for other assets
	Expense/monthly payment information complete
	Does it look reasonable?
	Are there any luxury items listed that might prevent patient/guarantor from paying our bill? – Country club, maid or lawn service, boat, high cable bills, etc.
	Has the patient/guarantor and spouse signed and dated form?
	Has the witness signed and dated form?
	Compare Total Family Monthly Income to Total Monthly Expense – Can patient/guarantor afford to make monthly payments? If so, contact patient/guarantor to establish payment arrangements – stop.
	If patient/guarantor can not afford monthly payments use Poverty Guidelines matrix to determine if patient/guarantor qualifies for Charity Care.
	If patient qualifies for Charity Care and total discount is less than $2000.00 logs on Charity Log, processes discount and send acceptance for Charity Care letter to patient.
	If patient qualifies for Charity Care and total discount is over $2000.00, logs on Charity Log and forwards all information to Patient Account Manager to review and approve.
	If patient does not qualify for Charity Care sends denial for Charity Care letter to patient/guarantor.
	If application is incomplete – return application and all supporting documentation to patient with letter to return what is needed.
	Patient Account Manager (see policy for approval levels) will approve and post discounts over $5000.00
	Patient Account Manager will return Charity Log and all supporting documentation to Financial Representative to send acceptance for Charity Care letter to patient.
	Financial Representative will send acceptance for Charity Care letter to patient and return all information to Patient Account Manager.
	Patient Account Manager selected this chart for Quality Review

Signature – Financial Representative	Date
Signature – Patient Account Manager	Date

TAB 14

Charity Care Standards and Guidelines

The *Charity Care Standards and Guidelines* are included in the following attachments and have been added to the CHI *Financial Reporting Manual*, at the CHI Public Folders, for use by all Market-Based Organizations (MBOs).

Charity ındardsGuidelines.7

Exhibit I.doc

Exhibit II.xls

Exhibit III.rtf

Exhibit IV.doc

Exhibit V.doc

Exhibit VI.doc

Exhibit VII.doc

Charity.Exhibit VIII.7.02.doc

Charity ındardsGuidelines.F

Exhibit VIII - FSG-4.doc

Other Information for St. Catherine Hospital:

Get a Medicaid denial before Charity Care is granted. If a patient does not have a social security number, then we know they don't meet the qualifications for Medicaid and we can go ahead and see if they quality for charity care. All others should go through the Medicaid (Midland) process first.

Update HUD table April 1st each year. http://www.huduser.org/datasets/il.html

Indicate on charity paperwork that they did not have a number or they were denied for Medicaid. For new visits within the 6-month time frame, a new Medicaid denial must be obtained.

Financial Assistance Information Gathering Process

During the process of interviewing the patient for resolution to the account, the opportunity may present itself in which Financial Assistance may be considered. Before offering Financial Assistance, the Patient Financial Counselor will need to ensure that there is no other payment options available for resolution to the account. Some of the avenues for payment may include, Insurance companies, (secondary insurance), Cobra, Liability, Cash, Credit Cards, Payment plans using hospital approved plans, such as the internal plan or MCR. The financial assistance is used as a last option for resolution to the account. Even then, once a need has been established, the applicant must provide a letter of denial from the SRS or Midland Capital Resources. This is to help ensure that all avenues for payment have been exhausted.

Patients are referred to the Financial Assistance Program in a number of ways. The Patient Financial Counselor will identify inpatients during his interview process. Midland staff will refer patients to the Patient Financial Counselor if there are not government programs available to assist them with their bills. Patient Accounts Service Center (PASC) will send an application when a patient has requested assistance with their bills. Patient Accounts associates will also send out applications when they are requested (ER or Outpatient Services registrars) or payment for services cannot be obtained at time of service. Patients are referred to the Patient Financial Counselor.

St. Catherine Hospital uses a sliding scale in determining the amount to be considered for charity care. The HUD Geographic Very Low Income Guidelines are used, these guidelines are updated every April. If a family's gross annual income falls under the base gross annual income they will qualify for 100% financial assistance. If the gross annual income falls between the base gross annual income and 116.7% of the base gross annual income the family will qualify for 75% financial assistance. If the gross annual income falls between the 116.7% and 133.4% of the base gross annual income the family will qualify for 50% financial assistance. If the gross annual income falls between the 133.4% and 150% of the base gross annual income the family will qualify for 25% financial assistance. If the gross annual income is over 150% of the base gross annual income financial assistance will be denied.

If a family qualifies for less than 100% financial assistance, the balance must be paid following the established payment policies of St. Catherine Hospital.

A patient may request financial assistance at any time during the billing process as long as judgment has not been received.

All financial assistance applications are received and logged by the Patient Financial Counselor. The Patient Financial Counselor is responsible for the follow up and assurance that all required information is received and the applications are processed in a timely manner. Patients are given 45 days to fill out the application and return it, with all required documentation, to the Patient Financial Counselor. If information is not received a phone call is made and/or a letter is sent reminding the patient what information is missing and giving them 10 days to provide the information. If information is not received a denial letter is sent to the patient stating that the application for Financial Assistance has been denied.

The Patient Financial Counselor first reviews the applications for Financial Assistance. Generally, the patient/guarantor may have received his/her application from the Patient Financial Counselor however, it is possible that the patient/guarantor obtained the application from Hospital Social Workers, other office staff members or other hospital departments. In order to consider the application, the applicant must have completed and signed the application and provided all the supportive documentation. The mandatory supportive documentation may be subject to verification. All applications are tested against an approved income guideline table.

After the initial review, if information is missing, the Patient Financial Counselor will contact the patient/guarantor by either telephone or correspondence. A patient/guarantor may also be contacted as his/her place of employment. Any applicants that do not respond within 10 days will receive a denial letter from the Patient Financial Counselor and may have the account subject to further collection processes.

When the application is completed along with all supportive paperwork, it is forwarded to the Director for review and approval. All qualifying applications will need to be reviewed and approved by the CFO. All applications bearing a balance of over $100,000.00 will need to be presented to the administrative team by the CFO for review and approval. After the CFO has approved the application, the adjustment sheet is sent to Information Systems for processing. Upon completion of the adjustment sheet to the I.S. department, the Patient Financial Counselor then prepares a report for the Director/Supervisor in which details the Financial Assistance activity for the week.

Any applications that were not approved are either followed up on per recommendations of the Director or directed for further collection activity. Those accounts that were approved will be sent a letter of approval telling the patient/guarantor the level of assistance. If the account is at a collection agency, the Patient Financial Counselor will notify the agency of the approved amount for charity by either telephone or e-mail. Note that accounts at a collection agency can only be considered for assistance up until the first appearance during legal action.

There are many obstacles, which present themselves during the course of gathering information for the financial assistance process. At times, we have undocumented patients/guarantors that we need to present other types of qualifying documentation in order to be approved. It is during the interview process that the Financial Counselor must determine which documentation may be submitted by the patient/guarantor.

Affidavits of Non-filing Income Taxes are generally used for the non-legal aliens who are working under illegal social security numbers. Along with this affidavit the applicant must show a current pay stub that displays the social security number he is using. The Patient Financial Counselor will then run the SSN through Metro Net or HART network to verify that the number does not belong to the applicant. The financial assistance once approved will be valid for six months after the initial date of approval.

Birth certificates are required for all children, if number of dependents is different than what is indicated on tax return or no tax return is available.

Credit report must be run if no tax return is available.

FINANCIAL ASSISTANCE FOR ACCOUNTS THAT HAVE BEEN TURNED TO ARSI

St. Catherine Hospital will grant financial assistance to applicants when their accounts have been referred to a collection agency. A patient may apply for financial assistance up to the time of first appearance in court. If the patient requests to apply for financial assistance at the first appearance a continuance will be requested, allowing the patient time to complete the financial assistance application and provide required documentation. If financial assistance is granted the patient will still be responsible for court costs.

If the accounts are with ARSI the following procedure must be followed:

1) Process financial application as usual.
2) After assistance has been approved, e-mail Nikki at ARSI with the following information:

    a) Original balance of the account
    b) % of write-off
    c) New balance of the account.

ARSI will adjust the interest by the percentage of the write off.

Example: Patient has an outstanding bill of 10,000.00. This account has been turned to ARSI for collection and legal action has been pursued. During the first appearance at court the patient requests to apply for the financial assistance program. The patient fills out an assistance application and provides all the required documentation. Based upon St. Catherine Hospital's guidelines the patient would qualify for a 75% write off. The account is approved and the necessary adjustments are made at St. Catherine's. E-mail Nikki stating that the total account had a beginning balance of $10,000.00, the patient had qualified for a 75% write off which brought the new account balance down to $2,500.00. ARSI would go into their system and adjust the interest based upon the new balance of $2,500.00. Once again, the patient would be responsible for the court costs.

ST. CATHERINE HOSPITAL GARDEN CITY, KANSAS POLICY & PROCEDURE	SCOPE: Patient Accounts	PAGE 1 OF 2
	SUBJECT: Follow up on Financial Assistance Applications	
ISSUE DATE: 07/07/2003 LAST UPDATE:	APPROVED: _____ ADMIN	_____ DIR

POLICY: To insure that all requests for financial assistance are followed up on in a consistent and timely manner. This policy will set deadlines for follow up on all application requests.

Financial Assistance Applications can be requested by all of St. Catherine Hospital's patients. By applying for St. Catherine Hospitals' financial assistance program patients can either have the entire balance of an account forgiven or a portion forgiven and qualify for lower monthly payments.

Financial Assistance Applications can be sent out directly from St. Catherine Hospital Patient Accounts associates or by employees of Patient Accounts Service Center in Houston. If an application is sent out by Patient Accounts Service Center, St Catherine Hospital will be notified via e-mail every Friday.

PROCEDURE:

APPLICATION PROCESS:

1. St Catherine Hospital Patient Accounts Associates need to take the following steps when they mail out a financial assistance application.

    a. Change self pay collector from HSP to ASSIST

    b. Set up reminder for Cathy Melgosa (CLM) for 30 days, reminder should state "follow-up on assistance application."

    c. E-mail Rebecca Doty (RJD) to cancel account at HSP

    d. Do not combine accounts.

2. When an application is sent from Patient Accounts Service Center in Houston the previous steps need to be taken. Rebecca Doty will be responsible for these steps.

3. When an application is received it is to be forwarded to Cathy Melgosa and she will verify that all required documentation has been included with the application.

4. If information is missing a letter will be sent to the applicant outlining the information still needed and giving them 15 days to supply the information. Incomplete applications will be filed, alphabetically, in Roberto Castro's office.

5. If an application is not received in 30 days Cathy is to set up a reminder for Roberto to

contact the applicant and remind them that they have 15 days to get the application filled out and returned to St. Catherine Hospital for processing.

6. If an application is not received within 45 days of being sent or additional information is not received within 15 days of request, a final notice will be sent to the patient giving them 15 days to contact St. Catherine Hospital or the account will be turned to collection.

7. If an account is turned to collection and it is documented that we have followed all of the steps, the account will not qualify for charity at a later date (first court appearance).

APPROVAL PROCESS:

1. Roberto Castro will be responsible for the following steps:

   a. Figuring annual income
   b. Filling out recommendation portion on back of application.

2. After review by Roberto the application will be forwarded to the Director of Patient Accounts for review and then to the CFO for final review.

3. After final review the applications will be sent to Information Systems for processing. Information systems will return a print out of all write-offs that were processed along with the applications. The report and the applications will be filed in the back area.

4. If applicant did not qualify for 100% write-off Roberto Castro will be responsible for changing the self pay collector from "ASSIST" to "SCH PA" or "MCR" for the balance due from the patient

Charity Care Eligibility at HUD Geographic Very Low Income Guidelines - 2003

Size of Family	Gross Annual Income (Less than or Equal to)			
	Base	116.7% of Base	133.4% of Base	150% of Base
1	$ 17,550	$ 20,481	$ 23,412	$ 26,325
2	$ 20,100	$ 23,457	$ 26,813	$ 30,150
3	$ 22,600	$ 26,374	$ 30,148	$ 33,900
4	$ 25,100	$ 29,292	$ 33,483	$ 37,650
5	$ 27,100	$ 31,626	$ 36,151	$ 40,650
6	$ 29,100	$ 33,960	$ 38,819	$ 43,650
7	$ 31,100	$ 36,294	$ 41,487	$ 46,650
8	$ 33,150	$ 38,686	$ 44,222	$ 49,725
		ADD		
For each additional family member	$ 2,000	$ 2,334	$ 2,668	$ 3,000

Write-off Eligibility	100%	75%	50%	25%

Notes: 1. Patients are eligible for partial discounts as income increases up to 150% of the HUD Geographic Very Low Income Guidelines. Income increases in the three columns (to the right of the base column) containing the HUD Geographic Very Low Income amounts are calculated by adding increments of 16.7% to the base gross annual income.

Examples - A family of four with gross annual income that does not exceed $25,100 would be eligible for a 100% charity write-off. That same family of four would be eligible for a write-off of 75% of charges if the family's annual income was between $25,100 and $29,292. The family would be eligible for a 50% write-off of charges if annual income was between $29,292 and $33,483 and eligible for a 25% write-off of charges if annual income was between $33,483 and $37,650. The family would not be eligible for a charity write-off in this example if gross annual income exceeded $37,650.

Charity Care Eligibility at HUD Geographic Very Low Income Guidelines - 2002

Size of Family	Gross Annual Income (Less than or Equal to)			
	Base	116.7% of Base	133.4% of Base	150% of Base
1	$ 17,550	$ 20,481	$ 23,412	$ 26,325
2	$ 20,100	$ 23,457	$ 26,813	$ 30,150
3	$ 22,600	$ 26,374	$ 30,148	$ 33,900
4	$ 25,100	$ 29,292	$ 33,483	$ 37,650
5	$ 27,100	$ 31,626	$ 36,151	$ 40,650
6	$ 29,100	$ 33,960	$ 38,819	$ 43,650
7	$ 31,100	$ 36,294	$ 41,487	$ 46,650
8	$ 33,150	$ 38,686	$ 44,222	$ 49,725
		ADD		
For each additional family member	$ 2,000	$ 2,334	$ 2,668	$ 3,000

Write-off Eligibility	100%	75%	50%	25%

Notes: 1. Patients are eligible for partial discounts as income increases up to 150% of the HUD Geographic Very Low Income Guidelines. Income increases in the three columns (to the right of the base column) containing the HUD Geographic Very Low Income amounts are calculated by adding increments of 16.7% to the base gross annual income.

Examples - A family of four with gross annual income that does not exceed $25,100 would be eligible for a 100% charity write-off. That same family of four would be eligible for a write-off of 75% of charges if the family's annual income was between $25,100 and $29,292. The family would be eligible for a 50% write-off of charges if annual income was between $29,292 and $33,483 and eligible for a 25% write-off of charges if annual income was between $33,483 and $37,650. The family would not be eligible for a charity write-off in this example if gross annual income exceeded $37,650.

St. Catherine Hospital
East Spruce ; Garden City, KS 67846-5679

FINANCIAL ASSISTANCE APPLICATION

Please complete and return with requested verification of income by _____. If you have any questions regarding this form, please contact the Financial Counselor, Roberto Castro at 620-272-2336, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Patient Name:_____ Patient Account Number(s)_____

Address: _____ Social Security Number :_____

_____ Phone Number:_____

Guarantor Name:_____ Social Security Number :_____

Address: _____ Home Number:_____

_____

Guarantor Employer:_____ Work Number:_____

THE FOLLOWING INFORMATION MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS IT FOR CONSIDERATION

nual Gross Income for Household:_____Number of Dependents including yourself:____

Please provide copies of the following for each household member currently employed (excluding minors):

____Current W2 Form ____Current Pay Stub ____Copy of Last Two Years Income Tax Returns (including ALL related schedules)

Other Income Verification:

___Social Security Insurance ___VA Assistance ___Railroad Retirement ___Child Support
___Disability ___Life Insurance ___Pension ___Alimony
___Unemployment ___Workman's Comp ___Other: Please List:
___Public Assistance ___Tuition/Grants

If you are receiving any of the above items for monthly income, please provide the following items:
1) Copy of monthly check;
2) Copy of last two monthly bank statements showing direct deposit of the checks;
3) Copy of Social Security Verification (received once a year from Social Security), if applicable

Fixed Monthly Expenses:

House Payment/Rent:_____ Medical Bills :_____ Child Support:_____
Utilities :_____ Prescription Drugs:_____ Child Care :_____
Telephone :_____ Groceries :_____ Other:_____
Cable TV :_____ Insurance :_____ Other:_____

Total Monthly Expenses:_____

(Continue on Back)

Revised: 7/8/2003

ASSISTANCE PENDING

you currently an applicant for any Federal, State, or private financial assistance programs? (Medicaid, Food Stamps, Social Security Insurance, WIC, etc.)

Name	Case Manager	Telephone #
_____	_____	_____
_____	_____	_____

REASON FOR REQUEST: (In your own words, describe your need for financial assistance.)

_____

_____

_____

_____

Is insurance offered at your current employer? Yes / No (circle one) Comments:_____

Start date of your current employment _____.

How often are you paid? ____Weekly ____Every other week ____2 times a month ____Monthly

"I hereby state that the above information is accurate and that no information requested has been intentionally omitted. I also understand that should any of the above information be found to be inaccurate or intentionally misleading the decision of the hospital may be reversed and I may become subject to criminal investigation. I further understand that at the hospital's discretion a Credit Report will be requested to verify and help determine financial status."

_____ _____

Applicant's Signature Date

For Hospital Use Only

Pre-screened by Midland and does not qualify: _____

OR

Denial received by Medicaid: _____ (attach copy)

Recommendation:

Financial Assistance $_____ ____% **OR** _____ Does not qualify

(Inpatient Account #s:_____) (Outpatient Account #s:_____)
Adjustment code 5004 Adjustment code 5034

Patient Responsibility $_____

How will balance be paid? _____Cash _____Check _____Credit Card _____Payment Arrangements

Comments: _____

Reviewed by_____ Date_____

Approved by_____ Date_____

Approved by_____ Date_____

Revised: 7/8/2003

Sent with Application

08/14/03

[redacted]

Dear [redacted]

Enclosed is a financial assistance application for you to fill out. When you have finished the application please call (620) 272-2336 to schedule an appointment to review your application. Please bring the necessary paperwork that is outlined on the application with you to the appointment.

To be considered for St. Catherine Hospital's financial assistance program, each applicant must apply for Medicaid. If your outstanding balance is $2,000.00 or more please contact The Midland Group at (620)272-2553. If your outstanding balance is less than $2,000.00 you will need to contact Social & Rehabilitation Services at (620)272-5800 and schedule an appointment.

If we do not hear from you by (45 days from date sent), we will assume you do not wish to apply for our assistance program and will proceed with our normal collection efforts.

Thank you,

Patient Finance Advisor

Letter sent requesting additional information

08/14/03

[redacted]

RE: Uncompleted Financial Assistance Application

Dear [redacted],

On _____ we received your application for financial assistance. At this time we are unable to make a decision because the application is incomplete, due to missing information.

Marked below is the information we still need from you. Please have this information back to St Catherine Hospital by 15 days from present If we do not receive the requested information by this date your application will be denied and you will be responsible for any balances still outstanding.

_____ Tax return(s) for _____ or affidavit on non-filing

_____ Copy of current W-2

_____ Copy of current pay stub

_____ Copy of monthly check

_____ Copy of last 2 monthly bank statements

_____ Letter of Non-Eligibility from Medicaid

_____ Copy of Social Security Verification

_____ Other _____

As always, if you have any questions please contact us.

Patient Account Department
272-2208

Letter Sent 30 days after application is mailed
if application has not been received

08/22/03

[redacted]

DEAR [redacted]

On _____ we provided you with an application for financial assistance. As of today we have not received the completed application or the required documentation.

Please have this information to me by _____ or your request for financial assistance will be denied and you will be responsible for any balances still outstanding.

Sincerely,

Roberto Castro
Patient Financial Counselor
620-272-2336
800-930-3984

Letter sent if no reply to request for additional information

08/14/03

[redacted]

DEAR [redacted]:

We received your application for financial assistance on _____, however, required information was missing and we contacted you requesting the required information. As of today, we have not received the requested information. Based upon this information we are denying your request for financial assistance.

The balance on your account is due now. Please contact me within 15 days to discuss payment arrangements. If I do not hear from you within the allowed time your account will be subject to immediate referral to our outside collection agency.

Sincerely,

Roberto Castro
Patient Financial Counselor
Patient Accounts Department
(620)272-2336
(800)930-3984

Financial Assistance
Approval Notice

08/22/03

[redacted]

Dear

Thank you for your recent application for financial assistance. After reviwing your application it has been determined that you qualify for a full or partial adjustment on your account.

In accordance with St Catherine Hospital Financial Assistance guidlelines, your balance has been reduced by $_____.

At this time the remaining balance of $_____ is your responsibility. We offer the following options to assist you in paying your account.

_____ Acceptance of all major credit cards

_____ Ability to set up monthly payments, with balance paid in full within 3 to 6 months (Interest free)

_____ Ability to set up monthly payments, with balance paid in full within 18 months. (This option includes a $15.00 application fee & interest is charged.

Please contact me by _____to discuss payment arrangements. If I do not hear from you by this date, St. Catherine Hospital will continue with our normal collection procedures.

Sincerely,

Roberto Castro
Patient Financial Counselor
620-272-2336
800-930-3984

Financial Assistance Denial

08/20/03

[redacted]

Dear[redacted]:

Thank you for your recent application for financial assistance. After reviewing your application, it has been determined that we are not able to approve your application as you do not meet the guidelines for assistance.

At this time the balance of your accounts remains your responsibility. We offer the following different options to assist you in paying your account:

_____ Acceptance of all major credit cards

_____ Ability to set up monthly payments, with balance paid in full within 3 to 6 months. (Interest free)

_____ Ability to set up month payments, with balance paid in full within 18 months. (This option includes a $15.00 application fee and interest will be charged)

Please contact me by _____ to discuss payment arrangements. If I do not hear from you by this date, St Catherine Hospital will continue with our normal collection procedures.

Sincerely,

Robert Castro
Patient Financial Counselor
620-272-2336
800-930-3984

TAB 15

Summary of Recommendations from HHS and CMS Meeting with Catholic Health Initiatives

January 27, 2004

Discount Program for Certain Uninsured Non-Charity Care Patients

A protection would be established to permit hospitals to discount bills for uninsured non-charity care patients who meet the following conditions and circumstances:

1. The class of patients would be established as follows:

    a. 100% of the account balance is the responsibility of the patient/guarantor, i.e., there is no available governmental or private insurance coverage;

    b. The patient/guarantor does not meet the provider's indigency/charity care requirements in that the he/she has income/assets in excess of the allowed amounts; and,

    c. The patient/guarantor has an annual income of less than two times the area median income adjusted by family size (HUD calculation).

2. The discount would be granted to this class of patients (described above) as follows:

    a. The discount would be at the rate of the average discount provided to commercial payors (insurance and managed care plans, geographically adjusted and specific to the provider) with which the provider has contracts; and,

    b. The discount would be offered for all account balances meeting the criteria outlined in 1.

3. No adjustments would be required to any governmental (Medicare, Medicaid, etc.) cost report for these discounts; they would be handled as a contractual allowance provided to any contracted payor.

4. The OIG would determine in advance and publish that such arrangements did not constitute an inducement for referral.

Presumption of Indigency/Charity Care Eligibility

Medicare regulations currently require substantial documentation to justify a patient's qualification for indigency/charity care. Such documentation is frequently not provided by patients who would certainly qualify. The indigency/charity provisions of the Medicare regulations would be clarified to allow the presumption of indigency for persons meeting specified indicators, examples of which are noted below. Under these circumstances it would not be necessary to provide the patient specific documentation required under the current Medicare regulations and eligibility for the hospital's charity care program would be presumed.

Examples of such indicators for presumptive eligibility would include but not be limited to:

- participation in WIC programs;
- residency in a subsidized or affordable housing developments;
- Medicaid eligibility for which the state doesn't pay;
- particular occupations (e.g., migrant farm workers); and
- specific addresses in marginalized locations.

The OIG would determine in advance and publish that such arrangements did not constitute an inducement for referral.

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TAB 16

Dear Patient/Responsible Party:

Thank you for contacting us regarding your account. You are receiving this letter and patient/responsible party questionnaire because one of our staff members was informed that a work out plan could not be made to satisfy the account timely.

Enclosed is a patient/responsible party questionnaire for you to complete. This patient/responsible party questionnaire is for our use in determining how we can assist you in resolving your balance. The patient/responsible party questionnaire will be reviewed to determine if it may be appropriate to seek reimbursement from governmental agencies (for example, Medicaid), set up a work out plan, settle the account or possibly write off the balance. If you have a specific monthly payment amount you would like to propose, please note it on the patient/responsible party questionnaire. The attached patient/responsible party questionnaire only applies to hospital bills and does not include any other medical bills you may have, such as physician, radiology, ambulance, etc.

Enclosed you will find the patient/responsible party questionnaire and instructions for completion. Follow the instructions closely and verify all fields are completed thoroughly. If the question does not apply to you, please mark N/A and explain your response. Enclose any additional documentation or explanation to the patient/responsible party questionnaire that you would like us to consider (for example, a list of bills).

You may notice this patient/responsible party questionnaire resembles a credit application. However, we are not a lending institution and we are not extending credit to you. In order to consider extending to you a work out plan, you must complete this patient/responsible party questionnaire. The bottom of the patient/responsible party questionnaire must be signed by the responsible party and one witness. The completed patient/responsible party questionnaire with all documentation must be returned to our office within 10 business days of receipt.

When the patient/responsible party questionnaire is received by our office, it will be reviewed and a credit check will be conducted. If the requested documentation is not returned with the patient/responsible party questionnaire, all paperwork will be returned to the sender. You will have an additional 10 business days to return the patient/responsible party questionnaire with the missing information. If you choose not to complete the patient/responsible party questionnaire or if you do not send all requested documentation within 10 business days, then NPAS will continue to process your account per its normal collection procedures. Each patient/responsible party questionnaire, its contents, and all attachments will be kept confidential within our office.

Please use the following checklist to verify all documentation is attached.

Most recent check stub	_____	Copy of bank statement	_____
W-2 from prior year	_____	Letters of explanation	_____
Tax return from prior year	_____	All fields completed	_____
Copy of SSI check	_____	Patient/responsible party questionnaire signed and dated	_____

Please allow 10 business days for our review process. We will send a letter to confirm our decision (unless the patient/responsible party questionnaire is sent back for additional documentation). We appreciate you taking the time to complete this patient/responsible party questionnaire, and upon receipt it will be given full consideration. Please return the patient/responsible party questionnaire to:

(Insert name and address)

Please feel free to call us at (insert phone number) if you have any questions regarding this patient/responsible party questionnaire.

Patient/Responsible Party Questionnaire

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'atient Name | Social Security # | D. O. B. | Hospital Name | Account #

'atient/Responsible Party Name | Relationship to Patient | D.O.B | Social Security #

Address | City, State Zip | Length of Residence

Previous Address (if less than 2 yrs at above) | City, State Zip | Length of Residence | Phone Number

Marital Status | # of Dependents in household (Names and Ages)

Employer (Patient/Responsible Party)	7. Previous Employer (Patient/Responsible Party)	8. Spouse Employer
Idress		
ob Title/Length of employment		
usiness Phone		
ourly Rate		
Ionthly Income Gross		
Ionthly Income Net		

. Other Income Source/Amount | Total Family Monthly Income | Total Family Income last 12 mos.

0. Have you applied for Medicaid or any other State/County Assistance? (check one) Yes_____ No_____

Patient/Responsible Party Questionnaire Date | Caseworker Name/Phone number

1. 'e you filed Bankruptcy?____ Chapter 7_____ Chapter 13_____ Date Filed_____ Discharge Date _____

2. . you a Homeowner? Yes / No Approx. $ Value | Approx. Balance on Loan | Years left on Loan

Bank Name | Checking Acct.# | Avg. Checking Acct. Balance | Savings Acct.# | Avg. Savings Acct. Balance

14. Automobile (s)

Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____

Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____

15. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

	Monthly Payment	Payment to	Acct #	Balance Due	Limit
Rent/Mortgage	$_____				
Credit Cards	$_____				
	$_____				
	$_____				
Bank Loans	$_____				
	$_____				
School Loans	$_____				

List Other Monthly Expenses:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$_____	MEDICATION	$_____	AUTO INS	_____
UTILITIES	$_____	LIFE INSURANCE	$_____	OTHER	_____
GAS (Automobile(s))	$_____	MEDICAL BILLS	$_____	OTHER	_____
	$_____	TOTAL MONTHLY PAYMENTS			

*Note: Attach additional sheet if necessary. Important: income verification must be attached: W-2, Pay Stub, Tax Return, etc.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. will apply for any and all assistance that may be available to help pay this hospital bill.
3. . understand the information submitted is subject to verification: therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of __(Insert Facility/PAS Name)___ information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I further authorize __(Insert Facility/PAS Name)___ to perform a credit check as to both patient/responsible party and spouse.

Signature _____ Date_____ Witness_____ Date_____

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DIRECTIONS FOR COMPLETING PATIENT/RESPONSIBLE PARTY QUESTIONNAIRE

All fields in this Patient/Responsible Party Questionnaire must be completed thoroughly. If any fields do not apply, answer N/A (for Not Applicable) or No.

LINE 1: Complete the patient name, patient's social security number, patient's date of birth, the name of the hospital visited, and the hospital account number(s) if known.

LINE 2: Complete the patient/responsible party name, relationship to patient, patient/responsible party date of birth, and patient/responsible party social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the patient/responsible party address and length of residence.

LINE 4: Complete the patient/responsible party previous address (if residence on line three is less than two years), and the patient/responsible party home phone number.

LINE 5: Complete the patient/responsible party marital status, and number of dependents in household. This should include the names and ages of those dependents.

SECTION 6: Complete the employer information. This is for the patient/responsible party or patient – whomever is responsible for the balance. In this section, complete the name of the employer, the employer's address, the patient/responsible party job title and length of employment. Also include the patient/responsible party business phone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, note how expenses are being met.

SECTION 7: Complete the previous employer information for the patient/responsible party. This includes the employer's name and address, the patient/responsible party job title and length of employment, business phone, hourly rate, and monthly income (both gross and net).

SECTION 8: Complete the income information of the patient/responsible party spouse. Include the name of the employer, the employer's address, job title/length of employment, business phone number, hourly rate, and monthly income (both gross and net).

SECTION 9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income from the last twelve months. If there has been no income, note how expenses are being met.

SECTION 10: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date. Also in the section, we ask for the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 11: Complete this area if you have ever filed bankruptcy. Verify all questions are completed. Attach additional paper if needed for explanation.

LINE 12: Complete the homeowner information. If you are a homeowner, note the approximate dollar value, the approximate balance on loan, and the number of years left on the loan.

LINE 13: Complete the banking information as requested. List the bank name. Then complete the checking account number, and the average checking account balance. Do the same for the savings account field.

SECTION 14: This area is requesting automobile information. List the make, model, and year of your vehicle. Also list the monthly payment amount, and the current balance due.

LINE 15: Complete this section listing other assets you may have. This may include stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTAGE: Verify the amount you are paying in rent or by mortgage. Note who the payment is made to, the account number and the current balance due. If you do not pay rent or mortgage, note why you have no payment, of if you live with relatives. Use additional paper if needed.

CHARGE CARDS: Note any charge card payments you are currently making. Note the monthly payment amount, who the payment is going to, the account number and the current balance due.
Also add the credit limit for each card. Use additional paper if needed to ensure this field is complete..

BANK LOANS: Note any bank loans you may be paying. Note the monthly payment amount, who the payment is being made to, the account number, and the current balance due. Use additional paper if needed to completely explain this field.

SCHOOL LOANS: List any educational loans you may be paying. This can include, but not be limited to college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Use additional paper if needed. Specify if you are paying school loans etc.

OTHER MONTHLY EXPENSES:

FOOD: List the amount used for food on a monthly basis.

UTILITIES: List the amount paid monthly for electricity, gas, water, trash, and any other utility you may pay. You may total these and place the total for all of them in the utilities field. Use separate sheet of paper if needed.

GAS (AUTO): List the amount paid monthly for transportation in your vehicle

MEDICATION: Add the amount you pay monthly in medication. If there are several prescriptions or medications you may take, add them together and place the total amount in this field.

LIFE INSURANCE: If you have a life insurance policy, note the monthly amount you pay.

MEDICAL BILLS: Add any medical bills you may be paying monthly. This may include, but not be limited to copays, deductibles, physician, other hospital, radiology, and ambulance bills. Use a separate sheet of paper to list these. Add them together and place the total amount paid monthly toward these accounts.

AUTO INSURANCE: Place the total amount you pay monthly for auto insurance.

OTHER: This will include any monthly payments you are currently making that are not listed above. Give details of what you are paying, to whom, and the balance due. Use a separate sheet of paper if needed.

TOTAL MONTHLY PAYMENTS: Total all of the above payments and place the amount in this section.

WHAT YOU ARE AGREEING TO:

You are stating that the patient/responsible party will apply for any assistance to pay this bill. This may include getting a bank loan or putting a balance on a credit card. You authorize __(Insert Facility/RSC Name)___ to obtain credit information and perform a credit check.

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DOCUMENTATION:

Your signature on this document means you agree to attach all income verification and complete the Patient/Responsible Party Questionnaire thoroughly. In addition to what is listed on the Patient/Responsible Party Questionnaire, you may need to attach bank statements, copies of social security checks, etc. If there is no income, verify how expenses are being met. Explain lack of income completely for full consideration of this Patient/Responsible Party Questionnaire. If the patient/responsible party or spouse is self-employed, attach 3 months of previous bank statements. All documentation must be attached for full consideration. If the Patient/Responsible Party Questionnaire is incomplete, it will be returned. We will not be responsible for follow up on incomplete Patient/Responsible Party Questionnaires.

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TAB 17

Dear Patient/Responsible Party:

You are receiving this letter and Income Attestation Form because you have requested an Uninsured Charity discount for your visit.

The Income Attestation Form is for you to complete and return to us. We will use this form to determine your eligibility for an Uninsured Charity discount using the Federal Poverty Guidelines. The Uninsured Charity discount would **only** apply to hospital bills from ___(name of HCA Facility)_____ and would not include any other medical bills you may have from other health care providers, such as physician, clinical laboratories, radiologists, ambulances, etc.

Detailed instructions have been provided to assist you in completing the Income Attestation Form. Please follow these instructions closely and verify all responses are completed thoroughly. If the question does not apply to you, please mark "N/A" and explain your response. Also, please attach any additional documentation or explanation that you would like us to consider (for example, a list of bills).

You may notice this form slightly resembles a credit application. However, we are not a lending institution and we are not extending credit to you. In order to be considered for an Uninsured Charity discount, you must complete the Income Attestation Form. The responsible party must sign the bottom of the Income Attestation Form. The completed form with all documentation must be returned to our office within seven (7) days of receipt.

When our office receives the completed Income Attestation Form and supporting documentation, we will review the information and make a determination as to your eligibility for the charity discount. If you choose not to complete the Income Attestation Form or required supporting documentation, then we will proceed with our normal collection processes.

If you provide the most current year's Federal Tax Return, additional supporting documentation is not required. If you are unable to provide your Federal Tax Return, please attach two of the following supporting documents:

State Income Tax Return
Employer pay stubs for the last six months
Written documentation from income source
Copy of all banks statements for the past three months
Current credit report

Please allow ten (10) business days for our review process. We will notify you of our Uninsured Charity determination via letter. If you have any questions or concerns, please feel free to contact us at any time. Thank you for taking the time to complete this documentation, and upon receipt it will be given full consideration. Please return the Income Attestation Form and supporting income validation documentation to:

(Insert PAS name and address)

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1. Patient Name | Social Security # | Hospital Name | Account #

2. Patient/Responsible Party Name | Relationship to Patient | Social Security #

3. # Of Dependents in household, including Spouse

4. Employer (Patient/Responsible Party)	5. Spouse Employer
Address	
Job Title/Length of employment	
Business Phone	
Hourly Rate	
Monthly Income Gross	

6. Other Income Source/Amount | Total Family Monthly Gross Income | Total Family Income last 12 mos.

7. Have you applied for Medicaid or any other State/County Assistance? (Check one) Yes_____ No_____

8. Caseworker Name/Phone number

9. Have you filed Bankruptcy?_____ Chapter 7_____ Chapter 13_____ Date Filed_____ Discharge Date _____

10. Are you a Homeowner? Yes / No Approx. $ Value_____ Approx. Balance on Loan_____ Years left on Loan_____

11. Bank Name | Checking Acct.# | Avg. Checking Acct. Balance | Savings Acct.# | Avg. Savings Acct. Balance

12. Automobile(s)

Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____

Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____

13. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

14.	Monthly Payment	Payment to	Acct #	Balance Due	Limit
Rent/Mortgage	$_____				
Credit Cards	$_____				
	$_____				
	$_____				
Bank Loans	$_____				
	$_____				
School Loans	$_____				

List Other Monthly Expenses:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$_____	MEDICATION	$_____	AUTO INS	_____
UTILITIES	$_____	LIFE INSURANCE	$_____	OTHER	_____
GAS (Automobile(s))	$_____	MEDICAL BILLS	$_____	OTHER	_____
	$_____	TOTAL MONTHLY PAYMENTS			

*Note: Attach additional sheet if necessary. Important: remember to attach supporting documentation detailed on first page.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. I hereby certify that as to the application for, any third party health benefits, which may include but not be limited to Medicare, Medicaid, private health insurance or a self funded employer-sponsored health benefit plan.
3. I understand the information submitted is subject to verification. I grant permission and authorization for an authorized agent of __(Insert Facility/PAS Name)___ to follow up and verify any information provided on this form for the purposes of making an Uninsured Charity discount determination.

Signature_____ Date_____

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DIRECTIONS FOR COMPLETING INCOME ATTESTATION LONG FORM

All responses in this Income Attestation Form must be completed thoroughly. If any questions do not apply, answer "N/A" (for Not Applicable).

LINE 1: Complete the patient name, patient's social security number, the name of the hospital visited, and the hospital account number(s), if known.

LINE 2: Complete the responsible party name, relationship to patient, and responsible party's social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the number of dependents in household, including Spouse.

SECTION 4: Complete the patient/responsible party's employer information. In this section, complete the name of the employer, the employer's address, the job title and length of employment. Also include the business phone number, hourly (salary) rate, and the monthly gross income. If there is no employment, note how expenses are being met.

SECTION 5: Complete the patient/responsible party spouse's income information. Complete the name of the employer, the employer's address, job title and length of employment, business phone number, hourly rate (salary), and monthly gross income.

LINE 6: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income for the last twelve months. If there has been no income, note how expenses are being met.

LINE 7: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date.

LINE 8: If the answer to LINE 7 is yes, complete the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 9: Complete this area if you have ever filed bankruptcy. Attach additional paper if needed for explanation.

LINE 10: Complete the homeowner information. If you are a homeowner, note the approximate dollar value of your home, the approximate balance of your mortgage(s), and the number of years left on the loan(s).

SECTION 11: Complete the banking information. List your bank name(s). Then complete the checking account number(s), and the average checking account balance(s). Do the same for your savings account(s).

SECTION 12: Complete the automobile information. List the make, model, and year of your vehicle(s). Also list the monthly payment amount(s), and the current balance(s) due.

SECTION 13: Complete this section listing other assets you may have. This includes stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT MORTAGE: Verify the amount(s) you are paying in rent or by mortgage. Note whom the payment is made to, the account number and the current balance due. If you do not pay rent or mortgage, note why you have no payment, of if you live with relatives or other individuals. Use additional paper if needed to give complete details.

CHARGE CARDS: Note any credit card payments you are currently making. Note the monthly payment amount(s), to whom the payment(s) are made to, the account number(s) and the current balance(s) due. Also add the credit limit for each card. Use additional paper if needed to give complete details.

BANK LOANS: Note any bank loans you may be paying. Note the monthly payment amount(s), to whom the payment(s) are being made to, the account number, and the current balance due. Use additional paper if needed to give complete details.

SCHOOL LOANS: List any educational loans you may be paying. This can include, but not be limited to college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Use additional paper if needed to give complete details. Specify if you are making payments on such loans.

OTHER MONTHLY EXPENSES:

FOOD: List the amount used for food on a monthly basis.

UTILITIES: List the amount paid monthly for electricity, gas, water, trash, and any other utility you may pay. You may total these and place the total for all of them in the utilities field. Use additional paper if needed to give complete details.

GAS (AUTO): List the amount used monthly for your vehicle

MEDICATION: List the amount you pay monthly for medication. If there are several prescriptions or medications you may take, add them together and place the total amount in this field.

LIFE INSURANCE: If you have a life insurance policy, note the monthly amount you pay.

MEDICAL BILLS: Add any medical bills you may already be paying monthly. This may include, but not be limited to; copays, deductibles, physician, other hospital, radiologist, clinical laboratory, and ambulance bills. Use additional paper if needed to give complete details. Add them together and place the total amount paid monthly toward these accounts.

AUTO INSURANCE: Place the total amount you pay monthly for auto insurance.

OTHER: This will include any monthly payments you are currently making that are not listed above. Give details of what you are paying, to whom, and the balance due. Use additional paper if needed to give complete details.

TOTAL MONTHLY PAYMENTS: Total all of the above payments and place the amount in this section.

WHAT YOU ARE AGREEING TO:
You are requesting an Uninsured Charity discount determination. You are certifying that the information is true and accurate and that you have no other means of payment for these hospital charges. You are also authorizing __(Insert Facility/RSC Name)___ to verify the information provided if necessary.

DOCUMENTATION:
If there is no income noted, you will need to verify how your expenses are being met. You should also explain all expenses as well as any lack of income completely.

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DIRECTIONS FOR COMPLETING INCOME ATTESTATION LONG FORM

All fields in this Income Attestation Form must be completed thoroughly. If any fields do not apply, answer N/A (for Not Applicable) or No.

LINE 1: Complete the patient name, patient's social security number, the name of the hospital visited, and the hospital account number(s) if known.

LINE 2: Complete the responsible party name, relationship to patient, and patient/responsible party social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the number of dependents in household, including Spouse.

SECTION 4: Complete the responsible party's employer information. In this section, complete the name of the employer, the employer's address, the job title and length of employment. Also include the business phone number, hourly (or salary) rate, and the monthly gross income. If there is no employment, note how expenses are being met.

SECTION 5: Complete the responsible party spouse's income information. Include the name of the employer, the employer's address, job title/length of employment, business phone number, hourly rate, and monthly income (both gross and net).

LINE 6: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income from the last twelve months. If there has been no income, note how expenses are being met.

LINE 7: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date.

LINE 8: If the answer to LINE 7 is yes, complete the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 9: Complete this area if you have ever filed bankruptcy. Verify all questions are completed. Attach additional paper if needed for explanation.

LINE 10: Complete the homeowner information. If you are a homeowner, note the approximate dollar value, the approximate balance on loan, and the number of years left on the loan.

SECTION 11: Complete the banking information as requested. List the bank name. Then complete the checking account number, and the average checking account balance. Do the same for the savings account field.

SECTION 12: This area is requesting automobile information. List the make, model, and year of your vehicle. Also list the monthly payment amount, and the current balance due.

SECTION 13: Complete this section listing other assets you may have. This may include stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

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HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTAGE: Verify the amount you are paying in rent or by mortgage. Note whom the payment is made to, the account number and the current balance due. If you do not pay rent or mortgage, note why you have no payment, of if you live with relatives. Use additional paper if needed.

CHARGE CARDS: Note any charge card payments you are currently making. Note the monthly payment amount, who the payment is going to, the account number and the current balance due.
Also add the credit limit for each card. Use additional paper if needed to ensure this field is complete..

BANK LOANS: Note any bank loans you may be paying. Note the monthly payment amount, who the payment is being made to, the account number, and the current balance due. Use additional paper if needed to completely explain this field.

SCHOOL LOANS: List any educational loans you may be paying. This can include, but not be limited to college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Use additional paper if needed. Specify if you are paying school loans etc.

OTHER MONTHLY EXPENSES:

FOOD: List the amount used for food on a monthly basis.

UTILITIES: List the amount paid monthly for electricity, gas, water, trash, and any other utility you may pay. You may total these and place the total for all of them in the utilities field. Use separate sheet of paper if needed.

GAS (AUTO): List the amount paid monthly for transportation in your vehicle

MEDICATION: Add the amount you pay monthly in medication. If there are several prescriptions or medications you may take, add them together and place the total amount in this field.

LIFE INSURANCE: If you have a life insurance policy, note the monthly amount you pay.

MEDICAL BILLS: Add any medical bills you may be paying monthly. This may include, but not be limited to copays, deductibles, physician, other hospital, radiology, and ambulance bills. Use a separate sheet of paper to list these. Add them together and place the total amount paid monthly toward these accounts.

AUTO INSURANCE: Place the total amount you pay monthly for auto insurance.

OTHER: This will include any monthly payments you are currently making that are not listed above. Give details of what you are paying, to whom, and the balance due. Use a separate sheet of paper if needed.

TOTAL MONTHLY PAYMENTS: Total all of the above payments and place the amount in this section.

WHAT YOU ARE AGREEING TO:
You are requesting a charity discount determination. You authorize __(Insert Facility/RSC Name)___ to validate the credit information provided to make a charity discount determination.

DOCUMENTATION:
Your signature on this document means you agree to attach supporting documentation and complete the Income Attestation Form thoroughly. If there is no income, verify how expenses are being met. Explain lack of income completely for full charity consideration.

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1. Patient Name Social Security # Hospital Name Account #

2. Patient/Responsible Party Name Relationship to Patient Social Security #

3. # Of Dependents in household, including Spouse

4. Employer (Patient/Responsible Party)	5. Spouse Employer
Address	
Job Title/Length of employment	
Business Phone	
Hourly Rate	
Monthly Income Gross	

6. Other Income Source/Amount Total Family Monthly Gross Income Total Family Income last 12 mos.

7. Have you applied for Medicaid or any other State/County Assistance? (Check one) Yes_____ No_____

8. Caseworker Name/Phone number

9. Have you filed Bankruptcy?_____ Chapter 7_____ Chapter 13_____ Date Filed_____ Discharge Date _____

10. Are you a Homeowner? Yes / No Approx. $ Value_____ Approx. Balance on Loan_____ Years left on Loan_____

11. Bank Name Checking Acct.# Avg. Checking Acct. Balance Savings Acct.# Avg. Savings Acct. Balance

12. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

*Note: Attach additional sheet if necessary.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. I hereby certify that as to the hospital charges for which I am asking for an Uninsured Charity discount, I am not currently eligible for, and have not made application for, any third party health benefits, which may include but not be limited to Medicare, Medicaid, private health insurance or a self funded employer-sponsored health benefit plan.
3. I understand the information submitted is subject to verification. I grant permission and authorization for an authorized agent of __(Insert Facility/PAS Name)___ to follow up and verify on any information provided on this form for the purposes of making an Uninsured Charity discount determination.

Signature_____ Date_____

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DIRECTIONS FOR COMPLETING INCOME ATTESTATION SHORT FORM

All responses in this Income Attestation Form must be completed thoroughly. If any questions do not apply, answer "N/A" (for Not Applicable).

LINE 1: Complete the patient name, patient's social security number, the name of the hospital visited, and the hospital account number(s), if known.

LINE 2: Complete the responsible party name, relationship to patient, and responsible party's social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the number of dependents in household, including Spouse.

SECTION 4: Complete the patient/responsible party's employer information. In this section, complete the name of the employer, the employer's address, the job title and length of employment. Also include the business phone number, hourly (salary) rate, and the monthly gross income. If there is no employment, note how expenses are being met.

SECTION 5: Complete the patient/responsible party spouse's income information. Complete the name of the employer, the employer's address, job title and length of employment, business phone number, hourly rate, and monthly gross income.

LINE 6: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income for the last twelve months. If there has been no income, note how expenses are being met.

LINE 7: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date.

LINE 8: If the answer to LINE 7 is yes, complete the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 9: Complete this area if you have ever filed bankruptcy. Attach additional paper if needed for explanation.

LINE 10: Complete the homeowner information. If you are a homeowner, note the approximate dollar value of your home, the approximate balance of your mortgage(s), and the number of years left on the loan(s).

SECTION 11: Complete the banking information. List your bank name(s). Then complete the checking account number(s), and the average checking account balance(s). Do the same for your savings account(s).

SECTION 12: Complete this section listing other assets you may have. This includes stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

WHAT YOU ARE AGREEING TO:
You are requesting an Uninsured Charity discount determination. You are certifying that the information is true and accurate and that you have no other means of payment for these hospital charges. You are also authorizing __(Insert Facility/RSC Name)___ to verify the information provided if necessary.

DOCUMENTATION:
If there is no income noted, you need to verify how your expenses are being met. You should explain all expenses as well as any lack of income completely.

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Uninsured Charity Policy and Procedures Effective 10/1/03

Executive Conference Call

September 8, 2003

New Uninsured Charity Policy to be implemented 10/1/03

HCA

- Standardized Self Pay(Uninsured) discount policy to be implemented for all hospitals (excluding Partnerships pending Board approval)
- Based on sliding income scale as % of Federal Poverty Guidelines

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Uninsured Charity Scale

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Income Level	Total Charges <$1,000	Total Charges $1,001 - $2,500	Total Charges $2,501 - $5,000	Total Charges $5,001 - $10,000	Total Charges $10,001 - $25,000	Total Charges $25,001 - $50,000	Total Charges >$50,000
0 – 200% of FPG	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

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Uninsured Charity Implementation Packet Includes:

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- PAS Implementation Plan
- Power Point Presentation
- Charity Discount Policy for Uninsured Patients
- Uninsured Charity Process Flows
- Federal Charity Guidelines
- IPLAN Master File Policy
- Insurance Dictionary Policy
- LOGID Master File Policy
- Bill Code Master File Policy
- Financial Class Master File Policy
- Financial Class Dictionary Policy
- Collection Series Master Files
- Standard Uninsured Charity Letters
- Income Attestation Forms
- Income Attestation Form Instructions
- Frequently Asked Questions Document
- Education Material – Education Website
- Clear Access Queries
- Charity Reconciliation Form

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Terms of Implementation

- This policy will only be offered to patients with no health insurance, or other state, or federal health payor assistance.
- Other Point of Service discounts cannot be applied in combination with the Uninsured Charity discount.
- Standard IPLANS associated with FC 15 will be used for Charity Pending and each level of Uninsured Charity Discount.
- All Uninsured Charity IPLANS will be logged and autoposted, including the Charity Pending IPLAN (charity pending will be modeled at 100% payment due), however discrepancies will not be generated.
- Charity Pending IPLAN will be assigned by registration, when the Income Attestation Form is provided to the patient.
- PAS (back office) personnel are responsible for the uninsured charity determination and posting of the discount.
- NPAS and NCO will not be posting uninsured charity discounts, however, they will provide the Income Attestation Forms when applicable.

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[illegible]ation – Cont.

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- All ER accounts and accounts with charges < $5,000 do not require income validation.
- Verification of Income is required for accounts with charges > $5,000. If validation documents are not received, a manager must review and approve the discount to be applied.
- The Uninsured Charity Policy applies to discharges 10/1/03 forward, unless a patient requests for a prior account to be reviewed for charity.
- Uninsured Charity Expense will be recorded to a standard set of General Ledger accounts effective 10/1/03. A charity reconciliation will be performed on a monthly basis.

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Outstanding Issues to be Clarified by Legal and Government Services

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- Accounts where a portion of the visit is non-covered
  - Medicaid Exhausted Benefits or Partial Coverage
  - Medicare Part B Only
  - Commercial (small plans or pre-existing)
  - Black Lung
  - VA

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Standardized IPLANS, LOGIDS and Contract Models

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Description	IPLAN	LOGID	Contract Model
Charity Pending	099-50	CPEN	**Attach model to calc 100% due
Charity 0 - 100%	099-51	C100	C200
Charity 101 – 200%	099-52	C200	C200
Charity 201 – 300%	099-53	C300	C300
Charity 301 – 400%	099-54	C400	C400
Charity 201 – 250%	099-55	C250	C200

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Procedure Codes and General Ledger

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**These procedure codes are only used when the IPLANS cannot be assigned and the discount must be manually posted

Description	Code	GL Account #
Charity 0 - 100% IP	920451	549451
Charity 101 - 200% IP	920452	549452
Charity 201-300% IP	920453	549453
Charity 301 - 400% IP	920454	549454
Charity 201-250% IP	920455	549455
Charity 0 - 100% OP	920951	549951
Charity 101 - 200% OP	920952	549952
Charity 201-300% OP	920953	549953
Charity 301 - 400% OP	920954	549954
Charity 201-250% OP	920955	549955

All charity discounts posted from 10/1/03 forward will be recorded to these GL accounts

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Frequently Asked Questions

- What are the acceptable documents required to support discounts for charges greater than $5,000?
  - Federal Income Tax Return or
  - Any 2 of the following:
    - State Income Tax Return
    - Employer Pay Stubs for the last 6 months
    - Copy of Bank Statements for last 3 months
    - Current Credit Report
    - State Specific Forms
- What are the acceptable documents required to support discounts for ER patients or accounts with charges < $5,000?
  - Income Attestation Form

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Frequent Questions – Cont.

- Will this corporate policy supercede our current Uninsured Charity policy and can the discount % be adjusted?
  - The corporate charity policy will supercede all PAS uninsured charity policies including specialized programs like the ER Discount Point of Service Program. The PAS can only change the discount when state law mandates another percentage.
- When can a patient apply for a uninsured charity discount?
  - At anytime during the account lifecycle. This will be accomplished by assigning the appropriate IPLANs or posting a manual discount. NPAS and NCO will be required to provide the forms, but they will not be making the determination or applying the discount.
- When we approve a charity application, should we process write offs for previous dates of service?
  - We will not automatically apply the charity discount to other accounts, however the patient/responsible party may request additional charity consideration on previous visits. The P&P outlines the steps to be taken in this scenario.

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Frequently Asked Questions – Cont.

- When can an uninsured charity application be denied?
  - Patient/Responsible Party does not meet the charity guidelines
  - Patient/Responsible Party does not provide the Income Attestation Form within 14 days
  - Patient/Responsible Party does not provide supporting income verification documents within 7 days from the request
- Will Charity IPLANS be used concurrently with the Pending Medicaid IPLAN and can the charity discount be applied when the patient qualifies for partial Medicaid?
  - Answer is pending response from Legal and Government Operations (See Outstanding Issues)

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Frequently Asked Questions – Cont.

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- How will we handle scenarios such as deceased patients, illegal aliens, homeless patients, and patients in jail?
  - The income attestation form must be obtained at a minimum. If the proper supporting documentation cannot be obtained, then refer to the Manager to review and approve/disapprove based on the information on the form and any other information available thru collection vendors, etc.
- If a patient/responsible party qualified for an Uninsured Charity discount based upon gross income but has other resources, can the Uninsured Charity discount be denied?
  - This Uninsured Charity discount policy relates to the patient/responsible party's income, family size, and total charges of the account. Other assets are not considered.

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Frequently Asked Questions – Cont.

- If other assets are not considered, then why are we asking for this information on the Income Attestation Forms?
  - The additional information requested is to support Managers that are reviewing for potential Uninsured Charity discounts. With the additional asset information, the Manager may want to request follow up with the creditor to make a more informed decision.
- How should other indigent programs be handled such as county indigent plans?
  - Application to these other government programs should be made first and completely exhausted before applying the uninsured charity policy. If the patient qualifies for these other programs, then the uninsured charity policy does not apply.
  - If assistance is provided on a patient basis, these discounts should be posted as a contractual adjustment. If lump sum funds are provided that are not applied on a patient basis, these should be recorded as a contra-expense account within the charity FS code.

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
PAGE: 1	**REPLACES POLICY DATED:** 01/23/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.COLL.018**

SCOPE:
All PAS and Facility areas responsible for requesting and evaluating Income Attestation Forms and supporting documentation obtained.

PURPOSE:
To define the policy for providing the financial relief to Uninsured Charity and patients with no health insurance or other state, or federal health payor assistance receiving non-elective care based on Federal Poverty Guidelines and to establish protocols for the requesting and processing of the Income Attestation Forms and supporting income validation documentation.

POLICY:
Uninsured Charity discounts will be provided to uninsured patients receiving non-elective care based on an income and a charge based discount as outlined in the scale included in this Section. A validation should be completed to ensure that no portion of the patient's medical services will be paid by any federal, or state governmental health care program (e.g., Medicare, Medicaid, Champus, Medicare HMO, Medicare secondary payor), private insurance company, or other private, non-governmental third-party payor source. Uninsured Charity discounts are not to be applied to deductibles and coinsurance under any circumstances.

Accounts with total charges of $5000.00 and greater will be required to have supporting income verification documentation. The preferred documentation will be the most current year's Federal Tax Return. However, if the patient/responsible party is not able to provide this documentation then two pieces of supporting documentation from the following list will be acceptable:

- State Income Tax Return for the most current year
- Employer Pay Stubs for the last six months
- Written documentation from income sources
- Copy of all bank statements for the last three months
- Current credit report

After thorough review of the Income Attestation Form and documented research through Medicaid Eligibility denial or other means, a manager may waive supporting documentation when it is apparent that the patient/responsible party is unable to meet the requirement and clearly meets Uninsured Charity guidelines.

Emergency room visits and accounts with total charges less than $5000.00 will NOT be required to have supporting income verification documentation. The thorough completion of the Income Attestation Short Form will be acceptable for determining Uninsured Charity discount application.

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
PAGE: 2	**REPLACES POLICY DATED:** 01/23/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.COLL.018**

Registrars, Financial Counselors and Collectors should utilize all relevant on-line systems available to gather correct information. All efforts should be documented in a clear, concise and consistent manner in the Collections System. Staff should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all staff. All guidelines set forth by this policy should be adhered to without exception.

INCOME AND CHARGE BASED DISCOUNT SCALE

	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges
Income Level	<$1,000	$1,001 – $2,500	$2,501 – $5,000	$5,001 – $10,000	$10,001 – $25,000	$25,001 – $50,000	>$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

This process will be managed by establishing IPLANS with a Financial Class of 15 for Charity Pending, Charity – 100%, Charity 101% - 200%, Charity 201% - 300% and Charity 301% - 400%. In those instances where state regulations exceed the company policy, additional standard IPLANS will be established. These IPLANS will be attached to standard LOGIDS with the appropriate standard models to calculate the applicable discount and auto post to the account at final bill. These logs will not be worked for discrepancies or any other purposes since self pay underpayments or overpayments would be identified as they are normally identified today thru our collections series and credit balance reports. Standard procedure codes will be established to use in those instances where the discount must be manually applied. In addition, the collection series (4) Uninsured Charity Pending Patient Liability and (108) Uninsured Charity Pending Insurance Liability should be attached to the Pending Charity IPLAN and collection series (208) Self Pay Liability and (109) Uninsured Charity Insurance Liability respectively for automated collection tracking for these accounts.

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
PAGE: 3	**REPLACES POLICY DATED:** 01/23/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.COLL.018**

PROCEDURE:

Responsible Party	**Action**
	Inpatient, Outpatient Surgery or Observation Patients
Registrar/Financial Counselor	Is any portion of the patient's medical services paid by any federal, or state governmental health care program (e.g., Medicare , Medicaid, Champus, Medicare HMO, Medicare secondary payor), private insurance company, or other private, non-governmental third-party payor source making payment directly to the hospital?
Registrar/Financial Counselor	• If so, does not meet Uninsured Charity policy guidelines. Continue normal collection process. • If not, continue with steps below.
Registrar/Financial Counselor	Registrar determines if the patient was previously evaluated for potential Medicaid coverage. • If so, apply the Pending Medicaid IPLAN if not previously applied. • If not, complete registration and begin financial counseling process.
Registrar/Financial Counselor	Determine if this visit is considered elective. • If elective, patient will not qualify for a Uninsured Charity discount. Collect monies. • If non-elective, continue with Uninsured Charity discount process.

Registrar/Financial Counselor	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Uninsured Charity Patients
PAGE: 4	REPLACES POLICY DATED: 01/23/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 10/01/2003	REFERENCE NUMBER: RCOM.PP.COLL.018

Registrar/Financial Counselor	Determine if the estimated charges will be $5000.00 or greater.
	• Estimated charges $5000.00 or greater will require additional supporting documentation.
	  o Provide the patient/responsible party with:
	  ▪ Income Attestation Long Form Letter (RCOM.FT.COLL.628)
	  ▪ Income Attestation Long Form (RCOM.FT.COLL.629)
	  ▪ Income Attestation Long Form Instructions (RCOM.FT.COLL.630)
	• Estimated charges less than $5000.00 will only require completion of the Income Attestation Short Form. (RCOM.FT.COLL.631)

Registrar/Financial Counselor	o Provide the patient/responsible party with:
	  ▪ Income Attestation Short Form (RCOM.FT.COLL.631)
	  ▪ Income Attestation Short Form Instructions (RCOM.FT.COLL.632)
	• If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.

Registrar/Financial Counselor	Apply Pending Charity IPLAN when Uninsured Charity forms have been provided to the patient/responsible party.
Registrar/Financial Counselor	Document in Meditech that the Uninsured Charity Attestation Form was provided to the patient. • If the patient/responsible party returned the form completed, document in Meditech that the form was completed and placed for scanning.
	Clinical Outpatient
Registrar/Financial Counselor	Is any portion of the patient's medical services paid by any federal, or state governmental health care program (e.g., Medicare, Medicaid, Champus, Medicare HMO, Medicare secondary payor), private insurance company, or other private, non-governmental third-party

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
PAGE: 5	**REPLACES POLICY DATED:** 01/23/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.COLL.018**

	payor source making payment directly to the hospital? • If so, does not meet Uninsured Charity policy guidelines. Continue normal collection process. If not, continue with steps below
Registrar/Financial Counselor	Determine if this visit is considered elective. • If elective, patient will not qualify for a Uninsured Charity discount. Collect monies. • If non-elective, continue with Uninsured Charity discount process.

Registrar/Financial Counselor
 	
Registrar/Financial Counselor
	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

Registrar/Financial Counselor	Determine if the estimated charges will be $5000.00 or greater.
	• Estimated charges $5000.00 and greater will require additional supporting documentation.
	  o Provide the patient/responsible party with:
	  ▪ Income Attestation Long Form Letter (RCOM.FT.COLL.628)
	  ▪ Income Attestation Long Form (RCOM.FT.COLL.629)
	  ▪ Income Attestation Long Form Instructions (RCOM.FT.COLL.630)
	• Estimated charges less than $5000.00 will only require completion of the Income Attestation Short Form. (RCOM.FT.COLL.631)
	  o Provide the patient/responsible party with:
	  ▪ Income Attestation Short Form (RCOM.FT.COLL.631)
	  ▪ Income Attestation Short Form Instructions (RCOM.FT.COLL.632)
	• If patient/responsible party completes the form and returns it to [illegible]

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Uninsured Charity Patients
PAGE: 6	REPLACES POLICY DATED: 01/23/2003
APPROVED:	RETIRED:
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	the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.
Registrar/Financial Counselor	Apply Pending Charity IPLAN when Uninsured Charity forms have been provided to the patient/responsible party. Document Meditech that the Uninsured Charity Attestation Form was provided to the patient. o If the patient/responsible party returned the form completed, document in Meditech that the form was completed and placed for scanning.
	Emergency Room Patients
Registrar Registrar	Is any portion of the patient's medical services paid by any federal, or state governmental health care program (e.g., Medicare , Medicaid, Champus, Medicare HMO, Medicare secondary payor), private insurance company, or other private, non-governmental third-party payor source making payment directly to the hospital? • If so, does not meet Uninsured Charity policy guidelines. Continue normal collection process. If not, continue with steps below
Registrar	Determine if patient/responsible party is able to pay estimated charges. • If so, collect monies • If not, determine if patient meets facility Medicaid Eligibility Criteria o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN o If not, continue
Registrar	Provide the patient/responsible party with: ▪ Income Attestation Short Form (RCOM.FT.COLL.631) ▪ Income Attestation Short Form Instructions (RCOM.FT.COLL.632) • If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
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Registrar	Apply Pending Charity IPLAN when Uninsured Charity forms have been provided to the patient/responsible party.
Registrar	Document Meditech that the Uninsured Charity Attestation Form was provided to the patient. o If the patient/responsible party returned the form completed, document in Meditech that the form was completed and placed for scanning.
	PAS Collections – Working from Uninsured Charity Collection Series
Collector/Support Services	Determine if Income Attestation Form was received.
Collector/Support Services	• If not received, evaluate if 14 days have passed since the Pending Charity IPLAN was assigned o If 14 days have passed, remove the Pending Charity IPLAN and send the appropriate Uninsured Charity denial collection letter to the patient advising Uninsured Charity has been denied. o If 14 days have not passed, step account 7 additional days. • If received, continue
Collector/Support Services	Determine if total charges are $5000.00 or greater • If so, was supporting documentation received? o If yes, continue o If no, send collection letter CHDOCR to the patient requesting additional information. o Forward to Manager for review and consideration for Uninsured Charity without supporting documentation. • If not, continue
Collection/Support Services	Using the Income Attestation, Manager approval or supporting documentation (if applicable), Federal Charity Guidelines and the Uninsured Charity Discount Table above to determine if the Uninsured Charity guidelines have been met and at what level the discount should be applied.

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
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Collection/Support Services Staff	• If the patient/responsible party does not qualify for any type of Uninsured Charity discount: o Send the appropriate Uninsured Charity denial collection letter to the responsible party o Remove the Pending Charity IPLAN o Document the account o Place account with NPAS • If the patient/responsible party qualifies for a partial Uninsured Charity discount: o Send collection letter CHPRTL to the patient o Apply the appropriate Charity IPLAN and reprorate o Document the account o Place account with NPAS • If the patient/responsible party qualifies for a full Uninsured Charity discount: o Send collection letter CHFULL o Apply the appropriate Charity IPLAN and reprorate o Document the account
	PAS Collections – Working from Correspondence Received
Collector/Support Services	Income Attestation or Income Validation received and scanned at the patient account level.
Collector/Support Services	Account is identified
Collector/Support Services	Determine if total charges are $5000.00 or greater • If so, was supporting documentation received? o If yes, continue o If no, document account • If charges are less than $5000.00, continue
Collector/Support Services	Using the Income Attestation, supporting documentation (if applicable), Federal Charity Guidelines and the Uninsured Charity Discount Table above to determine if the Uninsured Charity guidelines have been met and at what level the discount should be applied.

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
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	• If the patient/responsible party does not qualify for any type of Uninsured Charity discount:
	  o Send the appropriate Uninsured Charity denial collection letter to the responsible party
	  o Remove the Pending Charity IPLAN
	  o Document the account
	  o Place account with NPAS

Collector/Support Services	Determine if account is with a primary or secondary collection vendor or is in bad debt.
	• Account is with a primary or secondary agency or in bad debt:
	  o If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Post the manual discount
	  • Document the account

Collector/Support Services	o If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  • Send collection letter CHFULL
	  • Post the manual discount
	  • Document the account

Collector/Support Services	• Account is in current A/R:
	  o If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Apply the appropriate Charity IPLAN and reprorate
	  • Document the account
	  • Place account with NPAS
	  o If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  • Send collection letter CHFULL
	  • Apply the appropriate Charity IPLAN and reprorate
	  • Document the account

	Medicaid Eligibility Denied

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Uninsured Charity Patients
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	Medicaid eligibility denial received.

Collector/Support Services	Obtain a copy of the Medicaid eligibility application and supporting documentation.
	Evaluate for potential Uninsured Charity
	• Not Uninsured Charity
	  o Document account
	  o Determine if account is with an agency
	  ▪ If yes, no further action needed.
	  ▪ If no, place with NPAS
	• If potential Uninsured Charity, continue

Collector/Support Services
Collector/Support Services
	Determine if account is with a primary or secondary agency or in bad debt.
	• Account with a primary or secondary agency or in bad debt:
	  o Determine if additional supporting documentation is required
	  • Not Required:
	  • If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  o Send collection letter CHPRTL to the patient
	  o Post the manual discount
	  o Document the account
	  • If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  o Send collection letter CHFULL
	  o Post the manual discount
	  o Document the account
	  • Additional Documentation Required:
	  • Send patient/responsible party collection letter CHDOCR
	  • Document account.
	• Account is in current A/R:
	  o Determine if additional supporting documentation is required

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Collector/Support Services	• Not Required:
	  • If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  o Send collection letter CHPRTL to the patient
	  o Apply the appropriate Uninsured Charity IPLAN and reprorate
	  o Document the account
	  o Place account with NPAS
	  • If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  o Send collection letter CHFULL
	  o Apply the appropriate Charity IPLAN and reprorate
	  o Document the account
	• Additional Documentation Required:
	  • Send patient/responsible party collection letter CHDOCR
	  • Apply Pending Charity IPLAN and reprorate
	  • Document account.

Collector/Support Services	**Prior Discharge Requests** If the patient/responsible party requests Uninsured Charity discount for discharges prior to October 1, 2003.
Collector/Support Services	Obtain Manager approval for Uninsured Charity consideration. • Approved, continue • Not Approved, send the appropriate Uninsured Charity denial collection letter and document account
Collector/Support Services	Using the Income Attestation, supporting documentation (if applicable), Federal Charity Guidelines and the Uninsured Charity Discount Table above to determine if the Uninsured Charity guidelines have been met and at what level the discount should be applied.
Collector/Support Services	Determine if account is with a primary or secondary collection vendor

HCA

Confidential and Proprietary

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Policy for Uninsured Charity Patients
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Collector/Support Services	or is in bad debt.
	• If yes, determine type of Uninsured Charity:
	  o If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Post the manual discount
	  • Document the account
	  o If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  • Send collection letter CHFULL
	  • Post the manual discount
	  • Document the account
	• If not, and account is in current A/R determine type of Uninsured Charity:
	  o If the patient/responsible party qualifies for a partial Uninsured Charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Apply the appropriate Charity IPLAN and reprorate
	  • Document the account
	  • Place account with NPAS
	  o If the patient/responsible party qualifies for a full Uninsured Charity discount:
	  • Send collection letter CHFULL
	  • Apply the appropriate Charity IPLAN and reprorate

Vendor Representative	**Vendor Self-Pay/Uninsured Charity Flow**
Vendor Representative	Patient/Responsible is unable to pay balance.
Vendor Representative	Determine if Uninsured Charity discount has been previously applied. • If previously applied, continue normal collection processes. • If not, continue Determine if Uninsured Charity eligibility was previously denied.

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Uninsured Charity Patients
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Vendor Representative	• If previously denied, continue normal collection processes. • If not, continue
Vendor Representative	Send patient/responsible party Uninsured Charity documentation with the return address of the applicable PAS: • Income Attestation Short Form for total charges less than $5000.00 • Income Attestation Long Form for total charges $5000.00 and greater • Applicable Income Attestation Instructions • Uninsured Charity Introduction Letter

Vendor Representative	Document and time account for next follow up.
	Check for Income Attestation and supporting documentation (if applicable)
	• If documentation is available, determine if discount has been applied.
	  o Uninsured Charity discount denied of partial discount applied, continue normal collection process
	  o Full discount applied, account should close and return systematically
	  o No Discount applied, contact PAS for status

Collector/Support Services/PARS	**PAS Daily Review** On a daily basis, using Clear Access scripts, review all final billed accounts with a Charity IPLAN assigned to ensure that the account is logged and discount is auto posted. (Note: There is a known system bug where changing an non-logged IPLAN to a logged IPLAN, using the collection system, will not apply the account to a log and therefore would not auto post the discount. • If accounts have not been logged then process the appropriate IZ transactions.

REFERENCE:

- Federal Charity Guidelines
- Income Attestation Short Form
- Income Attestation Short Form Instructions

Income Attestation Short Form

1. Patient Name Social Security # Hospital Name Account #

. Patient/Responsible Party Name Relationship to Patient Social Security #

3. Total # in Household:_____

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4. Employer (Patient/Responsible Party)	5. Spouse Employer
Address	
Job Title/Length of employment	
Business Phone	
Hourly Rate	
Monthly Income Gross	

6. Other Income Source/Amount Total Family Monthly Gross Income Total Family Income last 12 mos.

7. Have you applied for Medicaid or any other State/County Assistance? (Check one) Yes_____ When? _____ No_____

8. Caseworker Name/Phone number

9. Have you filed Bankruptcy? Yes___ Chapter 7__ Chapter 13__ Date Filed_____ Discharge Date _____ No _____

10. Are you a Homeowner? Yes / No Approx. $ Value Approx. Balance on Loan Years left on Loan

11. Bank Name Checking Acct.# Avg. Checking Acct. Balance Savings Acct.# Avg. Savings Acct. Balance

12. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

*Note: Attach additional sheet if necessary.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. I hereby certify that as to the hospital charges for which I am asking for an Uninsured Charity discount, I am not currently eligible for, and have not made application for, any third party health benefits, which may include but not be limited to Medicare, Medicaid, private health insurance or a self funded employer-sponsored health benefit plan.
3. I understand the information submitted is subject to verification. I grant permission and authorization for an authorized agent of __(Insert Facility/PAS Name)___ to follow up and verify on any information provided on this form for the purposes of making an Uninsured Charity discount determination.

Signature_____ Date_____

DIRECTIONS FOR COMPLETING
INCOME ATTESTATION SHORT FORM

All responses in this Income Attestation Form must be completed thoroughly. If any questions do not apply, answer "N/A" (for Not Applicable).

.INE 1: Complete the patient name, patient's social security number, the name of the hospital visited, and the hospital account number(s), if known.

LINE 2: Complete the responsible party name, relationship to patient, and responsible party's social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the total number in household.

SECTION 4: Complete the patient/responsible party's employer information. In this section, complete the name of the employer, the employer's address, the job title and length of employment. Also include the business phone number, hourly (salary) rate, and the monthly gross income. If there is no employment, note how expenses are being met.

SECTION 5: Complete the patient/responsible party spouse's income information. Complete the name of the employer, the employer's address, job title and length of employment, business phone number, hourly rate, and monthly gross income.

LINE 6: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income for the last twelve months. If there has been no income, note how expenses are being met.

LINE 7: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date.

LINE 8: If the answer to LINE 7 is yes, complete the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 9: Complete this area if you have ever filed bankruptcy. Attach additional paper if needed for explanation.

LINE 10: Complete the homeowner information. If you are a homeowner, note the approximate dollar value of your home, the approximate balance of your mortgage(s), and the number of years left on the loan(s).

SECTION 11: Complete the banking information. List your bank name(s). Then complete the checking account number(s), and the average checking account balance(s). Do the same for your savings account(s).

SECTION 12: Complete this section listing other assets you may have. This includes stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

WHAT YOU ARE AGREEING TO:
You are requesting an Uninsured Charity discount determination. You are certifying that the information is true and accurate and that you have no other means of payment for these hospital charges. You are also authorizing __(Insert Facility/RSC Name)___ to verify the information provided if necessary.

DOCUMENTATION:
If there is no income noted, you need to verify how your expenses are being met. You should explain all expenses as well as any lack of income completely.

Dear Patient/Responsible Party:

You are receiving this letter and Income Attestation Form because you have requested an Uninsured Charity discount for your visit.

The Income Attestation Form is for you to complete and return to us. We will use this form to determine your eligibility for an Uninsured Charity discount using the Federal Poverty Guidelines. The Uninsured Charity discount would **only** apply to hospital bills from ___(name of HCA Facility)_____ and would not include any other medical bills you may have from other health care providers, such as physician, clinical laboratories, radiologists, ambulances, etc.

Detailed instructions have been provided to assist you in completing the Income Attestation Form. Please follow these instructions closely and verify all responses are completed thoroughly. If the question does not apply to you, please mark "N/A" and explain your response. Also, please attach any additional documentation or explanation that you would like us to consider (for example, a list of bills).

You may notice this form slightly resembles a credit application. However, we are not a lending institution and we are not extending credit to you. In order to be considered for an Uninsured Charity discount, you must complete the Income Attestation Form. The responsible party must sign the bottom of the Income Attestation Form. The completed form with all documentation must be returned to our office within seven (7) days of receipt.

When our office receives the completed Income Attestation Form and supporting documentation, we will review the information and make a determination as to your eligibility for the charity discount. If you choose not to complete the Income Attestation Form or required supporting documentation, then we will proceed with our normal collection processes.

If you provide the most current year's Federal Tax Return, additional supporting documentation is not required. If you are unable to provide your Federal Tax Return, please attach two of the following supporting documents:

State Income Tax Return
Employer pay stubs for the last six months
Written documentation from income source
Copy of all banks statements for the past three months
Current credit report

Please allow ten (10) business days for our review process. We will notify you of our Uninsured Charity determination via letter. If you have any questions or concerns, please feel free to contact us at any time. Thank you for taking the time to complete this documentation, and upon receipt it will be given full consideration. Please return the Income Attestation Form and supporting income validation documentation to:

(Insert PAS name and address)

Income Attestation Long Form

. Patient Name | Social Security # | Hospital Name | Account #

2. Patient/Responsible Party Name | Relationship to Patient | Social Security #

3. Total # in Household: _____

4. Employer (Patient/Responsible Party)	5. Spouse Employer
Address	
Job Title/Length of employment	
Business Phone	
Hourly Rate	
Monthly Income Gross	

6. Other Income Source/Amount | Total Family Monthly Gross Income | Total Family Income last 12 mos.

7. Have you applied for Medicaid or any other State/County Assistance? (Check one)Yes ___ When?_____ No____
8. Caseworker Name/Phone number
9. Have you filed Bankruptcy? Yes___ Chapter 7__ Chapter 13__ Date Filed_____ Discharge Date _____No_____
10. Are you a Homeowner? Yes / No Approx. $ Value_____ Approx. Balance on Loan_____ Years left on Loan

11. Bank Name | Checking Acct.# | Avg. Checking Acct. Balance | Savings Acct.# | Avg. Savings Acct. Balance

12. Automobile(s)
Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____
Make_____ Model_____ Year_____ Pmt. Amt._____ Balance Due_____
13. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

14.	Monthly Payment	Payment to	Acct #	Balance Due	Limit
Rent/Mortgage	$_____				
Credit Cards	$_____				
	$_____				
	$_____				
Bank Loans	$_____				
	$_____				
School Loans	$_____				

List Other Monthly Expenses:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$_____	MEDICATION	$_____	AUTO INS	_____
UTILITIES	$_____	LIFE INSURANCE	$_____	OTHER	_____
GAS (Automobile(s))	$_____	MEDICAL BILLS	$_____	OTHER	_____
	$_____	TOTAL MONTHLY PAYMENTS			

*Note: Attach additional sheet if necessary. Important: remember to attach supporting documentation detailed on first page.

1. I, the undersigned, certify that the above information is true and accurate to the best of my knowledge.
2. I hereby certify that as to the hospital charges for which I am asking for an Uninsured Charity discount, I am not currently eligible for, and have not made application for, any third party health benefits, which may include but not be limited to Medicare, Medicaid, private health insurance or a self funded employer-sponsored health benefit plan.
3. I understand the information submitted is subject to verification. I grant permission and authorization for an authorized agent of __(Insert Facility/PAS Name)___ to follow up and verify any information provided on this form for the purposes of making an Uninsured Charity discount determination.

Signature_____ Date_____

DIRECTIONS FOR COMPLETING
INCOME ATTESTATION LONG FORM

All responses in this Income Attestation Form must be completed thoroughly. If any questions do not apply, answer "N/A" (for Not Applicable).

LINE 1: Complete the patient name, patient's social security number, the name of the hospital visited, and the hospital account number(s), if known.

LINE 2: Complete the responsible party name, relationship to patient, and responsible party's social security number. If the patient/responsible party is the same as the patient, note "same" in this field.

LINE 3: Complete the total number household.

SECTION 4: Complete the patient/responsible party's employer information. In this section, complete the name of the employer, the employer's address, the job title and length of employment. Also include the business phone number, hourly (salary) rate, and the monthly gross income. If there is no employment, note how expenses are being met.

SECTION 5: Complete the patient/responsible party spouse's income information. Complete the name of the employer, the employer's address, job title and length of employment, business phone number, hourly rate (salary), and monthly gross income.

LINE 6: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This can also include rental income, alimony, pension income, welfare and V.A. benefits. Complete the total family income (add the patient/responsible party net income). Then complete the total family income for the last twelve months. If there has been no income, note how expenses are being met.

LINE 7: Complete the questions regarding Medicaid and other State/County assistance. Advise if you have applied for assistance and on what date.

LINE 8: If the answer to LINE 7 is yes, complete the Caseworker's name and phone number. You may attach a separate sheet if needed.

LINE 9: Complete this area if you have ever filed bankruptcy. Attach additional paper if needed for explanation.

LINE 10: Complete the homeowner information. If you are a homeowner, note the approximate dollar value of your home, the approximate balance of your mortgage(s), and the number of years left on the loan(s).

SECTION 11: Complete the banking information. List your bank name(s). Then complete the checking account number(s), and the average checking account balance(s). Do the same for your savings account(s).

SECTION 12: Complete the automobile information. List the make, model, and year of your vehicle(s). Also list the monthly payment amount(s), and the current balance(s) due.

SECTION 13: Complete this section listing other assets you may have. This includes stocks, bonds, property, boats, and businesses you may own. Use additional paper if needed to give complete details.

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTAGE: Verify the amount(s) you are paying in rent or by mortgage. Note whom the payment is made to, the account number and the current balance due. If you do not pay rent or mortgage, note why you have no payment, of if you live with relatives or other individuals. Use additional paper if needed to give complete details.

CHARGE CARDS: Note any credit card payments you are currently making. Note the monthly payment amount(s), to whom the payment(s) are made to, the account number(s) and the current balance(s) due.
Also add the credit limit for each card. Use additional paper if needed to give complete details.

BANK LOANS: Note any bank loans you may be paying. Note the monthly payment amount(s), to whom the payment(s) are being made to, the account number, and the current balance due. Use additional paper if needed to give complete details.

SCHOOL LOANS: List any educational loans you may be paying. This can include, but not be limited to college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Use additional paper if needed to give complete details. Specify if you are making payments on such loans.

OTHER MONTHLY EXPENSES:

FOOD: List the amount used for food on a monthly basis.

UTILITIES: List the amount paid monthly for electricity, gas, water, trash, and any other utility you may pay. You may total these and place the total for all of them in the utilities field. Use additional paper if needed to give complete details.

GAS (AUTO): List the amount used monthly for your vehicle

MEDICATION: List the amount you pay monthly for medication. If there are several prescriptions or medications you may take, add them together and place the total amount in this field.

LIFE INSURANCE: If you have a life insurance policy, note the monthly amount you pay.

MEDICAL BILLS: Add any medical bills you may already be paying monthly. This may include, but not be limited to; copays, deductibles, physician, other hospital, radiologist, clinical laboratory, and ambulance bills. Use additional paper if needed to give complete details. Add them together and place the total amount paid monthly toward these accounts.

AUTO INSURANCE: Place the total amount you pay monthly for auto insurance.

OTHER: This will include any monthly payments you are currently making that are not listed above. Give details of what you are paying, to whom, and the balance due. Use additional paper if needed to give complete details.

TOTAL MONTHLY PAYMENTS: Total all of the above payments and place the amount in this section.

WHAT YOU ARE AGREEING TO:
You are requesting an Uninsured Charity discount determination. You are certifying that the information is true and accurate and that you have no other means of payment for these hospital charges. You are also authorizing __(Insert Facility/RSC Name)___ to verify the information provided if necessary.

DOCUMENTATION:
If there is no income noted, you will need to verify how your expenses are being met. You should also explain all expenses as well as any lack of income completely.

TAB 20

Customer Service Reference Guide

NewYork – Presbyterian
Weill Cornell Medical Center

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Stockamp & Associates, Inc. has provided this information to the NewYork Presbyterian Weill Cornell Medical Center (NYP) on December 5, 2001. This document has been prepared based on and in reliance on information provided by NYP or others. It is the responsibility of the NYP to review information contained here for accuracy and completeness and to update this information, as appropriate, in light of any changes, including changes in payor, statutory, or regulatory requirements, occurring after this date. The NYP may not use this information in any manner that is not consistent with all applicable payor, statutory, and regulatory requirements. This document provides guidelines only. All actions taken on behalf of the NYP are the responsibility of the NYP and shall be determined by the NYP. NYP managers should use appropriate judgement and discretion in supervising the use of these materials.

New York-Presbyterian
Weill Cornell Medical Center
Stratified Processing Environment®
Customer Service Reference Guide

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New York-Presbyterian
Weill Cornell Medical Center
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Customer Service Reference Guide

CUSTOMER SERVICE TEAM MISSION AND OBJECTIVE

To be consistently recognized as providers of superior customer service, creating positive experiences for our patients.

The Customer Service Team (CST) provides callers the opportunity to discuss their account or ask questions regarding insurance or patient liability. The CST clarifies any ambiguity and sets the caller's expectations for resolution of the account while functioning as NewYork - Presbyterian's front line contact with patients. The CST is also critical to the operation of PFS by appropriately handling a high volume of patient calls and preventing unnecessary transfers or interruptions to the rest of the office.

CUSTOMER SERVICE TEAM EXPECTATIONS

1. PRIORITIZATION AND WORK HABITS
   - Effectively prioritize work as your supervisor determines to be appropriate
   - Transfer accounts to other units according to the Customer Service Transfer Procedure *(See Appendix A)*
   - Maintain accountability for an account unless it is appropriate for the account to be transferred
   - Maintain an acceptable volume of daily work
   - Maintain high quality standards
   - Treat co-workers with respect and professionalism
   - Assist in setting and reaching team goals
   - Communicate concerns and issues to your direct supervisor or manager instead of voicing the concerns to other departments or individuals
   - Maintain attendance according to departmental policies
   - Document your work according to established Customer Service Documentation Standards *(See Appendix B)*

2. PATIENT INTERACTIONS
   - Always treat patients with dignity and respect
   - Adhere to NewYork – Presbyterian's standards of Customer Service
     - Appropriately address patients on the phone and in person
     - Always use appropriate language and behavior
     - Maintain a sense of professionalism when dealing with patients
   - Appropriately set patient expectations regarding resolution of their concerns
   - Immediately address any and all potentially serious Customer Service issues with your supervisor
   - Openly share your successes and ideas with your supervisor
   - Work effectively as a team with other teams in PFS
   - Attend training meetings or individual training sessions as required
   - Use worklists and other tools as required

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CUSTOMER SERVICE POINTS OF FOCUS

To maximize effectiveness and success as a Customer Service Team Member, it is essential to *focus on the performance principles that will deliver results*

THE FOLLOWING ARE SIX POINTS OF FOCUS FOR CUSTOMER SERVICE:

1. **GOAL:** Focus on the goal of the CST, which is to provide excellent customer service to all patients
2. **OWNERSHIP:** Take ownership of your accounts Be accountable Make things happen
3. **ESCALATE:** Escalate problems, expectations and suggestions to your supervisor Any issues involving the concerns of patients or physicians in particular should be immediately escalated
4. **DOCUMENT:** Document your work clearly, completely, and concisely
5. **PROFESSIONALISM:** Always present a positive, professional image of NewYork – Presbyterian
6. **TEAM PLAY:** Work as a team effectively, both within the CST and externally with other teams or departments. Understand your role and expected contribution to the team.

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CUSTOMER SERVICE PRIORITY MATRIX

Daily Priority Matrix

Activity	*Frequency*	*Priority*
Greet all patients arriving in PFS Assess the reason for their visit Triage their request If possible, respond to the request Appropriately transfer the account if necessary	Daily	A1
Answer inbound customer service calls Assess the reason for the call Triage the request If possible, respond to the request Appropriately transfer the caller if necessary	Daily	A2
Return voicemail (Where Applicable) Assess the reason for the call Return the call If possible, respond to the request Appropriately transfer caller if necessary	Daily	A1

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GENERAL COMPONENTS OF CUSTOMER SERVICE

PROFESSIONALISM

Professionalism is critical to the success of delivering quality customer service. The most important element of a customer-focused attitude is to be professional and courteous at all times, even when the caller is angry. Maintaining professionalism allows you to be objective and helpful.

- Appropriately greet and verify the identity of all callers *(Good Morning/Afternoon, Patient Accounts this is {your name}, how can I help you?)*
- Use appropriate language and tone of voice - never respond to callers in frustration or anger
- Positively represent NewYork - Presbyterian

LISTENING

- Obtain a clear understanding of the reason the caller is contacting NewYork - Presbyterian
- After the patient has explained the reason for their call, summarize the request back to them to ensure that you have adequately understood the reason for their call

EXPECTATIONS AND ASSURANCE

Communicate clear expectations for resolution of the caller's issue. Providing specific expectations for resolution sets the caller at ease.

- Answer the caller's question in a clear, courteous manner - if you cannot immediately respond to the request, provide specific expectations for resolution
- Transfer the patient's call appropriately if the question cannot be handled within the CST

ACTION

Fix the problem... or facilitate fixing it. If you cannot do one of the aforementioned, do not promise that you can.

SYSTEM DOCUMENTATION

Appropriate system documentation ensures that your work on an account results in adequate follow-up from other areas of PFS and facilitates easier follow-up if you need to perform further work on the account.

- Document all interactions in Eagle account notes during or immediately after each call
- Adhere to NewYork - Presbyterian's written Customer Service Documentation Standards *(Appendix B)*

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DUE DILIGENCE STEPS

1. Attempt to collect insurance information

2. Attempt to collect a patient payment

3. If the caller is or may be eligible for Medicaid Sponsorship, refer them to a local Medicaid office (See *Appendix C*)

4. Attempt to set up a payment arrangement as outlined in the Customer Service Payment Arrangement Guidelines *(See Appendix D)*

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CUSTOMER SERVICE CALLS: OVERVIEW

GREETING – ANSWERING THE PHONE

The following greeting is recommended.

Introduction:
Good Morning/Afternoon, Patient Accounts this is *{your name}*, how can I help you?

After the Caller States Request:
May I have your account number located in box 1 (or reference number located in box 9) and the date of service in question?

After the Caller States Account Number:
May I have your name? What is your relationship to the patient?

After Verifying Caller's Address:
Thank you, may I have your current address and telephone number to verify that our records are correct?

If the Address is Incorrect:
We do not have your most current address in our system. Please hold a moment while I update our records

Verify Information:
Thank you. How may I help you?

IDENTIFY THE CALLER AND LISTEN

After greeting the caller, verify that you have the appropriate account and that it is appropriate to provide the caller with the patient information. Allow the caller to discuss the reason for their inquiry. Try not to interrupt. Listen carefully and take notes. Document information when talking to the patient/guarantor. If necessary, relay back to the patient/guarantor what you understand is the reason for their call or visit.

TRIAGE

Assess the complexity of the call. If the caller has a simple request (i.e., account balance), answer the question as rapidly as possible. If the caller has a more complex request, perform a rapid review of the caller's account to determine your next action

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RESEARCH

Without putting the caller on hold, review the following information (screens)

- Billing notes and essential account information Determine whether the call is a direct result of a message left by a follow-up representative - if so, reconnect the patient to the appropriate follow-up representative
- Account balance, payments, and adjustments Review all postings to gain an understanding of the account's financial status

Based on what you learn in this review, triage the call Determine if you will handle the request yourself, or if further assistance will be required.

COMMUNICATE EXPECTATIONS

Inform the patient of the anticipated resolution of the issue. Provide specific information about who will handle the request (department or individual), when the caller can expect resolution and in what form the resolution will be provided (phone call, bill sent out, etc). If the call is transferred to a patient account representative, supervisor or manager, do not provide their last name or extension.

Example: "Mr./Ms. _____, you should be receiving a statement for $1000 in around 5 business days. This amount is due upon receipt. Do you have any other questions?"

CLOSE

The end of your interaction with a caller should always include the following:

- Reassure the patient that their request has been understood and that action has been/will be taken
- Set the patient's expectations for any further required actions
- Ensure that the patient does not have any further questions or requests

Sample Closing Comments

Further Action Required:	"Mr. Anderson, I will pass along this information to the appropriate biller today. You should expect to hear from them within two business days They will provide you with the information you requested. Is there anything else I can help you with today?"
Request Processed:	"Thank you very much for calling. Is there anything else I can help you with today?"

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SITUATION RESPONSE: PATIENT CALLS

NEW INSURANCE INFORMATION: SELF-PAY PATIENT HAS INSURANCE

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Pull-up the appropriate account in Eagle and navigate to the insurance screens
- Obtain the name of the new insurance
- Check Eagle to see if the insurance carrier in question is currently listed in the account. If the carrier is not listed, obtain the following information from the caller or patient's insurance card.
    - Subscriber name
    - Policy number and/or group number
    - Social Security number of subscriber and patient
    - Name of insurance company
    - Claim processing phone number (phone number on card)
    - Claim mailing address (address on card)
    - Date of policy, effective dates
    - Type of plan (PPO, HMO, etc.)
    - If available, authorization number
- Note that new insurance information was added in the Eagle notes. Complete the bill cancellation process.
- If the insurance the patient is calling about is already listed, inform the patient of any denial or eligibility questions you encounter and remind the patient the account will remain self-pay liability until these issues are resolved. Encourage the patient to contact his/her insurance company if eligibility issues need to be resolved.
- Document all actions and expected resolution actions and timeframes in Eagle notes

CALLER REQUESTS BALANCE INFORMATION

Sometimes patients call asking for their balance to see if their insurance has paid or to see if a payment has been posted recently. Unless an unexpected circumstance arises, these calls should always be handled within the CST and should NEVER be transferred.

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- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Determine if the patient is asking about
  - Patient Liability *or*
  - Total Account Balance
- Provide the patient with the requested balance information
- Use this direct contact with the patient/guarantor to remind them of any outstanding balances and attempt to collect payment
- Document all actions and expected resolution actions and timeframes in Eagle notes

CALLER NOTES DISCREPANCY BETWEEN EOB AND NYP BILLING

Generally, discrepancies between EOBs and NewYork - Presbyterian billing involve a patient misunderstanding, an underpayment or an error in adjustment or cash posting.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Review the payment and adjustment screens as well as the billing notes to determine the cause of the discrepancy
- Explain the discrepancy to the patient and attempt to clarify any misunderstanding on the part of the patient
- If you do find an apparent error in cash or adjustment posting, inform the patient that NewYork - Presbyterian will resolve the issue and provide a specific expectation for a return call. If you determine the balance is inappropriate, follow the Customer Service Write-off and Adjustment Guidelines *(See Appendix E)*. If you determine that the EOB needs to be pulled to verify the correct balance, request the EOB, review it and return the call to the patient.
- Refer the patient to their insurance company if they do not understand their obligation as per their contract (i.e., private room charges). If the patient absolutely refuses to call their insurance company, a Customer Service Representative can make the call.
- Document all actions and expected resolution actions and timeframes in Eagle notes

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CALLER REQUESTS PATIENT STATEMENT

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Request the patient statement in Eagle
- Estimate for the caller the approximate dates the statement will be sent and received by the caller
- Document all actions and expected resolution actions and timeframes in Eagle notes

INQUIRIES ABOUT COLLECTION AGENCY REFERRALS

Patients may call NewYork - Presbyterian to inquire about collection agency activity on their account.

1. Final Notice Calls

Patients may call in response to a final notice letter. This letter is the last step before an account is transferred to a collection agency. When handling these calls, remember that this patient's account is extremely past due and must be resolved immediately to avoid collection agency activity.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Review notes to determine if the account has already been referred to a collection agency
- Attempt to set-up payment arrangements or settlements *(See Appendix D)*. Do not use the possibility of collection agency referral as a threat. Instead, work with the patient to agree upon resolution of the account. Collection activity is a negative experience for both the patient and NewYork - Presbyterian.
- If the patient does not agree to payment arrangements or settlements, inform them that the account will continue to be processed by the self-pay team and may be referred to a collection agency if payment is not made on the account
- Document all actions and expected resolution actions and timeframes in Eagle notes

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2. Calls Related to Accounts Already at a Collection Agency

The other type of collection agency call that the CST may receive is one where the patient's account has already been transferred to a collection agency. In general, patients must follow-up with the collection agency after an account as been referred.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required.
- Refer to Eagle notes and payment/adjustment screens to determine whether the account has already been listed with a collection agency. If so, provide the patient the number for the collection agency and recommend that the patient contact a representative of that agency to inquire about the account number in question.
- Patients who call in reference to collection activity on their accounts may be angered or upset. Try to negotiate through any problems that may occur. If the caller becomes extremely agitated or requests to be transferred, transfer the account to the Supervisor.
- Document all actions and expected resolution actions and timeframes in Eagle notes.

CALLS REGARDING PAYMENT ARRANGEMENTS AND SETTLEMENTS

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required. Be sure to verify that the account is not at a collection agency.
- Refer to the billing notes and review other open accounts related to the same patient. Inform the patient of their total outstanding balance.
- Attempt to obtain payment. Ideally, the entire account balance should be paid immediately (i.e., via credit card). Though ideal, this immediate payment will probably not be realistic for most patients. It is important, however, that the patient is initially asked to pay the entire balance (cash, check or credit card), before considering payment arrangements (*See Appendix D*)
- Begin the process of initiating payment arrangements or settlements through Eagle
- Document all actions and expected resolution actions and timeframes in Eagle notes

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PATIENT CALLS TO REQUEST STATUS OF BILLED ACCOUNT

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Review Eagle account notes and provide the caller with the status of the account
- If the issue requires further attention from the specific payer area, transfer the account to the appropriate Customer Service worklist by using the worklist transfer matrix. An account should only be transferred if resolution is not possible within the Customer Service department
- Document all actions, expected resolution actions, and timeframes in Eagle notes

PATIENT CALLS REGARDING PRICING INFORMATION

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required. Determine if the call is pre or post-service.
  - If the call is pre-service, tell the patient that you do not know that information due to issues with length-of-stay, tests that will be ordered, drugs that will be administered, etc.
  - If the call is post-service, review IMNET, refer the patient to the proper physician's office. Exceptions: if a patient of physician insists on speaking to a supervisor, refer the patient to Laura Meyers.

PATIENT CALLS REGARDING MEDICAL RECORDS

- Refer any questions regarding patients requesting medical records to the Medical Records Department

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SITUATION RESPONSE: NON-PATIENT CALLS

CALLS FROM INSURANCE COMPANIES

- If the caller is a representative of an insurance company:
  - Document the company name, the caller name and their telephone number
  - If the call is requesting a document (UB-92 or Itemized Statement), complete the request and send the documentation
- If the caller wants clinical information, refer the caller to the appropriate party:
  - Inhouse: Care Management (PCM)
  - Discharged: Medical Records
- If the call is in response to or requires additional PFS biller or collector follow-up, refer the account to the appropriate payer team representative via the Customer Service worklist
- Document all actions and expected resolution actions and timeframes in Eagle notes

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CHALLENGING PATIENT SITUATIONS

As a member of NewYork - Presbyterian's Customer Service Team, it is expected that you will be capable of dealing with all of the patients, family members or other interested parties who may call NewYork - Presbyterian. Some of the requests you receive will be relatively simple and involve friendly interactions Other calls may be more challenging and involve working with people who are frustrated or angry. These more challenging situations require a higher degree of skill and patience and are critical to our mission of providing excellent service to all callers

FRUSTRATED/ ANGRY CALLERS

Callers to NewYork - Presbyterian's Customer Service line are often facing one or more of the following

- Personal illness
- Family illness
- Challenges in working with their insurance company

All of these situations are stressful and can cause callers to respond in anger or frustration on the telephone When faced with this situation the following are your rules of engagement:

- **Listen**: Often the simple process of explaining the issue at hand and feeling "heard" will calm a frustrated caller

- **Be Empathetic**: Though their behavior may be angry, callers are not angry with you personally Chances are they are going through a difficult time.

- **Be Professional**: Though a caller's behavior will sometimes frustrate or upset you, it is NEVER acceptable to respond in anger or frustration. The Customer Service Team will always handle difficult situations calmly and professionally

- **No Holding**: If at all possible, do NOT place an already upset caller on hold. If you need a few moments to research the account, simply keep the caller on the line and ask that they be patient as you obtain the information you need to assist them.

- **Be Specific**: Callers who are already upset will have very low tolerance for perceived delay or incompetence in future interactions. Provide the caller with specific information about what they can expect and from whom they can expect it.

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- **Zero Tolerance for Threats or Abuse**. Verbal abuse or threats are very different from expressions of frustration. If a caller becomes verbally abusive, let the patient guarantor know that their concerns are important, but that you are unable to assist them until they calm down. If they continue to be abusive or make threats of any kind, inform the caller that you will be ending the call. Immediately notify your supervisor of the interaction. Note the time of the call, the account number, and the reason for ending the call. You are not expected to tolerate abusive callers or callers who in any way threaten you. Your supervisor will determine how to handle the situation after your explanation.

REPEAT PATIENT PHONE CALLS

If an upset patient calls in and states that no action has been taken on the account or that she/he has not received a return phone call, follow these guidelines to resolve the caller's complaints

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required

- Tell the caller, "I am sorry that you have not received a return phone call in a timely manner. What can I do to resolve this issue for you today?" It is important to focus on what can be done to resolve the call today.

- Review notes to determine the current status of the account

- Determine if the call should be transferred to another representative in PFS. Respond with, "I am glad you had a good experience with *(representative's name)*. Maybe I can help you with your account today."

- If a transfer is not necessary, take steps to bring the account to resolution

- Document all actions and expected resolution actions and timeframes in Eagle notes

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DEMEANOR

Assertiveness and professionalism are the most effective tools a collector can use when securing payment. Tips:

1. **Be direct**. You are responsible for ensuring that the caller fully understands their responsibility

2. **Be friendly but not personal** If you are too personal with the caller, it will become difficult to be direct in asking for payment. The caller may also expect you to do them a personal favor if your rapport has been personal to that point

3. **Be firm**. If the guarantor is making unreasonable suggestions or has unreasonable expectations, state the current NewYork - Presbyterian policy and explain that this is the best you can do to assist them. Waffling about these standards will only create further frustration for patients

4. **Choose words carefully** Do not promise a resolution unless you are sure that it can and will be done

5. **Redirect when necessary**. Callers may begin to tell you excessive details about their financial situation or explain why they cannot pay In this case, it is helpful to ask, "What do you suggest we do to arrange for payment and resolve this account today?"

6. **Be specific.** "I'll work on getting this paid," is not an acceptable payment arrangement. Strive to reach agreement with the caller on the specifics of the payment plan.

7. **Avoid Excessive Detail.** Limit the amount of patient detail you take down. To the best of your ability, answer any questions the patient may have, but avoid adding details about things not specifically addressed by the patient

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APPENDIX A
Customer Service Transfer Procedure and Phone List

Calls Requiring Follow-up by Another Person

- Emergency Call
  - Attempt to transfer to the appropriate person
- Call **requires** follow-up within 48 hours- Transfer account to appropriate CS Worklist
- Call **does not require** follow-up within 48 hours- Transfer account to appropriate Unit Worklist
- Call from Insurance Company- Transfer account to appropriate Unit Worklist
- Call **requires supervisor attention**
  - Return phone call **required** within 48 hours. Pass message directly to supervisor
  - Return phone call **not required** within 48 hours. Transfer to supervisor worklist

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- **Collection Agencies**

Network Recovery Services (NRS)	
If financial class starts with 7NX (outsourced)	1-866-822-5576
If financial class starts with 9 (in collections)	1-516-622-6730
Medical Billing Resource (MBR)	1-888-524-2484
Professional Claims Bureau (PCB)	516-681-1122
Revenue Maximization Group (Revgro)	516-222-7100
HRS	516-785-5605
MARGOLIN & MELTZER	212-268-8550
REDFORM	1-800-277-8440
EEC	1-800-876-0848
HCE	212-246-8960
T&K	212-687-0357
M&M	516-479-3322
TCC	914-421-3020
ZANUS	516-326-0808
MBI	718-767-0867
CCA	914-273-8666

	NYP	Queens
♦ **Case Management**	212-746-0685	718-670-1284
♦ **Medical Records**	212-746-0530	718-670-1090
♦ **ER Physician Billing**	718-670-1651 (Queens and NYP)	
♦ **Cosmetic Packages (Mimi Lopez)**	212-297-4207	

♦ **CUMC Main #'s**	**212-590-5706**
Department of Radiology	212-590-5710 or 5711
Department of Anesthesiology	212-590-5710 or 5711
Department of Cardiology	212-297-5467
Department of Pathology	212-746-6445
Ambulance Reports	212-746-0885
Medical Records Department	212-746-0510
Patient Services Administration	212-746-4293
Cash Posting	212-297-4553

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Customer Service Transfer Procedure and Phone List

Vendor Supervisior- Leslyn Reynolds	212-297-5426
Customer Service- Laura Meyers	212-297-5424
Correspondence/ Support- Diana Alago	212-297-4468

- **NYHQ – New York Hospital Medical Center of Queens**

Operator	718-670-1231
Cashier	718-670-1177
Patient Services -Carol Mutnick	718-670-1683
Kelly Anne Murray or Manju Mathew	718-670-1110
EPP (Emergency Practice Plan) Physician Bills for ED visit	1-800-666-2455
Radiology Associates	718-961-6220 or 1-800-666-2455
Pathology Billing/ Private Physician Billing Phone	718-670-1651
Physician Billing (Rosemary Brandt)	718-670-1884 or 1-800-777-2455
Medical Records	718-670-1092
Ambulance Charge (Marilyn Fong)	718-670-1010
Janet Cassella (manager for cashiers and clinics)	718-670-1329
Cassandra Pinkney (supervisor for Queens ED)	718-670-1818

- **Payne Whitney Clinic (525 East 68th Street)**

Supervisor (Betty Canton)	212-746-3732
Fax	212-746-8630
Medicare Coordinator/Admit Representative(Desiree La Motte)	212-746-3733
Admissions Representatives: Barbara Phillips	212-746-3731
Cindy Cheung	212-746-5746
Receptionist: Dionne Howell/ Nikachi Griffin	212-746-5700
38th Street Supervisor (Marcia Ricketts)	212-297-4459

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APPENDIX B
Customer Service Documentation Standards

Standardized documentation is the most efficient way NewYork - Presbyterian (NYP) has to "talk" interdepartmentally. Documentation can also be a very effective communication tool if completed correctly. Documentation in Eagle is one critical success factor for the Customer Service Unit. Accurate and complete system notes ensure that everyone who accesses an account has the information that they need to complete their work. Because of the importance of these records, documentation standards will be implemented for all units within NYP PFS. Following are three key points to remember when documenting in Eagle Notes.

Be Clear and Concise

Notes should briefly capture the essential content of a contact. Each account note should include the following elements for a specific contact:

- **Contact information** *(Who you talked to, Where are they, The phone number of the contact)*
- **Problem statement** *(The complication or concern about the account)*
- **Action statement** *(What action was taken?)*
- **Next Steps** *(What will your next course of action be? What happens next?)*

Be Consistent

Consistency in recording notes includes frequency and timeliness of documentation and the use of abbreviations.

- Documentation should be completed for each account contact or attempted contact. Because several departments across NYP access patient information, all information must be current. Document events as they occur
- Account notes must be completed as part of your daily work. It is not acceptable to complete documentation for an account at a later date
- Abbreviations in documentation should follow the standard abbreviation guidelines
- Documentation should be easy to understand for anyone else who may access an account

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APPENDIX B
Customer Service Documentation Standards

Standardize system documentation as follows.

- Use the suggested abbreviations when appropriate
- Indicate next follow-up date
- Provide information regarding any unique/special situations

Be Appropriate

Account notes are legal documents. For this reason, editorial comments, unnecessary personal opinions, or references about other departments or people should not be entered into the system.

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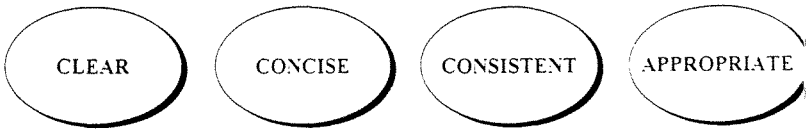
APPENDIX B
Customer Service Documentation Standards



KEY INFORMATION

1) Contact Information
   - Who you talked to
   - Where they are
   - Phone number of the contact

2) Problem Statement
   - What is the issue which you are taking action on

3) Action Statement
   - What action has or will be taken in regards to this issue

4) Next Steps
   - What will your next course of action be
   - When will you take this action

5) Activity Code and Tickle
   - i.e. 1200/ 10/31/01

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APPENDIX C
Medicaid Assistance Program (MAP) Offices
http://www.nyc.gov/html/hra/html/medicaid.html

BRONX	Bronx Lebanon Hospital Medicaid Office 1278 Fulton Avenue Bronx, NY 10456 718-588-2997	Lincoln Hospital Medicaid Office 234 East 149th Street (Basement – Room B75) Bronx, NY 10451 718-585-3224
	Morrisania Medicaid Office 1225 Gerard Avenue (Basement) Bronx, NY 10452 718-960-2799	North Central Bronx Hospital Medicaid Office 3424 Kossuth Avenue (1st Floor – Room 1A05) Bronx, NY 10456 718-920-1070
	St. Barnabas Hospital Medicaid Office 4422 Third Avenue (3rd Floor) Bronx, NY 10457 718-960-6325	
BROOKLYN	Boerum Hill Medicaid Office 88 Third Ave (1st Floor) Brooklyn, NY 11217 718-694-8722/23	Bushwick Medicaid Office 737 Flushing Avenue (4th Floor) Brooklyn, NY 11206 718-963-5080/81
	Coney Island Medicaid Office 2865 West 8th St. (Main Floor) Brooklyn, NY 11224 718-265-5601/02	Kings County Hospital Medicaid Office 441 Clarkson Avenue "T" Bldg (1st Floor) Brooklyn, NY 11203 718-221-2300/2301
MANHATTAN	Bellevue Hospital Medicaid Office 466 First Avenue & 27th St. "G" Link (1st Floor) New York, NY 212679-7153/7258	Gouverneur Hospital Medicaid Office 227 Madison Street (7th Floor) New York, NY 10002 212-238-7790
	Harlem Medicaid Office 6-20 West 137th Street (Room 130) New York, NY 10037 212-281-1240	Metropolitan Hospital Medicaid Office 1901 First Avenue (1st Floor – Room 1D18) New York, NY 1002 212-423-6583
	Presbyterian Hospital Medicaid Office 622 West 168th Street (First Floor) PH040 New York, NY 10032 212-342-5102/3	
QUEENS	Elmhurst Hospital Medicaid Office 79-01 Broadway (Room C4-5) Elmhurst, NY 11373 718-476-5904	Far Rockaway Medicaid Office 220 Beach 87th Street (Street Level) Far Rockaway, NY 11693 718-318-6580/81

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APPENDIX D
Customer Service Payment Arrangement Guidelines

These guidelines are only to be used on accounts that are not at a collection agency. Calls regarding accounts in collection should be handled by the specific agency. Representatives dealing with self-pay accounts have four main priorities when securing payment on an account.

Priority 1: Obtain any insurance information
Priority 2: Attempt to obtain payment in full or settle the account
Priority 3: Negotiate a payment arrangement
Priority 4: Determine Charity Care eligibility

The following document lists *recommended* guidelines for securing self-pay accounts. Representatives dealing with self-pay accounts should use appropriate judgement for each situation and consult their supervisors with any questions regarding payment options.

OBTAIN ANY INSURANCE INFORMATION

The first priority when dealing with a self-pay account is to obtain any insurance information that the patient may have. If insurance information is obtained, enter it into Eagle and bill the insurance company. If the patient does not have insurance, try to settle the account.

ATTEMPT TO OBTAIN PAYMENT IN FULL AND SETTLE THE ACCOUNT

The second priority of a representative dealing with self-pay accounts is to settle the account balance with the patient.

- First settlement offering is **100%** of the estimated account balance at discharge.
- Settlement is considered a payment in full
  - Discounts can be offered under the following guidelines, generally if the patient agrees to pay *within 30 days from settlement*
- Discounts greater than **25%** need to be approved by the Customer Service Supervisor. Payments that will be made after **30** days from settlement must also be approved.
- Full payment is due by the date (documented in Eagle) agreed to by the patient/guarantor and the Customer Service Representative (generally no longer than **30** days after settlement)
- The Settlement Option is only good for **30** days from the date it was offered.

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APPENDIX D
Customer Service Payment Arrangement Guidelines

NEGOTIATE A PAYMENT ARRANGEMENT

If the Customer Service Representative cannot reach a payment *settlement*, negotiate a payment *arrangement* with patient/guarantor for the full account balance.

- Determine financial situation of patient/guarantor. Ask questions such as
  - "What is your current financial situation?"
  - "What are your current binding financial commitments?"

- Use the following guidelines when establishing the payment arrangement timeframe.
  - Maximum plan of 12 months for account balances greater than $1,000
  - Maximum plan of 3 months for account balances less than $1,000
- If the patient is non-compliant with the criteria listed above, ask the patient to estimate their highest possible monthly payment. Inform the patient that you will ask your supervisor about their proposition and will contact them once you have received approval or disapproval from your supervisor.

Customer Service Supervisor's approval is necessary for any payment arrangement that entails a discount or timeframe greater than the approved arrangement guidelines listed above.

- Attempt to secure a down payment as a show of good faith (recommend one month's payment)
  - Offer a credit card payment (Visa, American Express, Mastercard)
- Inform the patient that a Payment Arrangement Letter will be sent to the patient to sign and return
- Document the payment arrangement terms in Eagle

DETERMINE CHARITY CARE ELIGIBILITY

If the patient appears eligible for Charity Care, refer the account to Laura Meyers for review.

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NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

New York Weill Cornell Medical Center
525 East 68th Street
New York, NY 10021
Tel: 212 746-5454

March 12, 2003

TO: Patient Accounts Customer Service Unit

SUBJECT: Charity Write off Procedures

When a patient facility bill has been identified as a possible write off to the Charity Restricted Fund the following steps will be taken.

- Attempt to offer a payment settlement on the balance
- Attempt to offer a payment plan on the balance

If the patient cannot afford a settlement or a payment plan they should forward a letter of hardship, which should include their financial status, to the following address:

New York Presbyterian Hospital
525 East 68th Street
Box 150
New York, NY 10021
Attention: Customer Service Supervisor

Please verify the address and phone number of the patient and advise him/her that they will be contacted again once the letter is received.

Letters requesting charity write-offs, for facility bills, addressed to other personnel should be forwarded to the Customer Service Supervisor for retention even if the addressee has the authority to write off the bill.

Mariam F. Beydoun
Manager
Network Patient Financial Services

Revised 08/27/03

NewYork-Presbyterian
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Revised 08/27/03

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APPENDIX E
Customer Service Write-off and Adjustment Guidelines

Accounts are eligible for write-off once:

- You have completed all applicable due diligence in accordance with your Customer Service Reference Guide and you determine that an account cannot be resolved, and/or

- You determine that a contractual adjustment needs to be taken or corrected. The majority of your adjustments will fall into the following categories:
  - **Administrative Write-offs** – accounts which are not payable due to some fault of NewYork - Presbyterian (denials for timely filing, denials for no pre-certification or authorization, denials for medical necessity) after appeal. Accounts greater than $1,000 require an appeal if we have proof that the admit/ procedure was authorized
  - **Contractual Adjustments** – accounts which require adjustment to correct a balance due to an incomplete or incorrect adjustment or charge transfer. Appeal any accounts greater than $1,000 if denied for timely filing or if the authorization was found in Eagle notes.

When an eligible account meeting the above criteria is identified, adhere to the following procedure:
Administrative Write-offs

- If the amount of the write-off is less than $5,000, write the account off by using the appropriate administrative transaction code (see list on p.30)
  - Document all action taken in Eagle

- Example situations for appropriate administrative write-offs:
  - Account denied coverage for past timely filing
  - Account denied coverage for no pre-certification
  - Account denied coverage for no authorization
  - Account denied coverage for medical necessity (not including Medicare accounts)
  - Account denied coverage for incorrect account coding
  - Notes state a write-off has been approved

- When taking an administrative adjustment on an account, remember to reverse the contractual allowance if appropriate

Contractual Write-offs

- If the amount of the adjustment is less than $10,000, take the adjustment by using the appropriate insurance contractual adjustment code (refer to p.30)
  - Document all action taken in Eagle

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APPENDIX E
Customer Service Write-off Guidelines

- Example situations for appropriate contractual adjustments:
  - Notes state a contractual adjustment should be taken
  - A review of the payments and adjustments screen proves the contractual adjustment is incorrect or inappropriate
  - Patient calls and provides convincing evidence from the EOB for why the account should be written-off (i.e., the caller must explain in detail what the correct balance should be)
  - After reviewing the EOB, it is determined that a contractual adjustment is appropriate

General Write-offs

- Document in Eagle a short summary of the account, including:
  - the current status of the account
  - the reason for the write-off or contractual adjustment
  - the transaction code to which the account will be adjusted
  - the amount of the write-off or contractual adjustment, and
  - any remaining balance and what it represents

- It will not be necessary to request an EOB, if the account balance is less than $50 and there is evidence that a write-off or adjustment is appropriate

- No NewYork - Presbyterian employee shall issue or approve a refund or adjustment for any relative or friend. All accounts involving relatives or friends should be immediately elevated to a Supervisor.

- All accounts above your approval threshold should be transferred to the Customer Service Supervisor regardless of who is responsible for ultimately approving the write-off/adjustment amount

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APPENDIX E
Customer Service Write-off Guidelines

NewYork – Presbyterian Entry Class Codes

- **AADJ** - Administrative Adjustment
- **ACUR** - Courtesy Allowance
- **AEMP** - Employee Allowance
- **AHCO** - Hospital Convenience
- **AIME** - Medicare IME Allowance
- **ALLC** - Manual Allowance Coll.
- **ALLW** - Manual Allowance
- **AMED** - Denials for Medical Necessity
- **ANAT** - No Authorization Denial
- **APPD** - Prompt Pay Discount
- **AQUE** - Quest Allowance
- **AUTS** - Untimely Submission Allowance
- **CASH** - Cash Payment
- **CCRD** - Credit Card Payment
- **CDEP** - Cash Deposit Payment
- **COIN** - Coinsurance Days
- **CPAY** - Copayment
- **CTRN** - Cash Transfer Payment
- **DEDT** - Deductible
- **IPRO** - PRO Denial
- **NYSC** - Surcharge
- **PEER** - Case Management Denial
- **RFND** - Refund
- **RSCH** - Research Allowance
- **SBWO** - Small Balance W/O
- **TRAN** - Balance Transfer

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TAB 21

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Customer Service
Situation Response Training

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Stockamp & Associates, Inc.

Stockamp & Associates, Inc. has provided this information to the Columbia Presbyterian Medical Center, in March, 2002. This document has been prepared based on and in reliance on information provided by the Client or others. It is the responsibility of the Client to review information contained here for accuracy and completeness and to update this information, as appropriate, in light of any changes, including changes in payer, statutory, or regulatory requirements, occurring after this date. The Client may not use this information in any manner that is not consistent with all applicable payer, statutory, and regulatory requirements. This document provides guidelines only. All actions taken on behalf of the Client are the responsibility of the Client and shall be determined by the Client. Client managers should use appropriate judgement and discretion in supervising the use of these materials.

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CUSTOMER SERVICE TEAM MISSION

To be consistently recognized as providers of superior customer service, creating positive experiences for our patients.

The Customer Service Team (CST) provides callers the opportunity to discuss their account or ask questions regarding insurance or patient liability. The CST clarifies any uncertainty and sets the caller's expectations for resolution of the account while functioning as NewYork - Presbyterian's front line contact with patients. The CST is also critical to the operation of Patient Financial Services (PFS) by appropriately handling patient calls and preventing unnecessary transfers or interruptions to the rest of the office.

CUSTOMER SERVICE TEAM OBJECTIVES

1. **PRIORITIZATION AND WORK HABITS**
   - Effectively prioritize work as your supervisor determines to be appropriate
   - Transfer accounts to other units according to the Customer Service Transfer Procedure *(See Appendix A)*
   - Maintain accountability for an account (regardless of patient type: IP, OP, Clinic) unless it is appropriate for the account to be transferred
   - Maintain an acceptable volume of daily work
   - Maintain high quality standards
   - Treat co-workers with respect and professionalism
   - Assist in setting and reaching team goals
   - Communicate concerns and issues to your direct supervisor or manager
   - Maintain attendance according to departmental policies
   - Document your work according to established Customer Service Documentation Section*(See Appendix B)*

2. **PATIENT INTERACTIONS**
   - Always treat patients with dignity and respect
   - Adhere to NewYork – Presbyterian's standards of Customer Service
     - Appropriately address patients on the phone and in person
     - Always use appropriate language and behavior
     - Maintain a sense of professionalism when dealing with patients
   - Appropriately set patient expectations regarding resolution of their concerns
   - Immediately address any and all potentially serious Customer Service issues with your supervisor
   - Openly share your successes and ideas with your supervisor
   - Work effectively as a team with other teams in PFS
   - Attend training meetings or individual training sessions as required
   - Use worklists and other tools

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CUSTOMER SERVICE POINTS OF FOCUS

To maximize effectiveness and success as a Customer Service Team Member, it is essential to ***focus on the performance principles that will deliver results***.

THE FOLLOWING ARE SIX POINTS OF FOCUS FOR CUSTOMER SERVICE:

1. **GOAL:** Focus on the goal of the CST, which is to provide excellent customer service to all patients.
2. **OWNERSHIP:** Take ownership of your accounts. Be accountable. Make things happen.
3. **ESCALATE:** Escalate problems, expectations and suggestions to your supervisor. Any issues involving the concerns of customers in particular should be immediately escalated.
4. **DOCUMENT:** Document your work clearly, completely, and concisely.
5. **PROFESSIONALISM:** Always present a positive, professional image of NewYork – Presbyterian.
6. **TEAM PLAY:** Work as a team effectively, both within the CST and externally with other teams or departments. Understand your role and contribution to the team.

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CUSTOMER SERVICE PRIORITY MATRIX

Daily Priority Matrix		
Activity	*Frequency*	*Priority*
Greet all patients arriving in PFS Assess the reason for their visit Triage their request If possible, respond to the request Appropriately refer the patient to your supervisor if necessary	As needed	A1
Answer inbound customer service calls Assess the reason for the call Triage the request If possible, respond to the request Appropriately transfer the caller if necessary	Daily	A2
Return voicemail (Where applicable) Assess the reason for the call Return the call If possible, respond to the request Appropriately transfer caller if necessary	Daily	A3

KEY:
A1= Urgent and Important Priority #1
A2= Urgent and Important Priority #2
A3= Urgent and Important Priority #3

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GENERAL COMPONENTS OF CUSTOMER SERVICE

PROFESSIONALISM

Professionalism is critical to the success of delivering quality customer service. The most important element of a customer-focused attitude is to be professional and courteous at all times, even when the caller is angry. Maintaining professionalism allows you to be objective and helpful.

- Appropriately greet and verify the identity of all callers ***(Good Morning/Afternoon, Patient Financial Services this is {your name}, how can I help you?)***
- Use appropriate language and tone of voice....Never respond to callers in frustration or anger
- Positively represent NewYork - Presbyterian

LISTENING

- Obtain a clear understanding of the reason the caller is contacting NewYork - Presbyterian
- After the patient has explained the reason for their call, summarize the request back to them to ensure that you have adequately understood the reason for their call

EXPECTATIONS AND ASSURANCE

Communicate clear expectations for resolution of the caller's issue. Providing specific expectations for resolution sets the caller at ease.

- Answer the caller's question in a clear, courteous manner - if you cannot immediately respond to the request, provide specific expectations for resolution
- Transfer the patient's call appropriately if the question cannot be handled within the CST

ACTION

Resolve the problem or facilitate resolving it. If you cannot do one of the aforementioned, do not promise that you can.

SYSTEM DOCUMENTATION

Appropriate system documentation ensures that your work on an account results in adequate follow-up from other areas of PFS and facilitates easier follow-up if you need to perform further work on the account.

- Document all interactions in Eagle account notes during or immediately after each call
- Adhere to NewYork - Presbyterian's written Customer Service Documentation Section *(Appendix B)*

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DUE DILIGENCE STEPS

1. Attempt to collect insurance information
2. Attempt to collect a patient payment
3. If the caller is or may be eligible for Medicaid Sponsorship, refer them to a local Medicaid office (*See Appendix C*)
4. Attempt to set up a payment arrangement as outlined in the Customer Service Payment Arrangement Section *(See Appendix D)*

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CUSTOMER SERVICE CALLS: OVERVIEW

GREETING – ANSWERING THE PHONE
The following greeting is recommended:

Introduction:
Good Morning/Afternoon, Patient Financial Services this is *{your name}*, how can I help you?

After the Caller States Request:
May I have your account number located in box 1 (or reference number located in box 9) and the date of service in question?

After the Caller States Account Number:
May I have your name? What is your relationship to the patient?

After Verifying Caller's Address:
Thank you, may I have your current address and telephone number to verify that our records are correct?

If the Address is Incorrect:
We do not have your most current address in our system. Could you please send proof of your new address? Any article of official mail that has been sent to you, such as a utility bill or credit card bill is acceptable. In the meantime, I will document your new information in the hospital's system notes. Once I have received the proof either by fax or mail, I will update the information in our records.

Verify Information:
Thank you. How may I help you?

IDENTIFY THE CALLER AND LISTEN

After greeting the caller, verify that you have the appropriate account and that it is appropriate to provide the caller with the patient information. Allow the caller to discuss the reason for their inquiry. Try not to interrupt. **Listen carefully and take notes**. Summarize the reason the patient/guarantor called or visited and the action steps you took to resolve the account. Document this summary in Eagle.

TRIAGE

Assess the complexity of the call. If the caller has a simple request (i.e., account balance, payment status, etc.), answer the question as rapidly as possible. If the caller has a more complex request, perform a rapid review of the caller's account to determine your next action.

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RESEARCH

Without putting the caller on hold, review the following information (screens) for all accounts:

- Billing notes and essential account information. Determine whether the call is a direct result of a message left by a follow-up representative - If so, reconnect the patient to the appropriate follow-up representative. Ensure that the representative you are transferring to answers the line before disconnecting the patient from your line.
- Account balance, payments, and adjustments. Review all postings to gain an understanding of the account's financial status

Based on what you learn in this review, triage the call. Determine if you will handle the request yourself, or if further assistance will be required.

COMMUNICATE EXPECTATIONS

Inform the patient of the anticipated resolution of the issue. Provide specific information about who will handle the request (department or individual), when the caller can expect resolution and in what form the resolution will be provided (phone call, bill sent out, etc). If the call is transferred to a patient account representative, supervisor or manager, do not provide their last name or extension.

Example: "Mr./Ms. _____, you should be receiving a statement for $1000 in around 10 business days. This amount is due upon receipt. Do you have any other questions?"

CLOSE

The end of your interaction with a caller should always include the following:

- Reassure the patient that their request has been understood and that action has been/will be taken
- Set the patient's expectations for any further required actions
- Ensure that the patient does not have any further questions or requests

Sample Closing Comments

Further Action Required:	"Mr. Anderson, I will request your EOB today. You should expect to hear from me within one week. Once I have received them, I will mail them to you. Is there anything else I can help you with today?"
Request Processed:	"Thank you very much for calling. Is there anything else I can help you with today?"

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SITUATION RESPONSE: PATIENT CALLS

NEW INSURANCE INFORMATION: SELF-PAY PATIENT HAS INSURANCE

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Pull-up the appropriate account in Eagle and navigate to the insurance screens
- Obtain the name of the new insurance
- Check Eagle to see if the insurance carrier in question is currently listed in the account. If the carrier is not listed, obtain the following information from the caller or patient's insurance card:
  - Subscriber name
  - Policy number and/or group number
  - Social Security Number of subscriber and patient
  - Name of insurance company
  - Claim processing phone number (phone number on card)
  - Claim mailing address (address on card)
  - Date of policy, effective dates
  - **Type of plan (PPO, HMO, etc.)**
  - If available, authorization number
  - Employer of insured
- Call the insurance company and verify the new insurance information
- Complete the bill cancellation process. Update the new insurance information in the RPF and FAM screens for inpatient accounts and the RFM and OUT/ REG screens for outpatient accounts. Note that new insurance information was added in the Eagle notes.
- If the insurance the patient is calling about is already listed, verify all insurance information in Eagle is correct. If so, inform the patient of any denial or eligibility questions you encounter and remind the patient the account will remain self-pay liability until these issues are resolved. Encourage the patient to contact his/her insurance company if eligibility issues need to be resolved.
- Document all actions and expected patient resolution actions and timeframes in Eagle notes
- Transfer the account to the appropriate worklist according to the Worklist Transfer Matrix via the STAT Edit form

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CALLER REQUESTS BALANCE INFORMATION

Sometimes patients call asking for their balance to see if their insurance has paid or to see if a payment has been posted recently. Unless an unexpected circumstance arises, these calls should always be handled within the CST and should not be transferred.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Determine if the patient is asking about:
  - Patient Liability *or*
  - Total Account Balance
- Provide the patient with the requested balance information
- Use this direct contact with the patient/guarantor to remind them of any outstanding balances and attempt to collect payment
- Document all actions and expected resolution actions and timeframes in Eagle notes

CALLER NOTES DISCREPANCY BETWEEN EOB AND NYP BILLING

Generally, discrepancies between EOBs and NewYork - Presbyterian billing involve a patient misunderstanding, an underpayment or an error in adjustment or cash posting.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Review the payment and adjustment screens, as well as the billing notes, to determine the cause of the discrepancy
- Explain the discrepancy to the patient and attempt to clarify any misunderstanding on the part of the patient
- If you do find an apparent error in cash or adjustment posting, inform the patient that NewYork - Presbyterian will resolve the issue and provide a specific expectation for a return call
- If you determine the balance is inappropriate, follow the Customer Service Write-off and Adjustment Guidelines *(See Appendix E)*
- If you determine that the EOB needs to be pulled to verify the correct balance, request the EOB via the EOBRQ QUIC Request Form. Verify the accuracy of the EOB against the contract. If you identify an underpayment, transfer the account to the payment review worklist via the STAT Edit form and return the call to the patient. Return the call to the patient to inform them of the underpayment and that it is being resolved.

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- Refer the patient to their insurance company if they do not understand their obligation as per their contract (i.e., private room charges). If the patient absolutely refuses to call their insurance company, a Customer Service Representative can make a conference call with the patient and the insurance company. If a conference call is necessary, request the EOB in order to have all pertinent payment information.

- Document all actions and expected resolution actions and timeframes in Eagle notes

CALLER REQUESTS PATIENT STATEMENT

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required

- Request the patient statement in Eagle

- Tell the caller the day the statement will be sent and approximately when it will be received by the caller

- Document all actions and expected resolution actions and timeframes in Eagle notes

INQUIRIES ABOUT COLLECTION AGENCY REFERRALS

Patients may call NewYork - Presbyterian to inquire about collection agency activity on their account.

1. Final Notice Calls

Patients may call in response to a final notice letter. This letter is the last step before an account is transferred to a collection agency. When handling these calls, remember that this patient's account is extremely past due and must be resolved immediately to avoid collection agency activity.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required

- Review notes to determine if the account has already been referred to a collection agency

- Attempt to set-up payment arrangements or settlements *(See Appendix D)*. Do not use the possibility of collection agency referral as a threat. Instead, work with the patient to agree upon resolution of the account. Collection activity is a negative experience for both the patient and NewYork - Presbyterian.

- If the patient does not agree to payment arrangements or settlements, inform them that the account will continue to be processed by the self-pay team and may be referred to a collection agency if payment is not made on the account

- Document all actions and expected resolution actions and timeframes in Eagle notes

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2. Calls Related to accounts already at a collection agency

The other type of collection agency call that the CST may receive is one where the patient's account has already been transferred to a collection agency. In general, patients must follow-up with the collection agency after an account has been referred. If the patient calls to settle the account within 20 days from referral date or is persistent and requires assistance, the Customer Service Representative should handle the call.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Refer to Eagle notes and payment/adjustment screens to determine whether the account has already been listed with a collection agency
- For all inpatient accounts, provide the patient the number for the collection agency (refer to Appendix A) and recommend that the patient contact a representative of that agency to inquire about the account number in question
- For all accounts, check the referral date in Eagle if the account is with the collection agency. If the account was referred within the last 120 days from the current date, provide the patient the number for the collection agency (refer to Appendix A) and recommend that the patient contact a representative of that agency to inquire about the account number in question. If the account was referred more than 120 days from the current date, the account should have been closed at the agency and returned to NYP. Therefore, in this situation, you should resolve the account yourself.
- Patients who call in reference to collection activity on their accounts may be angered or upset. Try to negotiate through any problems that may occur. If the caller becomes extremely agitated or requests to be transferred, transfer the account to the Supervisor.
- Document all actions and expected resolution actions and timeframes in Eagle notes

CALLS REGARDING PAYMENT ARRANGEMENTS AND SETTLEMENTS

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required. Be sure to verify that the account is not at a collection agency.
- Refer to the billing notes and review other open accounts related to the same patient. Inform the patient of their total outstanding balance.
- Attempt to obtain payment. Ideally, the entire account balance should be paid immediately (i.e., via credit card). Though ideal, this immediate payment will probably not be realistic for most patients. It is important, however, that the patient is initially asked to pay the entire balance (cash, check or credit card), before considering payment arrangements (*See Appendix D*).
- Begin the process of initiating payment arrangements or settlements through Eagle
- Document all actions and expected resolution actions and timeframes in Eagle notes

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PATIENT CALLS TO REQUEST STATUS OF BILLED ACCOUNT

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Review Eagle account notes and provide the caller with the status of the account
- If the issue requires further attention from the specific payer area, transfer the account to the appropriate Customer Service worklist by using the worklist transfer matrix and STAT Edit form. An account should only be transferred if resolution is not possible within the Customer Service department.
- Document all actions, expected resolution actions, and timeframes in Eagle notes

PATIENT CALLS REGARDING PRICING INFORMATION

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required. Determine if the call is pre- or post-service.
  - If the call is pre-service, tell the patient that you do not know that information due to issues with length-of-stay, tests that will be ordered, drugs that will be administered, etc.
  - If the call is post-service, review account notes in Eagle for pricing

PATIENT CALLS REGARDING MEDICAL RECORDS

- Refer any questions regarding patients requesting medical records to the Medical Records Department (Refer to Appendix A)

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SITUATION RESPONSE: NON-PATIENT CALLS

CALLS FROM INSURANCE COMPANIES

- If the caller is a representative of an insurance company:
  - Document the company name, caller name and telephone number
  - If the call is requesting a document (UB-92 or Itemized Statement), complete the request and send the documentation. Fax the document if possible.
- If the caller wants clinical information that concerns the situations below, document in Eagle the specific request for information. Tell the caller your supervisor will handle the account and when to expect a return call. Transfer the account to the supervisor worklist via that STAT™ Edit procedure (see Appendix G) ONLY IF the call pertains to:
  - Disputed dates of service
  - Incorrect patient type
  - Disputed private room responsibility
  - OP charges on an incorrect visit, warranting the creation of a new OP visit in Eagle
- If the call is in response to or requires additional PFS biller or collector follow-up, refer the call to the appropriate payer team representative and transfer the account via the Customer Service worklist according to the STAT Edit procedure (see Appendix G)
- Document all actions, expected resolution actions and timeframes in Eagle notes

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CHALLENGING PATIENT SITUATIONS

As a member of NewYork - Presbyterian's Customer Service Team, being capable of dealing with all of the patients, family members or other interested parties who may call NewYork – Presbyterian is a vital skill. Some of the requests you receive will be relatively simple and involve friendly interactions. Other calls may be more challenging and involve working with people who are frustrated or angry. These more challenging situations require a higher degree of skill and patience and are critical to our mission of providing excellent service to all callers.

FRUSTRATED/ ANGRY CALLERS

Callers to NewYork - Presbyterian's Customer Service line are often facing one or more of the following:

- Personal illness
- Family illness
- Challenges in working with their insurance company

All of these situations are stressful and can cause callers to respond in anger or frustration on the telephone. When faced with this situation the following are suggestions to ensure the conversation maintains a calm tone:

- **Listen**: Often the simple process of explaining the issue at hand and feeling "heard" will calm a frustrated caller

- **Be Empathetic**: Though their behavior may be angry, callers are not angry with you personally. It is likely that they are going through a difficult time.

- **Be Professional**: Though a caller's behavior will sometimes frustrate or upset you, it is not professional to respond in anger or frustration. The Customer Service Team will always handle difficult situations calmly and professionally.

- **No Holding**: If at all possible, do not place an already upset caller on hold. If you need a few moments to research the account, simply keep the caller on the line and ask that they be patient as you obtain the information you need to assist them.

- **Be Specific**: Callers who are already upset will have very low tolerance for perceived delay or incompetence in future interactions. Provide the caller with specific information about what they can expect and from whom they can expect it.

- **Zero Tolerance for Threats or Abuse**: Verbal abuse or threats are very different from expressions of frustration. If a caller becomes verbally abusive, let the patient/guarantor know that their concerns are important, but that you are unable to assist them until they calm down. If they continue to be abusive or make threats of any kind, inform the caller that you will be ending the call. Immediately notify your supervisor of the interaction. Note the time of the call, the account number, and the reason for ending the call. You should not need to tolerate abusive callers or callers who in any way threaten you. Your supervisor will determine how to handle the situation after your explanation.

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REPEAT PATIENT PHONE CALLS

If an upset patient calls in and states that no action has been taken on the account, or that she/he has not received a return phone call, follow these suggestions to resolve the caller's complaints.

- Verify the identity of the caller and the appropriate account number, referencing the dates of service and balance information as required
- Tell the caller, "I am sorry that you have not received a return phone call in a timely manner. What can I do to resolve this issue for you today?" It is important to focus on what can be done to resolve the call today.
- Review notes to determine the current status of the account
- Determine if the call should be transferred to another representative in PFS according to the situations explained in Appendix A. If the caller asks for a specific representative in PFS but you are able to resolve the call, respond with, "I am glad you had a good experience with *(representative's name)*. Maybe I can help you with your account today."
- If a transfer is not necessary, take steps to bring the account to resolution
- Document all actions and expected resolution actions and timeframes in Eagle notes

DEMEANOR

Assertiveness and professionalism are the most effective tools a collector can use when securing payment. Tips:

1. **Be direct:** You are responsible for ensuring that the caller fully understands their responsibility
2. **Be friendly but not personal:** If you are too personal with the caller, it will become difficult to be direct in asking for payment. The caller may also expect you to do them a personal favor if your rapport has been personal to that point.
3. **Be firm:** If the guarantor is making unreasonable suggestions or has unreasonable expectations, such as courtesy write-offs, state the current NewYork - Presbyterian policy. Explain that this is the best you can do to assist them. Being indecisive about these standards will only create further frustration for callers.
4. **Choose words carefully**: Do not promise a resolution unless you are sure that it can and will be done
5. **Redirect when necessary**: Callers may begin to tell you excessive details about their financial situation or explain why they cannot pay. In this case, it is helpful to ask, "What do you suggest we do to arrange for payment and resolve this account today?"
6. **Be specific:** "I'll work on getting this paid," is not an acceptable payment arrangement. Strive to reach agreement with the caller on the specifics of the payment plan.

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7. **Avoid Excessive Detail:** Limit the amount of patient detail you take down. To the best of your ability, answer any questions the patient may have, but avoid adding details about things not specifically addressed by the patient.

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APPENDIX A
Customer Service Transfer Procedure

Calls Requiring Follow-up by Another Person

- Emergency call
  - Attempt to transfer to the appropriate person
- Call regarding an account on a worklist not currently assigned to a follow-up representative - Transfer account to appropriate Customer Service worklist according to the most current Worklist Transfer Matrix
- Call regarding account currently on a worklist assigned to a follow-up representative- Transfer account to appropriate Unit Worklist according to the most current Worklist Transfer Matrix
- Call **requires supervisor attention**
  - Return phone call **required** within 48 hours: Pass message directly to supervisor
  - Return phone call **not required** within 48 hours: Transfer to supervisor worklist

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APPENDIX A
Customer Service Transfer Procedure and Phone List

- **Collection Agencies**

Network Recovery Services (NRS)	1-516-240-6607
Medical Billing Resource (MBR)	1-973-429-8082
Professional Claims Bureau (PCB)	1-516-681-1265
Revenue Maximization Group (Revgro)	1-516-222-7100
HRS	1-516-785-5605
EEC	1-800-876-0850
HCE	1-212-246-8960
Jzanus	1-516-326-0808
Genesis	1-516-781-6662
RTR	1-718-668-2881
PASC	1-713-266-5893

- **Medical Correspondence** 212-305-9906
- **ER Physician Billing** 718-670-1651
- **NYP-Columbia Presbyterian #'s**

Department	Telephone Number	
Neurology	305-3799	
Medicine PS	305-8300	
Radiology	800-683-5467	201-267-6300
E60th Radiology	923-0262	
Neuro-Int Radiology	923-0262	
Radiation/ Oncology	923-0262 / 305-6506	
Medicine (Private Practice)	305-8300	
Orthopedic Medicine	305-6243	
Rehabilitation Medicine	305-6503	
Pathology	305-7399	
Dermatology	305-5677	
Pediatrics	923-0846	
Psychiatry	305-2600	
Derma (Resident)	305-2149	
Otolaryngology	305-5820	
Oral Surgery	305-5690	
Hematology	305-4586	
Anesthesia	914-709-8158	
Physician Billing	305-7881	
New York Cornell - Inpatient	212-297-5424	
New York Cornell - Outpatient	212-294-4426	866-652-7517
Columbia Medical Center	212-393-2740	

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APPENDIX B
Customer Service Documentation

Documentation is the most efficient way NewYork - Presbyterian has to "talk" interdepartmentally. Documentation can also be a very effective communication tool if completed correctly. Documentation in Eagle is one critical success factor for the Customer Service Team. Accurate and complete system notes ensure that everyone who accesses an account has the information that they need to complete their work. Because of the importance of these records, it is essential to remember the following key points when documenting in Eagle Notes.

Be Clear and Concise

Notes should briefly capture the essential content of a contact. Each account note should include the following elements for a specific contact:

- **Contact information** *(Who you talked to, Where they are, The phone number of the contact)*
- **Problem statement** *(The complication or concern about the account)*
- **Action statement** *(What action was taken?)*
- **Next Steps** *(What will your next course of action be? What happens next?)*
- **STAT Edit status and Tickle days** *(ie. STAT Edit/ t=5)*

Be Consistent

Consistency in recording notes includes frequency and timeliness of documentation and the use of abbreviations

- Documentation should be completed for each account contact or attempted contact. Because several departments across NYP access patient information, all information must be current. Document events as they occur.
- Account notes should be completed as part of your daily work. It is not beneficial for account resolution to complete documentation for an account at a later date.
- Abbreviations in documentation should follow the standard abbreviation document attached
- Documentation should be easy to understand for anyone else who may access an account

Ensure accurate and concise system documentation by keeping the following suggestions in mind:

- Use the suggested abbreviations when appropriate
- Indicate next follow-up date
- Provide information regarding any unique/special situations

Be Appropriate

Account notes are legal documents. For this reason, editorial comments, unnecessary personal opinions, or references about other departments or people should not be entered into the system.

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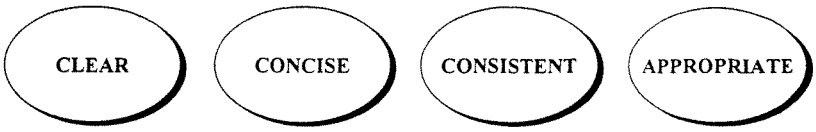
APPENDIX B
Customer Service Documentation



KEY INFORMATION

1) **Contact Information**
   - Who you talked to
   - Where they are
   - Phone number of the contact

2) **Problem Statement**
   - What is the issue which you are taking action on

3) **Action Statement**
   - What action has or will be taken in regards to this issue

4) **Next Steps**
   - What will your next course of action be
   - When will you take this action

5) **STAT Edit and Tickle**
   - i.e. STAT Edit/ t=5

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APPENDIX C
Medicaid Assistance Program (MAP) Offices

http://www.nyc.gov/html/hra/html/medicaid.html

BRONX	Bronx Lebanon Hospital Medicaid Office 1278 Fulton Avenue Bronx, NY 10456 718-588-2997	Lincoln Hospital Medicaid Office 234 East 149th Street (Basement – Room B75) Bronx, NY 10451 718-585-3224
	Morrisania Medicaid Office 1225 Gerard Avenue (Basement) Bronx, NY 10452 718-960-2799	North Central Bronx Hospital Medicaid Office 3424 Kossuth Avenue (1st Floor – Room 1A05) Bronx, NY 10456 718-920-1070
	St. Barnabas Hospital Medicaid Office 4422 Third Avenue (3rd Floor) Bronx, NY 10457 718-960-6325	
BROOKLYN	Boerum Hill Medicaid Office 88 Third Ave (1st Floor) Brooklyn, NY 11217 718-694-8722/23	Bushwick Medicaid Office 737 Flushing Avenue (4th Floor) Brooklyn, NY 11206 718-963-5080/81
	Coney Island Medicaid Office 2865 West 8th St. (Main Floor) Brooklyn, NY 11224 718-265-5601/02	Kings County Hospital Medicaid Office 441 Clarkson Avenue "T" Bldg (1st Floor) Brooklyn, NY 11203 718-221-2300/2301
MANHATTAN	Bellevue Hospital Medicaid Office 466 First Avenue & 27th St. "G" Link (1st Floor) New York, NY 212679-7153/7258	Gouverneur Hospital Medicaid Office 227 Madison Street (7th Floor) New York, NY 10002 212-238-7790
	Harlem Medicaid Office 6-20 West 137th Street (Room 130) New York, NY 10037 212-281-1240	Metropolitan Hospital Medicaid Office 1901 First Avenue (1st Floor – Room 1D18) New York, NY 1002 212-423-6583
	Presbyterian Hospital Medicaid Office 622 West 168th Street (First Floor) PH040 New York, NY. 10032 212-342-5102/3	
QUEENS	Elmhurst Hospital Medicaid Office 79-01 Broadway (Room C4-5) Elmhurst, NY 11373 718-476-5904	Far Rockaway Medicaid Office 220 Beach 87th Street (Street Level) Far Rockaway, NY 11693 718-318-6580/81

For all IP and ED accounts, patients can apply for Medicaid with the Medicaid Eligibility Unit (MEU) in the hospital

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APPENDIX D
Customer Service Payment Arrangement

These recommendations are only to be used on accounts that are not at a collection agency. Calls regarding accounts in collection should be handled by the specific agency unless the patient is calling to pay the account and the account was referred to the agency within the past 20 days. Representatives dealing with self-pay accounts have four main priorities when securing payment on an account:

Priority 1: Obtain any insurance information
Priority 2: Attempt to obtain payment in full or settle the account
Priority 3: Negotiate a payment arrangement
Priority 4: Determine fund eligibility

The following document lists ***recommended*** best practices for securing self-pay accounts. Representatives dealing with self-pay accounts should use appropriate judgement for each situation and consult their supervisors with any questions regarding payment options.

OBTAIN ANY INSURANCE INFORMATION

The first priority when dealing with a self-pay account is to obtain any insurance information that the patient may have. If insurance information is obtained, document the new information in the notes in Eagle. Call the insurance company to verify eligibility and benefits during dates of service. Once the insurance is verified, change the financial class and bill the insurance company. If the patient does not have insurance, try to settle the account.

ATTEMPT TO OBTAIN PAYMENT IN FULL AND SETTLE THE ACCOUNT

The second priority of a representative dealing with self-pay accounts is to settle the account balance with the patient

- First settlement offering is **100%** of the estimated account balance at discharge
- Settlement is considered a payment in full
  - Discounts can be offered under the following criteria, generally if the patient agrees to pay *within 30 days from settlement*
- Discounts greater than **25%** need to be approved by the Customer Service Supervisor via Discount Request Form. Payments that will be made after **30** days from settlement must also be approved by the Customer Service Supervisor.
- Discounted payment is due in full by the date (documented in Eagle) agreed to by the patient/guarantor and the Customer Service Representative (generally no longer than **30** days after settlement)
- If payment is not made, the settlement is void and full balance is due
- The Settlement Option is only good for **30** days from the date it was offered

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APPENDIX D
Customer Service Payment Arrangement

NEGOTIATE A PAYMENT ARRANGEMENT

If the Customer Service Representative cannot reach a payment *settlement*, negotiate a payment *arrangement* with patient/guarantor for the full account balance

- Determine financial situation of patient/guarantor. Ask questions such as:
  - "What is your current financial situation?"
  - "What are your current binding financial commitments?"

- Use the following guidelines when establishing the payment arrangement timeframe:
  - Maximum plan of 12 months for account balances greater than $1,000
  - Maximum plan of 3 months for account balances less than $1,000

- If the patient is non-compliant with the criteria listed above, ask the patient to estimate their highest possible monthly payment. Inform the patient that you will ask your supervisor about their proposition and will contact them once you have received approval or disapproval from your supervisor.

The Customer Service Supervisor's approval is necessary for any payment arrangement that entails a discount or timeframe greater than the approved arrangement criteria listed above.

- Attempt to secure a down payment as a show of good faith (recommend one month's payment)
  - Offer a credit card payment (Visa, American Express, Mastercard)
- Inform the patient that a Payment Arrangement Letter will be sent to the patient to sign and return
- Document the payment arrangement terms in Eagle

DETERMINE FUND ELIGIBILITY

If the patient appears eligible for funds, request proper document to verify eligibility. Once eligibility is determined, set up the account for a fund. Document in Eagle whether the patient has been set up for either the *Grace Lamb Fund* or the *Resoration Fund*.

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APPENDIX E
Customer Service Write-off and Adjustment

Accounts are eligible for write-off once:

- You have completed all applicable due diligence in accordance with your Customer Situation Response Training and you determine that an account cannot be resolved

- You determine that a contractual adjustment needs to be taken or corrected. The majority of your adjustments will fall into the following categories:
  - **Administrative Write-offs** – accounts which are not payable due to some fault of NewYork – Presbyterian. Administrative denials and write-offs include:
    - -denials for timely filing
    - -denials for no pre-certification or authorization
    - -denials for medical necessity after appeal
    - -courtesy write-offs

    Accounts greater than $1,000 require an appeal if we have proof that the admit or procedure was authorized or claim was filed timely.
  - **Contractual Adjustments** – accounts which require adjustment to correct a balance due to an incomplete or incorrect adjustment or charge transfer

When an eligible account meeting the above criteria is identified, adhere to the following procedure:

Administrative Write-offs

- If the amount of the write-off is less than $10,000, write the account off by using the appropriate administrative transaction code
  - Document all action taken in Eagle

- Example situations for appropriate administrative write-offs. Use appropriate entry class codes:
  - Account denied coverage for past timely filing
  - Account denied coverage for no pre-certification
  - Account denied coverage for no authorization
  - Account denied coverage for medical necessity (not including Medicare accounts)
  - Account denied coverage for incorrect account coding
  - Notes state a write-off has been approved

- When taking an administrative adjustment on an account, remember to reverse the contractual allowance if appropriate

- Adhere to NYP Write-off Review Policy (Appendix F)

Contractual Write-offs

- If the amount of the adjustment is less than $50,000, take the adjustment by using the appropriate insurance contractual adjustment code
  - Document all action taken in Eagle
  - Adhere to NYP Write-off Review Policy (Appendix F)

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APPENDIX E
Customer Service Write-off

- Example situations for appropriate contractual adjustments:
  - Notes state a contractual adjustment should be taken
  - A review of the payments and adjustments screen proves the contractual adjustment is incorrect or inappropriate
  - Patient calls and provides convincing evidence from the EOB for why the account should be written-off (i.e., the caller must explain in detail what the correct balance should be)
  - After reviewing the EOB, it is determined that a contractual adjustment is appropriate

General Write-offs

- Document in Eagle a short summary of the account, including:
  - the current status of the account
  - the reason for the write-off or contractual adjustment
  - the transaction code to which the account will be adjusted
  - the amount of the write-off or contractual adjustment
  - any remaining balance and what it represents

- It will not be necessary to request an EOB if the account balance is less than $50 and there is evidence that a write-off or adjustment is appropriate

- No NewYork - Presbyterian employee should issue or approve a refund or adjustment for any relative or friend. All accounts involving relatives or friends should be immediately elevated to a supervisor.

- All accounts above your approval threshold should be transferred to the Customer Service Supervisor regardless of who is responsible for ultimately approving the write-off/adjustment amount

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APPENDIX F
Write-off and Adjustment Review Guidelines

WRITE-OFF AND ADJUSTMENT REVIEW GUIDELINES

The purpose of this document is to outline the Write-off Approval Process for all representatives within New York Presbyterian Patient Financial Services at 555 West 57th Street.

Benefits of Write-off Review:

- Supervisors, managers, and the Director will review accounts with Stockamp & Associates representatives to ensure follow-up personnel are: 1) completing appropriate and necessary due diligence steps and 2) understanding and following contractual adjustment, refund, charity, bad debt, and administrative adjustment guidelines. This review also ensures all possible resolution steps have been exhausted and the correct transaction code is used to adjust the account balance if the account is deemed uncollectable.
- Write-off review also provides an opportunity to understand why certain write-offs occur (e.g., Past Timely Filing Deadline, Denied for Medical Necessity, etc.) and to implement any necessary communication and process changes to ensure these issues can be proactively addressed and have the improvement progress measured.

Write-off and Adjustment Categories:

Reasons for write-offs or adjustments that need to be reviewed at this time fall into the following six major categories:

1) *Early Bad Debt Transfers* – accounts which qualify for Bad Debt prior to qualification based on age
2) *Charity* – accounts which meet charity guidelines once all other forms of resolution and sponsorship are exhausted
3) *Patient Refunds* – accounts or credit balances which are due to the patient
4) *Third Party Refunds* – accounts or credit balances which are due to a third party payer
5) *Administrative Write-offs* – accounts which are not payable due to some fault of NewYork - Presbyterian (denials for timely filing, denials for no precertification or authorization, denials for medical necessity)
6) *Contractual Adjustments* – accounts that require adjustment to correct a balance due to an incomplete or incorrect adjustment or charge transfer. Adjustments are based on contractual reimbursement arrangements with the payer.

IMMEDIATE REVIEW LEVELS

Per the above categories, the levels of write-off review for all 57th Street Follow-up Representatives are as follows:

- Categories 1 – 5: Representatives should complete an Adjustment Request Form (see attached) and submit it to their immediate supervisor for any manual Early Bad Debt, Charity, Refund, or Administrative Write-off transaction greater than $10,000.
- Category 6: Representatives should complete an Adjustment Request Form and submit it to their immediate supervisor for any manual Contractual Adjustments greater than $50,000.

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Stockamp & Associates representatives will begin meeting with the appropriate New York Presbyterian Supervisor(s) and Manager(s) three times a week (Monday, Wednesday, and Friday) as necessary to ensure the write-offs are reviewed in a timely manner.

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APPENDIX G
STAT Edit Procedure

The STAT Edit Form is to be used when the Autokey function within Eagle is not available. Representatives should turn in all STAT Edit Forms with their STAT Worklist at the end of each day.

1. The STAT Edit Form is to be used for the following **reasons**:
   - When an account is not on a representative's STAT Worklist and work is performed on the account, the representative can STAT Edit (tickle) the account to the next appropriate day for follow-up.
   - As a representative receives correspondence and performs all necessary work on the account, the representative can STAT Edit the account to the next appropriate follow-up date.
   - A representative receives requested medical records back for an account and mails them to the respective payor. The representative can use a STAT Edit Form to update the accounts submit date and assign the date for the next follow-up, as necessary.

2. Updates to an **account's information** may pertain to any of the following:
   - An account needs to be worked earlier (or later) than originally tickled.
     - A representative's supervisor requests action to be performed on a specific account and the representative wants to update the account's next follow-up date (the account is not on the representative's current worklist)
   - An account needs to be assigned to a different worklist
   - An account's submit date needs to be updated

Directions

1. Complete the date and tech ID fields located at the top of the STAT Edit Form

2. Print the account number, patient name and the follow-up date that the account is to appear (Appear on Worklist field)

3. If an account's submit date requires updating, enter the new date in the Submit Date field

4. If the account is to be assigned to a new STAT Worklist, write the STAT Worklist number in the Worklist to Update field

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ATTACHMENT 1
TRAC ACCOUNT NUMBERS IN EAGLE

Inpatient Account Number: PAT # + SUFFIX #
Outpatient Account Number: PAT# + SUFFIX CODE + LAST SIX DIGITS OF REFERENCE #
Recurring Account Number: PAT# + SUFFIX CODE + LAST TEN DIGITS OF REFERENCE #

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ATTACHMENT 2
Customer Service Write-off

NewYork – Presbyterian Entry Class Codes

- **WADM** - Administrative Adjustment
- **WADM** - Courtesy Allowance
- **WADM** - Employee Allowance
- **RDPM** - Private Room Patient Request
- **MC/A** - Manual Allowance Coll.
- **MC/A** - Manual Allowance
- **WMCC**- Prompt Pay Discount
- **CASH** - Cash Payment or Discover Credit Card Payment
- **MAST** - Mastercard Credit Card Payment
- **AMEX** - American Express Credit Card Payment
- **VISA** - Visa Credit Card Payment
- **COIN** - Coinsurance Days
- **MDCH** - Deductible
- **NYSC** - Surcharge
- **REFD** - Refund
- **SBWO** - Small Balance W/O
- **TRAN** - Balance Transfer
- **BDTR** - Balance Transfer to Collections
- **PFIT** - Provider Fault
- **RASH** - Remittance
- **REST** - Restoration Fund
- **RSPY** - Collection Payment
- **MBAD** - Medicare Bad Debt
- **WGLB** - Global Fee Write Down
- **RDHM** - Hospital Convenience
- **RDMM**- Private Room Medical Necessity
- **RGLB**- Collection Global Payment

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ADDENDUM 1
Clinic Tips

In addition to calls regarding inpatient and outpatient services, Customer Service Representatives answer calls regarding clinic services. The suggestions below are tips to help you respond to and resolve calls from patients who need assistance with their clinic accounts.

Self Pay Patients

- Rated based on family income and family dependents
- Several types of fees exist. They are as follows:

  Full Fees: $225.00 (initial visit)
  $165.00 (follow-up visit)
  non-inclusive fee- all ancillary charges are extra (EAGLE IDENTIFIER – "F")

  Inclusive Clinic Fee: Includes all ancillary charges
  $40.00 (A)
  $50.00 (B)
  $60.00 (C)
  $70.00 (D)
  $80.00 (E)

  Administrative Ratings: To be assigned by SUPERVISORS ONLY, notation should be in GNE notes
  $10.00 (X)
  $20.00 (Y)
  $30.00 (Z)

  Clinic Ratings are noted on the back of the patient's clinic card

Managed Care Plans

- Include Oxford, Aetna – US Healthcare, Blue Cross, United Health, and Members Choice Plans for PPO, HMO, and POS products
- Patients enrolled in Managed Care Plans must attend only the Professional Clinics. (Refer to chart below)
- Professional clinics only accept Commercial Insurance (Managed Care and Indemnity Plans)
- Medicaid, Medicare, and Self Pay should NEVER be registered in these clinics
- Patients enrolled in a Managed Care Plan **may NOT receive services** from Specialty Clinics within the Vanderbilt Clinic

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Professional Clinics

Morgan	OCM390
	OCM391
	OCM392
180th Street	OCI383
	OCI384
	OCI385
135th Street	OC3910
	OC3911
Broadway	OCB380
	OCB381
	OCB382
Babies	VCB937
	VCB938
	VCB939

Nagle	OCN386
	OCN387
Allen	OAL917
	OAL919
Audubon	OCA393
	OCA394
Ft. Washington	OCF388
	OCF389
AIM	VCG912

Grants

- The Young Adult Family Planning Clinic (OCA458) services can be covered by a grant
- School Base Clinics are covered by either Medicaid or a grant only
- **No Grant** covers Emergency Room visits or any other clinic visits

Worker's Compensation Coverage

- Only Emergency Room visits can be covered by Worker's Compensation coverage
- **No** Clinic visits are covered by Worker's Compensation

No Fault

- Only New York State cases can be covered by No Fault
- To be eligible for No Fault Coverage, the accident must have occurred in New York State. **No out-of-states accepted.**

Medicaid

- Refer Medicaid patients who have had their services denied due to wrong sex or date of birth to Room 121. Patient **must** bring documentation. **Never update system based on patient's request.**

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General Note: Serial Numbers indicate the type of patient visit according to the following:

- Serial number begins with a 7
  -Clinics
  -Grants
  -Transplant (VSPRB)

- Serial number begins with a 5
  -Emergency Visit
  -Ambulatory Surgery
  -Referred Ambulatory

- Serial number begins with a 9
  -Recurring Visits
  -Physical / Occupational Cardiac Rehab
  -Speech Pulmonary Therapy
  -Radiation Therapy
  -Hemodialysis

- Serial number begins with a 1
  -Inpatient Visits

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NEW YORK-PRESBYTERIAN HOSPITAL VENDORS (38TH STREET)

VENDOR	PRODUCT LINE	% SELF
NETWORK RECOVERY SERVICES (NRS)	INPATIENT&OUTPATIENT PRIMARY SELFPAY COLLECTIONS AND MEDICAID	90%
JZANUS	INPATIENT SECONDARY SELFPAY COLLECTIONS	
PROFESSIONAL CLAIMS BUREAU(PCB)	OUTPATIENT PRIMARY SELFPAY AND SECONDARY OUTPATIENT COLLECTIONS	10%
HOSPITAL RECEIVABLES SYSTEMS(HRS)	INPATIENT & OUTPATIENT WORKER'S COMP AND NO FAULT	
GENESIS CONSULTANTS	INPATIENT COMMERICAL MANAGED CARE	
HCE,LLC	PMP(MEDICAID)	
REDFORM ENTERPRISE	PMP(MEDICAID)	
RTR FINANCIAL SERVICES	OUTPATIENT MANAGED CARE	
PAY-O-MATIC(POM)	OUTPATIENT WORKER'S COMP AND NO FAULT	
MCS	OUTPATIENT COMMERICAL & MANAGED CARE	
MILLER&MILONE	INPATIENT LEGAL SELFPAY AND MEDICAID	
MULLODY	OUTPATIENT LEGAL SELFPAY	
MEDICAL BILLING RESOURCES (MBR)	OUTPATIENT COMMERICAL & MANAGED CARE	

NO LONGER USED - BUT STILL HAVE LIMITED INVENTORY

REVGRO	NO LONGER USED - SELF-PAY	
PASC	SELF-PAY, MEDICAID	

March 12, 2003

To: Patient Accounts Customer Service

Subject: Charity Write off Procedures

When a patient facility bill has been identified as a possible write off to the Charity Restitution Fund the following steps will be taken.

- Attempt to offer a payment settlement on the balance
- Attempt to offer a payment plan on the balance

If the patient cannot afford a settlement or a payment plan they should forward a letter of hardship, which should include their financial status, to:

NewYork-Presbyterian Hospital
525 East 68th Street Box 150
New York, NY 10021
Attention: Laura Meyers, Customer Service Supervisor

Please verify the address and phone number of the patient and advise him/her that they will be contacted again once the letter is receive.

Letters requesting charity write offs, for facility bills, addressed to other personnel should be forwarded to Laura Meyers for retention even if the addressee has the authority to write off the bill.

Mariam F. Beydoun
Manager
Network Patient Financial Services

TAB 22

I Screening Form

Guarantor Last Name	First:	M.I.	DOB	SS #	Acct #
Address				Phone #	Date

Section 1 Does/Did Has/Had the Guarantor

			Yes	No
1	Have insurance coverage that has not been discovered or documented?			
	If Yes, Please list coverage:	Coverage / Effective Date		
		DOB of Each Policy Holder		
2	Currently receive benefits from:			
	Medicaid	ID #		
	Date coverage officially ends	Date		
	Commercial Insurance	ID#		
	Medicare	ID#		
	Family Health Plus	ID#		
	Child Health Plus	ID#		
	Other	ID#		
3	Received benefits in the past from:			
	Medicaid	Dates		
	Commercial Insurance	Dates		
	Medicare	Dates		
	Family Health Plus	Dates		
	Child Health Plus	Dates		
	Other	Dates		
4	Currently in the application process for:			
	Medicaid	Eligibility Worker		
	Commercial Insurance	Contact Person		
	Medicare	Eligibility Worker		
	Family Health Plus	Eligibility Worker		
	Child Health Plus	Eligibility Worker		
	Other	Eligibility Worker		

Section 2 Is the Guarantor:

			Yes	No
1	US Citizen	State of Residency		
	If Yes, Move to Question 3			
2	Legal resident alien?			

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Financial Screening Form

3 Currently employed?

If Yes, Please move to question 5

If No, Please move to question 4a

4 a. Please list the date of guarantor's most recent employment: Date

b. Did guarantor have Employee Sponsored Health Care for their children?

5 Does parent have Employee Sponsored Health Care?

If Yes, Please list coverage: Coverage | Effective Date

Section

3 Is the Guarantor:

1 Currently Pregnant? Yes No

If Yes, Expecting Date of Birth Date

2 Have any children under the age of 19? Yes No

If Yes, list the ages Ages

3 Marital status? Married | Single | Divorced | Widow/Widower

4 Number / age of dependents? # | Age of Dependents

5 Estimated monthly family income? $

Section

4 Other

1 Are services being provided as a result of being Assaulted, Shot, Knifed, Robbed, involved in a Hit & Run/ Drunk Driving/ Domestic Violence incident? Or Other? Yes No

If Yes, Please specify: Specification

*Please see VOC guidelines to define extent of coverage

2 Is the Guarantor HIV positive? Yes No

*Please see ADAP related programs to define possible coverage

3 Is the Guarantor:

A retired or active member of the United States military or a spouse or child of a retired, active, or deceased service member? Yes No

If Yes, list name, branch, and dates of service Name | Branch | Dates of Service

*Please see CHAMPUS guidelines to define possible coverage

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Financial Screening Form

Items Completed		Patient Received the following applications (Circle all Applicable)
Screening Form Complete ?		Medicaid. Family Child Health Plus. ADAP. TRICARE.
Memos Documented in Eagle/Med E?		CHAMPUS. COBRA. Healthy NY
Auto Key/Work List completed?		Pt. Had Existing Ins. Pt. Not Eligible Deposit Collected

Medicaid Eligibility Requirements									
2001 Monthly Income and Resource Level Requirements*									
Family Size	1	2	3	4	5	6	7	8	Add for Each Add'l
Monthly Net Income	$625	$900	$909	$917	$992	$1,134	$1,275	$1,417	$142
Reosurces	$900	$5,400	$5,450	$5,500	$5,950	$6,800	$7,650	$8,500	$850

*Subject to yearly adjustments

**Income and resources of other legally responsible relatives in household will be counted

*** Ownership of a car, home, and personal property does not make an individual ineligible.

Medicaid Eligibility Requirements								
2001 Expanded Income Levels for Children and Pregnant Women*								
Family Size	1	2	3	4	5	6	7	8
100% FPL**	$716	$968	$1,220	$1,471	$1,723	$1,975	$2,226	$2,478
133% FPL**	$953	$1,287	$1,622	$1,957	$2,291	$2,626	$2,961	$3,296
200% FPL**	$1,432	$1,935	$2,439	$2,942	$3,445	$3,949	$4,452	$4,955

*Subject to yearly adjustments

**Federal Poverty Level

100% FPL - Children ages 6 to 19; 133% FPL - Children over age 1, under age 6; 200% FPL - Infants to age 1 and pregnant women

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Financial Screening Form

Family Health Plus									
2001 Monthly Income Requirements*									
Family Size	Single Adult	Couples - No Children	2	3	4	5	6	7	
Income**	$716	$968	$1,287	$1,622	$1,957	$2,291	$2,626	$2,961	

*Subject to yearly adjustments
**Monthly income levels rounded to the next highest dollar amount

Child Health Plus A									
2001 Monthly Income Requirements*									
Family Size	1	2	3	4	5	6	7	8	Add for Each Add'l
Child Age 0-1 & Preg.	$1,422	$1,935	$2,430	$2,942	$3,445	$3,949	$4,452	$4,955	$504
Child Age 1-5	$953	$1,287	$1,622	$1,957	$2,291	$2,626	$2,961	$3,296	$335
Child Age 6-	$716	$968	$1,220	$1,471	$1,723	$1,975	$2,226	$2,478	$252

*Subject to yearly adjustments
**Pregnant women count as two people

Child Health Plus B*									
2001 Monthly Income Requirements**									
Family Size	1	2	3	4	5	6	7	8	Add for Each Add'l
No Cost (less than)	$1,146	$1,548	$1,951	$2,354	$2,756	$3,159	$3,562	$3,964	$403
$9 per Child per Month (between)	$1,146-$1,590	$1,548-$2,148	$1,951-$2,707	$2,354-$3,266	$2,756-$3,824	$3,159-$4,383	$3,562-$4,942	$3,964-$5,501	$403-$559
$15 per Child per Month (between)	$1,591-$1,790	$2,149-$2,419	$2,708-$3,048	$3,267-$3,678	$3,825-$4,307	$4,384-$4,936	$4,943-$5,565	$5,502-$6,194	$560-$630
Full Premium*** (more than)	$1,790	$2,419	$3,048	$3,678	$4,307	$4,936	$5,565	$6,194	$630

*If family income makes child elgibile for Child Health Plus A than child is ineligible for Child Health Plus B
**Subject to yearly adjustments
***Full premium will vary depending on selected insurer

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Financial Screening Form

Guarantor Last Name	First	M.I.	DOB	SS #	Acct #
Address				Phone #	Date

Section

1 Does/Did/Has/Had the Guarantor

		Yes	No
1 Have insurance coverage that has not been discovered or documented?			
If Yes, Please list coverage:	Coverage / DOB of Each Policy Holder	Effective Date	
2 Currently receive benefits from:			
Medicaid	ID #		
Date coverage officially ends	Date		
Commercial Insurance	ID#		
Medicare	ID#		
Family Health Plus	ID#		
Child Health Plus	ID#		
Other	ID#		
3 Received benefits in the past from:			
Medicaid	Dates		
Commercial Insurance	Dates		
Medicare	Dates		
Family Health Plus	Dates		
Child Health Plus	Dates		
Other	Dates		
4 Currently in the application process for:			
Medicaid	Eligibility Worker		
Commercial Insurance	Contact Person		
Medicare	Eligibility Worker		
Family Health Plus	Eligibility Worker		
Child Health Plus	Eligibility Worker		
Other	Eligibility Worker		

Section

2 Is the Guarantor:

		Yes	No
1 US Citizen	State of Residency		
If Yes, Move to Question 3			
2 Legal resident alien?			

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4 a. Please list the date of guarantor's most recent employment Date

b. Did guarantor have Employee Sponsored Health Care for their children?

5 Does parent have Employee Sponsored Health Care?

If Yes, Please list coverage: Coverage Effective Date

Section

Yes No

3 Is the Guarantor:

1 Currently Pregnant?

If Yes, Expecting Date of Birth Date

2 Have any children under the age of 19?

If Yes, list the ages Ages

3 Marital status? Married Single Divorced Widow/Widower

4 Number / age of dependents? # Age of Dependents

5 Estimated monthly family income? $

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Yes No

4 Other

1 Are services being provided as a result of being Assaulted, Shot, Knifed, Robbed, involved in a Hit & Run/ Drunk Driving/ Domestic Violence incident? Or Other?

If Yes, Please specify: Specification

*Please see VOC guidelines to define extent of coverage

2 Is the Guarantor HIV positive?

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3 Is the Guarantor:

A retired or active member of the United States military or a spouse or child of a retired, active, or deceased service member?

If Yes, list name, branch, and dates of service Name

Branch Dates of Service

*Please see CHAMPUS guidelines to define possible coverage

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Financial Screening Form

Items Completed		Patient Received the following applications (Circle all Applicable)
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Financial Screening Form

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Family Size	Single Adult	Couples - No Children	2	3	4	5	6	7	
Income**	$716	$968	$1,287	$1,622	$1,957	$2,291	$2,626	$2,961	

*Subject to yearly adjustments
**Monthly income levels rounded to the next highest dollar amount

Child Health Plus A*									
2001 Monthly Income Requirements*									
Family Size	1	2	3	4	5	6	7	8	Add for Each Add'l
Child Age 0-1 & Preg	$1,432	$1,935	$2,439	$2,942	$3,445	$3,949	$4,452	$4,955	$504
Child Age 1-5	$953	$1,287	$1,622	$1,957	$2,291	$2,626	$2,961	$3,296	$335
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*Subject to yearly adjustments
**Pregnant women count as two people

Child Health Plus B*									
2001 Monthly Income Requirements**									
Family Size	1	2	3	4	5	6	7	8	Add for Each Add'l
No Cost (less than)	$1,146	$1,548	$1,951	$2,354	$2,756	$3,159	$3,562	$3,964	$403
$9 per Child per Month (between)	$1,146-$1,590	$1,548-$2,148	$1,951-$2,707	$2,354-$3,266	$2,756-$3,824	$3,159-$4,383	$3,562-$4,942	$3,964-$5,501	$403-$559
$15 per Child per Month (between)	$1,591-$1,790	$2,149-$2,419	$2,708-$3,048	$3,267-$3,678	$3,825-$4,307	$4,384-$4,936	$4,943-$5,565	$5,502-$6,194	$560-$630
Full Premium*** (more than)	$1,790	$2,419	$3,048	$3,678	$4,307	$4,936	$5,565	$6,194	$630

*If family income makes child eligibile for Child Health Plus A than child is ineligible for Child Health Plus B
**Subject to yearly adjustments
***Full premium will vary depending on selected insurer

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Section 1- Identifying Insurance Coverage both Past and Present

The purpose of this section is to help determine if there are any existing insurance policies that may cover some, or all, of the expenses incurred during a hospital visit. If the patient has no current insurance coverage, it is important to determine if the patient or guarantor had medical insurance in the past or if they are currently in the application process. This may help in linking the patient or guarantor to potential benefits. Make sure to verify any information previously entered into the Eagle, Healthquest, or Medicaid Eligibility Enrollment (Med E) systems for the patient.

- Question 1: If you discover that the guarantor has existing insurance coverage:
  1. Gather all information available from the guarantor about his or her coverage
  2. List the insurance company and what type of program
  3. Ask for insurance information from provider card or any other available source
  4. Obtain the effective date of coverage
  5. Obtain the DOB of each policy holder

- Questions 2: If you discover that the guarantor is currently receiving Medicaid, Medicare, Commercial Insurance, Family Health Plus, Child Health Plus, or other insurance complete the following steps:
  1. If the guarantor is receiving Medicaid benefits, ask for:
     i. Medicaid ID number
     ii. The date coverage officially terminates
  2. If guarantor is currently receiving benefits from Medicare, Commercial Insurance, Family Health Plus, Child Health Plus, or other insurance please document their policy ID number.

- Question 3: If the guarantor received Medicaid, Medicare, Commercial Insurance, Family Health Plus, Child Health Plus, or other insurance in the past, but is no longer receiving benefits, record the date on which the patient last received benefits.

- Question 4: If the guarantor is currently in the process of applying for Medicaid, Medicare, Commercial Insurance, Family Health Plus, Child Health Plus, or other insurance please document the name of their eligibility worker or insurance contact.

Example:
Below is an example of the type of interaction you may have while interviewing a patient or guarantor. In this example the financial screening form is divided into different sections. Each section of the screening form will follow the directions explaining how to properly document the information obtained in the interview.

> *Through conducting a room visit you are able to meet with Susan Johnson, the mother of the patient Karen Johnson, to complete an in-house financial screening interview. You explain your intentions and she is willing to take a minute to talk with you. She explains to you that she is 35 years old and that her Social Security number is 898-45-2345. She also tells you that she has no health insurance. She used to have insurance through her work, but has been unemployed for at least five years. In addition, she had a Medicaid interview with a case worker named Ben Steinway about two weeks ago, but has not heard back from him about the status of her application. She is a resident of NY, was born on 11/08/65 and is currently married with 4 children ages 2, 4, 6, and 9. She claims to have a monthly income of about $2100 and answered*

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no to all questions for VOC eligibility. The child is not HIV positive and the family has no relations with the US military.

Please refer to the attached Financial Screening Form Example to see how the first section of the finalcial screening form would be completed.

The first step in completing the financial screening form is to verify that all the information in the Eagle, Healthquest, and Med E systems is both current and accurate. After reviewing the information with the guarantor, note any changes to be corrected in the Eagle, Healthquest, and Med E systems.

In the above example, the patient's mother indicated that she had begun the application process for Medicaid. Note how that information was entered into section 1 of the Linkage Screening Form. Even though the patient did not have current coverage, nor had she received benefits in the past, the questions were not left blank, but were answered by placing a "✓" in the box indicating "NO." This is an important aspect of completing the screening form as it will both help you remember what questions have been answered and give you the ability to make a quick assessment of the patient's eligibility.

Section 2 - Basic Demographic/Employment Information

The purpose of this section is to obtain demographic and employment information about the guarantor enabling you to make an initial eligibility determination. Understanding in which state the guarantor is a resident is important as it can determine whether they will be eligible to receive benefits from state sponsored programs. Legal resident aliens can be eligible for assistance with most programs. In addition, employment status, and employee sponsored health care questions can help determine for which assistance program the patient may be eligible.

As a result of the interview we know that the patient's mother is a resident of New York, is no longer employed, and is in the process of applying for Medicaid. The information has been listed in section two of the attached Financial Screening Form examplee.

Section 3- Dependents/Income Information

The purpose of this section is to help determine eligibility requirements based on the number and age of dependents, and family income. It is important to remember that Medicaid, Family Health Plus, and Child Health Plus eligibility requirements are based on family size, income, and age of children. Once all the information has been entered, refer to the charts found at the end of the screening form (charts are listed in order of age qualification).

It has been determined from the example interview that the patient's mother is 35 years old, married, and has a family size of six. Her four children are all under the age of ten and the total family monthly income is about $2,100. This information is shown in section three of the attached Financial Screening Form example.

Section 4- Other

The purpose of this section is to help determine eligibility requirements for Victims of Crime, ADAP, and TRICARE related programs. It is important to note that VOC is the payer of last resort thus a complete screening is

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needed in order to determine other eligible programs. HIV related programs include ADAP, ADAP Plus, and HIV Home Care. These programs may only be applied for if the patient is not eligible for Medicaid. To be eligible for TRICARE the patient must be a retired or active member of the US military, or be the spouse or child of a retired, active, or deceased service member.

From the information gathered in the interview we know that the patient is not eligible for VOC, HIV, or TRICARE related programs. This information is shown in section four of the attached Financial Screening Form example.

Completing the Financial Screening Process

We are now on the final steps of the financial screening process. Once all relevant information has been included in the financial screen form, determine for which program the patient is most likely to be eligible. This can be achieved by referencing the Payer Matrix, Insurance SRGs, and eligibility tables found at the end of the screening form. Locate the row and column that best describes the patient. If their monthly income is less than or equal to the dollar amount given, they may be eligible for the indicated benefits

> *It is important to remember that the screening form does not guarantee that the patient is eligible, but that they may be eligible. The patient or guarantor must complete an application for eligibility and be approved by state eligibility workers before benefits can be guaranteed.*

Example Summary:

Based upon the demographic, employment, and income information collected during the financial screening interview it was determined that the patient's family may be eligible for Family Health Plus benefits. It is important to remember that the family will not receive benefits until a completed application has been submitted and approved. However, in some instances, the entire family will receive health benefits if eligibility is approved. At this point you should review the information on the screening form with the patient's mother and fill out the sponsorship application. Once the application is complete, answer any additional questions the mother may have. Inform the mother that you will follow-up with her on the status of the application and provide her with your contact information in case there are further issues or questions.

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Columbia Presbyterian Medical Center
Financial Screening Form

TAB 23

..ction C - Third Party Insurance	Yes	No
1. Is any part of your present medical condition the result of a motor vehicle accident?	___	___
2. Does your injury or illness involve a lawsuit?	___	___
3. Is your injury or illness the result of a violent crime?	___	___
4. Did your injury or illness occur while you were on the job?	___	___
5. Are you or your spouse an Active Duty member or a Veteran of the U.S. Armed Forces?	___	___
If a Veteran, are you or your spouse receiving Veteran's Benefits?	___	___

If you answered "Yes" to:
Questions 1-5: Complete the following fields:

Policy Holder's Name _____ Phone Number: _____
Billing Address: _____ Policy Holder's S.S.# _____
_____ Claim Number: _____

Attorney's Name _____ Attorney's Phone: _____
Insurance Name: _____ Policy Number: _____

Patient may be eligible for Third Party Liability, Worker's Compensation, Victims of Crime or TRICARE.

..ction D - Medicaid/Family Health Plus/Child Health Plus Linkage	Yes	No
1. Are you under 21 years of age or did you turn 21 this month?	___	___
Are you pregnant?	___	___
..Are you currently receiving AFDC, FIC or WIC benefits?	___	___
4. Is there a child under 18 years of age, or age 19 in high school and expected to graduate before age 20 living in your home?	___	___
5. Are you a caretaker relative of a child who is not your son or daughter (e.g. you are a grandparent, aunt, uncle, etc.) and you and the child both want to obtain Medicaid?	___	___
6. Are you 65 years of age or older?	___	___
7. Are you or your spouse legally blind?	___	___
8. Are you or your spouse currently receiving Social Security, Aged or Disability benefits or Supplementary Security Income?	___	___
~~9. Have you applied for Social Security Disability (SSI-Disabled)~~ benefits within the last 6 months and your status is currently pending?	___	___
10. Are you unable to work because of a physical or mental illness, disability, injury or impairment expected to continue for longer than one year?	___	___
11. Do you or your spouse live in a nursing home?	___	___
12. Did the patient expire but prior to their expiration had a physical or mental disability?	___	___

If you answered "Yes" to:
One or more questions in section D, verify patients income using the attached resource guidelines.
Compare answers to Medicare, Family Health Plus and Child Health Plus eligibility charts and verify documentation of income
If patient is eligible, begin the application process. Collect as many documents as possible while patient is in house.

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Columbia Presbyterian Medical Center
Financial Screening Form

:dicaid Expediter: _____ Today's Date: _____

Patient's ID # _____

Contact Information

Patient's Name: _____ DOB: _____ SS#: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Ph. Number (H): _____ Ph. Number (W): _____

Nearest Relative or Friend Name and Ph. Number: _____

State of Residency _____ County of Residency _____

Marital Status _____

Language Spoken _____

Section A - Identify Past and Present Insurance	**Yes**	**No**
1. Do you have any health insurance coverage?	___	___
2. Does another individual's insurance policy provide coverage for your illness/injury?	___	___
3. Are you currently receiving, have received or are applying for benefits from Medicare, Medicaid, Family Health Plus, Child Health Plus, COBRA, TRICARE	___	___

Other: _____

ɔu answered "Yes" to:

Question 1 & 2: complete and verify the following: Insurance Name: _____

Policy Number: _____

Question 3: Follow up with corresponding agency about the status of the application or previous benefits.

Section B - Employment	**Yes**	**No**
1. Are you currently employed? (if yes go to question 3)	___	___
2. Were you employed sixty days ago?	___	___
3. Do/Did you receive health care benefits by your employer?	___	___

If you answered "Yes" to:

Question 1: If patient has benefits transfer to Patient Financial Advisor. If not, patient may be eligible to apply for Healthy NY.

Question 2 & 3: Patient may be eligible for COBRA benefits. Complete the following and contact the appropriate person.

Employer Name: _____ Employer Location: _____

Contact Name: _____ _____

Phone Number: _____ _____

Insurance Name: _____ Policy Number: _____

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TAB 24

NEW YORK-PRESBYTERIAN HOSPITAL
CHARITY CARE/FINANCIAL AID POLICY

I. BACKGROUND

- **The New York-Presbyterian Hospital recognizes its responsibility to provide charity care/financial aid for those in need.** New York-Presbyterian Hospital is committed to the comprehensive assessment of individual patient need and to providing charity care/financial aid when warranted, regardless of age, gender, race, national origin, socio-economic or immigrant status, sexual orientation or religious affiliation.

- The process for determining patient eligibility for charity care/financial aid and collecting patient debt will reflect New York-Presbyterian Hospital's commitment to treating all patients fairly and with dignity and respect.

- As part of the charitable mission of New York-Presbyterian Hospital, charity care/financial aid will be provided to persons that meet the qualifications described in this Policy.

- Charity care/financial aid is not intended to be a substitute for existing government entitlement or other assistance programs. Based on the individual circumstances of each patient, every reasonable effort will be made to explore appropriate alternative sources of payment and coverage from third parties, and other public and private programs, to allow New York-Presbyterian Hospital to provide care to persons in need without other payment alternatives.

- The availability of charity care/financial aid does not eliminate personal responsibility. Eligible patients are required, whenever possible, to access public or private insurance options, and are expected to contribute to their care based on their individual ability to pay.

- New York-Presbyterian Hospital will employ a consistent process to consider an individual's need for charity care/financial aid based on that individual's documented demonstration that the charges for services provided cannot be covered by another payment source and that (s)he is unable to pay for those services.

- New York-Presbyterian Hospital will communicate the availability of charity care/financial aid to patients, the public in general, and local community service agencies.

- New York-Presbyterian Hospital will maintain an accounting of the dollar amount charged as charity care.

II. POLICY

A. Definition

- Charity care/financial aid is the provision of free or reduced charge services that are medically necessary to persons who are determined to be unable to pay for their care in whole or in part, based on their financial situation.

B. Qualifications—General

- This Policy applies to inpatient and/or outpatient services rendered to an uninsured patient by New York-Presbyterian Hospital and does not include services provided by any other provider, *e.g.*, physicians or other service providers.

- This Policy applies only to medically necessary services. Some cosmetic services and any services deemed to be not medically necessary will not be considered for charity care/financial aid. Exceptions to this policy can be made by approval of a designated hospital executive. Disputes concerning medical necessity will be settled by the Utilization Review Department.

- Prior to submitting an application for charity care/financial aid, patients will have been screened for eligibility programs, when reasonable.

- New York-Presbyterian Hospital will offer charity care/financial aid to individuals who reside in its service area. Exceptions to this policy can be made by approval of a designated hospital executive.

- Eligibility for charity care/financial aid will be considered only upon submission of a completed application form accompanied by required documentation.

- Patients not uninsured, but who face extraordinary medical costs and are covered by a third party payer, as well as are unable to pay their deductibles, co-pays, and/or non-covered services, may be eligible for charity care/financial aid.

C. Collection Practices

- New York-Presbyterian Hospital will develop the standards and scope of practices to be used to collect outstanding patient debt, including the establishment of written policies about when and under whose authority patient debt is advanced for collection or legal action. New York-Presbyterian Hospital will obtain written agreement regarding these standards and scope of practices from collection agencies acting on the Hospital's behalf.

- New York-Presbyterian Hospital will not force the sale or foreclosure of a patient's primary residence to pay for an outstanding debt.

D. Education/Public Awareness

- New York-Presbyterian Hospital will train appropriate staff members who are to implement this Policy. Staff will be educated about the availability of charity care/financial aid and how to direct patients to obtain further information about the application process.

- Information about this Policy will be made available in the Emergency and main Admitting Departments of each New York-Presbyterian Hospital facility and will be

written in primary languages spoken by the residents of the community served by the facility.

- New York-Presbyterian Hospital will share information about this Policy with appropriate community health and human service agencies and other local organizations that help people in need.

III. PROCEDURE

A. Application —Timing/Location

- If appropriate, and when possible, the benefits of Medicaid and other public and private programs will be explained to the patient at the time of registration and potentially eligible patients will be asked to apply. Eligibility for charity care/financial aid will be determined only after eligibility for Medicaid and other public and private programs has been determined.
- Applications for charity care/financial aid may be requested from designated locations.
- Determinations will be communicated to the applicant as soon as practicable after the completed application is submitted. In some cases, additional information from the applicant may be needed to determine eligibility.

B. Application—Documentation and Standards

- Applicants may be asked to provide information/documentation including but not limited to the following:
  - Household income for the most recent three months;
  - Household income for a recent twelve-month period;
  - Number of people in household and relationship to applicant;
  - Net assets (*e.g.*, value of personal and real property, insurance policies, bank accounts, other investment accounts); and/or
  - Form 1040 (U.S. Individual Income Tax Return) or any other documentation that can be used to substantiate household income, in the absence of Form 1040.

- The information supplied on a completed application and from other sources will be used in the evaluation of the patient's financial situation and in making a decision regarding the patient's ability to pay for services provided, and eligibility for charity care/financial aid.

- It is an expectation that the patient will cooperate and supply all necessary information required to make a determination for charity care/financial aid eligibility. A designated hospital executive may waive such conditions in situations where the patient is not capable of meeting these requirements.

C. Payment Process

- New York-Presbyterian Hospital will provide free or reduced charge care to uninsured applicants:
  - With incomes below 300% of the federal poverty level as listed in the Federal Poverty Guidelines for Non-Farm Income which are published annually (income guidelines in effect at the time of receipt of the completed application, and not at the time of service, will be used in determining eligibility); and
  - Who have no available assets excluding applicant's primary residence.

  Exceptions to the above criteria may be authorized by a designated hospital executive.

- Charity care/financial aid is provided on an individual occurrence basis. When a patient applies for charity care/financial aid, compliance with prior financial obligations to New York-Presbyterian Hospital may be considered. When appropriate, the need for charity care/financial aid is to be re-evaluated. Times may include:
  - Subsequent to rendering of services;
  - Change in income;
  - Change in household size;
  - Reopening of a closed account; or
  - Completion of a financial evaluation more than a year ago.

- If a patient cannot pay the balance on an account, New York-Presbyterian Hospital will attempt to negotiate a payment plan with the patient. When negotiating a payment plan

with the patient, New York-Presbyterian Hospital may take into account the balance due and will consider the patient's ability to pay.

TAB 25

BILLING AND COLLECTION SERVICES AGREEMENT

This AGREEMENT, dated _____ __, 200__, between The New York and Presbyterian Hospital (NYPH), a New York not-for-profit corporation with offices located at 525 East 68th Street, New York, N.Y. 10021 (NYPH) and _____, a _____ Corporation having an address at _____ (Contractor).

WITNESSETH:

WHEREAS, NYPH desires to retain Contractor's services for billing and collection of NYPH claims for healthcare services provided to NYPH patients, and Contractor desires to provide such services.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is agreed as follows:

SECTION 1. SCOPE OF WORK

Subject to the terms and condition of this Agreement, Contractor shall provide services as described in Appendix A, which is attached hereto and made part of this Agreement. Contractor shall keep and maintain such documents and records as shall be required to verify Contractor's performance under this Agreement, including but not limited to, amounts collected, amounts paid to NYPH and amounts due to Contractor. Contractor shall make such documents and records available to NYPH for inspection upon reasonable prior notice.

SECTION 2. TERM AND TERMINATION.

2.1 Term. The term of this Agreement shall be for an initial period of two (2) years, commencing on the date hereof ("Initial Term"). This Agreement shall be automatically renewed for additional one year periods, each of which shall be hereinafter referred to as "Renewal Term", unless either party provides written notice of non-renewal to the other no later than thirty (30) days prior to the expiration of the Initial Term or the expiration of any Renewal Term thereafter.

2.2 Termination. Either party may terminate this Agreement, with or without cause upon thirty (30) days written notice to the other party. Parties shall agree on an orderly return by Contractor of all NYPH documents and other materials. Contractor shall destroy documents or materials not returned to NYPH and shall attest to such destruction.

SECTION 3. COMPENSATION.

3.1 Policy. Compensation shall be paid in accordance with all applicable federal, state and local law, regulations, rulings and binding interpretations. For Medicaid claims, it is the policy of NYPH not to base Contractor's compensation on the value or volume of any invoice, the value or volume of the amount of collections, or any percentage or discount of either invoices or collections.

3.2 Payment. Compensation to Contractor for each type of billing and collection service within the scope of work is detailed Appendix B which is attached to and made part of this Agreement. Contractor shall submit to NYPH monthly invoices

for amounts due as compensation. NYPH shall pay undisputed invoices within 60 days of receipt.

SECTION 4. COMPLIANCE

4.1 Contractor shall have in place and available for NYPH's review and approval, a compliance plan and active compliance program designed to comply with applicable federal and state law concerning fraud and abuse, including but not limited to anti-kickback and self-referral. NYPH shall have the right to audit and monitor Contractor's compliance program.

4.2 Contractor is aware of the federal False Claims Act, and will not knowingly submit, recommend or cause NYPH to submit any bill to any third party payor, including Medicaid and Medicare, which is false or fraudulent or otherwise in violation of applicable laws, regulations or rules.

SECTION. 5 HIPAA REQUIREMENTS.

5.1 HIPAA Applicability. NYPH is a covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as such must comply with the Administrative Simplification provisions of HIPAA, including the Privacy Standards found at 45 C.F.R. Parts 160 and 164.

5.2 NYPH Use and Disclosure. In order for Contractor to perform its obligations under this Agreement, NYPH intends to disclose certain Protected Health Information (as defined below) of NYPH patients ("PHI") to Contractor and anticipates that Contractor will receive PHI on behalf of NYPH.

5.3 Contractor Use and Disclosure. The parties anticipate that Contractor will be required to use and disclose PHI in order to perform its obligations under this Agreement. Therefore, Contractor will qualify as a "business associate" under the Privacy Standards.

5.4 Duties of Contractor Regarding Use and Disclosure of PHI

5.4.1 Receipt and Use of PHI. Satisfactory performance of its obligations under this Agreement by Contractor will require Contractor to receive and use Individually Identifiable Health Information that constitutes Protected Health Information ("PHI") obtained from NYPH. Contractor shall not use PHI except as permitted or required by this Agreement or as required by law. Contractor shall use PHI consistent with the Privacy Standards.

5.4.2 "Individually Identifiable Health Information". For purposes of this Agreement, Individually Identifiable Health Information shall mean information that is a subset of health information including demographic information collected from an individual, and that:

(i) is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse.

(ii) relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual; and

(iii) identifies the individual or contains sufficient information to form a reasonable basis to believe the information can be used to identify the individual.

5.4.3 "Protected Health Information" shall mean Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media; or (iii) transmitted or maintained in any other form or medium.

5.5 Disclosure of PHI. Contractor shall not disclose PHI except as permitted or required by this Agreement, or as required by law. Specifically, unless otherwise permitted by this Agreement, Contractor may disclose PHI only (i) for Contractor's proper internal management and administration, or (ii) to carry out the legal responsibilities of Contractor, provided that either of the following conditions are satisfied: (a) the disclosure is required by law; or (b) Contractor obtains reasonable assurances from the person to whom Contractor discloses the PHI that the PHI will be held confidentially, that the information will be used or further disclosed only as required by law or for the purposes for which it was disclosed, and that the person notifies Contractor of any instances where the confidentiality of the PHI has been breached.

5.6 Safeguarding PHI. Contractor shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by this Agreement. Contractor shall maintain an appropriate level of security with regard to all personnel, systems, and administrative processes used by Contractor to transmit, store, process, or otherwise handle PHI. Contractor shall not transmit PHI over any open network unless the transmission is encrypted or otherwise secured according to the appropriate standard of care. Within thirty (30) days of the date this Agreement is executed by the Parties, Contractor shall inform in writing NYPH of its security measures to protect PHI from improper use and disclosure.

5.7 Third Party Agreements. Under certain circumstances, Contractor may need to enter into agreements with third parties, including subcontractors, in order to satisfy its obligations under this Agreement. Contractor shall require that all of its agents, employees, subcontractors, and Contractors to whom it furnishes any PHI to agree in writing to be bound, and to abide in all respects by, all the obligations of Contractor under this Agreement to protect PHI.

5.8 Reporting of Unauthorized Uses and Disclosures. If Contractor becomes aware of any use or disclosure of PHI by Contractor, its employees, or its agents, that is not provided for in this Agreement, Contractor shall promptly report such violation to NYPH. NYPH shall investigate the unauthorized use or disclosure and Contractor shall cooperate fully with such investigation. In consultation with NYPH, Contractor shall promptly seek to cure or mitigate the unauthorized use or disclosure. If Contractor is unable promptly to cure or mitigate an unauthorized use or disclosure which constitutes a material breach of the Contractor's obligations under this Agreement, notwithstanding any other provision in this Agreement, NYPH shall have the right to terminate this Agreement for cause, to report the matter to the Secretary of the U.S. Department of Health and Human Services, or both.

5.9 Access to Information. Within ten business days of NYPH's written request, Contractor shall provide NYPH with access to PHI in Contractor's possession, if Contractor's information consists of PHI within a Designated Record Set held by NYPH. For the purposes of this Agreement, **"Designated Record Set"** shall mean a group of records maintained by or for NYPH that (i) consists of the medical records and billing records about individuals maintained by or for NYPH, (ii) constitutes the enrollment, payment, claims adjudication, and case or medical management record

systems maintained by or for a health plan, or (iii) is used, in whole or in part, by or for NYPH to make decisions about individuals. For the purposes of this paragraph, the term "Record" means any items, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for NYPH.

5.10 Availability of PHI for Amendment. The parties acknowledge that the Privacy Standards permit an individual who is the subject of PHI to request certain amendments of their records. Upon NYPH's written request, Contractor shall provide NYPH with any PHI contained in a Designated Record Set in Contractor's possession for amendment.

5.11 Accounting of Disclosures. Upon NYPH's written request, Contractor shall make available information to NYPH concerning Contractor's disclosure of PHI for which NYPH needs to provide an individual with an accounting of disclosure as required by the Privacy Standards. For this purpose, Contractor shall retain a record of disclosures of PHI for at least six (6) years from the date of disclosure. Disclosures of PHI for purposes of treatment, payment or operators of or by NYPH shall not be subject to this accounting requirement.

5.12 Availability of Books and Records. For purposes of determining NYPH's compliance with the Privacy Standards, Contractor agrees to make available to the Secretary its internal policies and procedures relating to the use and disclosure of PHI received from NYPH, or created or received by Contractor on behalf of NYPH.

5.13 Return of PHI at Termination. Notwithstanding the disposition of other documents and materials created by the Parties in performance of this Agreement, upon termination of this Agreement, Contractor shall, where feasible, destroy or return to NYPH all PHI received from NYPH, or created or received by Contractor on behalf of

NYPH. Where return or destruction is not feasible, the duties of Contractor under this Agreement shall be extended to protect the PHI retained by Contractor. Contractor agrees not to further use or disclose information for which the return or destruction is infeasible. Contractor shall certify in writing the destruction of the PHI and to the continued protection of PHI that is not feasible to destroy.

5.14 Representations of NYPH.

5.14.1 Obtaining Patient Permission. NYPH represents and warrants that it has obtained patient and individual permissions, consents, or authorizations, required under federal and state law that are necessary for Contractor to receive, use, and disclose PHI as contemplated under this Agreement.

5.14.2 Furnishing Appropriate Patient Notice. NYPH represents and warrants that it has undertaken steps necessary to adequately inform its patients, as required by state and federal law, about the disclosure of PHI to service providers and vendors such as Contractor and use and disclosure of such information by such entities. Such notification shall include, but is not limited to, distribution of a "notice for privacy practices," as this term is defined in the Privacy Standards.

SECTION. 6. MISCELLANEOUS.

6.1 Entire Agreement, Modification. This Agreement constitutes the entire agreement between the parties with respect to the matters set forth herein and may not be amended or modified except in writing signed by all the parties hereto.

6.2 Assignment. This Agreement may not be assigned by either party without the written consent of the other, except that NYPH may assign this Agreement to

a successor corporation in the event of a merger, consolidation or transfer or sale of all or substantially all of its assets.

6.3 Notice. Any notice required under this Agreement shall be deemed given when mailed by certified mail, return receipt requested, with a copy sent by regular first class mail, to the address listed in this Agreement or such other addresses as the parties may designate in writing.

6.4 Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the other provisions hereof, but the remaining provisions of the Agreement shall be construed in all respects as if such invalid or unenforceable provision or provisions were omitted.

6.5 Construction and Governing Law. This Agreement shall be governed by and interpreted in accordance with the laws of the State of New York without reference to an application of conflict of law principles or provisions.

6.6 Relationship of Parties. The parties hereto acknowledge and agree that this Agreement does not create the relationship of employer and employee between NYPH and Contractor, but rather, that the services to be performed by Contractor hereunder shall be performed by Contractor as an independent contractor. Each of the parties agrees not to hold itself out in any manner inconsistent with or contrary to the terms of this Agreement.

6.7 Waiver. The waiver by either party of noncompliance by the other party of any term or provision of this Agreement shall not be construed as a waiver of any other noncompliance.

6.8 Captions. The captions herein are for convenience and reference only and in no way define, limit or describe the scope or intent thereof, or in any way affect this Agreement.

6.9 Arbitration. In the event a dispute arises under any term or provision hereof, such dispute shall be settled by arbitration in the County or New York, State of New York by and in accordance with the rules then obtaining of the American Arbitration Association.

6.10 Counterparts. This Agreement may be executed in several counterparts, each of which shall be deemed an original, all of which together will constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date and year first above written.

CORPORATION	NEW YORK AND PRESBYTERIAN HOSPITAL
By: _____	By: _____
Title: _____	Title: _____

APPENDIX A

Scope of Services

Payors: Medicare _____

Medicaid _____

Commercial _____

Managed Care _____

Self Pay _____

Other _____

Services: Billing _____

Collection _____

Detailed Description of Services:

Appendix B

Compensation

For Medicaid and Medicare Claims
Contractor shall be paid a fee of $ _____ for each claim processed.

For Claims Other Than Medicaid and Medicare
Contractor shall be a contingency fee of _____% of amounts collected, less _____ % of any amounts collected by Contractor which must be refunded or repaid to the payor within 180 days of collection.

g:\cap\Billing and Collection Services Agreement

TENET PATIENT FINANCIAL SERVICES CENTRALIZED PATIENT FINANCIAL SERVICES	TITLE: Early Out Discounts Effective Date: 11/1/99	# Page 1 of 3

PURPOSE: TAB 26

The purpose of this policy is to establish operating protocols for Prompt Payment discounts, Settlement Discounts, and acceptance of monthly payments based on the patient's ability to pay. This policy covers all self pay account balances referred to the Early Out program from Tenet facilities.

PRIVATE PAY POLICY:

An essential function of the Early Out program is to negotiate and confirm payment commitments on all private pay accounts. It is the policy of TENET/Syndicated Office Systems (SOS) to always attempt to collect payment in full, however, if the patient is unable to pay in full one or more of the following may occur at the discretion of Early Out personnel.

- Prompt payment discounts within 30 days of assignment.
- Settlement discounts after assessment of patient's financial situation.
- Monthly payments will be scheduled for up to four (4) months from the date of Discharge/Service to conform to Tenet policy. Exceptions to this timeframe will be made on an individual basis, taking into consideration the patient's ability to pay. Accounts not paid in full within the Early Out cycle will assign to CFC.

The patient is required to pay their portion of the balance before any discount is applied to the account, partial charity accounts being the only exception. The facility will relieve the A/R using a 'Prompt Pay Discount'. Broken promises to pay and default payment arrangements will be recommended for referral to CFC and discount offer will be rescinded.

NEGOTIATION PROCESS:

1. Request payment of balance in full
2. Monthly payments up to 4 months from date of service.
3. Prompt payment discount offered for payment of balance in full.
4. Settlement discount for balance.

TENET PATIENT FINANCIAL SERVICES CENTRALIZED PATIENT FINANCIAL SERVICES	TITLE: Early Out Discounts Effective Date: 11/1/99	# Page 2 of 3

DETERMINING ABILITY TO PAY:

The following items may be taken into consideration when assessing the patient's ability to pay:

1. The family's net income after living expenses.
2. The number of dependents in household.
3. Net worth and liquidity may be assessed.
4. Employment status and capacity for future earnings may be assessed.
5. Other living expenses and financial obligations reviewed.
6. The previous exhaustion of all other available resources.

DOCUMENTATION:

The following documentation may be obtained as deemed appropriate:

1. Confidential Financial Statement signed by patient, or financial summary taken over the telephone.
2. Bank Statements, paystubs, income tax returns
3. Credit report
4. Asset investigation
5. Utility bills and proof of other living expenses

APPROVAL AUTHORITIES:

Early Out Management is authorized to discount up to the lesser of 70% or the inverse of the current Fiscal Year CFC PA rate for prompt pay discounts or settlement of accounts. Prompt pay/settlement discounts proposed in excess of this guideline require the prior approval of the facility BOM or CFO.

PROCEDURE:

1. Staff will seek appropriate approvals before notifying the patient of discount or payment arrangements.
2. Contacts patient to confirm payment commitment.
3. When the patient has paid their portion, an appropriate adjustment will be requested.

TENET PATIENT FINANCIAL SERVICES CENTRALIZED PATIENT FINANCIAL SERVICES	TITLE: Early Out Discounts Effective Date: 11/1/99	# Page 3 of 3

INDEMNITY/MANAGED CARE POLICY:

It is the policy of TENET/Syndicated Office Systems (SOS) to always attempt to collect payment in full. No discounts will be allowed, without prior facility approval.

TAB 27

CENTRAL FINANCIAL CONTROL POLICY AND PROCEDURE MANUAL	TITLE: Litigation of Self-Pay Acccounts Effective Date: 2/06/04	#C 23.1 Page 1 of 1

Purpose

To set forth the process and criteria for the litigation of self-pay (bad debt) accounts.

Definition

This policy is exclusively related to the litigation of self-pay (bad debt) accounts under the CFC line of business. For purposes of this policy, CFC line of business includes the financial classes identified as FC18, FC90, FC92, and FC 93.

Policy

This policy only impacts the collection of "self-pay" accounts. As such, accounts involving third party litigation, insurance, workers' compensation, managed care, and other types of accounts, which are not self-pay, are not covered by this policy. No self-pay collection lawsuit may be filed unless authorized per this policy.

Self-pay accounts which may be considered for placement with counsel and potential litigation, must meet the following minimum criteria:

- There must be a minimum principal balance of $1,250.00. No lawsuit will be filed on a principal balance less than $1,250.00, unless specifically approved by the Law Department.
- The consumer/patient must be gainfully employed.
- Minimum consumer/patient earnings must be at or above a moderate wage level. Alternatively, the consumer/patient must have other source(s) of income; (i.e., if the other sources of income substantiate the consumer's ability to pay their debts, without adverse financial impact upon the consumer's ability to maintain the consumer's household, the account may be considered for possible self-pay litigation). The identification of an independent income stream for the consumer/patient may not always be verifiable by collection personnel. In such cases, if collection personnel can strongly support there is an independent means to collect, (i.e., via credit report, other assets, or other relevant facts), then the account may be considered for possible self-pay litigation.
- The consumer/patient owns two or more parcels of real property.
- All other known or possible alternative sources of payment must be exhausted, (i.e., insurance, workers' comp, etc), before an account may be considered for collection via self-pay litigation.
- Prior to the referral of any self-pay collection account to litigation, the patient/consumer must receive an offer of settlement from CFC and that offer must be documented in the collection notes.
- The directives set forth in this policy are subject to update and modification.

Note, if collection litigation is filed and judgment obtained, collection counsel has a standing directive to not lien the primary residence of the patient/consumer.

To refer an account to the Law Department for consideration of self-pay litigation, bad debt collection operations must complete the Legal Account Assignment Form, scan/link physical account media, and electronically transfer the account to Law via action code L-3, option #2 (self-pay accounts).

TAB 28

TENET Tenet HealthSystem	BUSINESS OFFICE PROCEDURE MANUAL	No. 05.01.03
	FOLLOW-UP	Page: 1 of 1
	GENERAL GUIDELINES	Original Date: 03/01/00
	FINANCIAL AGREEMENTS	Revised Date:

POLICY

Every effort should be made to effect payment in full on patient balances. Failing, same facility may carry the account for a period not to exceed 120 days from date of service/discharge. Guarantors should be encouraged to use credit cards, obtain loans, and look to other sources of income, such as tax refunds, to satisfy outstanding account balances.

If further time payments are indicated, the following policy should be adhered to:

1. Advise patient that balance can be resolved on a monthly payment basis.
2. Negotiate the highest payment and shortest timeframe. Note: On any timeframes in excess of twelve months, the absolute minimum acceptable payment is $30.00 per month.
3. Thoroughly document guarantor's inability to pay in full, along with the reason for the time period negotiated.
4. Advise that the guarantor payment schedule will be monitored by Central Financial Control (CFC). No interest will be applied to the account; however, should the account go into a default status routine, collection agency practices will prevail.
5. Enter FUS activity code CMPAY. In remarks, note monthly payment and time period.
6. Enter AR 193. Obtain necessary approvals:

Business Office Manager (BOM)	All
Chief Financial Officer (CFO) Central Business Office (CBO) Director	Payments extending beyond one year

7. Change Financial Class (FC) to 95.

Post-assignment CFC will:

1. Send written notification confirming payment agreement.
2. Send monthly payment due notifications (statements).
3. Refer account to hard core collection unit should default occur.

TAB 29

CENTRALIZED PATIENT FINANCIAL SERVICES PROCEDURE MANUAL	TITLE: Interim Uninsured Settlement/Discount & Payment Plan Procedure Effective Date: DRAFT – 4/08/02	D-33 Page 1 of 4

POLICY:

In the effort to expedite the collection of Uninsured accounts, CPFS has established a protocol for offering Prompt Pay discounts, settlement discounts and payment plans to those patients who are unable to pay their account balance in full.

PROCEDURE:

This policy is intended to clarify and standardize the process of working accounts which meet the guidelines as stated in the Memorandum titled 'Interim Uninsured Settlement/Discount and Payment Plan Procedure' dated February 20th, 2003. This policy will allow CPFS to accept a settlement for a patient's outstanding balance as payment in full without requiring facility approval. **The discount policy applies only to Uninsured patient balances and does not apply to deductibles or co-pays.**

SCOPE:

Prompt Pay Discounts (33.1)

Accounts GT 120 days of DOS (33.2)

CENTRALIZED PATIENT FINANCIAL SERVICES PROCEDURE MANUAL	TITLE: Interim Uninsured Settlement/Discount & Payment Plan Procedure Effective Date: DRAFT – 4/08/02	D-33 Page 2 of 4

33.1 Prompt Pay Discount:

PROCEDURE
If the patient was not offered a Prompt Payment arrangement by the facility, CPFS may for the first 30 days from the date of service offer a Prompt Payment arrangement based on a Region/Facility matrix. Additionally, CPFS will honor any facility Prompt Payment agreements that has been offered and accepted by the patient up to 60 days from the date of service.

When the patient agrees to a Prompt Pay Discount under the Tenet Interim Policy, the following steps will be taken by the CPFS employee:

1. Document the body of the notes with the patient conversation.
2. Document the CZ notes with the Prompt Pay Discount, patient payment, and adjustment amount.
3. Enter the BU screen and update the adjustment requested field with the agreed upon write off amount.
3. Enter a PP or PF promise for tracking collections.
4. Enter the result code of 'QD' (quick discount)

At this time, the workflow will route the account to unit 202 and the primary status code will be updated to PPD (prompt pay discount).

T&C PROCEDURE
Once the payment posts, the account will be reviewed by the T&C representative to ensure the appropriate payment was received and adjustment requested. The action code of AA (audit adjustment) and result code of CW (client write off) will be completed and the account routed to unit 575.

If the patient is not received by the date expected, the account will automatically update the status code to BPT (broken promise). The T&C representative will review the due date and if appropriate refer the account back into the collection flow.

CENTRALIZED PATIENT FINANCIAL SERVICES PROCEDURE MANUAL	TITLE: Interim Uninsured Settlement/Discount & Payment Plan Procedure Effective Date: DRAFT – 4/08/02	D-33 Page 3 of 4

SUPPORT PROCEDURE
Support Services will communicate to the facility/CBO the adjustment request. Support Services will be responsible for follow up with the facility to ensure the adjustment is posted timely. Once posted, the account will show PIF.

33.2Patient Accounts GT 120 Days from the DOS

COLLECTOR PROCEDURE
CPFS may offer additional discounts, following the attached matrix, on those patient accounts greater than days from the date of service with the following requirements:

a. The patient did NOT already enter into a Prompt Pay arrangement with the facility
b. The patient has NOT contacted CPFS within the past days
c. The patient has NOT made a previous payment arrangement with either the facility or CPFS.

Monthly time payments of up to months from the date of service may be accepted, without interest, if the patient honors the payment agreement.

When a patient agrees to a discount under the Tenet Interim Policy guidelines, the following steps will be taken by the CPFS employee:

1. Document the body of the notes with the patient conversation.
2. Use the web-based calculator to ensure the account is eligible
3. Document the CZ notes with the Discount information
4. Enter the BU screen and update the adjustment requested field with the agreed upon write off amount.
5. Enter PP or PF promise for tracking collections
6. Enter result code of 'UD' (uninsured discount)

The workflow will refer the account to desk 575 and change the primary status code to UID (uninsured interim discount).

In the event the discount is offered, but not accepted, the user will document the offer in the CZ notes.

CENTRALIZED PATIENT FINANCIAL SERVICES PROCEDURE MANUAL	TITLE: Interim Uninsured Settlement/Discount & Payment Plan Procedure Effective Date: DRAFT – 4/08/02	D-33 Page 4 of 4

SUPPORT PROCEDURE

Support Services will communicate to the facility/CBO the adjustment request. Support Services will be responsible to follow up with the facility to ensure the adjustment was posted timely. Once posted, Support Services will transfer the account to desk 275 (for balances under $5000.00) pending receipt of the payment(s). Large balance accounts GT $5,000 will be referred back to the owner unit.

TAB 30	TITLE:	#C 24.1
CENTRAL FINANCIAL CONTROL	Charging of Interest on Bad Debt Accounts	Page 1 of 1
POLICY AND PROCEDURE MANUAL	Effective Date: 2/06/04	

Purpose

To set forth the process and criteria for the charging of interest on self-pay (bad debt) accounts assigned to CFC line of business.

Definition

This policy is exclusively related to the charging of interest on self-pay (bad debt) accounts under the CFC line of business. For purposes of this policy, CFC line of business includes the self-pay financial classes identified as FC18, FC90, FC91, FC92, FC93, ER, IC, IF, IG, OF & OG.

Policy

This policy for the charging of interest on self-pay (bad debt) accounts only impacts those financial classes set forth in the above definition. Concurrently, any financial class, included within the CFC line of business, which is not set forth above, will not accrue interest under this policy.

For purposes of consistency, all self-pay (bad debt) accounts as defined herein, assigned on or after the policy effective date, will be eligible for the accrual and dunning of interest, which will calculated as detailed below.

1) For all states, except Texas:

- CFC Letter 01 (FDCPA notice re consumer disclosures and rights) must have a mail date on the account.
- The interest start date for the account will be the same date as the CFC 01 letter mail date.
- The interest rate will be calculated at the lesser rate between state of service and guarantor state of residence.
- All rates will be based upon the simple interest rate for the respective state.
- A table of respective state interest rates will be set-up and maintained by the IS Department.

2) If the patient/consumer resides in the State of Texas:

- CFC Letter 01 (FDCPA notice re consumer disclosures and rights) must have a mail date on the account.
- A future interest start date will appear on the account, after the account has a CFC letter 01 mail date.
- The interest start date will be the 31st day after the CFC letter 01 mail date.
- The interest rate will be calculated at the lesser rate between state of service and guarantor state of residence.
- All rates will be based upon the simple interest rate for the respective state.
- A table of respective state interest rates will be set-up and maintained by the IS Department.

TAB 31

SYNDICATED OFFICE SYSTEMS CENTRAL FINANCIAL CONTROL POLICY AND PROCEDURE MANUAL	TITLE: Settlement Policy Effective Date: 9/27/93 Revised Date: 12-06-02	#E 1.1 Page 1 of 3

INTRODUCTION

This Policy and Procedure is intended to standardize required guidelines prior to negotiating a compromise settlement.

POLICY:

The Company may offer a compromise settlement on any Tenet account assigned to them, in accordance with the guidelines as set forth, unless other wise instructed by a specific Tenet client. The well being of our client should always be the primary consideration in negotiating proposed settlements

PROCEDURE

For all settlements on accounts with a principal balance of $5,000.00 or more the attached Settlement Request Form must be filled out completely by the collector, prior to submitting for Supervisor/Management approval. Supervisor approval is required on a settlement request prior to and offer or commitment being made.

NOTE: Do not use correction fluid on any settlement documents. All changes/corrections are to be made in ink and initialed with appropriate explanations for such changes/corrections.

Settlement proposals initiated by the debtor or any third party in an effort to avert the threat of legal action must be referred to and approved by either in-house corporate counsel or Tenet facility administration.

For all accounts that have had the approved settlement payment posted within the agreement's stated due date the account balance will be cancelled under the following status codes:

Non-Legal Accounts: CSF

Legal Accounts: LSF

In the event the patient or patient representative does not meet the agreed settlement terms and conditions, or if the payment remitted results in insufficient funds, the settlement offer will immediately become null and void and the original principal balance including interest (if applicable) will be reinstated.

GUIDELINES

Settlement Date Age From Date of Service	Discount	Net Acceptable Value
1-2 Years	%	%
2-3 Years	%	%
3-4 Years	%	%
4-5 Years	%	%

Net acceptable value percent is based on the original assigned balance exclusive of interest.

A collector may not solicit a discount on any account with an assigned balance of less than $300.00.

Interest of less than $100.00 may be settled/waived by the collector, provided there is a business/documented reason for the waiver. Interest of $100.00 or more may be settled/waived by the collector if it is determined to be in the company's best interest and only after Supervisor approval. The Supervisor must document their approval via collector notes. The settlement form does not have to be completed for interest.

This schedule does not preclude the assigning facility from further negotiations or settlement below the above stated guidelines. However, the name of the facility representative, the terms of the settlement, and the Supervisor's approval must be recorded via the collector notes. Additionally, Operations Managers, Divisional Director of Operations, the Divisional Legal Analyst, and in-house corporate counsel shall have "In Guideline" authority to settle legal accounts. At the discretion of the Divisional Operations Director or in-house corporate counsel, outside law firms may be authorized to operate under this policy and extend on assigned legal accounts a settlement discount up to % on all accounts with a principal balance of $5000.00 or less. In addition and for post judgment collection efforts, the Divisional Director or in-house corporate counsel may also authorize the outside law firm to offer a settlement discount up to % of the outstanding judgment balance on all judgment accounts with a principal balance due of $5,000.00 or less. For tracking and monitoring, all Law Firms authorized for these settlement guidelines will be required to remit to their designated Divisional Director Of Operations, a monthly report of all accounts settled. All legal settlements on accounts with a principal balance due of $5001.00 or more will require the standard level of approval or as authorized by in-house counsel in writing on an exception basis.

REDACTED VERSION

Guidelines Continued

All settlements outside of the stated guidelines must receive prior written or "ACE System" (MZ Notes) approval. On accounts with a principal assigned balance of $5,000.00 or less, prior approval must be received from the Collection Supervisor, or on legal accounts from the Operations Manager. All settlements outside of the stated guidelines on an account with a principal assigned balance for the range of $5,000.00 to $20,000.00, must receive prior approval from CFC Operations Manager.
For all settlements with a principal assigned balance of $20,000.00 or more, must receive prior approval from the Operations Manager and their Divisional Director of Operations or Divisional VP.

For all approved settlements, the authorized management personnel notation must be indicated on the cardless system note field for all approved settlements.

Settlement forms are to be maintained by the branch for 2 fiscal years.

TAB 32

SYNDICATED OFFICE SYSTEMS CENTRAL FINANCIAL CONTROL POLICY AND PROCEDURE MANUAL	TITLE: Urgency Payment Tracking Policy and Procedure Effective Date: December 2nd, 2002	#C19.1 Page 1 of 2

PURPOSE / BACKROUND:

This policy and procedure is intended to:

Define the required CFC Management process for tracking daily and monthly the individual volume of "*urgency*" type collections that are generated by a CFC collector. An urgency collection is defined as follows:

a. Credit Card
b. Check by Phone
c. Western Union Quick Collect
d. Walk-in Payment
e. Next Day Mail
f. Settlement Payment Received within same month it was offered

By establishing efficient and consistent tracking of urgency type collection by collector Self-Pay Management will have an additional quantified revenue parameter that will be used for evaluating the effectiveness of an individual collector's collection performance. The tracking of urgencies will also provide the Company with statistical data that can be referenced in determining the most cost effective urgency types.

POLICY:

To expedite account resolution, provide guarantors with flexible payment method options and enhance business cash flow, it is Company policy that all self-pay collectors as part of their daily standard collection communication with patients/guarantors, collectors will actively solicit collections be paid via urgency type methods. All self-pay collectors will be monitored for their urgency collection totals.

On a monthly basis, the Quality Assurance Department will track and monitor the volume and associated collection revenue for urgency type payments for all branch commission collector personnel. As captured by AS400 ACE Cash Posting payment descriptions, the reporting will include the following:

- Volume of Urgencies by Collector
- Total Collection Dollars
- Type of Urgency (as defined by ACE payment description)

At the conclusion of each month, QA will distribute to all self-pay Management, a monthly summary report, along with the urgency payment detail.

The completed report must be distributed at least one time per month to all self-pay collectors. The report totals will also be archived to provide Self-Pay Management will historical urgency reporting and trending.

PROCEDURE:

On a daily basis, the cash posting personnel will be required to use the appropriate and designated ACE cash posting payment description for each urgency type payment being posted. The currently available ACE payment description codes for urgencies are:

1. 060 = Visa
2. 061 = Master Card
3. 062 = Discover
4. 063 = American Express

As defined, additional codes for urgency payments will be added.

With the conclusion of each month, the designated Quality Assurance personnel will process the AS400 query reports to compile the summary and detail urgency date. QA will be responsible for distributing during the 1st week of the new month the monthly urgency report to all Self-Pay Branch Operations Managers. Upon receipt the Branch Operations manager is responsible for reviewing the urgency performances for their collectors with the self-pay Supervisors and have the supervisors provide constructive feedback to their collectors. In addition, Self-Pay Management may use the urgency performance totals for awarding monthly incentive funds.

Any Company employee(s) identified to be responsible for inappropriate/unethical activity and any activity not in compliance with this P&P will be subject to disciplinary action up to and including termination of employment.

TAB 33

SYNDICATED OFFICE SYSTEMS CENTRAL FINANCIAL CONTROL POLICY AND PROCEDURE MANUAL	TITLE: Self-Pay Time Pay Processing Policy and Procedure Effective Date: October 28th 2002	#C21.1 Page 1 of 3

PURPOSE / BACKROUND:

This policy and procedure is intended to:

Define the acceptable time-pay payment arrangement guidelines that CFC Collectors are required to follow when negotiating payment resolution with their assigned patient accounts.

By establishing cost effective and consistent guidelines for time payment arrangements, SOS will be better able to ensure the self-pay Collectors are performing due diligence towards first pursuing balance in full, prior to negotiating a time-payment arrangement. In addition, the defined guidelines will also ensure the Company self-pay Collectors are minimizing the volume of prolonged recovery terms while providing patients who can't pay their balance in full but want to pay their account, with a cost effective time payment arrangement.

POLICY:

It is Company policy that on accounts where the self-pay collector has confirmed that the patient cannot pay their account in full, as part of their payment resolution process, the self-pay Collectors will be authorized to negotiate payment arrangements based upon a pre-defined payment schedule. Upon the patient's confirmation of acceptance of the proposed payment arrangement, the self-pay Collector will use the designated ACE system codes to properly identify the account as a consummated time payment account and be responsible for performing timely follow-up on the time-pay account. In the event the patient defaults on the agreed time-pay arrangement, the self-pay Collector will be responsible for promptly canceling the time-pay arrangement and resume standard active collections with the patient for the full balance due.

PROCEDURE:

All self-pay Collectors will be required to reference the following Time-Payment grid when setting up all payment arrangements:

ACE Account Principal Balance	Min. Monthly Payment Arrangement as % of principal Balance	Payment Arrangement Stipulations	
$25.00 - $500		Arrangement cannot exceed	months
$50[illegible] 00 - $2000.00	%	Maximum Arrangement period is	months
$200[illegible] 00 -$5,000.00	%	Maximum Arrangement period is	months
>$5000.0	%	Maximum Arrangement period is	months and Operations Manager Approval

Sample Time-Pay Illustration

Account Balance	Payment Amount	Total Months
$500.00	$	
$2,000.00	$	
$4,000.00	$	
$10,000.00	$	

Once the self-pay Collector has confirmed the patient's acceptance of the approved payment arrangement, the collector will be required to perform the following ACE actions:

a. Notate Arrangement amounts and due dates in ACE notes.
b. Change Status to TPY
c. Send ACE monthly payment reminder letter

Additional Self-Pay Guidelines:

1) All FC95 accounts will be worked by the time pay clerical and not self-pay commissioned collectors. All FC95 accounts will assign directly to a time pay clerical unit for follow up. They will not be referred to the collection area unless they default; in which case they will be changed to a self pay financial class.

2) A self-pay collector can keep any account between the dollar range of $501.00 to $2,000.00 that will pay off within months on their unit. The account would be in a TPY status and would require periodic work effort. Without branch management approval, any account that pays for longer than months in this dollar range will not be eligible to remain on a self-pay collector unit. These accounts would be desk transferred to a time pay clerical unit for the remainder of normal payments.

3) A self-pay collector can keep any account between the dollar range of $2,000.00 to $5,000.00 that will pay off within months on their unit. The account would be in a TPY status and would require periodic work effort. Without branch management approval, any account that pays for longer than months in this dollar range will not be eligible to remain on a self-pay collector unit. These accounts would be desk transferred to a time pay clerical unit for the remainder of normal payments

4) With branch management approval, a self-pay collector can keep any account with a balance >$5,000.00 that will pay off within months on their unit. The account would be in a TPY status and would require periodic work effort. Without branch management approval, any account that pays for longer than months in this dollar range will not be eligible to remain on a self-pay collector unit. These accounts would be desk transferred to a time pay clerical unit for the remainder of normal payments

5) A self-pay collector can keep any account under $500.00 that will pay off within months on their unit. In these cases months is the maximum allowed time to accept payments on accounts under $500.00. It is the responsibility of management to remove accounts from collectors that make payments greater than months.

6) If a self-pay collector resigns or is terminated all TPY accounts will be transferred to a time pay clerical unit for follow up. If at a later time they default, they will be referred to the self-pay collector distribution desk.

To track each self-pay Collector's compliance with time-pay arrangements, the designated Collection Supervisor will be required to pull each month, the AS400 unit inventory report for TPY status accounts and spot check a minimum of 10 TPY accounts for quality control. All accounts deemed to be not in compliance with the defined guidelines will be immediately reviewed with the involved collector and if deemed appropriate by management the account will be removed from TPY status and the collector will be instructed to resume standard collection efforts for the remaining balance.

Time-payments outside of the defined guidelines may be required to be accepted based on special circumstances such as, Facility Administrative directive, Target 100 relations and/or Self-Pay Operations Manager determination. In all such exceptions, the ACE account must be fully noted with all details of the accepted payment terms.

On an ongoing basis, it is the responsibility of each Branch Operations Manager to ensure that their Collection personnel are performing all aspects of the defined procedures and workflows for proper processing of all time-pay accounts and if necessary, provide direction, or disciplinary action for insufficient performance and or inadequate handling.

Any Company employee(s) identified to be responsible for inappropriate/unethical activity and any activity not in compliance with this P&P will be subject to disciplinary action up to and including termination of employment.

TAB 34

TENET Tenet HealthSystem	BUSINESS OFFICE PROCEDURE MANUAL	No. 02.06.01
	PATIENT REGISTRATION	Page: 1 of 14
	CHARITY/INDIGENT/MEP	Original Date: 06/01/01
	CHARITY CARE POLICY	Revised Date: 08/22/03

POLICY

The determination of Charity Care generally should be made at admission or shortly thereafter. However, events after admission or at the time of service could change the ability of the patient to pay. Therefore, retrospective determination may be necessary. Designation as Charity Care will only be considered after all payment sources that could be a source of payment for the patient's bill have been exhausted. Patient account transactions for Charity Care must be posted in the month the determination is made.

In the event the account was assigned as bad debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

SCOPE

All Tenet Patient Accounting Platforms

PURPOSE

To define Charity Care, to distinguish Charity Care from accounts assigned to Bad Debts, and to establish policies and procedures to ensure consistent identification, accountability, and recording of such, at all Tenet entities and facilities.

DEFINITIONS

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately restate the revenue and any bad debt expense previously recorded.

Charity Care will be classified into four categories:

1. Charity Care – Statutory
2. Charity Care – Non-Statutory
3. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services
4. Charity Care – Catastrophic Medically Indigent

CHARITY CARE – STATUTORY

Statutory Charity Care will be defined by facility participation in various federal, state, and/or county uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or state or county regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application or just as application) (refer to *Exhibit B*). The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

- 5950-3934 Charity discount - Statutory I/P
- 5950-4934 Charity discount - Statutory E/R
- 5950-6934 Charity discount - Statutory O/P

CHARITY CARE – NON-STATUTORY

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's general Charity Care criteria; however, there may not be state or county programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application (refer to *Exhibit B*) is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3935 Charity discount - Non-Statutory I/P
- 5950-4935 Charity discount - Non-Statutory E/R
- 5950-6935 Charity discount - Non-Statutory O/P

CHARITY CARE – MEDICAID

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, but where Tenet facilities do not receive payment for their entire stay. Criteria for such Medicaid Charity Care must comply with governmental guidelines and/or state or county regulations. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application (refer to *Exhibit B)*, due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State Law/Regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co-insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide bad debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3940 Medicaid Denied Days I/P
- 5950-4940 Medicaid Denied Services E/R
- 5950-6940 Medicaid Denied Services O/P

CHARITY CARE – CATASTROPHIC MEDICALLY INDIGENT

For patients whose family income to Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or Local specific), but less than 300% of the FPG, the patient may be considered for Catastrophic Medically Indigent. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.
2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $ 24,680 x 2 = $49,360).
3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.
4. **Unable to Pay**—The patient is determined unable to pay a negotiated reduced amount of the bill.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3941 Catastrophic Medically Indigent discount - I/P
- 5950-4941 Catastrophic Medically Indigent discount - E/R
- 5950-6941 Catastrophic Medically Indigent discount - O/P

PROCEDURE

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC, MEP, and Centralized Patient Financial Services (CPFS) assigned patient accounts, post-discharge, that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

FACTORS TO BE CONSIDERED

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained, but is not required from a Confidential Financial Application. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.
   - Patients who are unemployed and do not qualify for a government program.
   - Patients that have no credit established and no bad debt collection accounts.
   - Patients with a lack of revolving credit account(s) information.
   - Patients with a lack of bank revolving accounts(s) information.
   - Patients with delinquencies reported on open trade line accounts.
2. The previous exhaustion of all other available resources.
3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.
4. Catastrophic illness.

MEP PROCEDURE

The MEP Patient Advocate should screen patients for potential linkage to government/county programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event that MEP is unable to obtain eligibility for the patient for government programs reimbursement. For potential linkage to government/county programs, the Patient Advocate will:

1. Change the financial class and assign the account to MEP within five days from discharge date, thereby, netting the account to expected governmental reimbursement.

2. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

3. Return the account to the facility for assignment by the Business Office to CPFS for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those that meet the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class.

If the initial interview with the patient reveals there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

1. Offer the patient a Confidential Financial Application form (refer to *Exhibit B*).

2. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

3. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC as deemed appropriate.

MEP PROCESSING FOR CHARITY CARE

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care Packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

FINANCIAL COUNSELOR PROCEDURE

Patients assessed by a Financial Counselor with no third-party coverage and/or benefits available will be reviewed for Charity Care if he or she meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

1. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

2. Patients that do not qualify for Charity Care should be treated as a Self-Pay and standard A/R collection procedures will apply.

TENET FINANCIAL ASSISTANCE CENTER

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to CPFS.

For patient accounts meeting the Charity Care guidelines:

1. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

2. The Charity Care Packet should include a Confidential Financial Application (refer to *Exhibit B)*, a Credit Bureau Report, and any other documents that substantiate the patient's financial requirement for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

   The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

   When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

   - A Credit Bureau Report or summary
   - An analysis that supports the recommendation for a Charity Care adjustment

3. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

   - Credit Bureau Report (including the lack thereof)
   - IRS tax returns
   - Payroll stubs
   - Declarations
   - Verbal attestation
   - Other forms used to substantiate the need for Charity Care consideration

4. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG Table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State Law/Regulation does not allow for consideration of Charity up to 200% of the FPG, the State Law/Regulation will take precedent and be enforced.

   a. If the family gross income falls below, or is at the designated income of the FPG ratio threshold (Tenet Policy's ratio is 200%, which is influenced by State Law/Regulation), the patient's account will be considered for Charity Care adjustment at 100%.

   b. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

      1) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

      2) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $ 24,680 x 2 = $49,360).

      3) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

      4) **Unable to Pay**—The patient is determined unable to pay a negotiated reduced amount of the bill.

      Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

5. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

6. TFAC is to review the application for Charity Care for appropriateness and completer Initialing the application indicates that it has been reviewed and meets the requirem for submission to the facility for Charity Care consideration and administr adjustment.

7. If the TFAC representative has exhausted all efforts for those patients who Government Programs or Charity Care criteria, but are unable to complete the req applications and documentation (e.g., unable to contact the patient, unable to pr sufficient documentation, etc.) and/or have a potential change in future circumsta and recovery, then the account will not be recommended for a Charity Care allowanc

8. Those patients who do not meet the guidelines for Charity Care will have their acc changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the collection, support, and management staff of TFAC are required to complete documentation on the account of all actions taken and all information received fror patient. It is the responsibility of the TFAC Operations management to ensure this poli adhered to.

DOCUMENTATION

CONFIDENTIAL FINANCIAL APPLICATION

In order to qualify for Charity Care, Tenet requests each patient or family to complet Confidential Financial Application (refer to *Exhibit B*). This application allows the collecti information about income and the documentation of other requirements as defined b Pending the completion of the application, the patient should be treated as a Charity Care p in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will the financial class changed to Charity Care on the facility HIS system.

In cases where the patient is unable to complete the written application, verbal attestati acceptable if it is not disallowed by State Law/Regulation.

A Confidential Financial Application completed by the patient may not be required for pa who are deemed to be already eligible for other Federal, State, and County Assistance Prog Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family mer in their household.

   a. Adults—In calculating the number of family members in an adult patient's hous include the patient, the patient's spouse and/or legal guardian, and all of dependents.

   b. Minors—In calculating the number of family members in a minor patient's hous include the patient, the patient's mother/father and/or legal guardian, and all o other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a. Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b. Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

INCOME VERIFICATION

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS form W-2, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

4. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate.

INFORMATION FALSIFICATION

Falsification of information will result in denial of the application for Charity Care. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will be forwarded to SOS/CFC for normal collection processes.

REVENUE CLASSIFICATION

It will be the responsibility of each business office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detail reports listing critical changes in account class between Self-Pay and Charity for any AR account assigned to CPFS/TFAC in the SOS system (ACE). The business office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

Critical changes in account class is defined as:

- Any account originally assigned to CPFS as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care.
- Any account originally assigned to CPFS as Charity that is re-classed to Self-Pay as a result of denying Charity Care.

DENIED CHARITY CARE RECOMMENDATIONS

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.

CUSTODIAN OF RECORDS

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

RESERVATION OF RIGHTS

It is the policy of Tenet HealthSystem and the Hospital to reserve the right to limit or deny financial assistance at their sole discretion.

- **Non-Covered Services**—It is the policy of Tenet and the Hospital to reserve the right to designate certain services that are not subject to the Hospital's Charity Care Policy.
- **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payors, patient transfers, emergency care, state-specific regulations, state-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

Exhibit A – Federal Poverty Guidelines

2003 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

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Exhibit B – Confidential Financial Application

TENET. Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A
MEDICAL ASSISTANCE SCREENING– *Please circle answer "Y" for yes to "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
   If yes, does the patient have a 30-day incapacitation?
5. Is the patient pregnant, or was the admission pregnancy related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B
FINANCIAL ASSISTANCE SCREENING
Total Number of Dependent Family Members in Household _____
(Include patient, patient's spouse and/legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size
_____ ÷ _____ = %

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each ·itional ·son, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

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TENET.

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient	
SSN:	DOB		
Home Address:			Phone #
Work Address:			Phone #
Gross income:	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly		
	Hours Per Week:		
If income is $0/unemployed, what is your means of support?	Circle One – ☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter		

SPOUSE

Responsibility Party:			
SSN:	DOB		
Home Address:			Phone #
Work Address:			Phone #
Gross income:	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly		
	Hours Per Week:		

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

_____
Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet HealthSystem's or its' subsidiaries provided care.

_____ _____
PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by _____ Date _____ Unit _____			
Approved or Denied by _____ Date _____ Title _____			

TAB 35

Tenet	BUSINESS OFFICE PROCEDURE MANUAL	No. 02.06.01
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	CHARITY CARE POLICY	Revised Date: 01/30/04

POLICY

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor. Patient account transactions for Charity Care must be posted in the month the determination is made.

The flat rate "co-pay" amount is based on patient type. Emergency patients and outpatients are required to pay $100 flat rate and inpatients are required to pay $200 per day, with a $2,000 cap.

In the event the account has been assigned as Bad Debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

SCOPE

All Tenet Patient Accounting Platforms

PURPOSE

To define Charity Care and to distinguish Charity Care from accounts assigned to Bad Debt. Additionally, to establish policies and procedures to ensure consistent identification, accountability, and recording of charity at all Tenet entities and facilities.

DEFINITIONS

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

Charity Care will be classified into four categories:

1. Charity Care – Statutory
2. Charity Care – Non-Statutory
3. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services
4. Charity Care – Catastrophic Medically Indigent

CHARITY CARE – STATUTORY

Statutory Charity Care will be defined by facility participation in various Federal, State, and/or County uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or State or County regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility. Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application—or, as application—as illustrated in *Exhibit B)*. The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

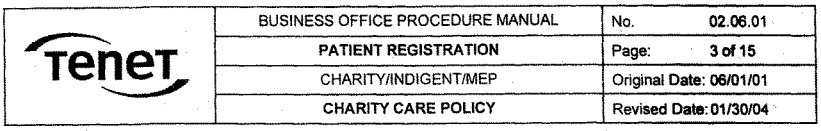
- 5950-3934 Charity Discount - Statutory I/P
- 5950-4934 Charity Discount - Statutory E/R
- 5950-6934 Charity Discount - Statutory O/P

CHARITY CARE – NON-STATUTORY

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's Charity Care criteria; however, there may not be State or County programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3935 Charity Discount - Non-Statutory I/P
- 5950-4935 Charity Discount - Non-Statutory E/R
- 5950-6935 Charity Discount - Non-Statutory O/P



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CHARITY CARE – MEDICAID

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, pursuant to governmental guidelines and/or State or County regulations, but where an outstanding patient balance exists, excluding waivers of deductibles and co-payments, unless otherwise documented and compliant with Tenet Regulatory Compliance Policy guidelines. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State law/regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co-insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide Bad Debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3940 Medicaid Denied Days I/P
- 5950-4940 Medicaid Denied Services E/R
- 5950-6940 Medicaid Denied Services O/P

CHARITY CARE – CATASTROPHIC MEDICALLY INDIGENT

For patients whose family income to the Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for the Catastrophic Medically Indigent category. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.
2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).
3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4. **Unable to Pay**—It is determined the patient is unable to pay.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3941 Catastrophic Medically Indigent Discount - I/P
- 5950-4941 Catastrophic Medically Indigent Discount - E/R
- 5950-6941 Catastrophic Medically Indigent Discount - O/P

PROCEDURE

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at the time of admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, the co-pay will be collected based on admission type, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC-, MEP-, and Early Out-assigned patient accounts—post-discharge—that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

FACTORS TO BE CONSIDERED

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained from a Confidential Financial Application, but is not required. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.
   - Patients who are unemployed and do not qualify for a government program
   - Patients who have no credit established and no Bad Debt collection accounts
   - Patients with a lack of revolving credit account(s) information
   - Patients with a lack of revolving bank accounts(s) information
   - Patients with delinquencies reported on open trade line accounts
2. The previous exhaustion of all other available resources.

3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.

4. Catastrophic illness.

MEP PROCEDURE

The MEP Patient Advocate should screen patients for potential linkage to Government/County programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event MEP is unable to obtain eligibility for the patient for Government Programs reimbursement. For potential linkage to Government/County programs, the Patient Advocate will:

1. Change the financial class and assign the account to MEP within five days from date of discharge, thereby, netting the account to expected governmental reimbursement.

2. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

3. Return the account to the facility for assignment by the Business Office to Early Out for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class. The co-pay should be collected by the hospital's Financial Counselor, Business Office representative, or TFAC representative.

If, during the initial interview with the patient, it is revealed that there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

1. Offer the patient a Confidential Financial Application form.

2. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

3. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC, as deemed appropriate.

4. Refer the patient to the hospital Financial Counselor for collection of the co-pay.

MEP PROCESSING FOR CHARITY CARE

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

FINANCIAL COUNSELOR PROCEDURE

Patients assessed by a Financial Counselor to have no third-party coverage and/or benefits available will:

1. Be offered the facility flat rate or Prompt Pay Discount Program where allowed by State law/regulation.

2. Be assessed for Charity Care in the event he or she is unable to pay the facility flat rate or Prompt Pay Discount Program amount (as applicable to State law/regulation), and meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

1. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken and the co-pay amount should be collected. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

2. Patients who do not qualify for Charity Care should be treated as a Self-Pay, and standard A/R collection procedures will apply.

TENET FINANCIAL ASSISTANCE CENTER

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to Early Out.

For patient accounts meeting the Charity Care guidelines:

1. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

2. The Charity Care packet should include a Confidential Financial Application, a Credit Bureau Report, and any other documents that substantiate the patient's financial need for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

   The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

- A Credit Bureau Report or summary
- An analysis that supports the recommendation for a Charity Care adjustment

3. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

   - Credit Bureau Report (including the lack thereof)
   - IRS tax returns
   - Payroll stubs
   - Declarations
   - Verbal attestation
   - Other forms used to substantiate the need for Charity Care consideration

4. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State law/regulation does not allow for consideration of Charity up to 200% of the FPG, the State law/regulation will take precedent and be enforced.

   a. If the family gross income falls below, or is at the designated income of the FPG ratio threshold, the patient's account will be considered for Charity Care adjustment at 100% minus the co-pay amount (Note: Tenet Policy's ratio is 200%, which is influenced by State law/regulation).

   b. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

      1) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

      2) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

      3) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4) **Unable to Pay**—It is determined the patient is unable to pay.

Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

c. If the co-pay was not collected at the time of service, the Financial Assistance Coordinator will attempt to collect the amount before the Charity Care packet is submitted.

5. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

6. TFAC is to review the application for Charity Care for appropriateness and completeness. Initialing the application indicates that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.

7. If the TFAC representative has exhausted all efforts for those patients who meet Government Programs or Charity Care criteria, but are unable to complete the required applications and documentation (e.g., unable to contact the patient, unable to provide sufficient documentation, etc.), and/or have a potential change in future circumstances and recovery, then the account will not be recommended for a Charity Care allowance.

8. Those patients who do not meet the guidelines for Charity Care will have their accounts changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the Collection, Support, and Management staff of TFAC are required to input complete documentation on the account of all actions taken and all information received from the patient. It is the responsibility of the TFAC Operations management to ensure adherence to this policy.

DOCUMENTATION

CONFIDENTIAL FINANCIAL APPLICATION

In order to qualify for Charity Care, Tenet requests each patient or family to complete the Confidential Financial Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a Charity Care patient in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will have the financial class changed to Charity Care on the facility's HIS system.

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by State law/regulation.

A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family members in their household.

   a. Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

   b. Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a. Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b. Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

4. **Homeless Patients**—Patients may be deemed homeless once verification processes have been exhausted by TFAC. The co-pay will be waived if no other guarantor appears on the patient account.

INCOME VERIFICATION

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS W-2 form, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.

2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

Information Falsification

Information falsification will result in denial of the Charity Care application. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will follow the normal collection processes.

Revenue Classification

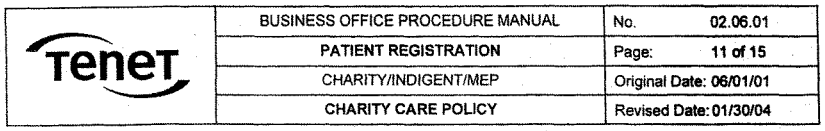
It will be the responsibility of each Business Office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detailed reports listing critical changes in account class between Self-Pay and Charity for any A/R account assigned to TFAC. The Business Office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

Critical changes in account class are defined as:

- Any account originally assigned to TFAC as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care
- Any account originally assigned to TFAC as Charity that is re-classed to Self-Pay as a result of denying Charity Care

Denied Charity Care Recommendations

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.



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CUSTODIAN OF RECORDS

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

RESERVATION OF RIGHTS

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion.

- **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care Policy.
- **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payors, patient transfers, emergency care, State-specific regulations, State-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

Exhibit A – Federal Poverty Guidelines

2003 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

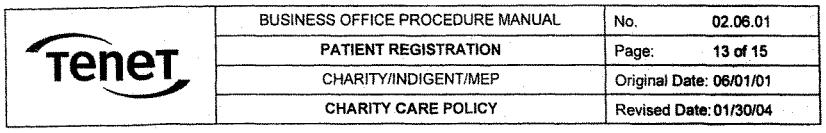

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Exhibit B – Confidential Financial Application

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A
MEDICAL ASSISTANCE SCREENING– *Please circle answer "Y" for yes or "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
   If yes, does the patient have a 30-day incapacitation?
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B
FINANCIAL ASSISTANCE SCREENING
Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size
_____ ÷ _____ = _____%

Type of Service Circle one ER OP IP

Service Date _____ to _____

Co-Pay Amount $_____

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Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One – Living on Savings/Annuity Live with parent/family/friends Homeless Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross income:	Check One - Hourly Daily Weekly Monthly Yearly	
	Hours Per Week:	

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.
Patient/Guarantor Initials _____

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

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OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			

Recommendation:

Prepared by _____ Date _____ Unit _____

Approved or Denied by _____ Date _____ Title _____

TAB 36

TENET'S COMPACT WITH UNINSURED PATIENTS

- Patients without insurance who receive health care services at hospitals operated by Tenet will be treated fairly and with respect during and after their treatment, regardless of their ability to pay for the services they receive.

- Tenet hospitals will provide financial counseling to all uninsured patients. This will include help in understanding and applying for local, state, and federal health care programs such as Medicaid.

- All patients without insurance at Tenet hospitals will be offered reasonable payments and payment schedules. Whenever possible, this will occur before the patients leave the hospital, as part of the financial counseling process.

- Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is not gainfully employed at the time services are rendered. Before taking legal action, hospitals will assure that the patient is not eligible for any assistance program and does not qualify under the hospital's financial assistance program. Nor will Tenet hospitals pursue legal action if the only recovery available would be to place a lien on the patient's home.

for the community

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TAB 37

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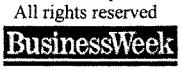

Business Week

May 24, 2004

SECTION: ECONOMIC VIEWPOINT; Number 3884; Pg. 30

LENGTH: 767 words

HEADLINE: The Health-Care System Needs Strong Medicine

BYLINE: By Robert Kuttner; Robert Kuttner is co-editor of The American Prospect and author of Everything for Sale.

BODY:
Corporate benefits managers are reeling from the latest premium hikes, even as the number of **uninsured** Americans sets a new record. In the 2004 Presidential campaign, George W. Bush and John Kerry, in very different ways, will try to square a policy circle -- attempting to simultaneously expand coverage and contain costs. For President Bush, market incentives serve both goals. Bush's recently enacted Medicare revision, for instance, offers new drug benefits, but with extensive out-of-pocket payments. This strategy limits government's cost and, presumably, creates incentives against overuse of expensive medicines. The Administration also relies on voluntary discounts by the pharmaceutical industry. It not only rejects price controls but explicitly prohibits Medicare from negotiating volume drug discounts. The law also creates incentives to encourage seniors to switch from conventional Medicare to managed-care plans, on the premise that competition will increase efficiency. It dramatically expands tax-advantaged medical savings accounts. President Bush proposes additional tax credits to subsidize the purchase of individual or small-group policies.

BY CONTRAST, JOHN KERRY WOULD OVERHAUL Bush's Medicare drug program. He'd find the money to pay for better drug coverage by restraining drug prices. Kerry supports public Medicare and opposes converting it into a system of vouchers. He would add a novel federal "stop-loss" reinsurance program to secure employer-provided insurance: If annual medical expenses exceeded $ 50,000 for any person insured by a qualified plan, the government would share the costs.

Kerry vows to raise the percentage of Americans covered by health insurance to 96% by allowing **uninsured** people to buy into the Federal Employees Health Benefit Program (or a pool just like it) and by expanding programs such as Medicare. By insuring more Americans, Kerry hopes more patients can be treated more efficiently -- in health plans rather than hospital emergency rooms, and in early treatment of diseases rather than costly interventions for the acutely sick.

Unfortunately, neither candidate quite comes to grips with the underlying forces driving health costs higher. Expenses are inexorably rising for three basic reasons. First, people are living longer, and oldsters consume more health dollars. Second, medical technology keeps finding ways to keep us alive. Third, health care can't get major productivity gains because it is a labor intensive enterprise. Some favorite remedies, such as malpractice reform and more consistent national application of the most appropriate

medical practices, could help restrain some costs. But absent more fundamental reform, the most likely source of cost reduction for employers, insurers, and government alike will be shifting the burden to individuals. Employer-provided insurance is already shifting costs at an alarming rate. As the Medicare and Medicaid budgets come under increased stress, fiscal pressure will mount to cap the government's costs, too.

In reality, most people who lack adequate health coverage can't afford it at prevailing prices. Bush's proposed health tax credit would cover only $ 1,000 of the cost of a decent family policy ($ 6,000 to $ 9,000), just as his Medicare drug program leaves very sick people paying about 50% to 75% of the cost of their medications. His health savings account requires insurance plans with high deductibles, which undermines the goal of preventive care. These "market incentives" aren't much help. Indeed, marketization can exacerbate the problem if it encourages insurers to fragment the risk pool and maximize profits by discriminating against people likely to get sick.

Kerry would actually deliver some expansion of coverage. Even so, allowing people on modest incomes access to the excellent Federal Employees plan isn't much use to families that can't afford the premiums. Absent stronger medicine (such as mandatory employer coverage or a universal, single-payer system), government incentives to employers or tax credits to individuals won't solve the problem. Advocates of universal coverage contend that only by putting everyone in the same risk pool -- and reducing the hundreds of billions of dollars that go to marketing, claims processing, and profit -- can we afford both to contain costs and cover the entire population. At the same time, however, society just can't afford to give every patient every possible treatment. That's a reality that no one wants to face.
URL: http://www.businessweek.com/index.html

LOAD-DATE: May 20, 2004

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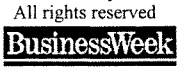


Business Week

May 31, 2004

SECTION: COVER STORY; Number 3885; Pg. 58

LENGTH: 4137 words

HEADLINE: Working...And Poor

BYLINE: By Michelle Conlin and Aaron Bernstein

HIGHLIGHT:
In today's cutthroat job market, the bottom rung is as high as most workers will ever get. But the political will to help them seems a long way off

BODY:
Katrina Gill, a 36-year-old certified nursing aide, worked in one of the premiere long-term care facilities near Portland, Ore. From 10:30 p.m. to 7 a.m., she was on duty alone, performing three rounds on the dementia ward, where she took care of up to 28 patients a night for $ 9.32 an hour. She monitored vitals, turned for bedsores, and changed adult diapers. There were the constant vigils over patients like the one who would sneak into other rooms, mistaking female patients for his deceased wife. Worse was the resident she called "the hitter" who once lunged at her, ripping a muscle in her back and laying her flat for four days.

Last month, Gill quit and took another job for 68 cents an hour more, bringing her salary to $ 14,400 a year. But like so many health-care workers, she has no health-care benefits from her job. So she and her garage mechanic husband pay $ 640 monthly for a policy and have racked up $ 160,000 in medical debts from their youngest son Brandyn's cancer care.

In New York City, Joseph Schiraldi, 41, guards one of the biggest terrorist targets in the world: the Empire State Building. For eight hours a day, he X-rays packages, checks visitors' IDs, and patrols the concourse. But on $ 7.50 an hour in the priciest city in the U.S., he's a security officer without security -- no pension, no health care, and no paid sick days, typical for a nonunion guard.

Bellingham (Wash.) day-care teacher Mandy Smith can't afford child care for her 6-year-old son, Jordan, on her take-home pay of $ 60 a day. Neither can commercial cleaner Theresa Fabre on her $ 8.50 an hour job. So her son, Christian, 9, waits for her after school in a crumbling upper Manhattan library where the kids line up five-deep to use one of two computers. The librarian doubles as a de facto babysitter for 40 or so other kids of the working poor.

Over the past year, the loss of lucrative white-collar work offshore has dominated news headlines, provoking economic anxiety among middle-class families who fear they may be next. But there's an equally troubling yet more often overlooked problem among the nation's working poor -- for whom the

raises come in dimes, the sick days go unpaid, and the benefits are out of reach.

Today more than 28 million people, about a quarter of the workforce between the ages of 18 and 64, earn less than $ 9.04 an hour, which translates into a full-time salary of $ 18,800 a year -- the income that marks the federal poverty line for a family of four (table). Any definition of the working poor, of course, involves some blurry lines. Some, like Gill, who make just above the $ 9.04 wage, often bounce around the threshold with their chaotic hours, slippery job security, and tumultuous lives.

There's also the fact that about one-third work only part-time, and more than a third are 18- to 25-year-olds, who may still live at home but may eventually work their way up the ladder. Some perhaps moonlight with a second job. And others may have spouses whose incomes lift their families up. But most poor workers tend to marry people with similar backgrounds, leaving both to juggle jobs as janitors, health aides, and retail workers that don't raise them into the middle class.

Overall, 63% of U.S. families below the federal poverty line have one or more workers, according to the Census Bureau. They're not just minorities, either; nearly 60% are white. About a fifth of the working poor are foreign-born, mostly from Mexico. And the majority possess high school diplomas and even some college -- which 30 years ago would virtually have assured them a shot at the middle class.

TOIL AND TROUBLE Now, though, most labor in a netherworld of maximum insecurity, where one missed bus, one stalled engine, one sick kid means the difference between keeping a job and getting fired, between subsistence and setting off the financial tremors of turned-off telephones and $ 1,000 emergency-room bills that can bury them in a mountain of subprime debt.

At any moment, a boss pressured to pump profits can slash hours, shortchanging a family's grocery budget -- or conversely, force employees to work off the clock, wreaking havoc on child-care plans. Often, as they get close to putting in enough time to qualify for benefits, many see their schedules cut back. The time it takes to don uniforms, go to the bathroom, or take breaks routinely goes unpaid. Complain, and there is always someone younger, cheaper, and newer to the U.S. willing to do the work for less. Pittsburgh native Edward Plesniak, 36, lost his $ 10.68-an-hour union job as a janitor when the contractor fired all the union workers to make way for cheaper, nonunion labor. So far, Plesniak has been able to dredge up work only as a part-time floor waxer. The pay: $ 6.00 an hour, with no benefits. "I feel like I'm in a nightmare," says the married father of three. "And I can't wake up."

What's happening in the world's richest, most powerful country when so many families seem to be struggling? And what can be done? There's no question that robust growth is a potent remedy: Recall that the full-employment economy of the late 1990s reduced the ranks of the working poor. Five years of a 4% jobless rate bid up wages across the board. That brought a healthy cumulative 14% pay hike, after inflation, to those in the bottom fifth between 1995 and 2003, when they averaged $ 8.46 an hour, according to an analysis of Census data by the Economic Policy Institute (EPI), a liberal Washington research group. The share of the workforce earning subpoverty pay actually shrank eight percentage points, to 24% last year, or 5 million fewer than in 1995.

That's real progress, certainly. But it still leaves many workers earning less than what it takes to lift a family above the poverty line. In other words, the boom didn't last long enough to bring more people into better circumstances. Now, in the current recovery, there has been brisk growth again, as well as high productivity and job creation. But so far, wages at the low end haven't budged much. Many of today's economic gains are flowing to profits and efficiency improvements, and the job market isn't tight enough yet to lift pay for average workers, much less for those on the bottom. Of course, if the recovery continues apace, a strong labor market could bump wages up.

Perplexing, too, are signs that many jobs the working poor hold won't, over time, lead them out of their straits. Five of the 10 fastest-growing occupations over the next decade will be of the menial, dead-end variety, including retail clerks, janitors, and cashiers, according to the Bureau of Labor Statistics (table, page 63). What's more, while full employment in the 1990s may have brought higher pay for people like health aides and maids, the ladder up into the middle class has gotten longer, and they are more likely than in other periods to remain a health aide or a maid.

A 2003 study of 1990s mobility by two economists at the Federal Reserve Bank of Boston found that the chances that poor Americans would stay stuck in their strata had increased vs. the 1970s. Given the economy's strong showing in the '90s, that's a concern. "If current trends persist, a greater and greater share of wealth will keep going into the hands of the few, which will destroy initiative," worries James D. Sinegal, CEO of Costco Wholesale Corp., which offers above-average pay and benefits in the retail sector. "We'll no longer have a motivated working class."

So although a fast-growing economy and full employment are necessary for powering wages at the bottom, they may not be enough in today's economy. To survive in waves of increasing global competition, U.S. companies have relentlessly cut costs and sought maximum productivity. That has put steady downward pressure particularly on the lowest rungs of the labor force, while rewarding the growing ranks of educated knowledge workers. In this increasingly bifurcated job market, workers who lack skills and training have seen their bargaining power crumble relative to those higher up the scale.

For one thing, globalization has thrown the least-skilled into head-on competition with people willing to work for pennies on the dollar. And a torrent of immigration, mainly poor rural Mexicans, has further swelled the low-end labor pool. Together, these trends have shoved many hourly wage occupations into a worldwide, discount labor store stocked with cheap temps, hungry part-timers, and dollar-a-day labor in India, Mexico, and China, all willing to sell their services to the lowest bidder. Against such headwinds, full employment offers only partial protection.

What's more, other traditional buffers don't help low-end workers as much anymore. While labor unions were largely responsible for creating the broad middle class after World War II, bringing decent wages and benefits to even low-skilled employees such as hotel and garment workers, that's not the case today. Most U.S. employers fiercely resist unionization, which, along with other factors, has helped slash union membership to just 13% of the workforce, vs. a midcentury peak of more than 35%.

GRAVITATIONAL PRESSURE The federal minimum wage, too, long served as a bulwark against low pay by putting a floor under the bottom as the rest of the workforce gained ground. At $ 5.15 an hour, it remains 30% less than it was in 1968, after inflation adjustments. It hasn't moved in nearly seven years, victim of a divided political Establishment in which programs for a relatively powerless group often get jammed up in bipartisan gridlock.

Add to all this the fact that a college degree, the time-tested passport to success, is today less available to those without family resources. The cost of college has exploded, leaving fewer than 5% of students from bottom-earning families able to get that all-important diploma. The result: The pattern of low skills crosses the generations (page 68). Columbus Harris, 50, a $ 6.75-an-hour driver for the elderly in Pine Bluff, Ark., couldn't help his kids with college. So his middle son Christopher joined the Army to get an education. "I worry about the fact that a lot of the gains in educational attainment are concentrated among the youngsters from rich and upper-middle-class families," says Gary Burtless, a senior fellow at the Brookings Institution.

There are no easy policy prescriptions for improving the working poor's prospects. Measures with any real impact are almost always costly and ignite political fights over priorities (table, page 64). Lifting the

minimum wage by $ 1.50 an hour, for example, would boost the incomes of more than 10 million workers. A majority of the gains would flow to adult women over age 20, mostly nonunionized workers in retail, according to an analysis by the EPI. To support the wage floor over the long term, the minimum would need to be linked to some measure of national living standards, such as inflation or average wages, to keep many families from simply slipping back into working poverty after a few years. Yet trying to hike the minimum wage always sparks a monumental battle in Washington. That's just what's happening now, after Senator Edward M. Kennedy (D.-Mass.) proposed to lift it to $ 7.00 an hour.

Writing some new rules for globalization would shore up low-end workers, too. Some Democrats advocate linking trade pacts to labor rights, by, for example, requiring countries that want favored trade status to allow workers to form unions. The idea isn't to eliminate low-wage competition -- an impossibility, in any case -- but simply to blunt its sharpest blows, particularly on less-skilled, predominantly male factory workers. Many economists calculate that globalization has been responsible for about one-fifth of the decline in blue-collar pay since 1973. But just think back to the fight over NAFTA a decade ago to see how far such proposals might go in Congress.

Curbing the flood of unskilled immigrants, assuming it could even be done, also would ease some of the gravitational pressure on low-end pay. Slowing the pace of entry, or shifting the flow toward higher-skilled workers, would mitigate the stiff wage competition among everyone from janitors to sales clerks. Yet if anything, political momentum seems to be moving in the opposite direction, such as President Bush's proposals earlier this year to set up a temporary worker program.

A hike in unionization would also give the working poor some leverage over wages. The rule of thumb used to be that union workers earn about one-third more than nonunion ones. But the differential has ballooned with the collapse of pay scales at the bottom. Today, blue-collar workers in a union make 54% more than unorganized ones and are more than twice as likely to have health insurance and pensions, according to an EPI analysis. Because unions boost workers' bargaining power and help them win a greater share of productivity gains, any resurgence would give low-wage workers more clout to deal with the effects of factors such as globalization, immigration, and technology. Still, the U.S. isn't likely to alter the laws governing unionization any time soon. Employers have body-blocked such attempts since the late 1970s, arguing that profits and economic growth would suffer. Today, labor law reform still goes nowhere, snagged in the broader political deadlock that grips the U.S.

America's divisions surface only sporadically as a pressing issue. Senator John Edwards (D-N.C.) put them at the core of his Presidential campaign, castigating the "two Americas" divided into rich and poor. This prompted John Kerry to adopt a populist tone for a while. Some Democrats urged him to target policies perceived as unfair to both low- and middle-income workers, from trade pacts to tax cuts for the wealthy. Kerry still mentions these issues, but they're hardly a central plank of his platform. Of course, that could change if Edwards ends up joining the ticket. A recent poll found that 78% of voters care more about fighting poverty than they do about gay marriage. "The issue is sitting out there for a candidate to seize on, but voters want to hear new solutions," says Democratic political consultant Tom Freedman.

WHERE HOPE LIES Still, historically, class-based appeals have had scant resonance in U.S. politics. In addition, there's little sustained outcry from the working poor themselves, who often are overwhelmed by their personal difficulties and politically disengaged. Only about 40% of them vote, vs. 74% of the investor class, according to the Russell Sage Foundation. "If you look at families in the bottom 20%, they are dropping out of the political system like flies," says foundation President Eric Wanner.

A few initiatives, though, have broad enough appeal to win support from both sides of the divide. Lawmakers from both political parties are struggling to devise ways to help the **uninsured** get health coverage. While they're split on this subject, too, nearly everyone agrees that something should be done.

The Children's Health Insurance Program (CHIP), which covers poor kids, was established by Democrats and Republicans alike, though a lot of children remain uncovered. Any expansion, or a broader solution that involves expanding Medicaid, would help many working poor adults, among the most likely to need coverage.

Similarly, the 1996 welfare reform effort has brought a rough consensus today that Congress should help welfare moms with child care so they can work. Washington could broaden eligibility for child-care help to include more working-poor families, too. Richer educational loan programs would also help. Given the country's soaring deficits, though, Congress isn't inclined to devote big resources to such projects. One place to look for money might be in the tax code, but in an election year, the high-profile investor class and the organized elderly are likelier to get any new largesse than the working poor.

Government may be stalled, but some employers are stepping up, at least in small ways. A number of leading companies, including Bank of America Corp. and Marriott International Inc., have programs to aid their low-wage workers -- they offer small emergency loans or grants to employees who face sudden crises, help them with child care, or find creative ways to make their workdays more flexible. "Assuming employers have answered the question as to whether they're paying market-based wages and benefits, there are still a lot of other things they can do, some of them relatively low cost," says Donna Klein, president of Corporate Voices for Working Families, a business group in Washington that sponsored a recent study on programs for low-wage workers.

Still, even those who push above a poverty-level wage can fall into a trap. Between $ 7 to $ 10 an hour, they make just enough to start losing what little safety net there is, says Ron Haskins, a former Republican staffer who helped spearhead the 1996 welfare reform, now a senior fellow at the Brookings Institution. They often become ineligible for food stamps or child-care assistance, and the earned income tax credit starts phasing out for a single parent at $ 13,730. "For them, Horatio Alger does not apply," says Haskins.

Women, especially single ones, have the most difficulty. Often, their wages barely cover the cost of child care. Low-income women's pay is actually up since 1973, but they still average just $ 7.94 an hour, much less than their male counterparts. That's one reason the U.S. has the highest child-poverty rate in the industrialized world. "Our low-income mothers work twice as hard as those in any other industrial country -- but their kids are the worst off," says Syracuse University public policy professor Timothy M. Smeeding.

THE WAL-MART EFFECT Lately, there's a new name for the downward pressure on wages: the so-called Wal-Martization of the economy. Most recently, the dynamic played out starkly in the five-month Southern California supermarket strike that ended in February. The three chains involved, Safeway, Albertson's, and Kroger, said they had no choice but to cut pay and benefits drastically now that 40 Wal-Mart Stores supercenters would be opening up in the area. The reason: Wal-Mart pays its full-time hourly workers an average of $ 9.64, about a third of the level of the union chains. It also shoulders much less of its workers' annual health insurance costs than rivals, leaving 53% of its 1.2 million employees uncovered by the company plan.

Now, after the strike, new hires will have lower wages and bear a much higher share of health costs than current union members, making health insurance too pricey for many of them, too. Eventually, many grocery jobs could wind up paying poverty-level wages, just like Wal-Mart's. "I used to load workers into my truck to take them down to United Way," says Jon Lehman, a former manager of a Louisville Wal-Mart who now works for the United Food & Commercial Workers Union. In his 17 years with Wal-Mart, he kept a Rolodex with numbers for homeless shelters, food banks, and soup kitchens. "They couldn't make it on their paychecks."

It's a prospect that deeply worries workers like Sherry Kovas. Over 26 years, she worked her way up to $ 17.90 an hour as a cashier at Ralph's Grocery Co. store in the posh California enclave of Indian Wells. To Kovas, the Medici-like lifestyles of her customers -- the personal chefs, the necklaces that would pay her yearly salary -- never seemed so much an emblem of inequality as a symbol of what was possible. Now, though, after the banks foreclosed on some strikers' homes and the repo men hauled away their cars, there's already talk of grocery store closings in the area because of the new Wal-Mart supercenter up the road. "They say Wal-Mart's going to kill us," says Kovas, who fears losing the three-bedroom modular home that she, her five-year-old son, husband, and mother-in-law share. "But I'm 44 years old. I'm too old to start over."

The U.S. has long tolerated wider disparities in income than other industrialized countries, mostly out of a belief that anyone with enough moxie and hustle could lift themselves up in America's vibrant economy. Sadly, it seems that path is becoming an ever steeper climb. Strong recovery and vigorous growth will again get wages growing. But as a new phase of prosperity begins, it may be time for some added advantages for those struggling in a brutal global economy. Otherwise, the outcome could be more polarization and inequality. The farther down that road the country goes, the harder it will be to change course.

The Working Poor: Who's In The Ranks
The majority are white, female, and high school educated

	LOW-WAGE* WORKFORCE	TOTAL WORKFORCE
	24%	100%
	AVERAGE HOURLY WAGE	2003
	$7.09	$17.15
GENDER		
Female	58%	45%
Male	42%	55%
RACE		
White	58%	73%
Hispanic	22%	11%
Black	14%	10%
Asian/other	6%	6%
EDUCATION		
Less than High School	23%	6%
High School	37%	29%
Some college	31%	29%
College or more	9%	36%
AGE		
18-25	37%	10%
26-35	22%	25%
36 plus	41%	65%
OCCUPATION		
Services	50%	18%
Operations	21%	24%
Clerical	15%	16%
Managers	12%	41%

Others	2%	1%

* Low-wage refers to hourly wage rate necessary for a family of four to just surpass the poverty line (weighted) with full-time, full-year work. In 2003, this wage was $9.04.

Data: Economic Policy Institute

Lowering The Hurdles: What Can Be Done

Liberals and conservatives agree broadly on some measures but remain deeply split on many others. Looming budget deficits also stand in the way of any major new initiatives.

CHILD CARE

Both sides largely agree that poor families, especially single moms, could work more and earn more if they had better day-care options.

EDUCATION

The No Child Left Behind Act could ultimately bring along disadvantaged students. So could dozens of lawsuits aimed at equalizing state spending on poor and affluent schools.

HEALTH CARE

The GOP and Dems both say they want to insure the **uninsured**, many of them working poor, although the parties are at a standoff on how to achieve that.

GLOBALIZATION

Putting labor standards in trade pacts would blunt the impact on the lowest-skilled workers, but companies argue that doing so would slow economic growth.

IMMIGRATION

Neither party has any real idea of how to stop desperate immigrants from undercutting U.S. pay levels. Tougher border policing and sanctions on employers haven't stopped the flood of new workers.

MINIMUM WAGE

Raising the wage floor from $5.15 an hour -- which is 30% lower after inflation than in 1968 -- would help millions of subpoverty workers, but employers successfully lobby against such measures.

TAXES

Payroll taxes are a huge burden on the working poor, but it would cost billions to phase them out or offset them by expanding the Earned Income Tax Credit.

UNIONS

Making it easier to form unions would allow low-wage workers to fight for higher pay as productivity improves.

URL: http://www.businessweek.com/index.html

GRAPHIC: Photograph: Photograph: STRUGGLING NEW YORKERS: (left to right) Eduardo Sanchez, security officer, $ 8.50 an hour; Cordie Green, chef, $ 6.90 an hour; Isaac Guindi, retail manager, $ 13 an hour; Barbara O'Rourke, nursing-home housekeeper, $ 7.97 an hour; Romona Lawrence, home health aide, $ 7 an hour. None but O'Rourke has benefits. PHOTOGRAPH BY BEN BAKER/REDUX PICTURES ; Photograph: Photograph: AT RISK: Grocery cashier Sherry Kovas of Palm Desert fears the impact of a new Wal-Mart PHOTOGRAPH BY STEVE LABADESSA ; Illustration: Illustration: Chart: Life At The Bottom: Working one's way up the ladder is becoming

harder, not easier. And the difficulty may get more severe. CHARTS BY ERIC HOFFMANN/BW ; Photograph: Photograph: PRICED OUT: Driver Columbus Harris of Pine Bluff, Ark., couldn't help his kids go to college PHOTOGRAPH BY STEVE JONES ; Photograph: Photograph: DEEP IN DEBT: Nursing aide Katrina Gill of Portland, Ore., with her son Brandyn. His cancer treatment is costly PHOTOGRAPH BY ROBERT MAXWELL

LOAD-DATE: May 27, 2004

TAB 39

A FAILING MISSION:

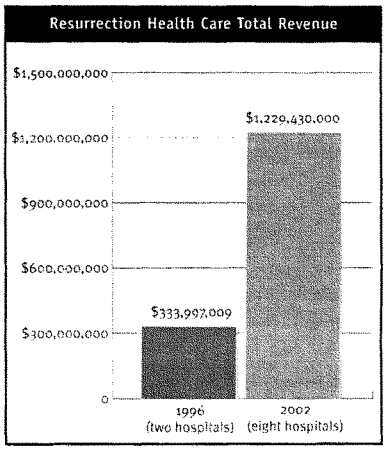
The Decline of Charity Care at Resurrection Hospitals

Executive Summary

By any measure, the recent growth of Resurrection Health Care (RHC) is impressive. In little more than a decade, the corporation has become a dominant player in Chicago's health sector. Its chain of eight local Catholic hospitals now produces annual revenue of more than a billion dollars.

But a closer look at Resurrection's books reveals an unpleasant truth: RHC has built up its bottom line by denying charity care — free health services for patients who cannot pay — to Chicago residents who lack health insurance and the funds to cover spiraling out-of-pocket costs.

This report reveals that since 2002, RHC has drastically reduced its provision of charity care to the uninsured and needy — in the process neglecting its historic, faith- and service-based mission.



Source: RHC audited financial statements, 1996,2002.

Corporate profits leap, uninsured Chicagoans lose

The year 2002 ended a two-year period in which Resurrection's total corporate profits grew more than 250%. It also marked the start of a new, restrictive corporate policy on providing charity care. Since that policy's inception, the eight RHC hospitals have cut their cumulative provision of free care to the uninsured and the needy by 57 percent.

Value of RHC charity care	
FY 2002	$36 million
FY 2003	$15 million
Percent change	**-57%**

Charity care now represents just 0.6% of all gross charges at RHC hospitals — a figure that's less than half the average for private hospitals in Cook County.

Resurrection's new policy: Those most in need are shut out

Aiming to maximize profits, RHC facilities now deny charity care to a significant percentage of patients based on factors such as residence, immigration status, and existing debt.

This approach is both harsh and exceptional. Of the more than 50 other private hospitals in Cook County, none deny charity care to patients based on where they live, and only four exclude undocumented immigrants.

- *Barring whole neighborhoods*
  Among those ruled ineligible for charity care is anyone not living in Resurrection's self-proclaimed "service area," a geographic domain that excludes nearly all of Chicago's Southwest and South sides and bars the predominantly African American and Latino, disproportionately low-income residents of those neighborhoods from receiving charity care.

- *Causing unequal harm to Latinos*
  Also newly ineligible for charity care are undocumented immigrants and anyone with outstanding medical bills at RHC hospitals. These mandates have an unequal negative effect on members of racial and ethnic minority groups — particularly Latinos, who are far more likely than whites to be undocumented, uninsured, and poor. Also, though RHC owns two hospitals on the city's Near Northwest Side, some nearby Latino neighborhoods are excluded from Resurrection's charity care service area.

- *Squeezing every last nickel*
  Capricious eligibility rules are Resurrection's chief tool to trim charity care, but not its only one. The corporation also instituted newly onerous financial disclosure requirements, wrote aggressive new collection policies and, workers report, acted to limit patients' access to information on charity care and instead diverted them to public hospitals.

Neglecting its traditional values

Resurrection's recent limitations on charity care suggest an increased emphasis on corporate growth and acquisitions over the Catholic faith-based mission to serve the needy that its hospitals previously pursued — some for more than 100 years. Many RHC frontline employees are deeply disturbed by this shift in emphasis and by the corporation's efforts to deny care to those who cannot pay.

It's not too late to turn back

The corporation should take immediate steps to reverse its course, serve its community, and fulfill its mission as a Catholic health care provider. Specifically, RHC should:

- *Restore* charity care to fiscal year 2002 levels;
- *Rewrite* policies that unfairly limit care based on residence, immigration status, and debt;
- *Reform* collection practices that punish the needy;
- *Reach out* to immigrants and other vulnerable populations; and
- *Return* to the Catholic faith-based mission that inspired its hospitals.

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Introduction

Resurrection Health Care (RHC), today the second-largest health system in the Chicago metropolitan area, began in 1953 as a single community hospital on the Northwest Side of Chicago. Currently Resurrection has eight hospitals and 33% of the health care market in the Northwest Chicago metropolitan area, and still has plans for further expansion. In recent years RHC has shifted away from its historic mission of providing health care to immigrants and the needy towards a more corporate and profit-making model of health care delivery.

As part of its growth strategy, RHC has sought to realize efficiencies and standardize policies across the system. On January 1, 2002, Resurrection executives implemented a new corporate-wide charity care policy. The results have been striking: Charity care at the eight Resurrection hospitals plummeted by 57% from June 2002 to June 2003.[1] This dramatic decline in charity care does not reflect lower demand. Rather, it is the direct consequence of Resurrection's revised charity care policy, which constructed artificial barriers and instituted newly onerous eligibility criteria unrelated to the financial needs of the patient. Specifically:

- Undocumented immigrants are now ineligible for charity care at Resurrection hospitals. RHC is the only religious provider and the only large health system in Cook County to exclude undocumented immigrants from charity care.

- Patients not living in a Resurrection defined "service area" are now ineligible for charity care. None of the 50 other private hospitals in Cook County have such a geographic restriction; patients from any zip code may apply for charity care at all other hospitals in the county.

- Patients who have an unpaid debt are excluded from charity care and prevented from receiving non-emergency services.

- In conjunction with changes to the charity care policy, Resurrection has an aggressive new collection policy.

In fiscal year 2003, charity care at Resurrection hospitals averaged 0.6% of gross charges, less than half the 1.3% average of all other private hospitals in Cook County. In total, RHC accounted for 7% of charity care at private hospitals in Cook County, but 15% of all gross charges to patients. As stated above, a survey of 50 other private hospitals in Cook County revealed that Resurrection hospitals are the only institutions that require patients to live in a certain zip code in order to be eligible for charity care. In addition, RHC is the only reli-

gious provider and the only large health system to require that patients document their status as a legal resident of the United States in order to apply for financial assistance.

There is a racial component to this policy change as well: Under the new rules, Latinos are disproportionately more likely to be denied charity care. As a group, Latinos are more likely to be uninsured as well as more likely to be undocumented. They are also over-represented among patients sued by Resurrection for bad debt. As the majority residents on Chicago's Southwest Side — an area that RHC has largely defined as outside its service area — many Latinos are now effectively being redlined from receiving charity care. St. Mary of Nazareth and St. Elizabeth hospitals, which serve more Latino inpatients than any other Resurrection hospital, have cut charity care by $13 million since the implementation of the new policy.

In sum, Resurrection has instituted a charity care policy that in combination with new collection policies reflect an aggressive move away from its historic mission to serve the uninsured and those who cannot pay for care, towards a bottom line approach to health care delivery. This is an alarming trend that merits serious scrutiny by the wider community. As the second-largest health system in the Chicago metropolitan area — and an entity that stresses its religious roots and charitable mission — RHC should be held to a standard that would preclude such exclusionary practices regarding charity care.

"Uncompensated Care" Not an Accurate Measure

Charity care is free or discounted care provided without expectation of payment. Charity care is different than bad debt. Bad debt is generally defined as patient charges that are not paid, often pursued through collection agencies and in the courts.

Charity care expenses are reported by hospitals as gross charges. These gross charges are far above the revenue a hospital would have received for these services from third party insurance and government payers, such as Medicare and Medicaid, which negotiate discounts from gross charges. At RHC, these discounts averaged 57% between fiscal years 1999 and 2002.[2]

However, to determine the true contribution a hospital makes to charitable care, charity care reported as gross charges is still a useful and meaningful tool. It can be compared across hospitals and years as a percentage of total gross charges, giving a common unit of measurement by which to evaluate an institution's commitment to providing charity care.

Uncompensated care, as reported by hospitals to the Illinois Department of Public Aid, includes not only charity care (free or discounted services), but also bad debt (unpaid medical bills). In some instances hospitals also include discounts to government payers. As a result, while uncompensated care numbers can be very large, they primarily reflect a hospital's success or lack thereof in collecting its debts, rather than providing an accurate indication of its provision of charity care.

In the fall of 2003, Resurrection Health Care sent a promotional mailing to Chicago households touting its provision of "over $175 million in uncompensated care during 2002 alone."[3] But as noted above, that "uncompensated care" may include any number of costs that do not truly reflect its charitable services. The $175 million which was cited may include bad debt (such as unpaid bills from uninsured patients whom RHC sued or unpaid bills from managed care and insurance companies), low cost and discounted care provided in Resurrection's six community clinics, community benefits (which may include marketing activity) or discounts given to government payers for Medicare and Medicaid patients.

Abandoning an Obligation to the Poor

A. Resurrection's historic mission to the poor

The Sisters of the Holy Family of Nazareth and the Sisters of the Resurrection — the two sponsors of Resurrection Health Care — have repeatedly and clearly articulated a commitment to serve the poor and uninsured. While education is the core of the ministries of both congregations, concern for the sick led each to a health care ministry.

The Congregation of the Sisters of the Holy Family of Nazareth began in 1875 under the leadership of Blessed Mary of Jesus the Good Shepard (Francis Siedliska). She "desired that her Congregation transcend national boundaries and be dedicated to the universal church and its needs," and this vision is realized today in the Sisters' presence in 14 countries around the world. In their mission statement, the Sisters of the Holy Family of Nazareth declare: "We are committed to creating communities of love and hope, which celebrate the oneness of the human family."[4]

Eleven sisters of the Congregation of the Sisters of the Holy Family of Nazareth came from Rome to Chicago in 1885 "to minister to the needs of immigrant Poles." To this end they founded St. Mary of Nazareth Hospital in 1894 and opened Holy Family Medical Center in 1961. They entered into co-sponsorship with the Sisters of the Resurrection in 2001, with the recognition of "the importance of a strong, integrated Catholic health care system for Chicago and agree[ment] that the best way to develop this organization was to collaborate with sponsors who share similar mission, vision and values and are committed to remaining in the health care ministry."[5]

The Congregation of the Sisters of the Resurrection of Our Lord Jesus Christ was founded in Rome in 1891 by a widow, Celine Borzecka, and her daughter Hedwig. Ten years later, in February of 1900, four sisters of the congregation, led by Sister Anne Strzelecka, C.R., arrived at St. Mary of Angels parish in Chicago, where they immediately "began teaching immigrants in the parish school."[6] Throughout the subsequent decades the Sisters expanded their education ministry, and eventually "The Sisters responded once again to community needs and opened Resurrection Medical Center in 1953. This was the beginning of what today is Resurrection Health Care, the largest Catholic health care system in the Chicago area."[7]

The mission statement of the Sisters of the Resurrection proclaims that "Our own trust in God's loving plan informs our ministry to those who are needy, broken and hopeless. In union with Jesus our service is characterized by selflessness. We are confident that the difference we make brings about the resurrection of society from deep within the hearts and souls of those we serve."[8]

The mission and core values of Resurrection Health Care reflect the historic commitment of their sponsors. A December 2003 mailing, *Inside RHC*, stated that:

> Consistent with the Mission and Core Values of Resurrection Health Care (RHC), we treat all patients — regardless of ability to pay — with compassion, respect and dignity. For over a century, the RHC Sponsors, the Sisters of the Holy Family of Nazareth and the Sisters of the Resurrection, have been dedicated to serving all who entered their doors, including the poor and uninsured.

The "Core Values," as articulated by Resurrection Health Care, of compassion, accountability, respect, excellence and service reflect a clear commitment to caring for those least able to afford health care, and specifically pledge the corporation to the following:

- **Compassion** "We develop systems and structures that attend to the needs of those at risk of discrimination because of age, lifestyle, ethnic background, religious beliefs or socioeconomic status."
- **Accountability** "We dedicate resources to the care of the poor and needy."
- **Respect** "We communicate openly and share needed information with each other."
- **Excellence** "We design and evaluate our organizational systems and structures to assure that we positively contribute to the health standard of the community we serve."
- **Service** "We empower co-workers to make decisions that are in the best interest of those we serve."

The mission of Resurrection Health Care to serve the poor through the health care ministry of its sponsors has also been affirmed by its current leaders. Recently, in discussing the importance of St. Mary of Nazareth Hospital to the communities it serves, Sister Sally Marie Keipura, the chief executive of St. Mary's, articulated the sponsors' commitment to the poor and indigent:

> The community has changed in 100 years repeatedly, and we have always evaluated and assessed our role here. Do the people need us? Is there a service we provide for them? And basically what always came on the table was the need of the people, particularly the indigent and those who were very much in need of the financial assistance in order to be able to have their health care needs provided for.[9]

Many of the hospitals that have joined the Resurrection system have long histories of service to the poor. For more than a century, St. Elizabeth Hospital was guided by the mission and values of its founders, the Poor Handmaids of Jesus Christ. These Sisters articulated their mission as "standing with the poor and powerless in the search for justice," and to "reduce health disparities among the poor and underserved through systematic change."[10]

B. The legal obligation to provide charity care

In addition to its moral mission as a health care provider, RHC has a legal obligation to provide charity care as part of the "charitable use" of property exempt from taxation in Illinois. In Illinois, non-profit hospitals exempt from property taxes must be "owned by institutions of public charity" and "actually and exclusively used for charitable or beneficent purposes."[11]

In 1996, the administrative law judge presiding over a case involving a Resurrection Health Care ambulatory facility denied the tax exemption and ruled that the primary use of the property was not for charitable purposes — one of the factual indicators of this judgment being the limited amount of services provided without charge.[12] In denying RHC's tax exemption for the facility, the judge stated that it was not enough for a property to be owned by a charitable institution or non-profit corporation, but that case law supports a set of factual indicators, including:

1. The level of support derived from charitable contributions or grants;
2. The level of public control;
3. The amount of services provided without charge;
4. The manner in which patients are billed and the degree to which collections are pursued;
5. The form and level of physician compensation;
6. Limitations on use; and
7. Open medical staffs.[13]

Tax exemption of non-profit hospitals

In order to qualify for a tax exemption, a property itself must be exclusively utilized in a charitable manner. In short, an organization must, as a primary function, provide charity. Illinois law is clear that hospitals whose primary function is making a profit should not enjoy exempt status, and that a hospital's provision of very low levels of charity care is "merely incidental" to profiting, and therefore does not entitle that hospital to an exemption.

Like many other states, Illinois holds out a specific test of whether sufficient levels of charity are being rendered on a given property to justify forgone tax assessments. Owners of charitable exempt properties in Illinois have an obligation to honor this charitable use requirement to maintain their exempt status for charitable service.

In the case of *Methodist Old Peoples Home v. Korzen,* 39 Ill.2d 149 (1968), the Illinois Supreme Court laid down six guidelines to be used in determining whether an organization is charitable. They are as follows:

(1) The benefits derived are for an indefinite number of persons;

(2) The organization has no capital, capital stock or shareholders, and does not profit from the enterprise;

(3) Funds are derived mainly from private and public charity, and are held in trust for the objectives and purposes expressed in its charter;

(4) Charity is dispensed to all who need and apply for it;

(5) No obstacles are placed in the way of those seeking the benefits; and

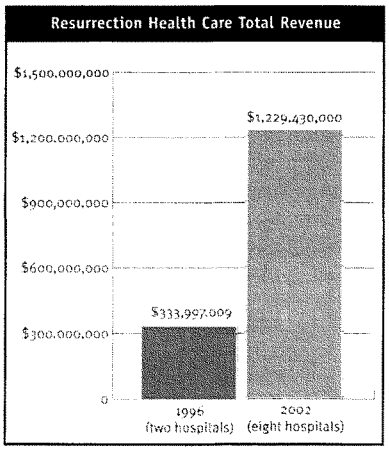
(6) The primary use of the property is for charitable purposes.

Illinois courts have accordingly found that a hospital which charges no fee to patients unable to pay, and a graduated fee according to ability to pay, which makes no profit, and which is maintained by voluntary and charitable contributions is exempt from taxation. However, a hospital which does not waive fees and pursues collections against those who are unable to pay clearly places obstacles in the way of those seeking the charitable benefit. An organization making a profit through its use of the exempt property further contradicts the established criteria.[14]

The family and community hardships suffered because of profiting hospitals whose "charitable" exemptions remain intact are many. In addition to withholding charitable health benefits to the communities to which they are indebted, the hospitals avoid paying millions of dollars into the tax base due to their charitable exemption. Meanwhile working families get squeezed by ever-rising property taxes that they can't elude. In recent months, the proliferation of uncharitable practices of charitable hospitals has been the subject of national media attention. Two Illinois cases were cited by *The Wall Street Journal* in an exposé of hospitals' failures to reasonably provide assistance to those in need combined with their harsh collections practices against those unable to pay.[15] In addition, an editorial in the *Chicago Tribune* recently noted that the American Hospital Association has taken the position that hospitals should reduce prices for the uninsured and those unable to afford health care.[16]

C. The corporatization of care

In the past 15 years, Resurrection Health Care has grown from a single community hospital to the second-largest health care system in metropolitan Chicago with $1.2 billion in annual revenue. The system now includes eight hospitals, 10 nursing homes, four retirement communities, a large home health care company and dozens of outpatient facilities. RHC is still expanding: Efforts are underway to add West Suburban Hospital in Oak Park as the ninth hospital in the system.



Source: RHC audited financial statements, 1996,2002.

In its initial expansion in 1988, Resurrection Medical Center — the system's original hospital — joined with John F. Kennedy Hospital, now Our Lady of the Resurrection Medical Center. The number of hospitals under RHC control doubled with the acquisition of St. Francis Hospital of Evanston in 1997 and Westlake Hospital of Melrose Park in 1998, then doubled again with the 2001 additions of Holy Family Medical Center (Des Plaines) and St. Mary of Nazareth Hospital, St. Joseph Hospital, and St. Elizabeth Hospital (Chicago). All located in the northwest area of Chicago and its suburbs, these acquisitions reflect the corporation's geographic strategy. Resurrection Health Care's market share related to recent acquisitions has grown from 15.5% in 1999 to 33% today, making RHC the leading health system in the northwest area of the Chicago metropolitan region.[17]

Resurrection management has indicated that this increase in size has already resulted in stronger leverage with managed care organizations and improved reimbursement rates for all its contracts.[18] RHC's corporate strategy to consolidate hospitals in the northwest area appears to be a success. But the mission of Resurrection has begun to suffer from the same corporatization and standardization. Resurrection CEO Joseph Toomey recently stated that the purpose of acquiring new hospitals is to "extend our ministry into markets adjacent to our service area."[19] But the facts do not bear out Toomey's assertion — at least not in terms of Resurrection's health care ministry to the poor and uninsured.

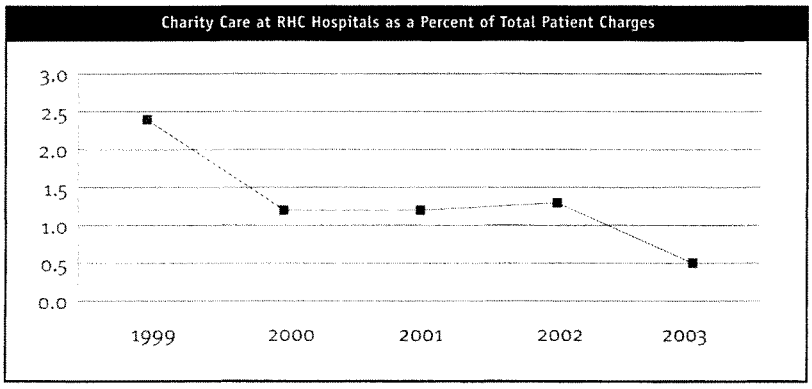
From June 2000 to June 2002, Resurrection Health Care Corporation's total revenue increased 63%, while its total profit increased 250%. During this period, the CEO and other Resurrection executives experienced dramatic salary increases. The CEO's salary

jumped 108% to $1,086,490, while total executive compensation at Resurrection swelled by 69%.[20] These numbers demonstrate RHC's corporate focus and substantial resources for key staff driving these changes.

But uninsured patients at Resurrection now face a colder and more indifferent system. A November 2003 study by AFSCME Council 31 documented the debt collection practices of Resurrection Health Care through the review of more than 1,700 case files of patients sued for medical debt by Resurrection over the past three years, as well as interviews with 40 of these debtors. The report found that Resurrection systematically failed to encourage needy patients to apply for charity care (informing just one of 40 interviewees about financial assistance options) and routinely ignored the financial reality of uninsured patients and their families (demanding lump sum or otherwise unrealistic payments on balances as high as $87,000). In more than 100 cases, Resurrection continued to pursue cases against individuals whom the court had previously certified as indigent.

One critical measure of a health care provider's service to the poor is its amount of charity care provided to needy patients. The eight RHC hospitals together provided an average of $31 million per year in charity care between 1999 and 2002,[21] but in fiscal year 2003 offered a total of just $15 million. The 57% decrease in the last fiscal year represents an alarming retreat from the longstanding commitment to serve the uninsured and those in need that was the original hallmark of many of Resurrection's hospitals. The following chart demonstrates this disturbing trend:

As a result of this drastic decline, charity care levels at the eight Resurrection hospitals now represent, on average, just 0.6% of gross charges — less than half the 1.3% average for all other private hospitals in Cook County. In absolute terms, cuts at RHC hospitals amounted



Source: Illinois Department of Public Aid[22]

to a $20 million loss in charity care between fiscal years 2002 and 2003. The cuts were comprehensive (charity care declined at every hospital in the Resurrection system) and deep (in 2003, every hospital in the system reported a rate of charity care as a percent of gross charges that was lower than the countywide average for private hospitals).

D. Resurrection's past policy

Prior to January 1, 2002, the charity care policy of Resurrection Health Care simply stated that "The need for charity care will be determined by a review of the patient's income and expenses." No other eligibility requirements were included in the policy, which stated that "RHC will prepare a plan and specific policies to provide charity care to the poor and indigent."[23]

The four hospitals added to the system in 2001 continued to operate under their existing charity care policies until the new system-wide protocols were introduced in January 2002. The policy and accompanying instructions for implementation established — in contrast to the simple income guidelines of earlier years — new "eligibility criteria." These criteria included:

- Residency within the RHC service area;
- Status as a citizen or legal immigrant;
- An account not in bad debt status (not with a collection agency); and
- Exclusion of services related to substance abuse.

The implementation of the hospital chain's new charity care policies has resulted in the exclusion from eligibility of individuals (e.g., undocumented immigrants) that are most likely to need financial assistance. In addition, information on the availability and eligibility requirements for charity care is not consistently or comprehensively offered to patients at Resurrection hospitals.

Resurrection employees have watched with alarm as changes in the charity care policy wrought stark, harmful consequences for uninsured patients and employee job quality alike. Working with AFSCME Council 31, Resurrection workers are bringing their concerns about the new charity care policy and the hardships it creates out into the open. The impact of these policies is demonstrated below through data on charity care from the Illinois Department of Public Aid, inpatient discharge data from the Illinois Department of Public Health, and from employees' firsthand experiences.

Resurrection's Uncharitable Policy Towards the Uninsured

On January 1, 2002, Resurrection Health Care implemented a new charity care policy that rendered free care inaccessible to hundreds of uninsured patients. With just a few pieces of paper, corporate managers effectively excluded from eligibility for charity care close to a quarter of their inpatients based on home address alone.

The new policy also excluded several groups most likely to be uninsured, including undocumented immigrants and patients already owing debts to RHC.

Interviews with Resurrection workers and a review of relevant documents reveal that the corporation is actively pursuing and implementing charity care and prepayment policies that limit access to care for the uninsured.

These policies have a disproportionate impact on Chicago's Latino population, an estimated 32% of whom are uninsured — a rate more than twice that of Chicago's general populace.[24]

RHC now summarily denies charity care to undocumented immigrants, substance abuse patients, anyone who cannot fully document their income, and all patients living outside Resurrection's newly designated service area.

The December 2003 mailing, *Inside RHC*, stated that "The RHC Financial Assistance Program provides qualified individuals ***in our primary service area*** [emphasis added] with varying discounts on hospital services up to 100 percent, depending on level of income and asset base. Personal, confidential interviews are arranged with financial counselors to determine eligibility for the program."

The chart on the following page outlines who does and does not qualify for financial assistance.

Qualifing for financial assistance

The instructions for the actual policy — quoted verbatim here — elaborate these requirements as follows:

Who qualifies for financial assistance?

*U.S. Citizens
*Resident Aliens
*Residents of the Resurrection Health Care service area!!
-proof of this is required to confirm that the patient lives in our service area!
-copy of drivers license
-Illinois state ID card
*Services performed are covered by Illinois Department of Public Aid
*Patient has exhausted all other means of payment on account
*Account is still in A/R or P/A status (not with a collection agency)

Who does not qualifies for financial assistance?

*non U.S. citizens (out of country visitors)
*substance abuse patients
*any services not covered under the Illinois Department of Public Aid (IDPA) programs
*any person who fails to complete the financial assistance form in its entirety
*any person who fails to provide the documents required to process the financial assistance form
*any patient whose account is in bad debt status does not qualify (only their A/R accounts would potentially qualify for financial assistance)

These instructions to workers making charity care decisions are completed with the admonition "If they're not qualified, don't bother even to give or send out the application because the patient will not even be considered for financial assistance!

Source: "Financial Assistance Program," Resurrection Health Care, April 10, 2002.

A. Undocumented immigrants: Denying charity care to the most vulnerable

Resurrection Health Care excludes undocumented immigrants from receiving charity care, referring to them at times as "out of country visitors." Other private hospitals in Cook County by and large do not exclude undocumented immigrants from applying for financial assistance. Advocate Health Care, the largest system in the Chicago area, as well as all other religious hospitals in the county do not require charity care applicants to be legal residents of the United States.

Instructions given for processing financial assistance applications note the problem as follows:

"How do you know if a person is a 'resident alien' or a 'naturalized U.S. citizen' that will qualify for financial assistance if they live in our Resurrection service area? We have problems with patients bringing in unfamiliar documents to prove who they are and if they are actual 'citizens' who qualify for assistance. A 'passport' does not prove citizenship or residency; it only proves that you're visiting from another country! We've seen drivers licenses from other states, but that patient states that they are a community resident but they have not yet obtained an Illinois license; we need proof of community residency!! Remember, we're not obligated to give any type of financial assistance without appropriate proof/documentation from the patient/applicant."

Source: Quoted verbatim from "Financial Assistance Program," Resurrection Health Care, dated April 10, 2002

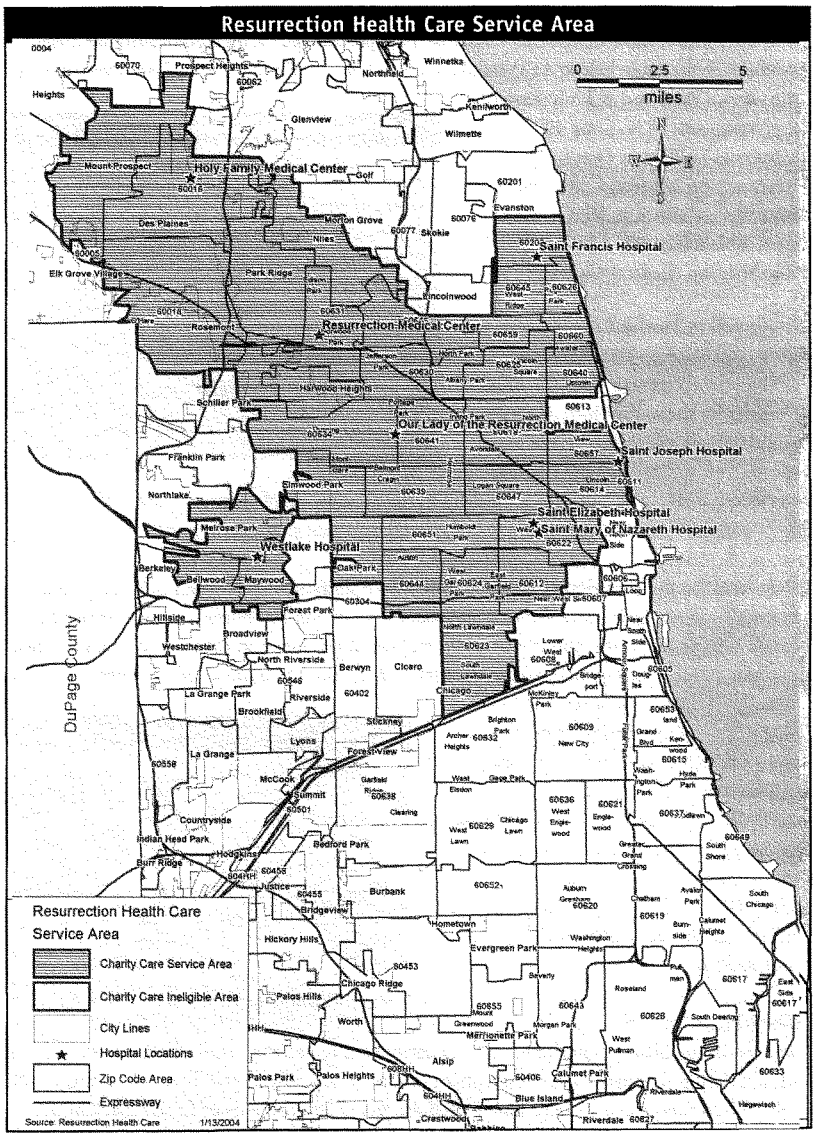
The U.S. Bureau of Citizenship and Immigration Services (formerly the U.S. Immigration and Naturalization Service) estimates that 302,000 residents of Chicago are undocumented. Of these, approximately 220,000 are active in the labor force.[25] The bureau further estimates that Illinois ranks fourth in the nation with an undocumented population of 432,000 statewide. Overall in Illinois 75% of all immigrants from Mexico and 21% of immigrants from Europe are undocumented.[26]

Immigrants without proper documentation are a particularly vulnerable population, as they only qualify for government programs for emergency and pre-natal care. A 2002 survey of undocumented immigrants in Chicago found that 75% are without health insurance[27] — a figure far higher than the estimated citywide rate of 15%.[28] By excluding this group, Resurrection eliminates the option of free or discounted care to those with the fewest alternatives for health care services.

B. Out-of-service area residents: Redlining in health care

Resurrection Health Care's charity care residency requirement is not based on financial need. It does not reflect the actual patient flows of individual hospitals but is uniform for the entire corporation. In a review of 50 other private hospitals in Cook County, AFSCME Council 31 has not been able to find another hospital or health care system with this policy.

Notably, this defined "service area" has no bearing on a patient's eligibility to receive services at Resurrection hospitals — anyone can receive care if they are willing and able to pay for it. In this usage, the service area is merely an artificial mechanism created by the corporation to peremptorily deny charity care to needy patients who do not meet this requirement.


Resurrection Health Care Service Area
0 2.5 5
miles
Holy Family Medical Center
Saint Francis Hospital
Resurrection Medical Center
Our Lady of the Resurrection Medical Center
Saint Joseph Hospital
Saint Elizabeth Hospital
Saint Mary of Nazareth Hospital
Westlake Hospital
DuPage County
Resurrection Health Care Service Area
Charity Care Service Area
Charity Care Ineligible Area
City Lines
Hospital Locations
Zip Code Area
Expressway
Source: Resurrection Health Care
1/13/2004

In 2001, 23% of the 100,886 inpatients treated at RHC hospitals resided in zip codes outside the Resurrection-defined service area. This percentage varies significantly by hospital as noted in the table below. At Westlake Hospital, 42% of inpatients in 2001 lived outside the service area, and at Holy Family this figure was 38%. Only 4% of inpatients in 2001 at Our Lady of the Resurrection Medical Center were from zip codes not in RHC's service area. This figure was 12% at Resurrection Medical Center.

Inpatients Living Outside the "Service Area" (2001)

Hospital	Percent
Westlake Hospital	42%
Holy Family Medical Center	38%
St. Joseph Hospital	31%
St. Francis Hospital of Evanston	25%
St. Mary of Nazareth Hospital	23%
St. Elizabeth Hospital	16%
Resurrection Medical Center	12%
Our Lady of the Resurrection Medical Center	4%

Source: Illinois Department of Public Health

Resurrection Health Care appears to have embarked on a sophisticated strategy to encourage wide use of its facilities by those who have insurance, while actively discouraging the uninsured. The eight hospitals now controlled by RHC experienced a 25% drop in the percentage of uninsured inpatients between 1997 and 2001 — a period in which the overall inpatient population grew by 15%.

Even prior to the adoption of the new residency requirement, the trend at Resurrection hospitals was towards more services for insured inpatients and fewer for the uninsured. From 1997 to 2001, the number of RHC inpatients not living in the service area grew faster than the number of inpatients from the service area, but the number of uninsured patients actually declined at a faster rate. As seen in the table below, hospitals now controlled by RHC saw an 11% increase in inpatients residing in the corporation's defined service area but a 19% decrease in the number of uninsured patients from the service area. The same hospitals admitted 24% more inpatients from outside the service area but cut the percent uninsured by a drastic 43%.

Change In Inpatient Discharges, 1997-2001

	Inpatient Total Change	Percent Uninsured Change
All RHC inpatients	+15%	-25%
RHC Service Area	+11%	-19%
Non-service Area	+24%	-43%
Southwest Side and Cicero	+30%	-68%
Cicero Only	+131%	-84%

Source: Illinois Department of Public Health.[8]

The RHC service area is defined in such a way that some hospitals no longer grant charity care to patients from adjacent urban areas, while offering free care to the residents of distant — and often predominantly white — suburbs. The system's charity care policy excludes the neighborhoods of Pilsen, Back of the Yards, Brighton Park, and Gage Park, as well as the town of Cicero — areas that are heavily Latino (between 63-77% by zip code, according to 2000 U.S. Census data).

C. Patients who have unpaid bills are sent away in non-emergent cases

RHC's new charity care policy also excludes any patient whose account has been turned over for collection — a provision that exacerbates the problems of those already burdened with unpaid medical debt. In addition, new collection policies require a patient to pay their balance within 30 days for bills under $500 and 60 days for bills over this amount. These stricter deadlines result in accounts being turned over to collection agencies at a faster rate. This policy disproportionately affects Latinos and African Americans, who comprised 37% of inpatients at Resurrection hospitals in 2001 but 60% of those sued by the corporation for medical debts in 2002.[30]

D. Onerous documentation requirements

In addition to completing a written application in full, patients are required to submit extensive documentation of income, which RHC sees as necessary to verify that the applicant really cannot pay. The lack of any of the required documentation is grounds for denial of the application for charity care. Instructions state in several places that "If the *application* is *incomplete* or *documents are missing*, application is **DENIED**."[31]

Required documents include:

- 4-6 paycheck stubs for the last 2 months, or signed letter with proof of income from employer if paid in cash;
- Most recent Federal Income Tax Return;
- Bank statements for checking, savings, Certificate of Deposit, etc.;
- Most recent W-2 and/or 1099 forms;
- Notarized Confirmation of Support Letter (if unemployed or student); and
- Two most recent rent or mortgage receipts.

In its instructions to employees, RHC's internal language referring to the needy is suspicious and shows insensitivity for those unable to pay that is inconsistent with a mission-based organization. Processors are warned to be skeptical if an applicant's rent is 80% of their income, or if an applicant is unemployed but still making ends meet.

These instructions also stress that applicants have no right to appeal a ruling once an application is denied. Although RHC's documents state that appeals may be considered by individual managers on a case-by-case basis, this is discouraged by statements that describe appeals, "all of these situations/examples take a lot of time to be reviewed on a case-by-case basis. This is very time-consuming for the analysts and management."[32]

The section regarding "Problems Encountered with Financial Assistance Applications" reads:

"Applicant is denied due to incomplete or lack of documentation and calls or writes to have this appealed:

-usually, the patient feels that he/she has provided all of the information which we requested, but something seems 'fishy' to us:

*income is only $1,000 per month but their rent is $800 per month

-how do you make ends meet?

*patient is 'unemployed' and shows $700 per month in 'interest income' for a CD; they qualify under income guidelines (technically, based on 'income'), but we know they've got 'big bucks' sitting somewhere that could pay off our bill !

*patient sends in 2000 income tax forms, not 2001 (we need more current)

*patient sends us W-2 forms, but not income taxes

(what if the person had 3 jobs but only sent us the W-2 from one?)

*patient's social security # on application does not match his SS# on income tax form !"

Source: Quoted verbatim from "Financial Assistance Program," Resurrection Health Care, April 10, 2002

E. Prepayment forces those who cannot pay to leave

In addition to the above policies that limit eligibility for charity care, RHC management developed new rules that require uninsured patients to prepay a minimum of 50% for any scheduled, elective, diagnostic or non-emergent services, regardless of cost. (As mentioned earlier, for bills of less than $500, the remaining balance must be paid in 30 days; bills higher than this amount must be paid in 60 days.) Uninsured patients seeking outpatient surgical procedures are required to pay the entire balance — at a rate of 125% of Medicare reimbursement — two days prior to the procedure or the surgery is cancelled. In cases where patients are unable to make the minimum payment, health care is withheld until a financial assessment can be made. Emergency patients are asked to make a $200 minimum deposit at the time of service, although this request is supposed to be made after services have been rendered.

Further, RHC documents state that "Patients are required to make satisfactory arrangements with a Financial Counselor on any outstanding bad debt account prior to current services being rendered."[33] In other words, patients with bad debt accounts are not merely ineligible for charity care — they are barred from receiving any health care at RHC hospitals unless their condition is emergent and federal law requires they be treated and stabilized.

Service fees paid by uninsured patients are also substantially higher than the fees paid by insurance companies and government programs (which are able to demand substantial discounts for the patients they cover). The "Point of Service Collections" policy does create discounts for uninsured patients who are able to prepay their entire service fee (including a 10% discount for services under $800 that are prepaid in full and a 25% discount for such services over $800), but these discounts are small in comparison to the 57% average contractual allowance given to insurance companies and the government.[34]

The Frontlines of Resurrection's New Policies

Resurrection employees have seen firsthand the severe impact the change in charity care policy has had on hospital practices. Those who work in patient registration, financial counseling and patient billing at RHC facilities are on the frontlines of these policy changes and in interviews have provided their observations on how Resurrection's new charity care policy has affected their work and the lives of patients they serve.

A. Workers are not empowered to help patients

Registration workers have confirmed that they are required to collect a 50% prepayment from uninsured patients, and deny services to those who cannot pay. They are forced to turn away uninsured patients who have serious health care needs without knowing if the patients would get their needs met elsewhere. One worker was told by her supervisor that she could be fired for spending too much time with individual patients, as she frequently took it upon herself to inform uninsured patients about nearby clinics and the county hospital when they were denied care by RHC. This worker was not able to authorize charity care, and as far as she knew, there was no policy for referring patients to customer service — the department that she believed made charity care determinations. Furthermore, this registration worker was unaware of any of the patients she saw actually receiving charity care.

A patient registration worker described an elderly, Spanish-speaking Latino man, who came in needing an X-ray — but with no insurance or the money required to pay in advance. Another worker who spoke Spanish and also happened to make charity care determinations came over to translate. Through the conversation it became clear that the man had no income. The registration worker recalls that the man was not offered charity care or any alternatives, but simply told he would have to come back when he had the $40.

Workers responsible for patient billing at Resurrection hospitals are disturbed by policy changes that force them to exclude large numbers of patients from charity care based on citizenship status and residential zip code. In particular, several workers have remarked that the exclusion of undocumented immigrants by the new policy has eliminated a large number of former charity care applicants. One worker reported that she felt terrible about the upset and even angry patients who need help paying their bills but are now rejected because they are undocumented. This worker also noted that the Resurrection-defined service area was "bizarre," as it excluded some zip codes adjacent to the hospital while including others farther away.

The new policy also forces employees to collect full payment on all balances within one or two months, no matter the size of the bill. According to workers interviewed, once this period is expired, outstanding accounts are automatically turned over to an outside agency for pre-collection and collection, regardless of the circumstances. As a result, workers have had to demand very steep payments that they knew could not be made — including instances when patient bills are $10,000 or more.

B. Resurrection fails to adequately promote charity care options

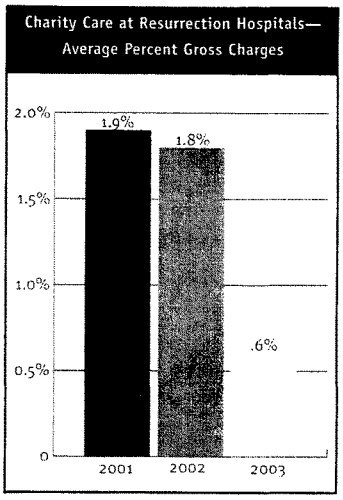
In December 2003, AFSCME Council 31 conducted a visual survey of emergency rooms, patient admission, registration, and waiting areas in all eight Resurrection hospitals. There is no notification posted in any of these areas — neither in the form of signs, notices or pamphlets — to inform Resurrection patients of the availability of charity care, let alone more detailed information on who is eligible and how to apply.

All of the practices outlined in the January 2002 policy and described by workers were confirmed as recently as January 2004. Two AFSCME Council 31 researchers separately called each of the eight hospitals. They asked about eligibility requirements for charity care. The results were universally consistent with the new charity care policy's written requirements of residency, documentation, and prepayment for services, along with information provided by Resurrection employees.

The Grave Consequences of Resurrection's Exclusionary Policies

A. Deep cuts in charity care system-wide

Resurrection Health Care cut charity care at its eight hospitals by 57% in the last fiscal year — from $36 million in 2002 to $15 million in 2003. Cuts in charity care were particularly dramatic at Holy Family Medical Center (which had the second highest out-of-service-area population and saw charity care decline by 87%) and St. Elizabeth Hospital (which had the highest Latino inpatient population of any Resurrection hospital[35] and cut charity care by 82%). Elsewhere, the policy served to further erode already low levels of charity care: Resurrection Medical Center — the system's original hospital — cut charity care by two-thirds (from $3 million in 2002 to $1 million in 2003) despite having profits in fiscal year 2002 of more than $17 million.



Source: Illinois Department of Public Aid.

As stated earlier, the amount of charity care provided by Resurrection hospitals in fiscal year 2003 equaled 0.6% of gross charges — less than half the 1.3% rate provided by other private hospitals in Cook County.

All Resurrection hospitals now rank below average in terms of the percentage of gross charges these facilities grant as charity care. Three are particularly woeful: Resurrection Medical Center, Westlake Hospital and Holy Family Medical Center each grant less than 0.1% of gross charges in charity care.

B. Charity care cuts at St. Mary of Nazareth and St. Elizabeth hospitals

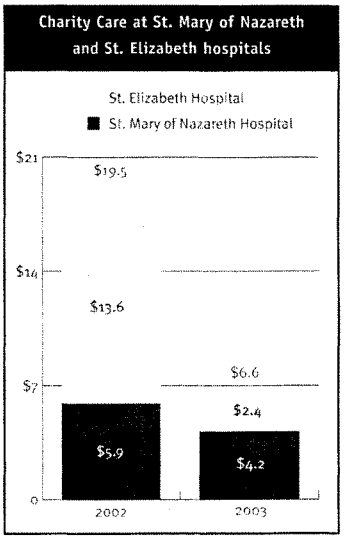
In 2002, St. Mary of Nazareth and St. Elizabeth Hospitals — two Resurrection hospitals located within several blocks of one another on the Near Northwest Side of Chicago — provided a combined total of more than $19.5 million in charity care. In 2003, charity care was drastically cut — particularly at St. Elizabeth Hospital, where charity care dropped 82%

Hospital	2002 "Before" New Policy		2003 "After" New Policy		Change in Charity Care
	Charity Care	Gross Charges	Charity Care	Gross Charges	
Resurrection Medical Center	$3,098,625	0.5%	$1,029,985	0.1%	-67%
Our Lady of the Resurrection	$3,856,404	1.1%	$1,523,936	0.4%	-60%
St. Francis Hospital	$3,973,481	1.1%	$3,920,712	1.1%	-1%
Westlake Hospital	$486,368	0.2%	$247,667	0.1%	-49%
Holy Family Medical Center	$2,099,896	1.3%	$264,494	0.1%	-87%
St. Mary of Nazareth Hospital	$5,888,496	1.9%	$4,195,810	1.2%	-29%
St. Joseph Hospital	$2,769,888	0.7%	$1,821,822	0.4%	-34%
St. Elizabeth Hospital	$13,647,752	7.8%	$2,394,453	1.1%	-82%

Source: Illinois Department of Public Aid

(from $13.6 million to $2.4 million). At St. Mary of Nazareth Hospital, charity care fell by 29% (from $5.9 million to $4.2 million).

The combined loss of nearly $13 million at these two hospitals in particular has the potential to disproportionately impact Latinos, as St. Elizabeth and St. Mary of Nazareth hospitals serve almost 60% of all Latino inpatients of the eight Resurrection hospitals. In 2001, 53% of all inpatients at St. Elizabeth Hospital were Latino; at St. Mary of Nazareth this figure was 42%.



Source: Illinois Department of Public Aid

Resurrection reported the sharp cuts of charity care to the Illinois Department of Public Aid in August of 2003. A month later, seeking to respond to concerns about its plan to merge the two hospitals, the corporation distributed a glossy brochure in the communities surrounding these hospitals. The booklet stated that "we provided a high degree of charity care and community benefits in 2002, as in previous years, and will continue to do so." Given that the total amount of charity care provided by these two hospitals had been cut by 66% in the previous year, Resurrection's promise both

Community Action: The Coalition for the Future of St. Elizabeth

In August 2003, community groups in the neighborhoods surrounding St. Elizabeth Hospital came together to form a coalition out of concern for the future of the hospital. The new group launched a petition campaign calling for an independent health impact study of the service closures Resurrection Health Care was proposing at the hospital. They collected over 3,200 signatures from community members concerned about the effects St. Elizabeth Hospital's closure and merger with St. Mary of Nazareth Hospital would have on charity care and care for the uninsured, as well as critical health care services and community jobs. The coalition intended to present these petitions to Resurrection management at a September 23, 2003, community meeting, but at the last minute Resurrection cancelled its participation. The community has continued to attempt to open a dialogue, but thus far Resurrection management has refused to meet.

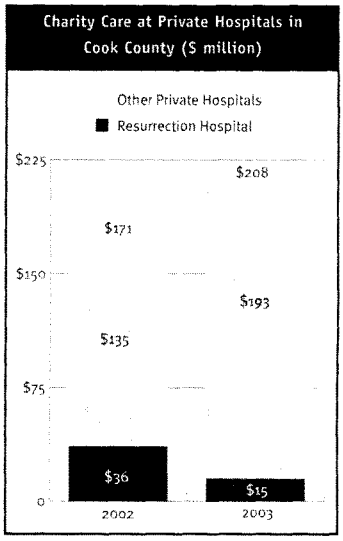
misrepresented the facts and raised grave concerns for the future. When asked at an Illinois Health Facilities Planning Board hearing on October 15, 2003, about the possible effect a merger might have on patients who cannot pay for their care, RHC Chief Financial Officer Thomas Capobianco stated that "Both of these hospitals have very generous charity care policies."

C. Resurrection Medical Center: The most profitable but least generous

Resurrection Medical Center, the oldest hospital in the system, provided just $10 million in charity care between fiscal years 1999-2002 — less than 0.5% of gross charges during this period which totaled $2.2 billion — while earning remarkable profits totaling over $98 million.

In 2003, charity care at Resurrection Medical Center dropped even lower than it had been since 1999 — to just 0.1% of gross charges.

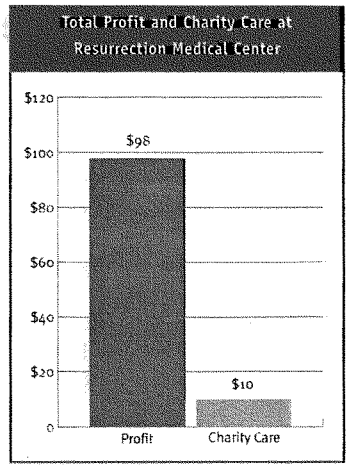
If Resurrection Medical Center had provided charity care equal to the 1.3% average rate for all private hospitals in Cook County, the poor and uninsured would have received an additional $8 million in critically needed free care.



Source: Illinois Department of Public Aid

D. The burden is falling on other private hospitals

Resurrection Health Care hospitals accounted for only 7% of charity care reported by private hospitals in Cook County, but 15% of total gross charges in fiscal year 2003. Had RHC provided a level of charity care equal to its share of gross charges in Cook County, its hospitals would have provided $16 million more in free care.



Source: RHC audited financial statements, 1996, 2002.

In fiscal year 2002, when private hospitals in Cook County provided a combined total of $171 million in charity care, Resurrection accounted for $36 million of that total. Countywide charity care reported in 2003 grew to $208 million, while RHC's share shrank to $15 million.

During this period, St. Elizabeth went from being the number one charity care provider, with charity care totally 7.8% of gross charges, to be ranked 15th in the county. In fact, every hospital in the Resurrection system fell in rank as a charity care provider measured as a percent of gross charges relative to other private hospitals in Cook County. In particular, Holy Family Medical Center dropped 26 places from being 13th to 39th in the county.

Solutions: Reviving the Charitable Mission

A. Immediately reverse recent decline in care

Resurrection should return to the minimal charity care level of $36 million it granted in 2002, and from there assess its ability to expand this program that is central to its purpose as a mission-based organization.

B. Redefine the policy to promote assistance to the uninsured

Resurrection should rewrite its charity care and collection policies to sensibly extend services to uninsured patients who need help. The policy should be posted and advertised in patient access areas of the hospitals.

C. Eliminate the "service area" requirement

Resurrection hospitals are the only hospitals in Cook County that require that a patient live in a certain zip code in order to receive services. This requirement should be dropped, and charity care determinations should be based on financial needs alone.

D. Make assistance to undocumented immigrants a priority

Rather than excluding undocumented immigrants from applying for charity care, a new policy should develop ways for the hospitals to reach out to the large portion of uninsured members of this population.

E. Reform collection practices

Resurrection should allow for payment plans that reflect the financial reality of uninsured patients. Current practices are overly aggressive and not in keeping with the historic mission of these Catholic health care providers.

F. Better government oversight

The Illinois Health Facilities Planning Board is charged with regulating changes in the hospital industry to ensure public access to quality health care. Unfortunately, it does not currently consider charity care or other community benefits when reviewing applications for

permits to acquire, merge, modify or construct health care facilities. A bill to be introduced in 2004 to the Illinois General Assembly would:

- Require the board to evaluate the community benefits and charity care impacts of all permit applications; and
- Require hospitals to maintain or increase levels of charity care and community benefits for five years following any merger, consolidation or acquisition.

Appendices: Research Methodology and Sources

A. Trend analysis: Charity care numbers for Resurrection hospitals

All data on charity care and total gross charges used in this report are based on annual reports made to the Illinois Department of Public Aid. Data is reported based on fiscal years beginning July 1 and ending June 30 of each year. Trend data for the eight Resurrection hospitals is examined prior to their acquisition by Resurrection Health Care. The point of the analysis is to examine what has occurred at all eight facilities over the same time period. The following table reports charity care data available for each of the eight RHC hospitals.

Charity Care Figures for Resurrection Hospitals

Hospital	2003 total charity care	2002 total charity care	2001 total charity care	2000 total charity care	1999 total charity care
Resurrection Medical Center	**$1,029,985**	**$3,098,625**	**$2,943,677**	**$1,677,020**	**$2,386,673**
St. Elizabeth	$2,394,453	$13,647,752	$5,171,512	$3,622,921	$3,471,054
St. Francis Evanston	**$3,920,712**	**$3,973,481**	**$4,036,284**	**$5,401,432**	**$6,071,038**
St. Joseph	$1,821,822	$2,769,888	$1,319,727		
St. Mary of Nazareth	**$4,195,810**	**$5,888,496**	**$7,234,254**	**$5,364,299**	**$16,913,670**
Westlake Community	$247,667	$486,368	$908,526	$1,017,172	
Holy Family Medical Center	**$264,494**	**$2,099,896**	**$1,457,445**	**$1,939,265**	**$1,114,115**
Our Lady of the Resurrection	$1,523,936	$3,856,404	$5,364,896	$4,361,259	$5,479,913
Total	**$15,398,879**	**$35,820,910**	**$28,436,321**	**$23,383,368**	**$35,436,463**

B. Charity care survey of Resurrection hospitals

Two researchers from AFSCME Council 31 called the main phone number at each of the eight Resurrection hospitals and asked for information on the hospitals' financial assistance programs. These calls were made between the hours of 9-11 a.m. and 1-4 p.m. the first week of January 2004. The results confirmed that the written policy adopted January 1, 2002, is still in effect, and matched observations shared by Resurrection employees.

C. Resurrection's service area

Resurrection Health Care's service area is comprised of 35 zip codes which are listed below. In January 2004, AFSCME Council 31 researchers called the Resurrection Health Care informational phone number, 877-RES-INFO, and were given this list of zip codes by two different operators. The researchers asked the operators to list the zip codes in which a patient had to live in order to qualify for financial assistance, or in other words the "service area" of Resurrection Health Care.

60016	60612	60631	60651
60018	60614	60634	60656
60056	60618	60639	60657
60068	60622	60640	60659
60104	60623	60641	60660
60153	60624	60644	60706
60160	60625	60645	60707
60202	60626	60646	60714
60302	60630	60647	

D. Charity care of private hospitals in Cook County

This report examines charity care and total gross charges provided by private acute care hospitals in Cook County in fiscal years 2002 and 2003 as reported to the Illinois Department of Public Aid. Although they provide a high level of free care, public hospitals were excluded from the analysis as they have special reimbursement streams for this care. The private hospitals included in this analysis are listed with charity care figures and total gross charges in the table on page 35. St. James (Olympia Fields and Chicago Heights), Sacred Heart, Evanston, Ingalls Children's, Lorreto, MacNeal, Michael Reese, Norwegian-American and Roseland Community hospitals all did not report charity care numbers to the Illinois Department of Public Aid in fiscals years 2002 and 2003.

E. Charity care survey of all 50 private hospitals

In order to compare the charity care policies of Resurrection Health Care to those of other hospitals AFSCME Council 31 called each of the 50 private acute care hospitals in Cook County. Specifically, AFSCME Council 31 was interested in finding out whether any other hospitals in the county limited charity care to a certain set of zip codes — their service area — and whether other hospitals excluded undocumented immigrants. In making these calls AFSCME researchers spoke with financial counselors and asked the following questions:

Cook County Private Hospitals Charity Care 2000–2003						
Cook County Private Hospitals	Charity Care as a Percentage of Gross Charges 2003	Total Charity Care 2003	Total Gross Charges 2003	Charity Care as a Percentage of Gross Charges 2002	Total Charity Care 2002	Total Gross Charges 2002
Advocate Bethany	**7.6%**	**$8,676,690**	**$114,274,522**	**5.2%**	**$5,333,655**	**$102,616,386**
South Shore	5 1%	$4,505,864	$87,912,194	4 2%	$3,622,761	$86,223,202
Jackson Park	**4.8%**	**$4,850,000**	**$101,521,000**	**1.5%**	**$1,580,000**	**$104,792,000**
Ronald McDonald Children's	3 9%	$4,934,723	$126,015,413	2 8%	$3,447,778	$121,400,375
St. Bernard	**2.6%**	**$2,918,888**	**$113,637,654**	**3.9%**	**$4,090,397**	**$104,008,422**
Methodist	2 2%	$1,393,038	$64,565,158	2 9%	$1,994,626	$69,274,727
Northwestern Memorial	**2.1%**	**$33,624,650**	**$1,595,745,034**		**Not available**	
Advocate Northside Health System	2 0%	$16,999,706	$840,251,026	2 5%	$22,937,703	$908,006,386
Rush Presbyterian - St. Luke's	**1.6%**	**$20,408,180**	**$1,290,302,671**		**Not available**	
University of Chicago-Children's	1 6%	$15,016,000	$964,444,000	1 8%	$14,359,757	$790,584,103
University of Chicago	**1.6%**	**$13,240,000**	**$850,404,000**	**1.8%**	**$13,896,187**	**$765,061,959**
Rush Children's Services	1.5%	$2,371,349	$153,332,850		Not available	
Swedish Covenant	**1.3%**	**$7,763,231**	**$591,159,106**	**1.2%**	**$6,011,204**	**$500,802,893**
St Mary of Nazareth	1 2%	$4,195,810	$339,364,522	1 9%	$5,888,496	$310,724,482
Alexian Brothers Medical Center	**1.1%**	**$7,674,924**	**$674,462,848**	**1.0%**	**$5,920,776**	**$594,687,049**
St Elizabeth's	1 1%	$2,394,453	$216,960,043	7 8%	$13,647,752	$175,991,884
St. Francis, Evanston	**1.1%**	**$3,920,712**	**$364,338,864**	**1.1%**	**$3,973,481**	**$351,701,651**
Mercy	1 0%	$3,466,207	$361,800,410	0 8%	$2,771,410	$357,659,873
St. Alexius	**0.9%**	**$4,263,387**	**$463,734,132**	**0.5%**	**$1,930,461**	**$392,051,169**
Holy Cross	0 9%	$3,055,839	$335,646,180	1 1%	$3,299,900	$302,469,625
Foster G. McGaw	**0.9%**	**$8,700,278**	**$1,019,634,587**	**0.7%**	**$6,467,222**	**$871,867,625**
Thorek	0 8%	$926,932	$119,429,408	0 6%	$746,814	$115,064,577
Advocate Lutheran General	**0.7%**	**$3,527,421**	**$498,959,260**	**0.8%**	**$4,133,368**	**$493,230,411**
Advocate Lutheran General Children's	0 7%	$3,291,603	$465,602,510	0 8%	$2,928,634	$349,470,822
Mount Sinai	**0.7%**	**$3,271,488**	**$471,579,861**	**1.3%**	**$6,078,441**	**$454,243,208**
Gottlieb Memorial	0 5%	$2,214,648	$441,898,271	0 7%	$2,982,527	$398,583,830
St. Anthony	**0.5%**	**$738,878**	**$149,831,205**	**0.5%**	**$790,867**	**$150,524,896**
Advocate Christ	0 4%	$3,066,899	$686,485,378	0.4%	$2,033,588	$532,877,340
Advocate Hope Children's	**0.4%**	**$2,297,114**	**$514,179,288**	**0.4%**	**$1,613,411**	**$422,775,268**
Ingalls Memorial	0 4%	$1,932,833	$453,167,930		Not available	
St. Joseph	**0.4%**	**$1,821,822**	**$459,806,861**	**0.7%**	**$2,769,888**	**$426,116,083**
West Suburban	0 4%	$1,946,632	$502,461,759	0 4%	$1,860,140	$469,668,149
Lagrange Memorial	**0.4%**	**$1,349,643**	**$356,979,548**		**Not available**	
Northwest Community	0 4%	$1,959,568	$528,396,288	0.6%	$3,309,522	$558,164,486
Advocate Trinity	**0.4%**	**$1,013,272**	**$283,918,689**	**0.4%**	**$1,040,009**	**$246,489,139**
South Suburban	0 2%	$829,968	$334,221,427	0 8%	$2,384,600	$289,583,595
Oak Park	**0.2%**	**$417,777**	**$172,460,280**		**Not available**	
Palos Community	0.2%	$821,577	$515,225,527		Not available	
Holy Family	**0.1%**	**$264,494**	**$181,342,236**	**1.3%**	**$2,099,896**	**$159,582,883**
Resurrection	0.1%	$1,029,985	$720,286,940	0 5%	$3,098,625	$638,222,136
Lincoln Park (formerly Grant)	**0.1%**	**$110,223**	**$106,549,788**	**0.2%**	**$221,507**	**$120,019,041**
Westlake Community	0.1%	247,667	$242,689,660	0 2%	$486,368	$232,454,052
Little Company Of Mary	**0.1%**	**$402,009**	**475,873,116**	**0.1%**	**203,098**	**394,089,681**
Children's Memorial		Not available		0 8%	3,242,867	381,914,262
Louis A. Weiss Memorial		**Not available**		**1 1%**	**$2,905,615**	**$262,791,844**
Rush North Shore Medical Center		Not available		0 6%	$2,209,159	$367,523,950
St. Francis Blue Island		**Not available**		**0.7%**	**$2,565,984**	**$355,499,602**

1. In order to apply for your hospital's financial assistance or charity care program, does a patient have to live in your hospital's service area, for example a certain zip code?
2. Does the applicant have to be a U.S. citizen or legal resident? In other words, can undocumented immigrants apply for charity care?

The results of the survey were that no other hospital in Cook County is limiting charity care to their service area, and that only four of the 50 require the applicant to be a legal resident of the United States. Three hospitals stated that they had no financial assistance or charity care program available, although all three reported charity care figures to the Illinois Department of Public Aid for fiscal year 2003.

Notes

1. Resurrection Health Care reports charity care to the Illinois Department of Public Aid for each hospital in the system by their fiscal year, which begins July 1 and ends June 30. As a result, complete 2003 fiscal year charity care data is already available. This means that charity care numbers examined in this report reflect the company's behavior as recently as June 2003.
2. Resurrection Health Care Audited Financial Statements, 1999-2002.
3. "RESource," Resurrection Health Care Marketing Department mailing, Fall 2003.
4. *http://www.csfn.org*, accessed January 7, 2004. (Website of the Congregation of the Sisters of the Holy Family of Nazareth)
5. *http://www.reshealth.org/about/sponsors.cfm*, accessed December 30, 2003.
6. *http://www.pgsa.org/ArchChiPolPar/SistersResurrectionNorPk.htm*, accessed January 7, 2004. (Website of the Polish Genealogical Society of America)
7. *http://www.reshealth.org/about/sponsors.cfm*, accessed December 30, 2003.
8. *http://www.bsac.ac.uk/SRA/decof%20mission.htm*, accessed January 7, 2004.
9. Sister Sally Marie Keipura, testifying before the Illinois Health Facilities Planning Board, October 15, 2003.
10. Poor Handmaids of Jesus Christ. "Health Visions Midwest." Available at *http://www.hvusa.org*. Accessed 5/21/03.
11. Illinois Property Tax Code, 35 ILCS 200/15-65.
12. Resurrection Health Care Corp., *Applicant v. State of Illinois Department of Revenue*, Docket No. 98-PT-0002.
13. Resurrection Health Care Corp., *Applicant v. State of Illinois Department of Revenue*, Docket No. 98-PT-0002.
14. Alivio Medical Center, *Applicant v. State of Illinois Department of Revenue*, Docket No. 93-16-982.
15. *Wall Street Journal*, "Hospitals Try Extreme Measures to Collect Their Overdue Debts," October 30, 2003.
16. *Chicago Tribune*, "Easing Hospital Bill Sticker Shock," January 10, 2004.
17. Fitch Ratings, October 9, 2002
18. Fitch Ratings, October 9, 2002
19. Ancilla Systems press release "St. Elizabeth Hospital Joins Resurrection Health Care." October 3, 2001.
20. Resurrection Health Care IRS 990 Forms, 2000-2002.
21. This is a minimum estimate. Charity care totals do not include Westlake Hospital in 1999 and St. Joseph Hospital in 1999 or 2000, as these numbers were not reported to the Illinois Department of Public Aid. The 1999 charity care total for Holy Family is taken from the audited financial statement for that year, as it was not reported to the Illinois Department of Public Aid.
22. Data for 1999 and 2000 are minimum estimates of charity care provided in those years. St. Joseph Hospital did not report in either year, and Westlake Hospital and Holy Family Medical Center did not report data in 1999. The 1999 charity care total for Holy Family is taken from the audited financial statement for that year, as it was not reported to the Illinois Department of Public Aid.
23. Charity Care Policy of Resurrection Health Care, effective July 1995.

24. Chicago Partnership for Public Health, "Chicago Plan for Public Health System Improvement," January 1, 2000, p. 34.
25. Mehta, Chirag, et al. "Chicago's Undocumented Immigrants: An Analysis of Wages, Working Conditions, and Economic Contributions," Center for Urban Economic Development, University of Illinois at Chicago, February 2002, p. 9.
26. Paral, Rob and Michael Norkewicz, "The Metro Chicago Immigration Fact Book," Institute for Metropolitan Affairs, Roosevelt University, June 2003, pp. 16-17.
27. Mehta, Chirag, et al. "Chicago's Undocumented Immigrants: An Analysis of Wages, Working Conditions, and Economic Contributions," Center for Urban Economic Development, University of Illinois at Chicago, February 2002, p. 30.
28. Chicago Partnership for Public Health, "Chicago Plan for Public Health System Improvement," January 1, 2000, p. 34.
29. For the purposes of this table the Southwest side and Cicero includes 60804, 60608, 60609, 60629, 60632, 60638.
30. Based on the Illinois Department of Public Health 2001 Annual Hospital Questionnaire, and data collected by AFSCME Council 31 through review of service documents of Resurrection patients sued for medical debts.
31. Instructions for "Processing of Financial Assistance Applications," from "Financial Assistance Program," Resurrection Health Care, dated April 10, 2002.
32. Instructions for "Problems Encountered with Financial Assistance Applications," from "Financial Assistance Program," Resurrection Health Care, dated April 10, 2002.
33. Resurrection Health Care policy for Point of Service Collections, p. 1 of 3.
34. Resurrection Health Care Audited Financial Statements, 2000-2002.
35. According to the Illinois Department of Public Health 2001 Annual Hospital Questionnaire, 53% of inpatients of St. Elizabeth Hospital in that year were Latino. For other Resurrection hospitals, the number of Latino inpatients ranges from 42% (St. Mary of Nazareth Hospital) to 8% (Resurrection Medical Center) in 2001.

TAB 40

HEALTH CARE FOR THE UNINSURED

Preliminary Report from the Social action committee, Genesee Conference Free Methodist Church

On May 3, 1997 the pastors and delegates of t he Genesee Conference Unanimously approved the following resolution:

In as much as ten to twenty percent of the people in our conference lack health insurance

and in as much as hospitals often charge those without insurance up to two to three times as much for a given outpatient Xray , Lab or ER visit than local insurance companies pay for the same service

Be it resolved that the Genesee Conference of the Free Methodist Church believes that it is unjust for hospitals to ask that those without insurance to pay more for a given service than they accept as payment in full from an insurance company for the same service.

And be it further resolved that the Social Action Board of our conference publicize our position and network with other organizations to promote justice in this area

and be it further resolved that our churches be encouraged to advocate for the uninsured and that the Social Action Board provide material to our pastors and churches to enable them to do this.

In the fall of 1997 our committee decided to gather more facts by sending a questionnaire to all the hospitals in our conference. Surveys were sent to the directors of finance of 40 hospitals. There was initially 5 responses and after a second mailing 4 more responses. Of note is the fact that 31 hospitals failed to respond to the simple one page survey and failed to provide us with their charges for 5 simple procedures.

The hospitals that responded are as follows: Lockport, Lady of Vintory, Buffalo Childrens ,F Thompson, Noyes memorial in Dansville, St. James Mercy in Hornel, Buffalo General, St. Jeromes in Batavia and Jones Memorial in Wellsville.

The survey was designed to determine two things. First, how much does the hospital charge those without insurance for three different lab procedures, and 4 different Xray examinations .We then wanted to compare this charge with the amount that Medicare pays for the same service. Secondly, to find out if the hospital gave discounts to those without insurance, and more imporant, were all patients without insurance told about the discount and given an application, or did they have to ask to find out.

CHARGES FOR THOSE WITHOUT INSURANCE

1. CBC Medicare pays $7.93. Most hospitals charged 12 to 13 dollars, although one charged 37 and one 30 dollars.

2. SMA 12 which is a automated chemistry profile. Medicare $12.81. If a person had no insurance they would be charged between 21 and 63 dollars for the same test, depending on what hospital it was done. Two hospitals charged 22 dollars, two 21, one 39, one 40, one 51 and one 63 dollars for this test.

3. TSH which is a common thyroid blood test Medicare pays 24 dollars. One hospital charged 25 , one 32 and one 40 dollars. Most others charged over 50 dollars with one hospital charging 77 dollars for this test.

4. Chest film PA and Lateral Medicare pays 29 dollars. The lowest cost hospital charged 36 dollars, 2 others charged under 50 dollars and 4 charged over 50 dollars, with one charging eighty dollars.

5. X Ray of Forearm Medicare pays 24 dollars. One hospital, Lady ofVictory actually charges those without insurance less, only 21 dollars. The others charge 35, 39 dollars, 43, 48, 53, 54 and one charges 80 dollars.

6. IVP which is a kidney X Ray. The procedure includes a injection of dye into the patients vein and then a series of X Rays. Medicare pays 78 dollars. Lady of Victory Hospital only charges 71 . All the other hospitals charge between 100 and 150 except for one that charges 169 and St. James Mercy which charges 342 dollars.

7. Abdominal Ultrasound Medicare pays 102. All but one hospital charged between 180 and 210 except for St. James Mercy which charged 406.

COMMENTS: Clearly those without insurance were charged more than Medicare pays , often 2 to 3 times more. Insurance companies such as blue Cross also receive a discount which averages 50 percent. We feel that those without insurance and especially those with lower incomes, should receive the same discount. They should not have to pay 2 or 3 times more. Secondly, no one tells a patient what the charges are, in fact 31 hospital out of 40 refused to reveal their charges to us. Normally in a competitive market charges are published so people can compare, In this case , a person cannot even find out. Even the physicians who order the tests are not normally informed of what the charges are. One hospital had charges for X Rays that were way above what other hospitals charged, yet no one in that community including the physicians know that. We can criticize that hospital but at least they told us what they did charge which is more than 31 other hospitals did. The Biblical term that can describe such a system is Unjust.

AVAILABILITY OF DISCOUNTS

Fortunately most hospitals will provide discounts for some people who do not have insurance and in some cases, charge them nothing at all. This is commendable. Our survey asked if they had a discount policy, and if people had to apply for the discount or was is automatic. Our feeling was that a discount equal to what the insurance companies get should be automatic and then a person would have to apply for a further hardship discount. No hospital had a automatic discount.

Secondly we felt that everyone without insurance needed to be told about the availability of the discount and how to apply. We asked about this and 3 hospitals told everyone . At the other hospitals a person had to go and tell them that they did not have much money and ask if they could apply for a discount. Since the charges to these individuals were 2 to 3 times what the insurance companies pay for the same service, we thought that everyone without insurance needed to be informed that discounts were available and told how to apply.

MEETING WITH THE HOSPITAL ASSOCIATION OF WESTERN NEW YORK.

We meet with officials of the hospital association of Western New York. They have a program which encourages more people to get insurance. Child Health Plus is a low cost insurance for children. Also the Rochester area as ValuMEd which is a lost cost insurance program for adults. The hospital association offered to make available to our pastors information about these insurance's that could be passed on to people who lack insurance.

COMMENT: There are really two problems. The first and most important is getting insurance for everyone. Until we have a national health insurance program we will not have this, but can try in selected cases to help people get low cost insurance.

The second problem, however is what should those without insurance be charged and should they be given a discount, at least as much as the insurance companies receive. The hospital association only wanted address the first question. Our church and hopefully other churches will deal with the second. one.

OBJECTIONS TO OUR CONCERNS;
One objection has been that everyone should have insurance and if they do not have it, then it is their fault and they should have to pay more. In fact some people who have preexisting conditions will have trouble getting insurance, at any price. Secondly a person trying to raise a family on a 15000 dollar a year income may find it pretty hard to take a third of that income for health insurance if his employer does not provide the insurance. We are not asking that everyone without insurance not be charged, because there are

some people who can afford the insurance and choose not to have it. What we are asking is that those without insurance to be charged extra as they are now.

A second objection is that people who do not have insurance do not pay anyway so why does it matter what they are charged. WE feel that this is an absurd objection, since many do pay and many of those who do not are sent to a collection agency.

A third objection was that many do not pay and those without insurance who pay should make up for those who do not pay with higher charges. Again, why not let the insurance companies help make up for some of that.

RECOMMENDATIONS

1. Pastors be given information on low cost insurance.

2. Pastor or lay people make an appointment with the director of finances of those 31 hospital who did not respond to our survey. Take the survey in, tell them that you are sorry they did not respond before, but that your church in their community would like to know the answers. Let them know that you especially want to know abut any discount policy they might have and that your church believes that discounts need to be available to everyone without insurance and that everyone should be told about the discount and how to apply for it.

3. Pastors and lay people share this study with leaders and board members of your local hospital. Maybe they cannot change everything right now, but they can at least work to have everyone without insurance told if there is a discount policy and how to apply. If there is not automatic discount, then prices of popular tests should be posted.

Report written by Norman Wetterau MD

May 1997

Dear Director of Finance,

The Genesee Conference of the Free Methodist Church represents approximately 40 churches in Rochester, Buffalo and the Southern Tier of New York State. At our recent conference on May 3, the pastors and delegates instructed the Social Action Committee to study the matter of those without insurance. The delegates were especially concerned with the fact that those without health insurance are often asked to pay more for a given service than the insurance companies pay. As part of this study we are trying to obtain information on the subject. We are asking if you would kindly provide us the following information:

A. Your hospital charges for the following outpatient services:
   1. CBC
   2. SMA 12
   3. TSH
   4. Chest film PA and LAT
   5. X Ray of the forearm
   6. IVP
   7. Obstetrical Ultrasound

B. Does your hospital have a discount policy for those without insurance?
   If it does, does it apply to all outpatient services?

   Is the policy automatic?

   If people have to apply for the discount, are they told about it and given an application at the time of service?
   or
   Is the application mailed with their bill?
   or
   Do they have to request information and an application for the discount?

   If they have to request information, how are they told that such a policy exists/
   or
   are they not told and have to ask?

   If you have information on your discount policy, we would be interested in it.

C. Finally, we are sure that you are as concerned about the uninsured as we are. Do you have any special thoughts about this or any suggestions for our churches or denomination? Any suggestions you have may be publicized, but not with the attachment of your name or institution unless you prefer it.

Sincerely,

Nelson Grimm
Superintendent, Genesee Conference
Free Methodist Church

HOSPITAL CHARGES AND THE UNINSURED

Name of your Hospital:

A. Does your hospital have a discount policy for those without insurance?
YES NO go to B

1. Does it apply to all outpatient services? Yes No
   If not , then to what services?

2. Is there a income limit above which patients receive no discount? Yes No
   What would this limit be for a single person? family of 4?

3. Do people have to apply for the discount? Yes No

4. If people have to apply for the discount, how are they given an application ?
   a. At the time of service
   b. the application is mailed with their bill
   c. they have to request an application for the discount
   d. other

5. If they have to request an application, how are they told that such a policy exists?

If you have information on your discount policy, we would be interested in it.

B. What are your hospital charges for the following outpatient services.? (Medicare CPT codes listed but we want the charges for those without insurance)

1. CBC 85021
2. SMA 12 80012
3. TSH 84443
4. Chest film PA and Lat. 71020
5. X Ray of forearm 73090
6. IVP 74400
7. Abdominal ultrasounnd-complete 76700

C. Finally, we are sure that you are as concerned about the uninsured as we are. Do you have any special thoughts about this, or any suggestions for our churches or denomination? Any suggestions you have may be publicized, but not with the attachment of your name or institution unless you prefer.

If you have any questions about this survey, please call Dr. Norman Wetterau, our medical consultant and member of the social action committee. Office 716 468 2581

Thank You.

Address letters to Director Of Finance

Genesee Memorial 127 North St. Batavia 14020

S t. Jerome 16 BankA t. Batavia 14020

Lakeside Memorial Hosp 156 West Ave. Brockport 14420

Buffalo

Brylin 11438 Genesee St. Alden 14004

Buffalo Ciolumb us 300 Niagara 14201

Buffalo eneral 10 0 High S t. 14203

Childrens Hosp 219 Bryant S t. 14222-2006

Erie County Med Center 462 Grinder St. 14215

Mercy Hosp 565 AbbottRd. 14220

Mildred Fillmore 3 Gates Circle 14209

Roswell Park Elm and Cariton St. 14263

Sheehan Memorial Hospital 425 Michigan Avenue 14203

Sisters of Charity Hospital 2157 Main Street 14214

Frederick Thompson Hospital 350 Parish Street Canandaigua 14424

Saint Josephs Hospital 2605 Harlam Road Cheektowaga 14225-4097

Cuba Memorial Hospital 140 West Main Street Cuba, NY 14727

Nicholas Noyes Memorial Hospital 111 Clara Barton Street Dansville 14437-9527

Brooks Memorial Hospital 529 Central Avenue Dunkirk 14048

Try County Memorial Hospital 100 Memorial Drive Gowanda 14070

Saint James Mercy Hospital 411 Canisteo Street Hornell

Lakeshore Hospital Roots 5 and 20 Irving 14081

Women's Christian Association Hospital 207 Foote Avenue Jamestown 14701

Kenmore Mercy Hospital 2950 Elmwood Avenue Kenmore 14217

Our Lady of Victory Hospital 55 Melroy Lackawanna 14218

Mount Saint Mary's Hospital of Niagara Falls 5300 Millitary Road Lewiston 14092-1997

Lockport Memorial Hospital 521 East Avenue Lockport 14094

Medina Memorial Hospital 200 Ohio Street Medina 14103

Inner Community Memorial Hospital 2600 Williams Street Newfane 14108

Niagara Falls Memorial Medical Center 621 Tent Street Niagara Falls 14302

Degraff Memorial Hospital 445 Tremont Street North Tonawanda 14120

Olaen General Hospital 515 Main Street Olean 14760

The Genesee Hospital 224 Alexander Street Rochester 14607

Highland Hospital 1000 South Avenue Rochester 14620

Park Ridge Hospital 1555 Longpond Road Rochester 14626

Rochester General Hospital 1425 Portland Avenue 14621

Saint Mary's Hospital 89 Genesee Street Rochester 14611-3285

Strong Memorial Hospital 601 Elmwood Avenue Rochester 14642

Bertrand Chaffee 224 East Main Street Springville 14141

Wyoming County Community Hospital 400 North Main Street Warsaw 14569

Jones Memorial Hospital 191 North Main Street Wellsville 14895

Westfield Memorial Hospital 189 East Main Street Westfield 14787

Statement of Representative Cliff Stearns
O&I Hearing on Hospital Billing
June 24, 2004

- Florida Hospitals Association proposed legislation this year that would have increased the charity threshold to 200% pegged to the Federal Poverty Level (FPL).

Florida Hospitals	**CHARITY POLICY**	**DISCOUNT**	**2003 CHARITY**
Munroe Regional Medical Center, Ocala, FL	200% FPL threshold	Up to 300% FPL sliding scale	~ $19M & ~ $32M Bad Debt Write-off
West Marion Community Hospital/Ocala Regional Medical Center, HCA, Ocala, FL			Over $7.1M & $22.3M Bad Debt Write-off
Orange Park Medical Center, HCA, Orange Park, FL		Application will indicate what benefits you qualify for	Over $9.4M & & $29.4M Bad Debt Write-off
Shands Healthcare, Gainesville, FL	200% FPL threshold	Up to 400% FPL sliding scale	~ $159M & ~ $100M Bad Debt Write-off
North Florida Regional Medical Center, HCA, Gainesville, FL			Over $12.5M & 22M Bad Debt Write-off
St. Vincent's Ascension Health	Goes up to 400% FPL	Mobile Unit provided ~ 18,000 free services to uninsured of underinsured	

Bad debt write off = those not qualified for charity of sliding scale

Example: MRMC has a sliding scale were bills above the 200% threshold will be reduced up to 35% when the responsible party agrees to prompt payment of the remainder.

The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?

Issue Update

2004

Jack Hadley, Ph.D. and John Holahan, Ph.D.

Prepared for the Kaiser Commission on Medicaid and the Uninsured
May 10, 2004

The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?

Today, there are nearly 44 million Americans without health insurance coverage. A substantial body of research shows that there are serious health and financial consequences associated with being uninsured. Moreover, research shows that leaving a large share of the population without health insurance affects not only those who are uninsured, but also the health and economic well-being of the nation. Yet, despite these findings, the number of uninsured Americans continues to grow. Although the national debate over ensuring health coverage for more Americans periodically gains momentum, it then stalls—perhaps in part because not enough is known about both the benefits and the costs of expanding coverage to more, if not all, of the uninsured.

This issue update contains findings from a new study examining the cost of medical care for the uninsured and how much care the uninsured receive compared to fully insured people. In addition, the study measures the cost of additional medical care if all the uninsured were provided coverage and used the health system at rates comparable to the insured population. By estimating how much medical care the uninsured use and who pays for it, the study identifies the resources that are already in the medical care system and potentially available to help pay for expanded insurance coverage.

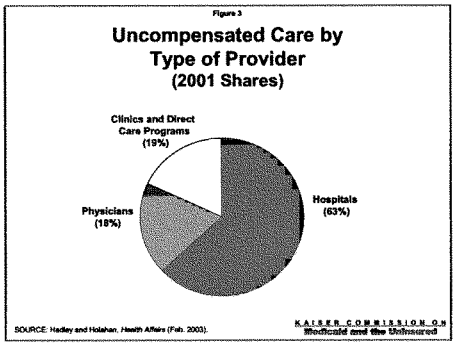
This issue update addresses the following questions:

- How much uncompensated care is provided to the uninsured each year?
- Who provides uncompensated care and how is it funded?
- Does uncompensated care fully make up for the lack of health insurance?
- How much more would it cost to cover all of the uninsured?
- How do the costs of expanding health coverage compare to the benefits?

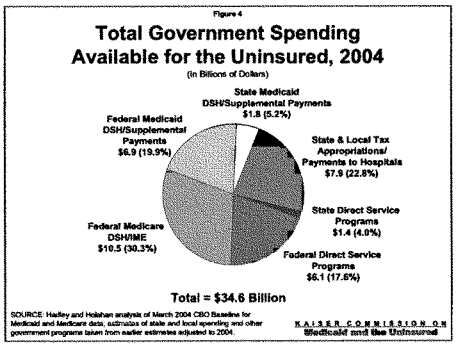
Who provides uncompensated care and how is it funded?

Most uncompensated care dollars are incurred by hospitals, where services are most costly. In 2001 hospitals accounted for over 60% of uncompensated care dollars; office-based physicians' share and that of direct care programs/clinics accounted for just under 20% each.

Physicians' uncompensated care is generally not subsidized through government dollars unless they are providing care in community health clinics or service programs (e.g., Bureau of Primary Care programs, the Indian Health Service, and Veteran's Affairs programs) that largely care for uninsured Americans. Direct service programs are partly supported by government funds—but their subsidy relative to hospitals is considerably smaller, less than $8 billion in 2004.



The primary source of funding for uncompensated care is government dollars. Projected federal, state, and local spending available to pay for the care of the uninsured in 2004 is **$34.6 billion—about 85% of the total uncompensated care bill.**



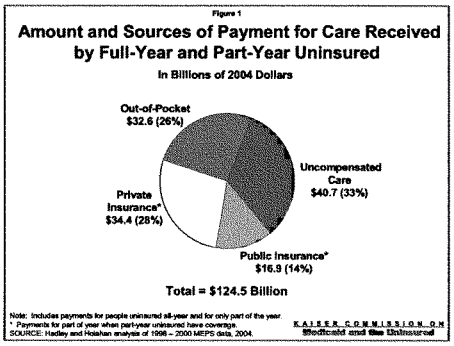
Over two-thirds of government spending for uncompensated care comes from the federal government, most of which goes toward payments to hospitals in the form of disproportionate share hospital (DSH) payments—payments intended to offset losses hospitals incur when large shares of their patients are unable to pay their hospital bills.

How much uncompensated care is provided to the uninsured each year?

Uncompensated care is medical care received, but not fully paid for, either out-of-pocket by individuals or by a private or public insurance payer. The cost of unpaid care is estimated by using the benchmark of what would have been paid for the services by private insurance.

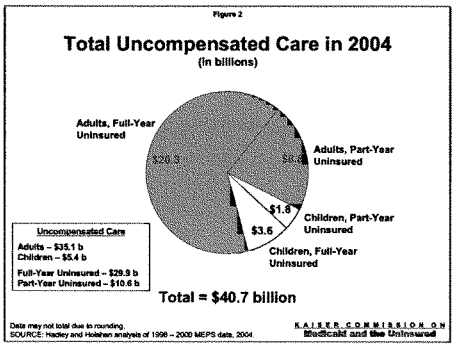
Total medical care expenditures among all of the uninsured in 2004 (including both those without coverage for all or part of the year) are almost $125 billion. Individuals may be without health insurance for long periods of time or for a matter of months. In the survey years (1998-2000) used to project current costs for this analysis, over 60 million were uninsured for either all or part of a year—with just a little over half being uninsured for the full year.

A third of the medical costs for the uninsured are uncompensated. About a quarter of the total medical care costs are paid directly by the uninsured out-of-pocket, however people who are uninsured for the full year pay for over a third of their care (35%) out-of-pocket—a considerably higher share than paid by either the full-year or part-year insured populations, who paid for just under 20% of their care out-of-pocket.



In 2004, uncompensated care is estimated to be $40.7 billion. Adults uninsured for the full year receive the majority of uncompensated care, $26.3 billion (65% of the total amount). Children are less likely to be uninsured and their average health care costs are less than adults as well.

Uncompensated care represents 2.7% of the projected total personal health care spending for 2004 of $1.5 trillion.



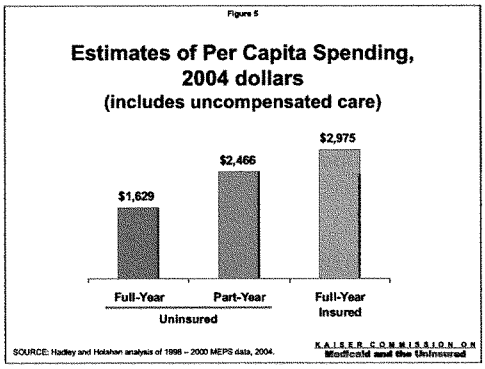
Does uncompensated care fully make up for the lack of health insurance?

The uninsured who are without coverage for the full year receive about half (55%) of the medical care per person compared to those who have health coverage for the entire year, even after taking uncompensated care into account.

Per capita medical spending for persons uninsured for the full year in 2004 is $1,629 compared to $2,975 by persons who are insured for the full year. This spending gap holds for both adults ($1,864 compared to $3,653) and children ($802 compared to $1,640).

Health services research has consistently documented an insurance disparity in access to and use of medical services. Compared to persons who have health insurance, the uninsured:

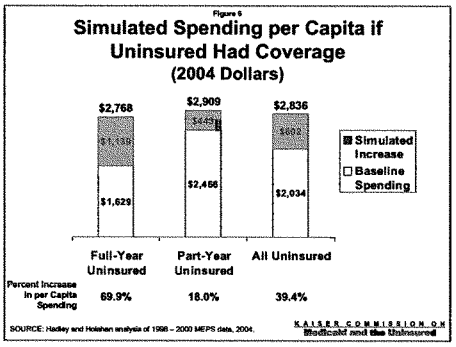
- receive less preventive care,
- are diagnosed at more advanced disease states,
- and once diagnosed, tend to receive less therapeutic care and have higher mortality rates.



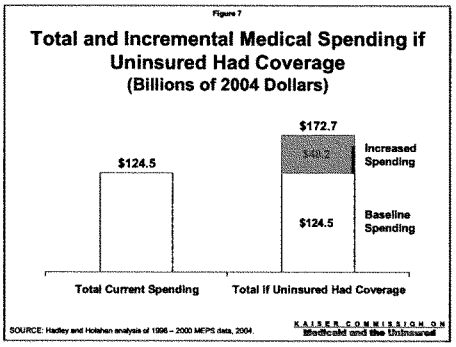
How much more would it cost to cover all of the uninsured?

Having health insurance increases medical care use, and so an important question in the ongoing national debate over whether and how to extend insurance to people who are uninsured is—how much more will it cost, over and above what is currently being spent on the cost of their medical care?

Extrapolating from the experience and behavior of people who are insured for the full year and have incomes in the low and lower-middle income range (under 400% of the poverty level), **if the uninsured had full-year coverage, their per person spending would increase from $2,034 to $2,836**—a 39% rise. The increase would of course be greater for those who had been uninsured for the full-year, growing by nearly 70%, from $1,629 to $2,768.



Total spending for those who would gain coverage under a universal expansion would increase by $48 billion. Added to the current spending level of almost $125 billion (which includes all uncompensated care, out-of-pocket payments, and insurance payments for those covered for part of the year) the new dollars would bring the total to $173 billion if coverage were similar to the average low to middle income person with health insurance. It reflects the potential increase in overall health spending directly attributable to the uninsured, but does not take into account the additional costs associated with major health coverage proposals.



A benefit of a comprehensive rather than an incremental approach to covering all of the uninsured is that some of the public money already being used to pay for care received by the uninsured could be reallocated towards the cost of insurance. However providers caring for the uninsured now, primarily hospitals that now receive the largest subsidies for uncompensated care, may be reluctant to relinquish their existing subsides unless assured that all people will have health insurance.

How do the costs of expanding health coverage compare to the benefits?

Research showing that having health insurance positively affects the use of health services is clear and widely accepted—and the case has also been made that having health insurance leads to improved health and longer lives by means of better access to medical care.

- A conservative estimate based on the full range of studies is that a reduction in mortality of 5-15% could be expected if the uninsured were to gain continuous health coverage.[1]

- It has been estimated that the number of excess deaths among uninsured adults age 25-64 is in the range of 18,000 a year.[2]

- The annual economic value of foregone health among the 40 million uninsured in 2000 has been estimated to be between $65 and $130 billion in that year.[3] If the middle of that range ($97.5 billion) is inflated to 2004 dollars, the annual economic value of the foregone health of those 40 million uninsured increases to $103 billion—a sum considerably larger than the $48 billion in increased costs of expanding coverage to all of them.

The additional $48 billion/year of medical spending needed to provide universal coverage, beyond what is currently being spent, can be viewed from several broader perspectives:

- Relative to current government spending for public health insurance programs and the subsidization of private insurance in 2004, the additional spending to cover the uninsured is relatively small.
    - Medicare will cost $266.4 billion;
    - Medicaid will cost $280.7 billion;[4] and
    - the tax subsidy for private insurance will be $188.5 billion[5]

- The new dollars would constitute less than 3% of total personal health care spending in this country.

- The $48 billion would increase the share of GDP going to health care by 0.4%.

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[1] Hadley, J. "Sicker and Poorer – The Consequences of Being Uninsured" *Medical Care Research and Review* (60:2), June 2003.
[2] Institute of Medicine. 2002. *Care Without Coverage, Too Little, Too Late.* Washington, DC. p. 161-165.
[3] Institute of Medicine. 2003. *Hidden Costs, Value Lost.* Washington, DC, p. 112.
[4] Medicare and Medicaid budget projections are from http://www.cms.hhs.gov/statistics/nhe/projections-2002/t5.asp.
[5] Sheils and Haught, *Health Affairs*,(Web Exclusive), Feb. 25, 2004, http://www.healthaffairs.org/WebExclusives.ph, p. w4-106.

Table 1
Uncompensated Care[a] Received by the Uninsured
(2004 $s)

	All Uninsured	Full-Year Uninsured	Part-Year Uninsured
Cost of Uncompensated Care (billions)	$40.7	$30.1	$10.6
Adults	35.1	26.3	8.8
Children	5.4	3.6	1.8
Uncompensated Care as a Share of Total Care	32.7%	58.6%	14.5%
Adults	33.1	57.7	14.6
Children	29.3	63.2	14.2

Notes:
[a] Sum of Other Public Sources, Other Private Sources, and Donated In-Kind care from Table 3.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 2
Total and Per Capita Medical Care Spending,
By Insurance Status
(2004 $s)

Insurance Status	Population N (millions)	Population (%)	Total Spending[b] ($ billions)	Per Capita Spending[b] ($)
All Nonelderly Adults and Children				
Full-Year Insured	175.7	*74.2%*	$522.7	$2,975
Total Uninsured (full and part year)	61.2	*25.8*	124.5	2,034
Uninsured, Full Year	(31.6)	*(13.3)*	(51.4)	(1,629)
Uninsured, Part Year	(29.6)	*(12.5)*	(73.1)	(2,466)
Total Population[a]	236.9	*100.0*	647.1	2,732
Nonelderly Adults				
Full-Year Insured	116.5	*72.5%*	$425.6	$3,653
Total Uninsured (full and part year)	44.3	*27.5*	106.0	2,394
Uninsured, Full Year	(24.5)	*(15.2)*	(45.6)	(1,864)
Uninsured, Part Year	(19.8)	*(12.3)*	(60.4)	(3,047)
Total	160.8	*100.0*	531.6	3,306
Children				
Full-Year Insured	59.2	*77.8%*	$97.1	$1,640
Total Uninsured (full and part year)	16.9	*22.2*	18.4	1,087
Uninsured, Full Year	(7.1)	*(9.3)*	(5.7)	(802)
Uninsured, Part Year	(9.8)	*(12.9)*	(12.7)	(1,293)
Total	76.1	*100.0*	115.5	1,518

Notes:
[a] Civilian, non-institutionalized population under age 65, excluding those with any Medicare coverage.
[b] Includes uncompensated care for the uninsured.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 3
Total Medical Care Spending,
By Insurance Status and Source of Payment
(2004 $s, billions)

Insurance Status	(1) Self	(2) Private[a]	(3) Public[b]	(4) Other Public[c]	(5) Other Private[d]	(6) Donated In-Kind[e]	(7) Total Spending
Full-Year Insured	$104.0 *(19.9%)*	$345.6 *(66.1%)*	$53.9 *(10.3%)*	$10.6 *(2.0%)*	$8.5 *(1.6%)*	$0.0 *(0.0%)*	$522.6 *(100.0%)*
Uninsured, Full-year	18.1 *(35.2)*	3.3 *(6.4)*	0.0 *(0.0)*	9.3 *(18.1)*	10.0 *(19.5)*	10.7 *(20.7)*	51.4 *(100.0)*
Uninsured, Part-year	14.5 *(19.8)*	31.1 *(42.5)*	16.9 *(23.1)*	2.4 *(3.3)*	2.8 *(3.8)*	5.4 *(7.4)*	73.1 *(100.0)*
All Nonelderly[f]	136.6 *(21.1)*	380.0 *(58.7)*	70.8 *(10.9)*	22.3 *(3.4)*	21.3 *(3.3)*	16.1 *(2.5)*	647.1 *(100.0)*

Notes:
[a] Includes Tricare/CHAMPVA and workers' compensation.
[b] Medicaid and Medicare.
[c] VA, other federal, state and local, and public programs.
[d] Other private sources and unknown sources
[e] Estimated from data on charges and expected payments if privately insured.
[f] Civilian, non-institutionalized population under age 65, excluding those with any Medicare coverage.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 4
Sources of Funding Available to Providers for Uncompensated Care of the Uninsured (2004 $s, billions)

	Federal	State/Local	Total
Government Funds Available for Uncompensated Care	Billions of dollars (2004)		
State/Local Government			
Tax appropriations to hospitals	--	3.3	3.3
Payments to hospitals from indirect care programs	--	4.6	4.6
Medicare			
DSH payments	7.6	--	7.6
Share of Indirect Medical Education	2.9	--	2.9
Medicaid			
DSH payments	6.2	1.6	7.8
Supplemental provider payments	0.7	0.2	0.9
Other Government Programs[a]	6.1	1.4	7.5
All Government Spending	$23.5	$11.1	$34.6
Estimated Cost of Uncompensated Care	--	--	$40.7

Notes:

[a] Includes Bureau of Primary Care Programs, National Health Service Corps, Maternal and Child Health, Indian Health Service, and Veterans Affairs Programs.

Sources:

Medicare and Medicaid estimates derived from CBO March 2004 Baseline with same assumptions about share of payments attributable to uncompensated care as described in Jack Hadley and John Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for It?", *Health Affairs* Web exclusive, February 12, 2003. Estimates of state local spending and other government programs taken from earlier estimates (*Health Affairs*, February 12, 2003) and adjusted to 2004 using the Consumer Price Index.

Table 5
Simulated Per Capita Spending If Uninsured Were Fully Insured, By Baseline Insurance Status and Age
(2004 $s)

Insurance Status	Percent with any spending		Spending per capita	
	Baseline	Simulated, Full-Year Insured	Baseline[a]	Simulated, Full-Year Insured
All Uninsured	66.7%	79.9%	$2,034	$2,836
Full-Year	56.4	77.0	1,629	2,768
Part-Year	77.7	83.0	2,466	2,909
Uninsured Adults	65.9	79.5	2,394	3,388
Full-Year	56.0	76.5	1,864	3,188
Part-Year	78.1	83.2	3,047	3,634
Uninsured Children	69.0	80.9	1,087	1,367
Full-Year	58.0	78.7	802	1,296
Part-Year	76.9	82.6	1,293	1,419

Notes:
[a] Includes uncompensated care.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 6
Cost of Covering the Uninsured:
Simulated Total and Incremental Spending
If Uninsured Were Fully Insured
(2004 $s, billions)

Insurance Status	Baseline Spending[a] (billions)	Simulated Spending		
		Total Spending	Incremental Spending	% Increase over Baseline
All Uninsured	$124.5	$172.7	$48.2	38.7%
Full-Year	51.4	87.0	35.6	69.2
Part-Year	73.1	85.7	12.6	17.3
Uninsured Adults	106.0	150.0	44.0	41.5
Full-Year	45.6	78.0	32.4	71.0
Part-Year	60.4	72.1	11.6	19.3
Uninsured Children	18.4	22.7	4.3	23.5
Full-Year	5.7	9.0	3.3	58.5
Part-Year	12.7	13.7	1.0	7.8

Notes:
[a] Includes uncompensated care.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

APPENDIX

Methods Used in Updating the Estimates to 2004

Previously, the costs of medical care provided to the uninsured, the costs of uncompensated care, who bears those costs, and how much more it would cost to cover all of the uninsured were estimated—largely based on household data from the 1996-1998 Medical Expenditure Panel Surveys (MEPS). Estimates were then inflated to 2001 dollars. In order to make this work more germane to the current political debate over the costs and value of covering the uninsured, the researchers updated both the underlying data sources and extended the projections from these sources to 2004 health care costs.

Estimates of care used by the uninsured, sources of payment, and the effects of insurance coverage on the amount of medical care received were derived from the 1998-2000 MEPS household surveys. Rather than estimating separate models of the effects of full-year coverage based on Medicaid and lower-middle income private insurance as previously done, a single model that combined the uninsured with all people with full-year coverage with family incomes less than 400% of the poverty level was estimated. This choice reflects the assumptions that extending Medicaid-like coverage to all uninsured would increase political pressure to make program payments more generous and closer to rates paid by private insurance and that, as a result, making separate projections based only on the Medicaid experience would be unrealistic.

As with the 2001 estimates, all spending estimates from the MEPS data are limited to the nonelderly civilian noninstitutionalized population excluding any people who have Medicare coverage because of either disability or end-stage renal disease. All dollar values in the 1998-2000 MEPS were expressed in 2004 dollars using the annual percentage change in total personal health care spending as inflators. Actual data were used through 2001 and CMS projections for 2002-2004 (National Health Expenditures Projections, http://www.cms.hhs.gov/statistics/nhe/projections-2002/t5.asp).

More recent estimates of spending for uncompensated care by Medicare and Medicaid were obtained from the March 2004 CBO Baseline budget estimates. Other data on government spending from 2001 were trended forward to 2004 by the annual change in the Consumer Price Index.

THE COST OF NOT COVERING THE UNINSURED PROJECT

While the national debate over ensuring health coverage for more Americans continues, the number of uninsured is growing. The debate periodically gains momentum, then stalls—perhaps in part because not enough is known about both the benefits and the costs of expanding coverage to more, if not all, of the uninsured.

The Kaiser Family Foundation initiated *The Cost of Not Covering the Uninsured Project* to explore what is known and what needs to be known about the costs society incurs when so many have no health insurance coverage. Under this initiative, we convened an expert advisory group that worked with staff of the Kaiser Commission on Medicaid and the Uninsured to plan and oversee new analyses and reports that would further the understanding of this critical issue.

Three major reports have been issued from the project thus far (all of which can be found on our website, as well as in journal publications). In order to make these reports more germane to the current debate over the costs and value of covering the uninsured, two of the reports concerning the costs of uncompensated care, who bears those costs, and how much more would it cost to insure all Americans were updated to provide 2004 estimates and the results are summarized here.

The project's major reports, published in 2003, include:

"Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income."
Hadley, Jack. *Medical Care Research and Review*, 60(2) Supp. June 2003
Available at: http://www.kff.org/content/2003/4115/

"How Much Medical Care Do the Uninsured Use, and Who Pays for It?"
Hadley Jack and John Holahan. Health Affairs (Web Exclusive). Feb. 12, 2003
Available at: http://www.healthaffairs.org/WebExclusives/2202Hadley.pdf

"Covering the Uninsured: How Much Would It Cost?"
Hadley, Jack and John Holahan. Health Affairs (Web Exclusive). June 4, 2003.
Available at: http:www.healthaffairs.org/WebEXclusives/
Hadley_Web_Excl_060403.htm

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy. The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

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Comments by the
Service Employees International Union
On Hospital Billing Disparities for the Uninsured
June 24, 2004

The 1.6 million members of the Service Employees International Union (SEIU) are grateful that the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee has focused attention on the impact of hospital pricing, billing, and collection practices on uninsured and underinsured patients. Indeed, the impact is financially and personally devastating for many families, and it highlights the need for reforms from the hospital industry, government, and employers. In this document, we have attempted to add to the investigation of these critical issues by sharing the experiences of our members and the results of our own local research and advocacy effort on hospital collection practices.

SEIU members include health care workers and health care consumers. We see the impact of the uninsured and underinsured in over-crowded emergency rooms, in untreated illnesses and conditions that jeopardize jobs and family living standards, and in growing burdens on local safety net providers and state Medicaid programs.

SEIU also organizes and represents categories of workers who are least likely to have health insurance: immigrants working in low-wage, often part-time, service sector jobs. Our Justice for Janitors Campaign holds the profitable real estate industry accountable for creating jobs with employer-sponsored health coverage. Our organizing efforts among in-home caregivers have led to health coverage for tens of thousands of workers who previously were ineligible for job-based coverage. The struggles and sacrifices our members must make to win and maintain affordable coverage are enormous as employers of every size, in every industry and sector, continue to shift costs to workers and scale back coverage.

The Failing Safety Net

Some observers look at the problems of rising costs and rising numbers of uninsured Americans and say, "It's not as bad as it appears, because hospitals must and do treat all patients with 'emergency' health conditions." There is a perception among some policy makers that the complex and large public subsidies, together with private philanthropy provided to and by hospitals, in particular, creates a "safety net" for the uninsured. The experience of real patients with real illnesses and injuries suggests that the health safety net is failing to cushion the financial and health impacts of being uninsured and underinsured in America.

Medical Debt is a Growing Problem for Both the Uninsured and Insured

With the cost of health insurance increasing at double-digit rates, and employers shifting more of the financial responsibility to working families, a growing number of families are becoming burdened with medical debt. A 2003 Commonwealth Fund survey found that two of five adults--both uninsured and insured -- had problems paying their medical bills or accrued medical debt.[1] The problem was most severe among those who were uninsured at the time of the survey or had experienced a gap in insurance coverage in the past year. But even those who were insured continuously over the last 12 months reported problems. Not surprisingly, over half of those with incomes less than $35,000 per year were struggling with medical bills or paying off medical debt. In fact, nearly half of all personal bankruptcies are due in part to medical expenses.[2] The burden of medical debt is exacerbated by aggressive pricing policies and bill collection practices widespread in the hospital industry.

The Service Employees International Union's research at Yale-New Haven Hospital in Connecticut, Advocate Health Care in Chicago, and Sutter Health in Northern California found shockingly aggressive debt collection practices on the part of these non-profit, tax-exempt hospitals and their agents. Not only is home ownership threatened when hospitals place liens on primary residences, but employment security is undermined by wage garnishments, and the growing use of credit histories by employers in making hiring decisions.

At both Yale and Advocate we found institutions that garnished wages or placed liens on the homes of *their own employees* to recover debts incurred by ex-spouses or uninsured family members, or resulting from uncovered services or disputed coverage. [3], [4]Patients' bills often included interest rates of 10% and higher, and patients were encouraged to pay with credit cards carrying even higher rates. In one of the most egregious cases at Yale, we worked with a widower still burdened with interest and principal totaling almost $40,000 twenty years after his wife's hospital stay at Yale-New Haven Hospital. At Sutter, we met uninsured patients with small, fixed incomes whose modest savings accounts were drained by its collection agency. In Chicago, a Wal-mart worker could not afford food or medication and struggled to care for her hearing impaired daughter after her already low wages were garnished by Advocate Health Care. We found an unwillingness to work out reasonable payment plans with patients that recognized their economic circumstances and their good faith efforts to pay at Yale, Advocate, and Sutter.

"Full Sticker Prices" Stick the Uninsured with Even Bigger Bills

One unfortunate hospitalization can bring financial ruin to families that are uninsured or underinsured. The prices charged by hospitals to the uninsured, or "self-pay" patients whose coverage is denied or can be as much as three times higher than the prices paid on behalf of

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[1] The Commonwealth Fund Biennial Health Insurance Survey, 2003.

[2] Jacoby, Melissa B., et al, "Rethinking the Debate on Health Care Finance: Evidence from Bankruptcy Courts," New York University Law Review, vol. 76, no. 2, May 2001.

[3] Connecticut Center for a New Economy, Uncharitable Care: Yale-New Haven's Charity Care and Collections Practices, 2003.

[4] SEIU Hospital Accountability Project, Insult to Injury: Hospital Debt and Aggressive Collections Practices by Advocate Hosptals, 2003.

insured patients by third party payers such as Blue Cross. Testimony provided recently to the House Ways and Means Committee by Professor Glen Melnick at the University of Southern California noted that the national average hospital price markup was 211% above costs in 2003, but in some states, such as California, Florida, and Nevada, the ratio of charges to costs is almost 300%.[5] This "sticker price" is the price from which discounts are granted to private and public insurance programs. Unfortunately, the uninsured and other "self-pay" patients are generally charged the full "sticker price."

SEIU's research in Chicago highlights that even within a state or metropolitan area, hospital charges to uninsured patients can vary dramatically. Advocate Hospital and Health Care Corporation, a system including eight hospitals and two children's hospitals, set the highest gross charges in the market, and made the highest rate of profit from uninsured patients. After adjusting for severity of illness, SEIU found that Advocate's charges to uninsured and other "self-pay" patients were 40% higher than other private hospitals' charges in Cook County.[6] Data from the California Public Employees Retirement System (CalPERs) also indicates that some hospital systems, such as the Sutter system, have charges out of line with the rest of the industry in the state. In California, where the statewide average charges are already high, Sutter's charges are 80% higher than the average hospital charges, according to CalPERs.[7]

SEIU has supported policies at the state and local level to remedy the problems of discriminatory pricing and predatory lending. We supported legislation in Connecticut that requires hospitals to offer discounts to low-income uninsured patients at cost, limits the interest rates on outstanding hospital balances, and offers patients other important protections. We are working in both California and Illinois on similar legislation. In Maine, we fought for comprehensive health care reform that includes publication of average hospital charges for fifteen of the most common procedures and treatments, the disclosure of these prices by individual providers, and a new buying pool for small businesses and individuals that allows them access to third party discounts.

Because hospitals claimed federal regulations forced them to adopt aggressive pricing and collections policies, SEIU reviewed Medicare regulations and concluded that hospitals faced few legal barriers to adopting explicit discounting policies, more generous charity care policies, and more reasonable collection efforts. We were encouraged to see Secretary of Health and Human Services Thompson provide strong encouragement to the hospital industry in these areas, and we are pleased that some hospital systems and hospital associations are taking voluntary steps to do more. Two of the first hospital systems to acknowledge the problems of high charges and aggressive collections practices for the uninsured, and take steps to reduce the burden on the uninsured before Secretary Thompson's letter were HCA and Tenet, both for-profit hospital chains. HCA has publicized its sliding scale discount policies, which apply to uninsured and underinsured patients well-above the poverty level at all its hospitals.

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[5] Melnick, Glenn, Ph D, Director of Center for Health Financing, Policy and Management, University of Southern California, Testimony before the Subcommittee on Health, House Ways and Means Committee, March 9, 2004.

[6] SEIU Hospital Accountability Project, Uninsured and Overcharged: Why the Working Poor Pay More than Their Fair Share for Hospital Care, 2003.

[7] Rapaport, Lisa, "CalPERS Could Drop 15 Sutter Hospitals," Sacramento Bee, 2/19/04.

Investor-owned hospital companies have begun to disclose the impact on shareholders of the bad debt from uninsured patients. They are also beginning to quantify the impact that higher cost sharing for insured patients is having on their bottom lines. In a recent call with Wall Street analysts, Tenet Healthcare reported that uninsured discharges were up 12.8% for the last quarter of 2003, and the previous quarter had grown nearly 20%. In fact, most of patient volume growth came from uninsured discharges.[8] We hope greater recognition of this impact will prompt both for-profit and nonprofit hospitals, and their respective trade associations, to devote more of their political efforts to solving the problem of the uninsured.

Charity Care is a Well-Kept Secret

Charity care is usually defined as care that is "written off", with no attempt at collection because the patient is low-income ("indigent") and uninsured. [9] Tax-exempt "501(c)(3)" status at the federal level is granted to health care providers that are organized and operated for charitable purposes and meet a "community benefits" standard as defined in a series of Internal Revenue Service rulings. Adopting a charity care policy, communicating that policy to the public, and quantifying the amount of charity care provided are actions that tax-exempt hospitals should take to demonstrate they are meeting their community benefits obligation. The federal tax code and regulations do not require that tax-exempt hospitals provide a minimum amount of charity care, nor do they define minimum patient eligibility standards for charity care.

There is extraordinary variation across hospitals in the actual provision of charity care. For example, the City of San Francisco reports that the City's public hospital, San Francisco General, accounts for 78% of all of the charity care patients in the City. [10] It also notes that two hospitals belonging to Sutter Health System, St. Luke's Hospital and California Pacific Medical Center, had widely different charity care policies. By contrast, the two San Francisco hospitals belonging to Catholic Healthcare West had identical charity care policies. In the aggregate, the value of the federal, state, and local tax exemptions of the San Francisco tax-exempt hospitals was almost *seven* times the value of the amount of charity care they provided.

Charity care makes up a minor portion of the "community benefits" that hospitals provide. A recent report done by the Washington State Hospital Association indicates that only 26% of the aggregate amount of community benefits calculated was devoted to charity care. The majority—52%--was a Medicaid "shortfall" calculation, or the financial loss hospitals estimate they experience treating Medicaid patients. The remaining 22% was spent on community services, such as health education and outreach programs. [11] The total value of the tax exemptions calculated by the Washington State Hospital Association was also well in excess of the collective amount devoted to charity care by the state's hospitals. Calculations done by the Washington State Department of Health indicate that, in total, hospitals barely spent 1% of their total revenues on charity care in 2001. [12] Like the San Francisco study, the Washington State

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8 Transcript of Tenet Fourth Quarter 2003 Earnings Conference Call, March 16, 2004.

9 See 42 CFR Sec. 413.80(b)(2).

10 San Francisco Department of Public Health, Office of Policy and Planning, FY 2002 San Francisco Hospital Charity Care Reporting, 2003.

11 Washington State Hospital Association, Community Benefits Inventory, December 2003.

12 Washington State Department of Health, Charity Care in Washington Hospitals, 2001, June 2003.

data indicates that charity care is highly concentrated in a small number of hospitals. King County is home to the City of Seattle, and like San Francisco, the public hospital Harborview Medical Center, provides the overwhelming majority of charity care in King County. SEIU's analysis of data from Chicago also indicated that almost 25% of all of the charity care provided in that market was provided by Cook County Hospital. [13]

SEIU's research at Yale-New Haven Hospital revealed that despite having significant resources to devote to charity care, Yale's charity care accounts dropped by 46% from 1996 through 2001. In its own accounting statements, Yale-New Haven Hospital identified $37 million that donors had contributed expressly to enable the provision of "free bed" days. After accounting for Medicaid disproportionate share subsidies, the amount of free or charity care provided was a mere $12,000. We found that most uninsured patients were never notified of the availability of free care, and those that asked were rarely qualified. Instead, they were subject to aggressive billing practices, including collections agencies that routinely garnished 25% of paychecks, seized modest savings accounts, imposed court costs and attorneys' fees, and moved to foreclose on families' primary residences. Despite profit margins well above the California statewide average, Sutter Health devotes less than 1% of its revenues to charity care, a proportion well below the statewide average. [14]

Local communities and policymakers should better define charity care, and require uniform reporting from hospitals so that they can evaluate the performance of tax-exempt hospitals on this important community benefit. Washington State and San Francisco have begun to do this through setting common definitions and standardized reporting mechanisms, and releasing public reports. SEIU recommends other states and localities consider similar reforms. It is also important to look at charity care in the context of the distribution of direct and indirect subsidies, which include Medicaid disproportionate share payments, local tax support, and the value of tax exemptions. Ohio, as part of its formula for distributing Medicaid disproportionate share funds, defines a minimum charity care threshold, requires uniform hospital reporting, distinguishing between charity care and bad debts, and maintenance of individual patient account logs. Few other states require such detailed reporting in their disproportionate share programs.

Medicaid Disproportionate Share: More Transparency, Better Targeting Needed

For over twenty years, Congress has required that states recognize the financial stress placed on hospitals that serve a "disproportionate share" of Medicaid and low-income patients. The federal commitment to Medicaid disproportionate share hospital payments is roughly $10 billion. Title X of the recently enacted Medicare Modernization Act requires states to provide more detail on the distribution of Medicaid disproportionate share funding, and the extent to which Medicaid DSH funds reduce hospital uncompensated care costs by hospital. This is a positive step. SEIU strongly supports the Medicaid disproportionate share program, but recognizes the need for more transparency and accountability in the program. Combined, federal and state Medicaid disproportionate share payments are by far the largest source of funding for

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[13] SEIU Hospital Accountability Project, The Myth of Charity Care at Advocate Hospitals, 2003.

[14] Health Access and SEIU Local 250, Your Money or Your Health: Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health, April 2004.

hospital uncompensated care, dwarfing any private contributions made by hospitals themselves.[15]

Conclusion

SEIU is encouraged by the Subcommittee's interest in these issues, and we hope that it will lead to broader action by the Congress to increase accountability in the non-profit hospital sector and address the health care crisis. We have a shared obligation to act now, before the crisis worsens.

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[15] Hadley, Jack and John Holahan, "Covering the Uninsured: How Much Would It Cost?", Health Affairs, June 2003 www.healthaffairs.org.

August 5, 2004

Anthony M. Cooke, Esquire
Majority Counsel
Office of Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
H2-316 Ford House Office Building
Washington D.C. 20515

Dear Mr. Cooke,

Enclosed, in question and answer form, are the responses of Tenet Healthcare Corporation to the questions put forth in the July14, 2004, letter from Mr. James C. Greenwood, Chairman of the Subcommittee on Oversight and Investigations.

If you have any additional questions, please contact me at 469-893-6579.

Sincerely,

Douglas S. Clarkson
Assistant General Counsel
Tenet Healthcare Corporation

DSC/vrd
Enclosure

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Responses from Mr. Trevor Fetter, President and CEO of Tenet Healthcare Corporation to Questions for the Record, Dated July 14, 2004 From The Honorable James C. Greenwood Regarding the June 24, 2004, Subcommittee on Oversight and Investigations Hearing Entitled "A Review of Hospital Billing and Collection Practices"

1. **Please produce, for the record, a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.**

   Tenet previously provided materials regarding Tenet's collection and billing practices. The following items are provided to supplement prior submissions:

   a. Memo of January 27, 2004 regarding Tenet Charity Care Policies.

   b. Business Office Procedures Manual (Charity Care Policy). (revised 1/30/04)

   c. Medical Eligibility Program (Procedures for qualifying self-pay patients for government programs/financial assistance). (Eff. Nov. 1, 2003)

   d. Medical Eligibility Program (Procedures for routing account cancelled from Medical Eligibility Program). (Eff. May 12, 2004)

   e. Centralized Patient Financial Services-Tenet Financial Assistance Program. (Procedures for Charity Care Recommendations Effective 1/1/2003)

   f. Business Office Procedures Manual (Indigent Care Policy). (Revised 9/11/03)

2. **If your system has implemented any changes recently to your charity and collection policies and procedures, with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures, with respect to uninsured/self-pay patients, please state the planned date of implementation of each such change.** There have been no recent changes in our collection policies and procedures except as necessary to implement the Compact with the Uninsured. Attached is Tenet's most recent implementation schedule for discounts for the uninsured under the Compact.

3. **Please produce, for the record, all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures, with respect to uninsured/self-pay patients.**

   Attached is the most recent draft of training materials to be used in implementing the discounts under the Compact with the Uninsured.

4. **How are patients made aware of your charity policy and how is the substance of that policy made available to patients; e.g., brochures, postings in the hospital or on the system website?**

   Hospital financial counselors and Patient Advocates are trained to identify uninsured patients and educate them on the key elements of the Compact with the Uninsured, including patient discounting policies. Signs which tell uninsured patients about the Compact and how they can obtain more information will also be prominently displayed in hospital patient waiting areas. Lastly, the key elements of the Compact with the Uninsured are two "clicks" away on the company website, tenethealth.com.

5. **For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of poverty?**

   a. **Are there plans to change the discount percentage rates as charges rise?**

   Tenet's Compact with the Uninsured proposes discounts to the uninsured without reference to a sliding scale based on federal poverty guidelines. Tenet is looking at an appropriate alternative to uninsured discounts in Texas since state law currently limits our ability to offer uninsured discounts there. In Texas we are considering a sliding scale policy based on the patient's financial condition, similar to our current charity policy. Our current Charity Policy provides relief from bills to patients who fall under 200% of federal poverty guidelines (300% for catastrophic illness). The policy primarily focuses on the patient's financial condition and not the charges.

6. **The AHA states that, in 2002, the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care . . . for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursement and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?**

This question suggests that DSH payments are intended to provide some form of subsidy or offset to hospitals for the cost of caring for the uninsured. This is not our understanding of the purpose of DSH payments.

Congress made DSH payments available for certain PPS hospitals because studies concluded that low income patients were more costly for hospitals to treat. See Social Security Act Section 1886(d). The DSH payment mechanism was established to compensate specific hospitals that treat a high proportion of low income patients, specifically, those who qualify for federal Supplemental Security Income ("SSI") coverage, to assure that these hospitals are not penalized financially for doing so. Currently, there is no measure for uncompensated care in the DSH payment formula, so the relationship between DSH payments and uncompensated care for the uninsured appears tenuous. For continuing operations, the sum received from state and federal agencies for providing uncompensated care is approximately 30% less than the cost to deliver the uncompensated care.

7. **Did HHS / OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self-pay patients? What specific further guidance is needed?**
The guidance has been sufficient. We will continue to seek guidance on state law, such as in Texas, which may affect how we may implement uninsured discounts in specific jurisdictions.

8. **Have your ever reviewed and investigated complaints from patients against any of your collection agencies?**

Yes. We take allegations about collections problems very seriously. We actively pursue any patient complaints and take appropriate disciplinary action. Furthermore, we train our collections staff on the Compact with Uninsured and our customer service expectations.

9. **Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse other means of paying undiscounted charge master rates(except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?**

No. Patients without insurance that do not meet the terms of other government programs will be offered the uninsured discount (where permitted by state law). The only exception will be for cosmetic surgery and other elective procedures and for international patients entering the US for the sole purpose of receiving healthcare.

10. I am concerned that some hospitals may not be negotiating contracts with HMO's in good faith and then instituting a "billed charges" policy that results in increases in Medicaid costs. Do you believe this is a significant problem? What ways do you suggest combating the issue?

We assume this question regards negotiations between hospitals and HMO's that cover Medicaid-eligible populations. This is not a significant problem. HMO's frequently pay no more than (and sometimes pay less than) Medicaid fee for service rates for services provided to Medicaid eligible populations at a non-contracted hospital.

QUESTION NUMBER 1

MEMORANDUM

Date: January 27, 2004

To: Distribution

From: Mike Gallo

Subject: Tenet Charity Care Policy Revision

Tenet's Charity Policy has been revised. As law and regulation differs from State to State, any specific State Law will take precedence over the Tenet Policy guidelines. This policy supports Tenet's ability to identify and classify patients to the extent that Charitable Care was provided to a patient who is not, nor is ever, expected to be able to pay for treatment.

The significant change to the policy is the implementation of co-pay provision summarized as follows:

- The co-pay amount is based on patient type; Emergency Room patients and Outpatients will be charged a flat fee of $100, inpatients will be charged $200 for each day in the hospital with a cap of $2,000.
- Since the Charity determination is often made after the patient's discharge, attempts should be made at the time of admission to collect the co-pay amounts for all uninsured patients, not just those presumed to be charity.
- If the facility practice is to collect a larger down payment than is called for in the Charity policy, they may continue to do so provided that if a patient qualifies for charity; they are refunded the difference between the original down payment and the charity copay.
- Facilities that have prompt pay discounts for self pay patients may continue their current practice.
- Any uncollected co-pay amounts will be written off to bad debt and follow Tenet's normal collection process.

The policy has been approved by Finance leadership and is effective immediately. Please notify Financial Counselors and Admitting Departments of this change. For additional information or clarification, you may contact Heather Smith at 469.893.4026 or Fawzia Hirji at 714.704.9387.

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POLICY

The determination of Charity Care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Designation as Charity Care will only be considered after all payment sources have been exhausted. The co-pay amount will be pursued for all charity accounts with the exception of deceased and homeless patients with no other guarantor. Patient account transactions for Charity Care must be posted in the month the determination is made.

The flat rate "co-pay" amount is based on patient type. Emergency patients and outpatients are required to pay $100 flat rate and inpatients are required to pay $200 per day, with a $2,000 cap.

In the event the account has been assigned as Bad Debt to SOS/CFC as part of the monthly SOS journal entry, it will reverse the PA recovery that was given on an account determined to be Charity Care.

Note: EMPLOYEES OF TENET SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A WRITE-OFF TO CHARITY CARE UNTIL THE DETERMINATION HAS BEEN MADE.

SCOPE

All Tenet Patient Accounting Platforms

PURPOSE

To define Charity Care and to distinguish Charity Care from accounts assigned to Bad Debt. Additionally, to establish policies and procedures to ensure consistent identification, accountability, and recording of charity at all Tenet entities and facilities.

DEFINITIONS

Charity Care represents all healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt expense previously recorded.

Charity Care will be classified into four categories:

1. Charity Care – Statutory
2. Charity Care – Non-Statutory
3. Charity Care – Medicaid Denied Stays/Care, Non-Covered Services
4. Charity Care – Catastrophic Medically Indigent

CHARITY CARE – STATUTORY

Statutory Charity Care will be defined by facility participation in various Federal, State, and/or County uncompensated care programs. Criteria for such Charity Care must comply with governmental guidelines and/or State or County regulations. Statutory Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility. Each patient who appears eligible for Statutory Charity Care determination and requests such determination must complete a Confidential Medical and Financial Assistance Application (hereafter referred to as the Confidential Financial Application—or, as application—as illustrated in *Exhibit B)*. The patient/guarantor must complete all areas of the application and attest to the accuracy of the information by signing the application. The application will be processed in accordance with the Tenet Charity Care Program Policy and Procedures.

Each facility may need to have a number of Statutory Charity Care accounts to provide for the separation and identification of Charity Care by specific program and/or obligation. Statutory Charity Care will generally be identified at the time of admission by the facility, Tenet Financial Assistance Center (TFAC), or while the patient is in-house; however, it may also be identified after discharge.

The following accounts have been added to the Acute Chart of Accounts:

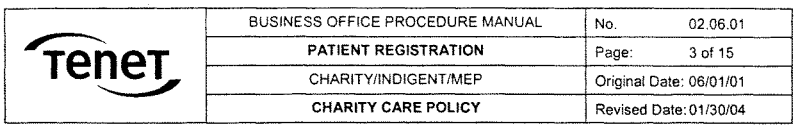
- 5950-3934 Charity Discount - Statutory I/P
- 5950-4934 Charity Discount - Statutory E/R
- 5950-6934 Charity Discount - Statutory O/P

CHARITY CARE – NON-STATUTORY

Non-Statutory Charity Care is defined as patient Charity Care meeting Tenet's Charity Care criteria; however, there may not be State or County programs in which the facility participates or where the facility does not have specific obligations to provide Charity Care. TFAC will determine eligibility for Non-Statutory Charity Care. The determination will be performed after the Confidential Financial Application is submitted for processing. An effort will be made to secure a signed application, but this may not be possible in all cases and will not prevent an account from being qualified by TFAC as Charity Care.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3935 Charity Discount - Non-Statutory I/P
- 5950-4935 Charity Discount - Non-Statutory E/R
- 5950-6935 Charity Discount - Non-Statutory O/P



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CHARITY CARE – MEDICAID

Medicaid Charity Care will be defined as a category of patients who qualify for Medicaid, pursuant to governmental guidelines and/or State or County regulations, but where an outstanding patient balance exists, excluding waivers of deductibles and co-payments, unless otherwise documented and compliant with Tenet Regulatory Compliance Policy guidelines. Medicaid Charity Care also includes any Charity Care obligations as defined in contractual agreements documenting the acquisition of the facility.

Each patient who appears to be eligible for Medicaid Charity Care determination will not be required to complete a Confidential Financial Application due to the fact that Medicaid eligibility, in itself, is deemed to meet the requirements of Charity and, therefore, meets Tenet's criteria for Charity Care.

Under the Tenet Medicaid Charity Care Policy definition, these patients are eligible for Charity Care write-offs. Charges not billable or "un-billable" to the patient may not be claimed as Charity Care where it is not allowed by State law/regulation. Billable charges related to denied days, denied days of care, non-covered services, and any denied treatment authorizations will be included as Medicaid Charity Care. In addition, Medicare patients who have Medicaid coverage for their co-insurance deductibles for which Medicaid will not make any additional payment, and for which Medicare does not ultimately provide Bad Debt reimbursement, will also be included as Charity Care.

At no time shall a facility claim Charity Care attributed to Medicaid billable charges as either Statutory or Non-Statutory Charity.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3940 Medicaid Denied Days I/P
- 5950-4940 Medicaid Denied Services E/R
- 5950-6940 Medicaid Denied Services O/P

CHARITY CARE – CATASTROPHIC MEDICALLY INDIGENT

For patients whose family income to the Federal Poverty Guidelines (FPG) ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for the Catastrophic Medically Indigent category. The determination for this is completed after comparing the patient's gross income, income to FPG ratio, and amount of hospital charges as follows:

1. **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.
2. **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).
3. **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4. **Unable to Pay**—It is determined the patient is unable to pay.

The following account descriptions have been revised in the Acute Chart of Accounts:

- 5950-3941 Catastrophic Medically Indigent Discount - I/P
- 5950-4941 Catastrophic Medically Indigent Discount - E/R
- 5950-6941 Catastrophic Medically Indigent Discount - O/P

PROCEDURE

The hospital Financial Counselor or MEP Patient Advocate will attempt to identify potential Statutory and Non-Statutory Charity Care at the time of admission or while the patient is in-house. At the time of Charity identification, the financial class will be changed to Charity Care, the co-pay will be collected based on admission type, and a 100% Charity Care allowance should be taken for these patients. At the time of the financial class change, the patient's account will be assigned to TFAC and the Confidential Financial Application should be forwarded to TFAC for review and processing. Additionally, all CFC-, MEP-, and Early Out-assigned patient accounts—post-discharge—that qualify to be reviewed for Charity Care should be forwarded to TFAC. Completed Charity Care packets will be forwarded to the respective facility. TFAC will also retain the Charity Care packets, including applications for Charity Care, appropriate back-up documentation, and recommendations for possible retrospective audit by the Business Office and/or Tenet Audit Services.

FACTORS TO BE CONSIDERED

Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published FPG, or an equivalent thereof. The patient's gross income information may be obtained from a Confidential Financial Application, but is not required. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, Financial Assistance Coordinator, or other specifically designated Tenet employee.

Other factors may include, but are not limited to, the following:

1. The patient's employment status, credit status, and capacity for future earnings.
   - Patients who are unemployed and do not qualify for a government program
   - Patients who have no credit established and no Bad Debt collection accounts
   - Patients with a lack of revolving credit account(s) information
   - Patients with a lack of revolving bank accounts(s) information
   - Patients with delinquencies reported on open trade line accounts
2. The previous exhaustion of all other available resources.

3. International patients are considered on a case-by-case basis for ER treatment and/or ER admission only.

4. Catastrophic illness.

MEP PROCEDURE

The MEP Patient Advocate should screen patients for potential linkage to Government/County programs. During the screening process, the Advocate should secure a Confidential Financial Application. The application is to be used for potential Charity Care determination only in the event MEP is unable to obtain eligibility for the patient for Government Programs reimbursement. For potential linkage to Government/County programs, the Patient Advocate will:

1. Change the financial class and assign the account to MEP within five days from date of discharge, thereby, netting the account to expected governmental reimbursement.

2. Make a final determination as to whether linkage will prevail within an additional 25 days from the assignment date, totaling no more than 30 days from date of discharge.

3. Return the account to the facility for assignment by the Business Office to Early Out for Self-Pay if it is determined that program linkage will not prevail within the additional 25 days from assignment date, and there are no other payment or third-party payment sources. Those meeting the financial guidelines for Charity Care will be assigned by the Business Office to TFAC with the appropriate financial class. The co-pay should be collected by the hospital's Financial Counselor, Business Office representative, or TFAC representative.

If, during the initial interview with the patient, it is revealed that there is no viable source of payment and the patient will not qualify for any governmental programs, the Patient Advocate will:

1. Offer the patient a Confidential Financial Application form.

2. Assist the patient in completing a Confidential Financial Application, which will document the patient's financial need.

3. Obtain the patient's signature on the Confidential Financial Application and forward the application to the Financial Counselor or TFAC, as deemed appropriate.

4. Refer the patient to the hospital Financial Counselor for collection of the co-pay.

MEP PROCESSING FOR CHARITY CARE

For those accounts that remain in MEP past 30 days from assignment with no government program linkage and that meet the financial criteria for Charity Care, MEP should have gathered all substantial information to enable the facility to affect Tenet's Charity Care Policy. Included in the Charity Care packet is a Confidential Financial Application. If the MEP representative has exhausted all efforts to secure all necessary verifications, the application for Charity Care should be submitted to TFAC for review and finalization without the verifications.

MEP is required to notify the Business Office of the inability to obtain eligibility, or the potential qualification for Charity Care classification, and to return the account to the Business Office.

The Business Office is required to update the plan ID and financial class for assignment to TFAC.

TFAC will further assess the application.

FINANCIAL COUNSELOR PROCEDURE

Patients assessed by a Financial Counselor to have no third-party coverage and/or benefits available will:

1. Be offered the facility flat rate or Prompt Pay Discount Program where allowed by State law/regulation.

2. Be assessed for Charity Care in the event he or she is unable to pay the facility flat rate or Prompt Pay Discount Program amount (as applicable to State law/regulation), and meets the income/asset and other guidelines set forth by the Charity Care Policy.

The Financial Counselor will take the appropriate steps as outlined below:

1. For patients who appear to meet the income guidelines set forth in this policy for Charity Care, the account should be updated with the financial class of Charity on the facility system, at which time, a 100% Charity Care reserve should be taken and the co-pay amount should be collected. The patient account is then assigned to TFAC for review follow-up and a final Charity Care recommendation. The Financial Counselor should forward the Confidential Financial Application to TFAC.

2. Patients who do not qualify for Charity Care should be treated as a Self-Pay, and standard A/R collection procedures will apply.

TENET FINANCIAL ASSISTANCE CENTER

All accounts assigned to TFAC that are potentially Charity Care will be evaluated within 25 days. During the assessment period, the account's financial class may be changed to Charity Care on the facility's system and a 100% reserve taken.

Those accounts that do not meet the financial guidelines, which were assigned to TFAC for Charity Care assessment, will have the financial class changed to Self-Pay on the facility's system and will be assigned to Early Out.

For patient accounts meeting the Charity Care guidelines:

1. The TFAC Financial Assessment Coordinator will gather all substantial information to enable the facility to affect Tenet's Charity Care Policy.

2. The Charity Care packet should include a Confidential Financial Application, a Credit Bureau Report, and any other documents that substantiate the patient's financial need for Charity consideration. Where the patient is unable to complete a written Confidential Financial Application, verbal attestation is acceptable.

   The amount of information to support a Charity Care recommendation will vary depending on TFAC's ability to effectively obtain the information from the patient or family.

When TFAC is unable to obtain hard-copy documentation from the patient or family, but all indications—from the information received verbally or in writing at the time of service (or soon thereafter)—are that the patient would qualify for Charity Care, then TFAC will complete a Confidential Financial Application recommending Charity Care. The application will include:

- A Credit Bureau Report or summary
- An analysis that supports the recommendation for a Charity Care adjustment

3. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

   - Credit Bureau Report (including the lack thereof)
   - IRS tax returns
   - Payroll stubs
   - Declarations
   - Verbal attestation
   - Other forms used to substantiate the need for Charity Care consideration

4. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG table (refer to *Exhibit A*), which is updated annually. The patient's family size is used to determine whether monthly or annual income falls at, below, or exceeds 200% of the FPG. Where State law/regulation does not allow for consideration of Charity up to 200% of the FPG, the State law/regulation will take precedent and be enforced.

   a. If the family gross income falls below, or is at the designated income of the FPG ratio threshold, the patient's account will be considered for Charity Care adjustment at 100% minus the co-pay amount (Note: Tenet Policy's ratio is 200%, which is influenced by State law/regulation).

   b. For patients whose family income to the FPG ratio is greater than the designated threshold allowance (Tenet, State, or local-specific), but less than 300% of the FPG, the patient may be considered for a Catastrophic Medically Indigent discount. The calculation for this is completed after comparing the patient's gross income, income to the FPG ratio, and the amount of hospital charges as follows:

      1) **Income/FPG Ratio**—Gross income to FPG ratio is greater than 200% or less than or equal to 300%.

      2) **Income Limit**—Gross family income is not to exceed two times the FPG for a family of six (2003 Guidelines $24,680 x 2 = $49,360).

      3) **Charges > 2 Times Income**—Total hospital charges for a patient for the preceding six months is more than twice the family's total gross annual income.

4) **Unable to Pay**—It is determined the patient is unable to pay.

Note: All four of the above criteria must be met for consideration as Catastrophic Medically Indigent.

c. If the co-pay was not collected at the time of service, the Financial Assistance Coordinator will attempt to collect the amount before the Charity Care packet is submitted.

5. The Financial Assistance Coordinator will complete a Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG guidelines.

6. TFAC is to review the application for Charity Care for appropriateness and completeness. Initialing the application indicates that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.

7. If the TFAC representative has exhausted all efforts for those patients who meet Government Programs or Charity Care criteria, but are unable to complete the required applications and documentation (e.g., unable to contact the patient, unable to provide sufficient documentation, etc.), and/or have a potential change in future circumstances and recovery, then the account will not be recommended for a Charity Care allowance.

8. Those patients who do not meet the guidelines for Charity Care will have their accounts changed back to Self-Pay, and standard A/R follow-up will begin.

At all times, the Collection, Support, and Management staff of TFAC are required to input complete documentation on the account of all actions taken and all information received from the patient. It is the responsibility of the TFAC Operations management to ensure adherence to this policy.

DOCUMENTATION

CONFIDENTIAL FINANCIAL APPLICATION

In order to qualify for Charity Care, Tenet requests each patient or family to complete the Confidential Financial Application. This application allows the collection of information about income and the documentation of other requirements as defined below. Pending the completion of the application, the patient should be treated as a Charity Care patient in accordance with Tenet's Charity Care Policy as set forth here. The patient's account will have the financial class changed to Charity Care on the facility's HIS system.

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by State law/regulation.

A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.

1. **Family Members**—Tenet will require patients to provide the number of family members in their household.

   a. Adults—To calculate the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all of their dependents.

   b. Minors—To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

2. **Income Calculation**—Tenet requires patients to provide their household's yearly gross income.

   a. Adults—The term "yearly income" on the application means the sum of the total yearly gross income of the patient and the patient's spouse.

   b. Minors—If the patient is a minor, the term "yearly income" means the income from the patient, the patient's mother/father and/or legal guardian, and all of their other dependents.

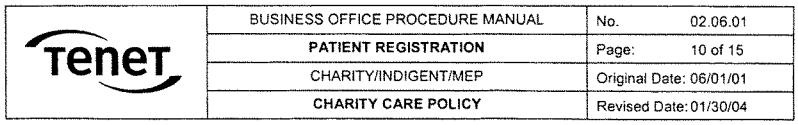
3. **Expired Patients**—Expired patients may be deemed to have no income for purposes of the Tenet calculation of income. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient's financial status will be reviewed at the time of death by TFAC to ensure that a Charity Care adjustment is appropriate. The co-pay will be waived if no other guarantor appears on the patient account.

4. **Homeless Patients**—Patients may be deemed homeless once verification processes have been exhausted by TFAC. The co-pay will be waived if no other guarantor appears on the patient account.

INCOME VERIFICATION

Tenet requests patients to attest to the income set forth in the application. In determining a patient's total income, Tenet may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. Any of the following documents are appropriate for substantiating the need for Charity Care:

1. **Income Documentation**—Income documentation may include IRS W-2 form, Wage and Earnings Statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, signed attestation to income, bank statements, or verbal verification from patient.



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2. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.

3. **Assets**—All liquid assets should be considered as a possible source of payment for services rendered. For patients with no source of regular income (employment, SSI, disability, etc.) other than liquid assets, those assets would be the patient's income source and should be measured against the FPG.

INFORMATION FALSIFICATION

Information falsification will result in denial of the Charity Care application. If, after a patient is granted financial assistance, the hospital/SOS finds material provision(s) of the application to be untrue, Charity Care status may be revoked and the patient's account will follow the normal collection processes.

REVENUE CLASSIFICATION

It will be the responsibility of each Business Office to maintain the integrity of account classification on the hospital patient accounting system. Prior to month-end close, TFAC is responsible for providing detailed reports listing critical changes in account class between Self-Pay and Charity for any A/R account assigned to TFAC. The Business Office is required to use those reports to update the changes in the patient accounting system prior to the month-end.

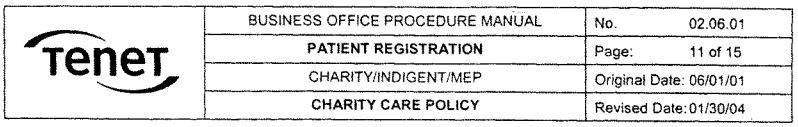
Critical changes in account class are defined as:

- Any account originally assigned to TFAC as Self-Pay that is re-classed as a result of meeting the criteria for Charity Care

- Any account originally assigned to TFAC as Charity that is re-classed to Self-Pay as a result of denying Charity Care

DENIED CHARITY CARE RECOMMENDATIONS

In the event the CFO denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial. The packet is then to be forwarded to TFAC for review. After an initial review and discussion with the CFO, for those patient accounts where disagreement still prevails, and the accounts that meet Tenet guidelines for Charity Care as set forth here, a denial summary will be sent to the respective Tenet Regional Vice President of Finance by TFAC for resolution. For those patient accounts that the Regional Vice President of Finance has denied that have met the Tenet Charity Care guidelines as set forth here, a denial summary will be sent to the respective Tenet Divisional Senior Vice President of Finance for conference and resolution.



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CUSTODIAN OF RECORDS

TFAC will serve as the custodian of records for all Charity Care documentation for all accounts identified by SOS, MEP, and CPFS.

RESERVATION OF RIGHTS

It is the policy of Tenet and the hospital to reserve the right to limit or deny financial assistance at their sole discretion.

- **Non-Covered Services**—It is the policy of Tenet and the hospital to reserve the right to designate certain services that are not subject to the hospital's Charity Care Policy.
- **No Effect on Other Tenet Regions/Hospital Policies**—This policy shall not alter or modify other Tenet policies regarding efforts to obtain payments from third-party payors, patient transfers, emergency care, State-specific regulations, State-specific requirements for Statutory Charity Care classification, or programs for uncompensated care.

Exhibit A – Federal Poverty Guidelines

2003 Federal Poverty Guidelines (FPG) are as follows:

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	**200% of FPG**	**300% of FPG**	**100% of FPG**	**200% of FPG**	**300% of FPG**	**100% of FPG**	**200% of FPG**	**300% of FPG**
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

TENET

Exhibit B – Confidential Financial Application

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A
MEDICAL ASSISTANCE SCREENING- *Please circle answer "Y" for yes or "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
   If yes, does the patient have a 30-day incapacitation?
5. Is the patient pregnant, or was the admission pregnancy-related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B
FINANCIAL ASSISTANCE SCREENING
Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/or legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

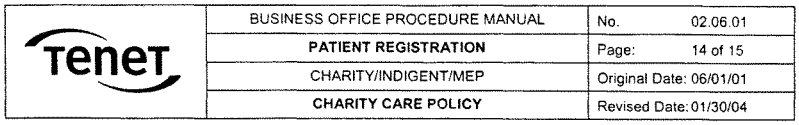
Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size
_____ ÷ _____ = _____%

Type of Service Circle one ER OP IP

Service Date _____ to _____

Co-Pay Amount $_____



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	CHARITY/INDIGENT/MEP	Original Date: 06/01/01
	CHARITY CARE POLICY	Revised Date: 01/30/04

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	**200% of FPG**	**300% of FPG**	**100% of FPG**	**200% of FPG**	**300% of FPG**	**100% of FPG**	**200% of FPG**	**300% of FPG**
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,860	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Check One – ☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Check One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. _____
Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet's or its subsidiaries provided care

_____ _____
PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			

Recommendation:

Prepared by _____ Date _____ Unit _____

Approved or Denied by _____ Date _____ Title _____

TENET TENET PATIENT FINANCIAL SERVICES MEDICAL ELIGIBLITY PROGRAM POLICY AND PROCEDURE MANUAL	TITLE: MEP-Financial Screening of Inpatient Self-Pay Patients Effective Date: November 1,2003	M14 Page 1 of 1

PURPOSE: The purpose of this policy is to ensure that all self-pay uninsured or underinsured patients are screened properly for government programs and financial assistance.

POLICY: It is the policy of MEP to work collaboratively with facilities and coordinate a process of screening every self-pay inpatient for ability to pay or linkage to a government program and or Potential Qualification of the Tenet Financial Assistance Program.

PROCEDURE:

1. Upon admission, the hospital admitting department will register self-pay patients in Self-Pay financial class.

2. The Hospital Financial Counselor will screen patients at bedside for patient's ability to pay. Any discounts or cash pay arrangement will be made at this time. If insurance is identified at this time, Hospital Financial Counselors will re-classify the account appropriately on the HIS System.

3. If the patient has no ability to pay or cash arrangements were not made, the Hospital Financial Counselor will refer the account to MEP Patient Advocate for further screening.

4. MEP Patient Advocate will screen patients at bedside for linkage to government programs and Financial Assistance programs. MEP will assist the patient with completion of CFS form in the event Financial Assistance will be considered at a later date.

5. If linkage is identified, MEP will re-class the account appropriately to an MEP financial class for assignment.

6. If no linkage is identified, the MEP Patient Advocate will refer the account back to the Hospital Financial Counselor prior to patient discharge. The MEP Patient Advocate will update the financial class to 'Financial Assistance' or' Self-Pay' as appropriate.

7. The Hospital Financial Counselor will make one more attempt to discuss a payment plan or discount cash-pay options with the patient. If the patient commits to cash arrangement, the Hospital Financial Counselor will update the financial class appropriately.

8. In the event MEP is unavailable for screening, the Hospital Financial Counselor will complete the MEP Patient Screening form. If the outcome of the screening indicates MEP referral, the account will be classed as MEP pending in financial Class 52 (MEP Pending Screening).

TENET PATIENT FINANCIAL SERVICES MEDICAL ELIGIBILITY PROGRAM	TITLE: MEP Cancel Procedure Effective Date: May 12, 2004	Page 1 of 2

POLICY:

To appropriately route/re-class the receivable upon cancellation from the MEP line of business.

SCOPE/IMPACT:

Open active inventory within the Medical Eligibility Program to be cancelled from the line of business. Cancellation process is to be completed by Supervisor or above. Appropriate actions should be taken on patient account within the ACE and Hospital IS platform to classify the receivable accurately.

Separate procedures are identified for HL7 and non HL7 environments. Utilize the correct processes for the appropriate IS environment and platform.

PROCEDURE:

Once determined all work effort has been exhausted within the Medical Eligibility Program line of business, the following procedures will be utilized to determine appropriate routing of accounts to either TFAC or the facility for further action.

A. Determination made by Supervisor or Manager that the MEP work effort was complete and the file should be cancelled from the line of business.

1. If potential eligibility exists for qualification to the Tenet Financial Assistance program the CFS and any supporting documentation will be win-faxed to TFAC prior to cancellation. The following functions will be completed in ACE upon cancel from MEP.

a. Document CZ line with the following information if available.

- Reason for cancel from MEP
- Total Charges on account
- Any additional information necessary for TFAC processing

2. If patient **does not** potentially qualify for Tenet Financial Assistance Program, the file will be returned to the facility for further processing. The following information will be completed in ACE upon cancel from MEP.

a. Document CZ line with the following information if available.

- Reason for cancel from MEP
- Total Charges on account
- Share of cost balance due by patient

b. **For NON HL7 facilities:**
Utilize Action and result codes corresponding to cancel reason.

Reason	Action	Result	Status	Financial class
Cancel Share of Cost	9M	9C	CSC	38
Cancel not eligible	9M	9E	CNE	70
Cancel not cooperative	9M	9N	CNC	70
Cancel Insurance	9M	9I	CPI	20
Cancel Assigned in error	9M	9A	CAE	70
Cancel TFAC screen	9M	9T	TFR	51

If enough information is available to determine charity care qualification, please utilize TFAC screen cancel instead of not cooperative.

Enter corresponding activity code on P-bar or submit notification to facility for Non-Pbar IS platforms.

CSC=IMCSC (MEP Cancel Balance Share of Cost)
CNE=IMCNE (MEP Cancel Not Eligible/Patient Uncooperative w/no info)
CPI= IMCPI (MEP Cancel Primary Insurance)
CAE=IMCAE (Assigned in Error to MEP)
TFR=IMTFR (MEP Cancel Charity Review/Patient Uncooperative w/info for charity)

For HL7 facilities:
Utilize FC change and Payor Code update on **PBAR**. Updates to ACE currently do not work.

Financial Class should be the same as in the table above. Payor codes are as follows:

Reason	Payor Code	Financial class
Cancel Share of Cost	WM354	38
Cancel not eligible	66281	70
Cancel not cooperative	66281	70
Cancel Insurance	OTH01	20
Cancel Assigned in error	66281	70
Cancel TFAC	WM3C1	51

In the future we will look at providing more exact payor codes for insurance.

CENTRALIZED PATIENT FINANCIAL SERVICES TENET FINANCIAL ASSISTANCE CENTER PROCEDURE MANUAL	TITLE: CFC Charity Care Effective Date: Date 1/1/2003	Page 1 of 2 M-16

CFC PROCEDURES FOR CHARITY CARE RECOMMENDATIONS

A. Charity Care may be considered after all payment sources that could be expected to be a source of payment of the patient's bill have been exhausted. Recognition of charity care may be identified after assignment to bad debt only if one of the follow criteria is met:

1. The guarantor(s) are deceased with no estate/surviving guarantor or homeless
2. The balance of the account is representative of a balance due after the settlement of a third party case in which the funds available for repayment of debt(s) is less than the balance owed.
3. The account was assigned to bad debt while the TFAC is the process of finalizing a charity care recommendation.
4. Patient has been screened for financial assistance at the facility, while assigned to MEP, Early Out, or CFC
5. Request to do so by CFO, DPS, BOM etc. or other Tenet Senior Management
6. No prior documented attempts to screen for charity (HNW for example)

B. If the account does not meet one of the criteria mentioned in "A" above, the account may not be recommended for charity care, but may be reviewed for indigent care using the following criteria:

1. A patient is financially or medically indigent, but has a potential change in future circumstances and future recovery (pending liability case, student of higher education or vocation studies, etc.).

C. Recommendation for Charity Care

1. In an effort to ensure patients do not have the ability to pay, not the unwillingness to pay, if patient contact is made, CFC will perform phone screening and notate the account in ACE of the following:

   a. Confirm address and phone number is accurate
   b. Marital status (Marriage, Single, Divorced, Separated)
   c. Guarantors' Family Size (Immediate family)
   d. Guarantors' Gross Income (Per hour, day, week, or year. Whichever applies)
   e. Spouses' Gross Income (Per hour, day, week, or year. Whichever applies)
   f. Own or Rent
   g. Resources (Savings Accounts, Home Owners Insurance, Revolving Credit.

PROCEDURES IN ACE

CFC Responsibility

1. CFC staff will perform the following steps before an account will be accepted by TFAC:

    a. Request letter CFC01 (request for CFS) for the patient

    b. Notify patient once the CFS is received by TFAC then only will the account will be reviewed for financial assistance

    c. Document the ACE as to the qualifications for charity care consideration (see C # 1 above)

    d. Request a current credit report

    e. Forward any supporting documentation substantiating charity care (patient's inability to pay) such as current pay stubs, tax returns, bank statements, etc. that CFC may have received to TFAC. This information needs to be scanned into VI.

    f. Do not forward the account to the TFAC desk as TFAC will pull the account once it has received the CFS from the patient unless the patient is deceased or homeless

2. Steps to transfer accounts for patients that are **deceased** (with no estate/surviving guarantor) or **homeless**:

    a. Desk Transfer to 072

    b. Change the Status Code to PCA

    c. Change the Financial Class to 00

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	PATIENT REGISTRATION	Page: 1
	INDIGENT	Original Date:
	INDIGENT CARE POLICY	Revised Date: 9/11/03

POLICY

Classification of patient accounts to Indigent Care occurs when a patient appears to meet Charity Care criteria and *does not or is unable to meet the documentation requirements for charity care* determination (e.g. unable to contact, transient, non-complaint) due to insufficient documentation.

Additionally, Indigent Care may be identified when there are insufficient *patient demographics* (mail return, no home/work/emergency phone number, or identification number such as a social security number) or when a patient is financially or medically indigent, but *may have a potential change in future circumstances and future recovery* (pending liability case, student of higher education or vocation studies, etc.).

Should an indigent patient be considered non-complaint to the extent that a determination to recommend charity care cannot be completed, the patient account will be classified as Indigent Care. Where possible the patient will be advised that unless they comply and provide the required information, no further consideration will be given for Charity Care processing. Such determination does not preclude a re-assessment in the future of charity care upon presentation of additional documentation or information.

SCOPE

All Tenet Patient Accounting Platforms

PURPOSE

Distinguish Indigent Care from Charity Care and Bad Debt and to ensure consistent identification, accountability, and recording of such, at all Tenet entities and facilities.

DEFINITIONS

For the purposes of this policy, the following terms are being defined:

Indigent Care represents patients who are determined unable to pay due to lack of income or resources, unemployment, or potential change in future circumstances/recovery, and are non-complaint with the required documentation or information to identify charity care..

Charity Care represents patients that do not have the ability to pay and are able to comply with the documentation or information requirements to demonstrate such classification.

Bad Debt represents patients that have the ability, but not the willingness to pay.

PROCEDURE

CRITERIA FOR INDIGENT CARE

To determine a patients' ability to pay for health care service requires an assessment of financial data or information obtained at the time of service or discharge, and current and past credit data. If the patient did not provide financial information, or the patient is not complying with documentation requirements to determine their ability to pay, then credit data may be utilized to make an appropriate determination for indigent care or bad debt.

Specifically, patients who do not have the ability to pay may be identified as indigent after assessing credit data and when one of the follows occurs:

- All efforts are exhausted to secure a Confidential Medical Financial Assistance Application (CMFAA) for purposes of charity classification.
- The CMFAA does not specify household gross annual income and family size in order to perform an income calculation for charity consideration

- Documentation to validate statements contained in the CMFAA for charity care consideration when the patients' credit history does not support the data contained in the application.
- Non-residents who required emergency care, but did not present for the sole purpose of medical care treatment and:
  - All efforts are exhausted to secure a Confidential Medical Financial Assistance Application (CMFAA) for purposes of charity classification.
  - Patient is does not or is unable to comply with the Charity Care process which may include insufficient patient demographics to allow for follow up to determine charity care or bad debt classification
- Incarcerated patients
- Patient accounts with insufficient admitting demographics defined as mail return and no home/work/emergency contact number, or identification number such as a social security number (only after appropriate skip tracing has been exhausted).
- Skilled or professional individuals unemployed due to a temporary disability who do not qualify for a government program and may have a change in future circumstances.
- Students of higher education or vocation studies who have likelihood to be able to pay in the future.
- Patients who have a potential liability case that may change their future ability to pay for services provided.

INDIGENT CARE CLASSIFICATION AND TREATMENT

After the standard AR revenue cycle has concluded and an account is identified as indigent care, it will be assigned to CFC. Upon assignment to CFC the account will re-class to indigent care expense during the month it assigns through the normal month end SOS journal entry process.

CFC will notify the patient of their financial obligation through the standard CFC dunning letter cycle. If mail sent to the patient's address was returned or the address itself is insufficient to mail a letter, CFC may periodically conduct skip-tracing efforts in an automated fashion in an attempt to locate the patient's current address. If the patient does not comply, their debt may be reported to a credit bureau agency after 75 days. Additionally, at any time CFC may refer the patient's account to a secondary placement agency for additional collection efforts.

QUESTION NUMBER 2

Uninsured Contract Modeling & Loading
Roll Out
DRAFT 7/28/2004

Facility Code	Facility Name	CarePricer Training	Contract Live Net down of accounts
KRM	Kenner Regional Medical Center	5/3/2004	5/3/2004
BMC	Brookwood Medical Center	5/10/2004	5/10/2004
FLO	Florida Medical Center	5/24/2004	6/1/2004
NOS	North Shore Medical Center	5/25/2004	6/1/2004
PGH	Palmetto General Hospital	5/26/2004	6/1/2004
SMH	St. Mary's Medical Center	5/27/2004	6/1/2004
PBG	Palm Beach Gardens Medical Center	5/28/2004	6/1/2004
HIA	Hialeah Hospital	6/1/2004	6/1/2004
PRM	Parkway Regional Medical Center	6/2/2004	6/2/2004
CGH	Coral Gables Hospital	6/3/2004	6/3/2004
TCC	Cleveland Clinin	6/4/2004	6/4/2004
DEL	Delray Medical Center	6/7/2004	6/7/2004
WBO	West Boca	6/8/2004	6/8/2004
NRM	North Ridge Medical Center	6/9/2004	**est. 9/1/2004**
HOL	Hollywood	6/10/2004	6/10/2004
GSM	Good Samaritan Medical Center	6/11/2004	6/11/2004
CCA	Central Carolina Hospital	6/15/2004	6/21/2004
AXR	Alexander Hospital	6/16/2004	7/1/2004
FRM	Frye Regional Medical Center	6/16/2004	7/1/2004
PMC	Piedmont Healthcare System	6/17/2004	7/1/2004
GBH	Atlanta Medical Center	6/22/2004	7/1/2004
NFR	North Fulton Regional Hospital	6/23/2004	7/1/2004
SFM	South Fulton Medical Center	6/24/2004	7/1/2004
SRE	Spalding Regional Hospital	6/25/2004	7/1/2004
SYL	Sylvan Grove Hospital	6/25/2004	7/1/2004
ECH	East Cooper Regional Medical Center	7/6/2004	**est. 9/1/2004**
HHH	Hilton Head Medical Center	7/7/2004	7/15/2004
GCM	Gulf Coast Medical Center	7/8/2004	**est. 9/1/2004**
NOT	NorthShore Regional Medical Center	7/12/2004	**est. 9/1/2004**
MEA	Meadowcrest Hospital	7/13/2004	**est. 9/1/2004**
MBH	Memorial Medical Center - Baptist	7/13/2004	**est. 9/1/2004**
ASN	Lindy Boggs	7/14/2004	**est. 9/1/2004**
DHJ	Doctors Hospital of Jefferson	7/14/2004	**est. 9/1/2004**
STC	St. Charles General Hospital	7/15/2004	**est. 9/1/2004**
GRA	Graduate Hospital	7/20/2004	**est. 9/1/2004**
HAH	Hahnemann University Hospital	7/20/2004	**est. 9/1/2004**
RXH	Roxborough	7/21/2004	**est. 9/1/2004**
BUK	Warminster Hospital	7/21/2004	**est. 9/1/2004**
SCH	St Christopher	7/22/2004	**est. 9/1/2004**
DHW	Des Peres Hospital	7/26/2004	**est. 9/1/2004**
DHC	Forest Park Hospital	7/27/2004	**est. 9/1/2004**
SLU	Saint Louis University Hospital	7/28/2004	**est. 9/1/2004**
SAM	St. Alexius Hospital	7/29/2004	**est. 9/1/2004**
SFH	Saint Francis Hospital	7/26/2004	**est. 9/1/2004**
	Bartlett	7/27/2004	**est. 9/1/2004**
SJH	Creighton University Medical Center (St. Joseph)	7/28/2004	**est. 9/1/2004**

California Core Facilities **estimated 4th Qtr**

QUESTION NUMBER 3

Uninsured Discount Program

I. Introduction

Purpose:
To introduce and define the Uninsured Discount Program for all Tenet Facilities.

Objective:
After completing this section, you will be able to define:

- What is Tenet's Uninsured Discount Program?

Tenet's Goal for the Uninsured:
Tenet's goal in developing the Uninsured Discount Program is to give uninsured patients the opportunity to pay for hospital services in a manner and amount similar to non-government insurance plans, without abuse of any biding laws.

What does this goal mean?
This goal means that a patient, *without* a third party source of payment (uninsured) and who meets the criteria of the program, will be offered a discount similar to what a non-government insurance plan would be given.

Tenet's Compact with Uninsured Patients
Tenet compact with the Uninsured Patient consists of:

- Patients without insurance at Tenet hospitals will be treated fairly and with respect during and after their treatment, and regardless of their ability to pay for the services they receive.
- Tenet hospitals will provide financial counseling to uninsured patients. This will include help in understanding and applying for local, state and federal health care programs such as Medicaid.
- After uninsured patients* receive treatment at Tenet hospitals and are provided with financial counseling, they will be offered discounted pricing for the services provided at rates equivalent to the hospital's current managed care rates, which are substantially discounted from retail or "gross" charges.
- All patients without insurance at Tenet hospitals will be offered reasonable payments and payment schedules and, subject to their acceptance of the offer, will be billed at discounted local market rates. Whenever possible, this will occur before the patients leave the hospital, as part of the financial counseling process.
- Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is unemployed or without other significant income. Before taking legal action for non-payment, our hospitals will assure that the patient is not eligible for any assistance program and does not qualify under the hospitals' charity care policy. Nor will our hospitals pursue legal action if the only recovery available would be to place a lien on the patient's home.

* Patients will not be considered "Uninsured Patients" if they reside outside of the United States and travel to the United States for the purpose of receiving specialized medical care.

Uninsured Discount Program

Testing Your Understanding:

To ensure that you understand the goal of the Uninsured Discount Program, please read and answer each question below.

1. Can a patient have a third party source of payment and still qualify for the Uninsured Discount Program?

2. The Uninsured Discount Program is based on a decision of the facility instead of the patient's ability to pay or source of payment?

Uninsured Discount Program

Answers to Testing Your Understanding:

The answers to Testing Your Understanding are listed below.

1. ***Can a patient have a third party source of payment and still qualify for the Uninsured Discount Program?***
   Under the criteria for the Uninsured Discount Program, the patient cannot have a third party source of payment. This program is not for patients who want to bill their own insurance. Patients with insurance do not qualify for this program.

2. ***The Uninsured Discount Program is based on a decision of the facility instead of the patient's ability to pay or third party source of payment?***
   All uninsured patients who have no other third party insurance will receive the Uninsured Discount.

Uninsured Discount Program

II. Eligibility Of Determination

Purpose:
To define the steps of determining eligibility of the Uninsured Discount Program.

Objective:
After completing this section, you will be able to define:

- Steps to determine eligibility of the Uninsured Discount Program
- Flow Charts for determining eligibility

Steps to determine eligibility for the Program
All patients receiving services at a Tenet Facility will be eligible for the Uninsured Discount Program. Each step detailed below will help the Facility staff complete the financial screening process and refer patients to MEP for Medicaid, Disability, or other state, county or Federal insurance programs as appropriate.

The steps to determine eligibility of each patient are:

Scheduled Patients/Walk-In (Non-Emergent)

1. Patient presents at the facility
2. For patients that did not go through the insurance eligibility and benefit verification, this process will need to be performed prior to services being performed.
3. For patients that have completed the benefit eligibility and insurance verification process and been classified as Uninsured, obtain the patient's diagnosis, procedure, procedure code and length of stay.
4. Refer to the *Uninsured Discount Schedule or the Flat Rate Fee Schedule (*dependent upon service type).
   a. If the service is listed, the patient is required to pay the indicated amount in full prior to or at the time of service.
   b. If the service is not listed, the patient's liability will be calculated based on an estimate of the patient's portion of the bill and any other unpaid patient balances. This liability is determined from the average charges associated with the patient's admitting diagnosis.
5. Financial Counselor will generate a credit report / credit check or obtain the report from Data Access to assist in the counseling process. (Please see the Patient Access Community Space for sample scripts for using credit report / credit check information.)
6. Financial Counselor will explain Tenets Compact for the Uninsured Policy or the Flat Rate Fee Schedule, present estimated bill and ask patient how he/she would like to pay for charges.
7. If Patient indicates inability to pay, complete additional screening questions for potential qualifications of government/charity programs, Financial Counselor will meet with the patient to review the following questions:

Uninsured Discount Program

- Are you under 21 or over 65?
- Are you a single parent or a child under 21?
- Are you a caretaker or guardian of a child under 21?
- Are you a married parent of a minor child?
- Are you pregnant or was you admission pregnancy related?
- Is there a potential that you will be disabled for 12 months?
- Were you a Victim of Crime?
- Do you have COBRA or had an insurance policy on which the premium lapsed?
  a. If the patient answers "**yes**" or expresses uncertainty to any of the above questions, the account should be referred to the Medical Eligibility Program (MEP) for additional screening.
     i. If it is determined that the patient has a commercial third party payment source, or meets criteria for governmental assistance, the hospital will follow its normal business practices with referral and invoicing the patient or payor appropriately.
     ii. If the patient does not qualify for a source of third party payment, MEP will determine whether the patient potentially qualifies for charity care pursuant to Tenet's Charity Care Policy.
     iii. If the patient does not meet the criteria for Tenet's Charity Care Program, the hospital will designate the patient as uninsured and will referred the account back to the Financial Counselor for follow-up.
  b. If the patient answers "**no**" to all of the above questions, the hospital staff will provide the patient with a verbal estimate of the charges less the uninsured discount and request payment prior to services being performed if applicable.
     i. All outstanding patient accounts will be identified and payment requested prior to discharge from the hospital.
        NOTE: The old accounts will be adjusted based on the facility/CFO discount directive.
     ii. If the patient indicates they do not have the ability to pay the uninsured rate, offer payment arrangements and/or other financing options.

8. The Financial Counselor will work with the patient and facility administration to resolve the account(s).

Emergency Room

1. Patient arrives at the Tenet Emergency Room. In compliance with EMTALA, the Medical Screening Exam (MSE) must be completed and any necessary stabilizing treatment begun prior to any financial clearance

process occurring.

2. Once the facility staff has been notified that the MSE is complete and stabilization treatment has begun, they will determine whether the patient has a third party payment source (i.e., Medical Insurance, Government Program, etc)
3. If the patient is determined to be uninsured, The ED Financial Counselor will generate a credit report / credit check or obtain the report from Data Access to assist in the counseling process.
4. The ED Financial Counselor will speak with the attending nurse to obtain / verify the level of care that has been given to the patient.
5. Financial Counselors will explain Tenet's Compact for the Uninsured Policy, present estimated bill, and ask patient how he/she would like to pay for charges.
6. If Patient indicates inability to pay, complete additional screening questions for potential qualifications of government programs. The ED Financial Counselor will meet with the patient to review the following questions:
   - Are you under 21 or over 65?
   - Are you a single parent or a child under 21?
   - Are you a caretaker or guardian of a child under 21?
   - Are you a married parent of a minor child?
   - Are you pregnant or was you admission pregnancy related?
   - Is there a potential that you will be disabled for 12 months?
   - Were you a Victim of Crime?
   - Do you have COBRA or had an insurance policy on which the premium lapsed?
     a. If the patient answers "**yes**" or expresses uncertainty to any of the above questions, the account should be referred to the Medical Eligibility Program (MEP) for additional screening.
        i. If it is determined that the patient has a commercial third party payment source, or meets criteria for governmental assistance, the hospital will follow its normal business practices with referral and invoicing the patient or payor appropriately.
        ii. If the patient does not qualify for a source of third party payment, MEP will determine whether the patient qualifies for charity care pursuant to Tenet's Charity Care Policy.
        iii. If the patient does not meet the criteria for Tenet's Charity Care Program, the hospital will designate the patient as uninsured and will referred the account back to the Financial Counselor for follow-up.
     b. If the patient answers "**no**" to all of the above questions, the hospital staff will provide the patient with a verbal estimate of the charges

Uninsured Discount Program

less the uninsured discount and request payment prior to services being performed if applicable.

i. All outstanding patient accounts will be identified and payment requested prior to discharge from the hospital.

   NOTE: The outstanding accounts may be adjusted based on the facility/CFO discount directive.

ii. If the patient indicates they do not have the ability to pay the uninsured rate, offer payment arrangements and/or other financing options.

7. The Financial Counselor will work with the patient and facility administration to resolve the account

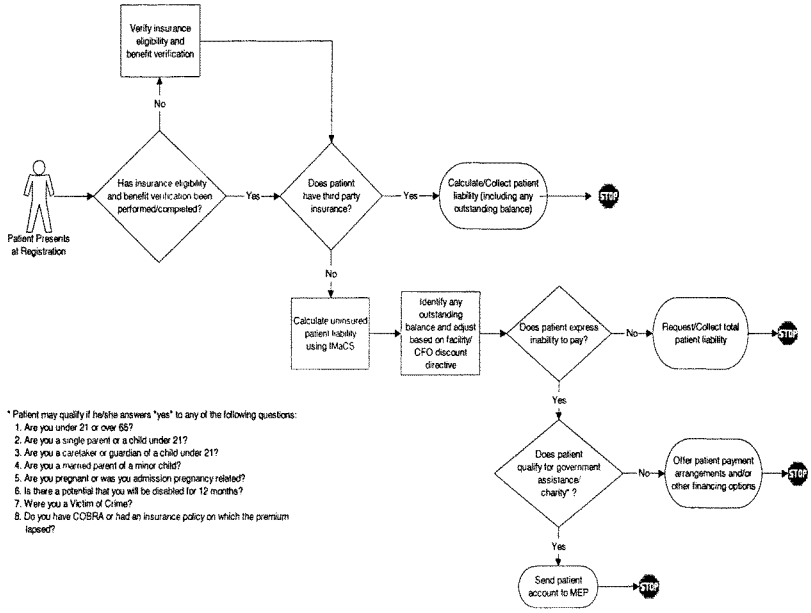
Tenet has developed two flow charts; Uninsured Patient Flow, Direct Admits/Urgent/Non-Emergent/Transfer (Figure 2.1, Page 8) and an Uninsured Patient Flow, Emergency Room (Figure 2.2, Page 9); to determine if a patient will be deemed as uninsured and will qualify for the Uninsured Discount Program. This flow chart will walk you through each of the steps, with closed-ended ("yes" or "no") questions, which will help you, determine what the facility's next course of action should be.

NOTE: It is suggested that all admitting staff have access to a copy of the written "Steps to Determine Eligibility for the Uninsured Program" along with the flow chart of the steps.

Uninsured Discount Program

Figure 2.1

Uninsured Patient Flow
(Non-Emergent)

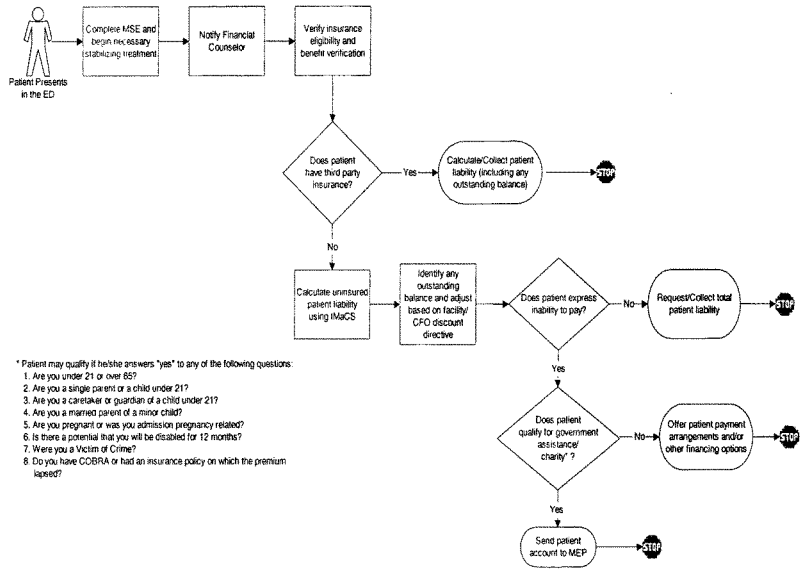


* Patient may qualify if he/she answers "yes" to any of the following questions:
1. Are you under 21 or over 65?
2. Are you a single parent or a child under 21?
3. Are you a caretaker or guardian of a child under 21?
4. Are you a married parent of a minor child?
5. Are you pregnant or was you admission pregnancy related?
6. Is there a potential that you will be disabled for 12 months?
7. Were you a Victim of Crime?
8. Do you have COBRA or had an insurance policy on which the premium lapsed?

Uninsured Discount Program

Figure 2.2

Uninsured Patient Flow (ED)



Uninsured Discount Program

Testing Your Understanding:

To ensure that you understand the Eligibility Determination of the Uninsured Discount Program, please read and answer each question below.

1. Only patients stating that they have no means of payment will be screened for the Uninsured Discount Program?

2. The Uninsured Discount Program will replace the Medical Eligibility Program and Charity Care Program?

3. The Intake Department will be the only department that will determine and offer the Uninsured Discount Program?

4. If a patient presents at the Emergency Room, they will not be offered the Uninsured Discount Program?

Uninsured Discount Program

Answers to Testing Your Understanding:
The answers to Testing Your Understanding are listed below.

1. ***Only patients stating that they have no means of payment will be screened for the Uninsured Discount Program?***
   All patients presenting will be screened for the Uninsured Discount Program at the appropriate time. All EMATLA regulations must be followed within the Emergency Room processing.

2. ***The Uninsured Discount Program will replace the Medical Eligibility Program and Charity Care Program?***
   The Uninsured Discount Program *will not* replace any type of government assistance program (i.e.: Medical Eligibility Program, Charity Care Program, Local or County Programs). This program will further Tenet's efforts to reduce the cost of service billing by offering those patient not eligible for Medical Eligibility or Charity Care a discount method of payment and lower Tenet's cost of the administrative collection process.

3. ***The Intake Department will be the only department that will determine and offer the Uninsured Discount Program?***
   Although the Intake Department will be the first point of awareness of the Uninsured Discount Program for the patient, it *is not the only department* that will help determination of the eligibility. At the appropriate time of financial screening, if it is determined that the patient might be eligible for any type of government assistance program, the Medical Eligibility Program or Financial Assistance Program, both of those departments will help in the determination process. If the determination process concludes the patient is not eligible for the Medical Eligibility Program or Charity Care Program, then the Early Out Department will offer the patient the Uninsured Discount Program.

4. ***If a patient presents at the Emergency Room, they will not be offered the Uninsured Discount Program?***
   This is incorrect. Patient presenting in the Emergency Room *will be offered* the Uninsured Discount Program, after all EMATLA regulations have been followed.

Uninsured Discount Program

III. Uninsured Discount Program Tools

Purpose:
To define the tools that will be used in offering the Uninsured Discount Program.

Objectives:
After completing this section, you will be able to define:

- Placard
- Confidential Medical and Financial Assistance Application
- IMaCS ***CarePricer*** Tool

Tenet Financial Assistance Program PLACARD:
The Tenet Financial Assistance Program Placard is an explanation of the various financial programs (i.e. Uninsured Discount Program, Medical Eligibility Program, and Tenet's Financial Assistance Program) available to the patient in his/her own language. (Figure 3.1, Page 10)

This placard will be used by all facility advocates assisting in obtaining and completing the financial screening of the presenting patient. Each facility, based on the department structure and staff availability, will determine the specific flow of referral to the Tenet Financial Assistance Program.

NOTE: You will need to consult with your manager for confirmation of flow of referral at your facility.

Uninsured Discount Program

Figure 3.1

Hospital Name/Uninsured Assistance Programs

Thank you for choosing our Hospital for your healthcare needs. We offer several programs to assist you with the financial aspects of your healthcare if necessary.

Patient Assessment and Counseling

The hospital Financial Counselor will assist you with assessing potential liabilities associated with your healthcare services and guide you to the appropriate Tenet program for which you may be entitled.

Medical Eligibility Program (MEP)

The Medical Eligibility Program is a community /hospital service provided to you at no cost. You may qualify for government programs, which pay for all or part of your hospital and medical expenses. Our Patient Advocates will assist you with the application process for benefits in which you may be entitled.

Programs which you may qualify for:

Medicaid	Temporary Assistance for Needy Families
Social Security Disability	Supplemental Security Income
County Indigent	Victims of Crime Fund

Eligibility criteria may include monthly household income compared to the Federal Poverty Level, available resources, medical condition, age and residency. Specific exemptions apply in most programs such as homestead and unavailable assets.

Tenet Financial Assistance Program (TFAC)

The Tenet Financial Assistance Program is available to patients that do not have the means to pay for hospital expenses and do not qualify for any medical assistance programs. You will be required to complete a Confidential Financial Application regarding your household finances to qualify for this program. Documentation will be requested to verify your circumstances in order to determine eligibility.

Contact the Tenet Financial Assistance Center at (888) 233-7868, Monday – Friday 8:00 a.m. to 5:00 p.m. for information on any of the programs.

Uninsured Discount Program

All Uninsured Patients are eligible for discounts. The discount is similar to rates paid by managed care insurance plans. The discounts are offered to you under the Program entitled ***Tenet's Uninsured Discount Program.***

Participation in the Program precludes patients and or guarantor to refrain from seeking reimbursement from a third party for hospital services covered under the Program.

Hospital employees in accordance with Tenet Policy and program procedures, will maintain the confidentiality of all information received from or about the patient/applicant during any of these program processes.

Uninsured Discount Program

Confidential Medical and Financial Assistance Application:
The Confidential Medical and Financial Assistance Application is utilized by the facility as a screening tool to determine whether an uninsured patient is potentially eligible for linkage to government programs such as Medicaid or other state or county funded programs. (Figure 3.2, Page 14 and 15)

NOTE: Section B is for Internal Tenet use only and should not be provided to patients.

The hospital advocate will ask the presenting patient or responsible party, the Section A, Medical Assistance Screening, questions that follow:

1. Is the patient under the age of 21 or over the age of 65?
2. Is the patient a single parent of a child under the age of 21?
3. Is the patient a caretaker or guardian of the child under the age of 21?
4. Is the patient a married parent of a minor child?
5. Is the patient pregnant, or was the admission pregnancy related?
6. Will the patient potentially be disabled for 12 months?
7. Is the patient a victim of crime?
8. Does the patient have a "COBRA" or insurance policy for which the premium has lapsed?

At the time that Section A is completed, the hospital advocate will begin Section B, Financial Assistance Screening. The patient will need to answer all financial based questions and/or initial a homeless affidavit and understanding of eligibility for the Uninsured Discount Program. The patient will also be required, in writing, to bind the information that was provided as the truth.

Once the questions are answered and the Financial Assistance formula is calculated for Federal Poverty Guidelines ratios (FPG—updated annually by the federal government, please refer to MEP procedures & documents), one of the following steps should take place:

1. If the patient answers "yes" to any one of the questions in Section A and the income to FPG ratio in Section B is under 200% or if the hospital charges may qualify the patient for catastrophic medically indigent classification refer the presenting patient to the Medical Eligibility Program (MEP) for further screening and financial assistance. (Please see BOPM Charity Care Policy #02.06.01 for more information on catastrophic charity care.)
2. If the patient does not answer "yes" to any question in Section A or if his/her

income to FPG ratio is Section B is greater than 200%, refer the patient to a Financial Counselor for payment.

3. If the answers to the questions are not straight forward and the patient indicates they do not have an ability to pay or indicates they are homeless, refer the patient to the MEP Patient Advocate for further screening.

Payment Option:
The following guidelines should be used when we allow the patient to liquidate their account over time via regular payments. Based on the balance due from the patient, use the following table to determine the amount of down payment required and the maximum number of months allowed for payout. Keep in mind that this is the maximum allowable timeframe. The shortest possible payout time should always be negotiated with the patient. Also, the down payment may be waived if necessary.

Tenet Account Liquidation Terms:

Balance	*$0- $250*	*$251- $500*	*$501- $1000*	*$1001 - $2500*	*$2501- $5000*	*$5001 + **
% Down	0%	0%	10%	10%	5%	5%
# of Pmts	4	6	10	12	24	36

*** Admitting Director/DPS/CFO Approval Required**

Uninsured Discount Program

Figure 3.2

Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name	SSN	DOB
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A
MEDICAL ASSISTANCE SCREENING– *Please circle answer "Y" for yes to "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
5. Is the patient pregnant, or was the admission pregnancy related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B
FINANCIAL ASSISTANCE SCREENING
Total Number of Dependent Family Members in Household _____
(Include patient, patient's spouse and/legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size
_____ ÷ _____= %

Size of Family	48 States Gross Yearly			Alaska Gross Yearly			Hawaii Gross Yearly		
	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG	100% of FPG	200% of FPG	300% of FPG
1	$8,980	17,960	26,940	$11,210	22,420	33,630	$11,330	20,660	30,990
2	12,120	24,240	36,360	15,140	30,280	45,420	13,940	27,880	41,820
3	15,260	30,520	45,780	19,070	38,140	57,210	17,550	35,100	52,650
4	18,400	36,800	55,200	23,000	46,000	69,000	21,160	42,320	63,480
5	21,540	43,080	64,620	26,930	53,860	80,790	24,770	49,540	74,310
6	24,680	49,360	74,040	30,860	61,720	92,580	28,380	56,760	85,140
7	27,820	55,640	83,460	34,790	69,580	104,370	31,990	63,980	95,970
8	30,960	61,920	92,880	38,720	77,440	116,160	35,600	71,200	106,800
Each additional person, add	3,140	6,280	9,420	3,930	7,860	11,790	3,610	7,220	10,830

Uninsured Discount Program

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:			Relationship to patient
SSN:	DOB		
Home Address:			Phone #
Work Address:			Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly		
	Hours Per Week		
If income is $0/unemployed, what is your means of support?	Circle One – Living on Savings/Annuity Live with parent/family/friends Homeless Shelter		

SPOUSE

Responsibility Party:			
SSN:	DOB		
Home Address:			Phone #
Work Address:			Phone #
Gross Income:	Check One - Hourly Daily Weekly Monthly Yearly		
	Hours Per Week:		

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. _____
Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statue, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Tenet Charity Care programs is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Tenet HealthSystems or its' subsidiaries provided care.

_____ _____
PATIENT/GUARANTOR SIGNATURE **DATE**

OFFICE USE ONLY

Family Size:	Account Number(s)	Balance	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			
Prepared by		Date	Unit
Approved or Denied by		Date	Title

Uninsured Discount Program

IMaCS CarePricer Tool:
IMaCS has developed ***CarePricer***, an easy-to-use tool for the quick entry and discount calculation of services provided to Uninsured Patients. The internet-based software will also accommodate the generation of a printed invoice for immediate collections while the patient is still on premise. A ***CarePricer*** guide is available by contacting a Patient Access Trainer.

IMaCS CarePricer Purpose:
The purpose of the IMaCS CarePricer is to:

- Provide a Tool for a formal invoice for services provided to uninsured patients.
- Draw prices and discounts from Compact for the Uninsured contract which is downloaded into IMaCS.
- Allow easier collection efforts with written documentation to the patient.

*Compact for the Uninsured will be rolled out to every state except:

1. Texas
2. Massachusetts

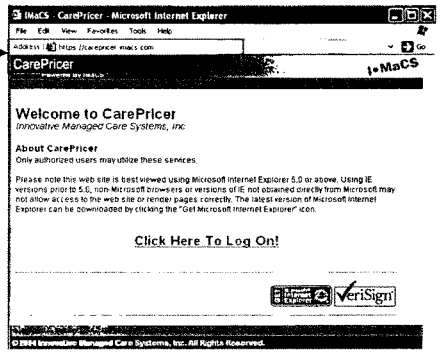
IMaCS CarePricer Quick Reference Screens and Steps:

1. Ensure all staff have completed a security access form from IMaCS. (This is given by IMaCS)

2. Print and review the training presentation and the IMaCS CarePricer User Guide with staff.

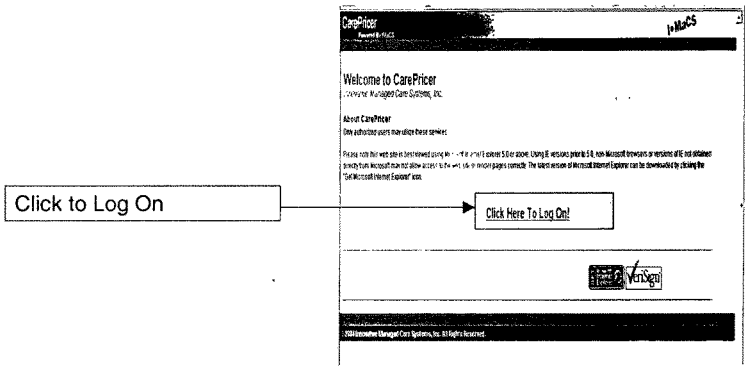
3. Access IMaCS at: https://carepricer.imacs.com

Open internet browser and enter the internet address: https://carepricer.imacs.com

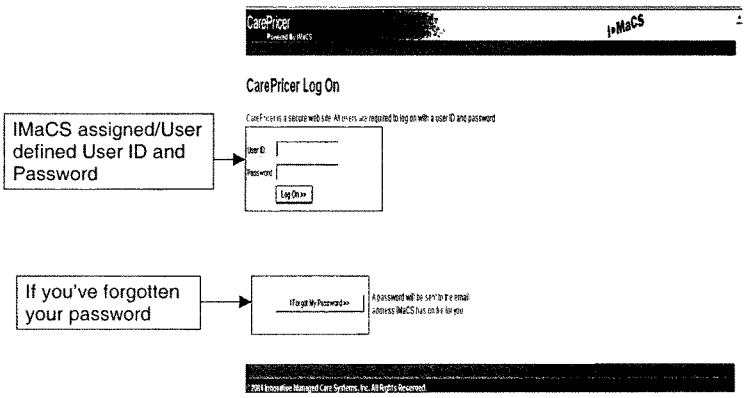


Uninsured Discount Program

4. Once the site is accessed a preliminary welcome screen appears.

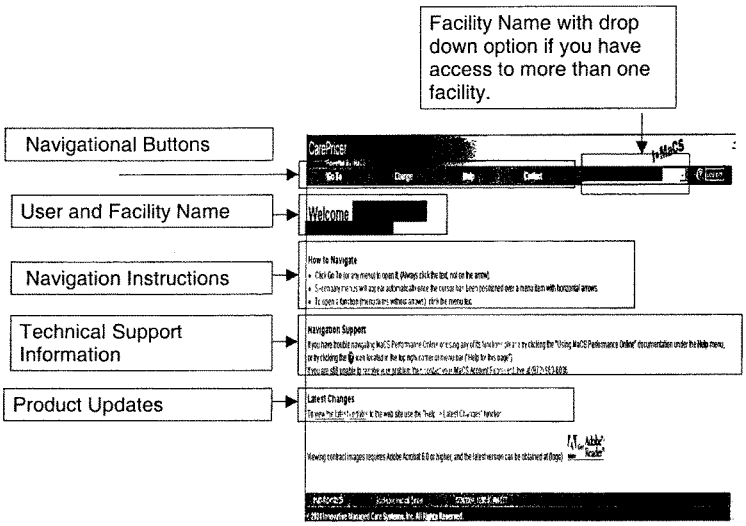


5. On the Log-on Screen, enter your User ID and Password. If you have forgotten your User ID and Password, Help is available.

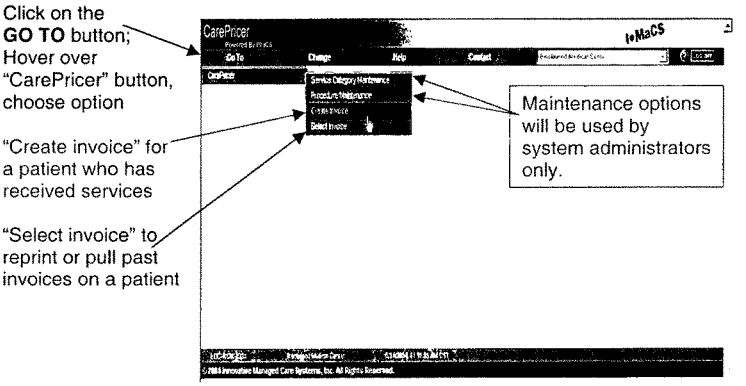


Uninsured Discount Program

6. The next screen is the "Welcome" Screen.



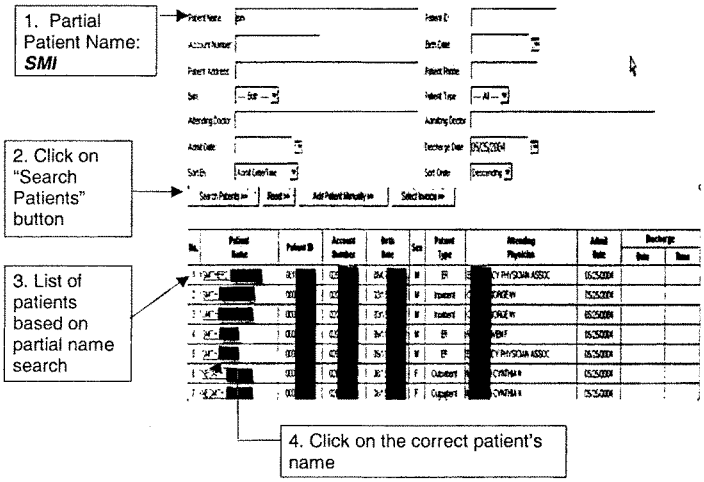
7. Creating and Selecting Invoices:



Uninsured Discount Program

8. Patient Search Screen:

- List of patients registered in system will appear at the bottom of the search screen.
- If this is for a patient who has already been in the system
    - Type in a partial name or account number and click on "search patients"
    - Registered patients will be displayed based on the search criteria given
- Choose the correct patient
    - Click on the patient's name
    - Patient information will populate the remainder of the fields for the invoice.

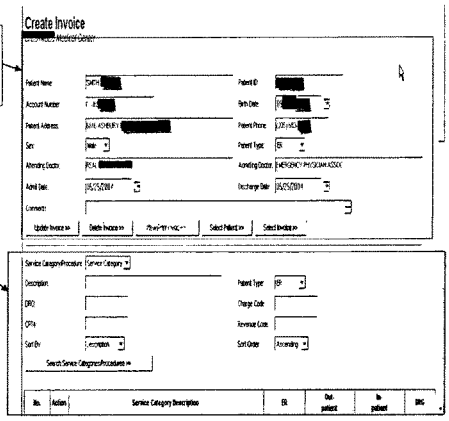


Uninsured Discount Program

9. Invoice Patient Fields:

The top half of the invoice will be populated by the patient's information via an HL7 feed.

The bottom half of the screen (cropped off for viewing purposes) contains the search for the service of procedure provided to the patient that will be added to the invoice. Further details of process on following slides.



10. Service/Category Procedures:

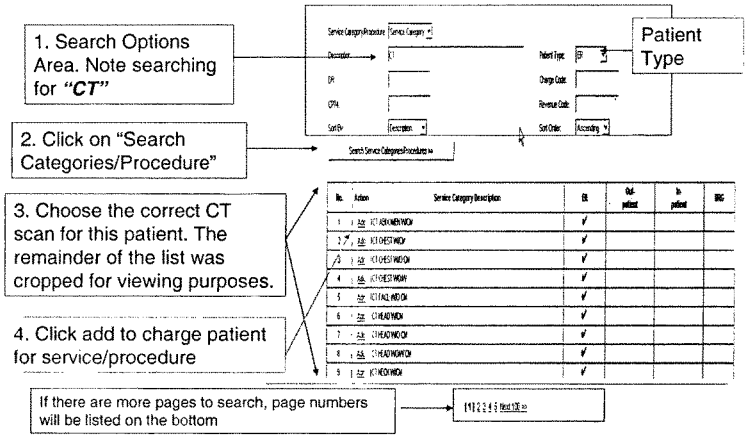
- Each invoice will list the various services based on the patient type.
- For example, if your facility charges additional for a CT or MRI performed during an ER visit, these procedures will be listed for Patient Type: ER.

Search options

- Partial name for a service or procedure in "Description" field
- Type in "CT" to look for a Computerized Tomography Scan of the abdomen.
- CPT, DRG, Charge Code, Revenue Code
- Sort Options
- Description, CPT, DRG, Charge Code, Revenue Code
- Ascending or Descending
- Click "Search Service Categories/Procedures" button
- Click the "Add" button next to the correct procedure.
- Continue to search and add any additional procedures to be charged.

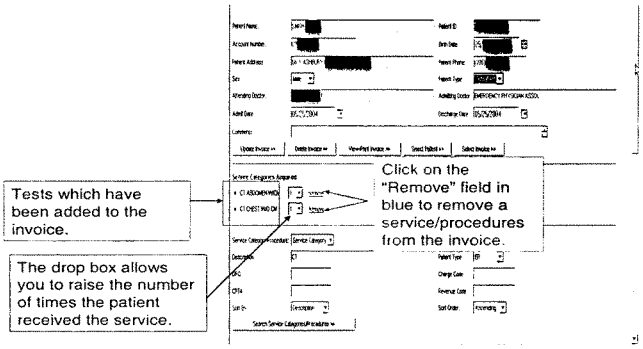
Uninsured Discount Program

11. Adding Services:



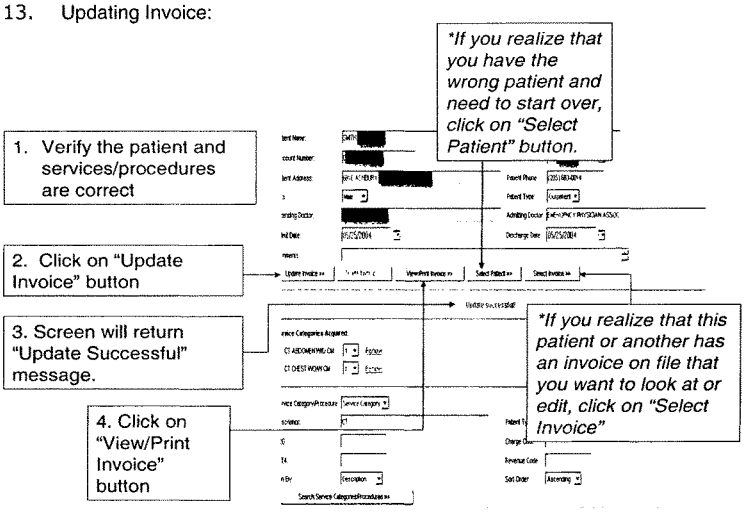
*This is the lower half of the Patient Search Screen.

12. The Invoice with Tests:
This is the preliminary invoice for patient Smith, outpatient, coming in for a CT of abdomen and chest.

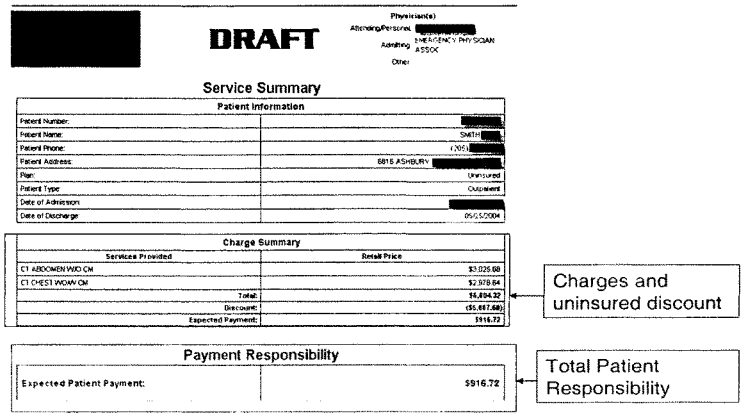


Uninsured Discount Program

13. Updating Invoice:



14. Invoice (Top):



Uninsured Discount Program

15. Invoice (Bottom):

Payment Responsibility

Expected Patient Payment:	$916.72

At this time, we can only estimate your charges, and you may incur additional charges resulting from your visit today. All questions about your account should be directed to our business office ([redacted]). We appreciate your putting your trust in [redacted] Medical Center. NOTE: Charges from your physician or other physicians affiliated with the hospital will be billed from their offices, and are not included on this statement.

Under the criteria for the Uninsured Discount Program, the patient cannot have a third party source of payment. This program is not for patients who want to bill their own insurance. Patients with insurance do not qualify for this program.

Print Invoice >> | Edit Invoice >> | Create Invoice >> | Select Invoice >>

Click to print

Click to edit

Click to start over

Click to look for an all ready created invoice

16. Selecting an Invoice:

Select Invoice [redacted]

1. Use the following fields to search for existing invoices

2. Click on "Search Invoice" button

3. Invoices will be listed

Uninsured Discount Program

17. Selecting Invoices:

No.	Invoice	Patient Name	Patient ID	Account Number	Birth Date	Sex	Patient Type	Admit Date	Discharge Date	Discharge Time	Invoice Printed
1	View	SIXTH [redacted]								22:06:02	✓
2	Edit/View	THOMPSON [redacted]								17:54:51	
3	Edit/View	MONTANO [redacted]								10:38:19	
4	View	HOOD [redacted]								10:33:44	✓
5	Edit/View	[redacted]								09:42:49	
6	Edit/View	HATCH [redacted]								16:43:32	

*You can only edit those invoice not yet printed. Click on the "Edit/View field of the invoice you need.

*Note, where you can only view an invoice, there is a red check mark in the printed column.

18. Manually Adding Patients:

- You can manually add patients
  - Schedulers can run an invoice at time of scheduling
  - Patient Access Representatives can run an invoice at time of pre-registration
- Invoices should ***not*** be run on ER patients prior to completion of Medical Screening Exam

Patient Name: | Patient ID:
Account Number | Birth Date:
Patient Address | Patient Phone:
Sex: --- Both --- | Patient Type: --- All ---
Attending Doctor | Admitting Doctor:
Admit Date: | Discharge Date: 05/24/2004
Sort By: Admit Date/Time | Sort Order: Descending
Search Patients >> | Reset >> | Add Patient Manually >> | Select Invoice >>

- Choose "Create Invoice"
- On "Select Patient" Screen, click on "Add Patient Manually"
- This brings you directly to the screen to add services/procedures.
- The patient information on the screen will be blank.

Uninsured Discount Program

19. Creating Manual Invoice:

    - Search and choose patient's service/procedure's)
    - Fill in required fields
        - Patient's name (last, first)
        - DOB (mm/dd/yyyy)
        - Gender
    - Click on "Update Invoice" if correct
    - Click on "View/Print Invoice"
    - Print Invoice and deliver to patient

20. Helpful Hints:
    - Understand the Compact for the Uninsured and its limitations/requirements for the use of CarePricer
    - Searching for service/procedures is easier if you've given IMaCS test identifiers at the beginning of your tests (e.g. CT, MRI, US, NM...) to build into the system
        - This limits the time spent searching for services/procedures
    - Set policies in place as to scanning and copying the invoice, in case the system is not available if there are questions.

21. Technical Issues:

    - Contact IMaCS:

      Innovative Managed Care Systems, Inc.
      Webpage: http://www.imacs.com
      Voice: (972) 960-6036
      Fax: (972) 960-2726
      Email: imacs@imacs.com

    - Find out the name of your area representative

Uninsured Discount Program

IV. Offering the Uninsured Discount Program

Purpose:
To define the steps of offering the Uninsured Discount Program after determination of eligibility.

Objectives:
After completing this section, you will be able to define:
Preconditioning for the Program Participation

- Offering the Uninsured Discount Program to a Direct Admit/Urgent/Non-Emergent/Transfer Patients
- Offering the Uninsured Discount Program to Emergency Room Patients
- Offering the Uninsured Discount Program to Patient after the time of discharge (Early Out)

Preconditioning for the Program Participation:
All uninsured patients will participate in the Uninsured Discount Program.

Note: If the patient fails to pay in full at the time of discharge, Tenet will initiate its normal course of business collection efforts to recover the amount due. If Tenet's collection efforts fail, Tenet will write off the unpaid discounted charges invoiced to bad debt.

Uninsured Discount Program for Direct Admit/Urgent/Non-Emergent/Transfer Patients
The Uninsured Discount Program, as it applies to Direct Admit/Urgent/Non-Emergent/Transfer Patients, is best described in Figure 2.2. However, additional tools, such as Talk Offs/Scripting, are available to the hospital advocate that is offering the Uninsured Discount Program.

Let's review the steps of the flow for the Uninsured Discount Program to a Direct Admit/Urgent/Non-Emergent/Transfer Patient:

1. Patient is admitted per hospital policy
   - Facility must determine conditions under which an elective or non-emergent admission would not be accepted or would be routed through the ER. Examples may include transfers that are not required by COBRA that have no source of payment or admissions that do not meet medical criteria for admission as determined by Case Management, etc.
   - Before financial counseling can take place, the patient financial responsibility must be determined.
   - Plan of Treatment must be determined.
   - Physician's Office and/or Case Management must provide estimated length of stay and type of service if per diem price varies by service (Clinical

Uninsured Discount Program

Responsibility). *If the facility agreement with the uninsured is based on a function of the Medicare DRG reimbursement, Health Information Management (HIM) can assist in determining a preliminary DRG.*

- Patient is offered discount amount based on a facility specific discount rate for intended plan of treatment and estimated length of stay (medical, surgical, ICU). Additional costs, such as carve outs, implants or high cost drugs or infusion, will not be included in the discount rate and should be applied to the facility specific discount rate prior to offer being made.

2. Patient may be offered the Uninsured Discount Program prior to arrival at the facility or when he/she presents for admission.
   - If the patient is a direct admission and at any time appears in need of medical evaluation (or upon request), the patient should be taken to the ER immediately.
   - The arrangements may be completed over the phone if the admission is not scheduled immediately. As an example, chemotherapy and seizure studies may be direct admissions that are planned hours in advance.

3. Does the patient qualify for an alternative source of funding (e.g., Medicaid, Charity)? YES (See Proposed Scripting)

4. Complete Section A of the "Confidential Medical and Financial Assistance Application for screening and potential qualification of linkage to a county, state or federal medical program that may assist with payment of hospital and medical expenses.
   - If the patient answers "Yes" to any question in Section A, then the patient has a possible linkage to a state or federal medical program. Proceed to section B.
   - Ask the patient to provide the estimated Gross Annual Household Income
   - Calculate the estimated gross annual household income to the federal poverty guidelines by dividing the gross annual household income amount against the family poverty guidelines based on family size.

5. Change financial class to indicate "pending Medicaid eligibility". This will allow the Medical Eligibility Program representatives to access and complete a second check for linkage to a state or federal medical program.

6. Either through the Hospital Financial screening or through the MEP screening the patient may potentially qualify for charity, the financial counselor should attempt to collect the charity program co-pay at time of service.

7. If the patient does not qualify for Charity, Medicaid or any other government/state programs, the patient is referred back to the financial counselor.

8. Request for payment is based on The Compact for the Uninsured contract estimation, *Emergency Room* levels of care are designated 1 - 5 regarding payment amount.

Uninsured Discount Program

9. Identify outstanding patient account and request payment prior to discharge from the hospital.

   NOTE: The outstanding accounts may be adjusted based on the facility/CFO discount directive.

10. Document financial payment terms in the system notes.

11. All monies collected must be processed in compliance with the hospital's cash control policies.

12. The patient will need to be seen by the financial counselor/patient access staff for collection of additional per diems/charges before discharge.

Uninsured Discount Program for Emergency Room Patients
The Uninsured Discount Program, as it applies to Emergency Room Patients, is best described in Figure 2.1. However, additional tools, such as Talk Offs/Scripting, are available to the hospital advocate that is offering the Uninsured Discount Program.

Overview of the Uninsured Discount Program to an Emergency Room Patient:

Scenario One: Straight ER Treatment

1. Process Begins Post Medical screening and Registration
   - Patient must have completed the Medical Screening Exam (MSE) and any necessary stabilizing treatment begun prior to any financial counseling.
   - Facilities must determine based on EMTALA and their by-laws, at what point in the process the EMTALA standards have been met.

2. Once the patient has met the EMTALA requirements, the patient's financial responsibility can be determined.
   - ER Level must be available to the financial counselor.
   - Patient is offered discount amount based on ER Level of care.
   - High cost procedures such as CT Scans or MRI's may be an additional charge and/or factored into the IMaCS contracts per facility.
   - Assistance from the clinical areas is required for both the Level charges and routing of patients to the financial counselor (Clinical Responsibility)

3. Does patient qualify for alternative source of funding (e.g., Medicaid, Charity)? YES (See Proposed Scripting)
   - Complete Section A of the "Confidential Medical and Financial Assistance Application" to determine possible linkage to a state or federal medical program that may assist with payment of hospital and medical expenses.

     NOTE: If the patient answers "Yes" to questions 1-8 this may indicate possible linkage

Uninsured Discount Program

- Ask the patient to provide the estimated Gross Annual Household Income
- Calculate the estimated gross annual household income to the federal poverty guidelines by dividing the gross annual household income amount against the family poverty guidelines based on family size.

4. Refer to "pending Medicaid eligibility" for MEP screening (place in MEP FC as appropriate).

   - If the patient does not qualify for Charity, Medicaid or other government programs, the patient is referred back to the hospital financial counselor.
   - Educate the patient on the uninsured discount program via Placard.
   - If an MEP representative is not available during off hours, the account will be reviewed for potential Government Programs eligibility upon assignment to the Self Pay Early Out Program.

5. For patients that do not qualify for an alternative source of funding (e.g., Medicaid, Charity), see proposed Uninsured Discount Scripting for guidance on educating the patient on the uninsured discount program.

6. Identify outstanding patient account and request payment prior to discharge from the hospital.

   NOTE: The outstanding accounts may be adjusted based on the facility/CFO discount directive.

7. Request and collect total patient responsibility.

8. If patient cannot pay full amount, collect deposit and establish payment method.

9. Determine tools for collection of payments after the patient returns home (e.g. over the phone credit card payment if patient does not have wallet in ER, provide mail-back envelope).

10. Document financial payment terms in the system notes.

11. All monies collected must be processed in compliance with the hospital's cash control policies.

Uninsured Discount Program

Scenario Two: Admission following ER Treatment

1. Process Begins Post Medical screening and Registration

2. Plan of Treatment must be determined:
   a. Patient must have completed the Medical Screening Exam (MSE) and any necessary stabilizing treatment begun prior to any financial counseling.
   b. Facilities must determine based on EMTALA and their by-laws at what point in the process the EMTALA standards have been met.

3. Once the patient has met the EMTALA requirements, the patient's financial responsibility can be determined.
   - Plan of Treatment must be determined:
     - Assistance from the clinical areas is required for estimated length of stay or plan of treatment if per diem level charges vary by service
     - Notification by the clinical areas will also be required prior to transfer of the patient.

4. Does patient qualify for alternative source of funding (e.g., Medicaid, Charity)? YES (See Proposed Scripting)
   - Complete Section A of the "Confidential Medical and Financial Assistance Application" to determine possible linkage to a state or federal medical program that may assist with payment of hospital and medical expenses.
     NOTE: If the patient answers "Yes" to questions 1-8, this may indicate possible linkage
   - Ask the patient to provide the estimated Gross Annual Household Income
   - Calculate the estimated gross annual household income to the federal poverty guidelines by dividing the gross annual household income amount against the family poverty guidelines based on family size.

5. Refer to "pending Medicaid eligibility" (place in MEP FC as appropriate).

   - If the patient does not qualify for Charity, Medicaid or other government programs, the patient is referred back to the hospital financial counselor.
   - Educate the patient on the uninsured discount program via Placard.
   - If an MEP representative is not available during off hours, the account will be reviewed for potential Government Programs eligibility upon assignment to the Self Pay Early Out Program.

6. For patients that do not qualify for an alternative source of funding (e.g., Medicaid, Charity), see proposed Uninsured Discount Scripting for guidance on educating the patient on the uninsured discount program.

7. Identify outstanding patient account and request payment prior to discharge from the hospital.

   NOTE: The outstanding accounts may be adjusted based on the facility/CFO discount directive.

Uninsured Discount Program

9. Determine tools for collection of payments after the patient goes to the room if the patient does not have means to pay in the ER (e.g., they left their wallet at home).

10. Document financial payment terms in the system notes.

11. All monies collected must be processed in compliance with the hospital's cash control policies.

12. The patient will need to be seen by the financial counselor/patient access staff for collection of additional per diems/charges before discharge.

Uninsured Discount Program for Early Out
Since eligibility for the Uninsured Discount Program is determined at the hospital, accounts assigned to Early Out for collection should already have the discount posted. In these cases, normal collection efforts will ensue. In the case where Early Out determines that the patient should not have been eligible for the discount (insurance is discovered, or third party liability), then Early Out will change the financial class and insurance plan, backing out the uninsured discount and re-adjudicating the claim.

Uninsured Discount Program

v. Scenario Scripting – Talk Offs

Purpose:
To define the Uninsured Discount Program Suggested Scripting/Talk Offs.

Objectives:
After completing this section, you will be able to identify the Uninsured Discount Program appropriate scripting/ talk off for:

- Emergency Room Patients
- Direct Admits/Urgent/Non Emergent/Transfer Patients
- Early Out Patients

Uninsured Discount Program-Suggested Scripting/Talk Offs
Scenario # 1 - Emergency Department Treatment

Patients treated in the Emergency Department should receive financial counseling on the day of treatment after the patient has received the proper medical screening evaluation and necessary stabilizing treatment has begun.

Once the patient has met the EMTALA requirements and it is determined that the patient is uninsured, the financial counseling process may be initiated.

Step #1: Check Conditions of Service for a patient signature. Review face sheet
Step #2: Identify location for the financial interview, compliance with privacy
Step #3: Review charges, estimate cost for treatment including discounts
Step #4: Gather all pertinent information, including past due amounts
Step #5: Prepare financial kit to include:
- PLACARD
- Confidential Medical and Financial Assistance Application
- Payment Option Forms (facility specific)

The Financial Counselor or hospital advocate may use the following talking points when presenting the program to the uninsured patient in the Emergency Department:

> *"Good afternoon, Mr. or Mrs._____, my name is _____ and I'm the Financial Counselor at this facility. How are you feeling?"*
>
> *"I am glad to hear you are feeling better" or "I am sorry you are still not feeling well Mr. or Mrs. _____."*
>
> *"I just wanted to review the information previously obtained from you to make sure that everything is correct. Our records show that you are not covered by medical insurance, is this correct?"*

Uninsured Discount Program

If the patient doesn't want to pay the full amount on the date of service, the following script may be used:

> *"Mr. or Mrs. _____, I can imagine how you must feel with this unexpected medical bill. Please keep in mind that your payment in full will help us reduce our billing costs and allow us to continue to offer these great discounts to other uninsured patients. If you decide to use your credit card today you won't have to worry about sending additional payments to the hospital, and still have the benefit of paying in monthly until your account is paid in full. We want you to focus on getting better, not on sending monthly payments back to us. Should I go ahead and prepare the paperwork?"*

Every effort should be made on collecting payment in full on patient balances, failing the Financial Counselor may offer an alternative payment method that is approved by the facility.

The Financial Counselor will be required to negotiate the highest payment and shortest timeframe. Payments may be extended within reasonable limits, depending on the amount owed and according to policy.

> *"Mr. or Mrs. _____ here is your receipt for today's payment and my business card. Is there anything else I can do for you?*
>
> *"OK Mr. or Mrs. _____, should you have any questions after your discharge please doesn't hesitate to contact me and thank you for choosing _____ hospital for your healthcare needs. Have a great day."*

The Financial Counselor or hospital advocate will be required to document the notes in the patient accounting system detailing the patient responsibility and/or payment terms/arrangement.

The Financial Counselor or hospital advocate will assist the patient in completing **Section A (Medical Assistance Screening) of the Confidential Medical and Financial Assistance Application**.

The FC or hospital advocate will assist the patient in completing **Section B (Financial Assistance Screening)** of the **Confidential Medical and Financial Assistance Application**. The Federal Poverty Guidelines (FPG) is an important factor in determining financial eligibility for medical or financial assistance programs. Other eligibility criteria may include available resources, medical condition, age or residency.

4. If the patient answers "Yes" to any of the questions in section A and the income to Federal Poverty Guidelines (FPG) ratio in section B is under 200% or if hospital charges may qualify the patient for the catastrophic medically indigent classification refer to the Medical Eligibility Program (MEP) for further screening. (Please see BOPM Charity Care Policy #02.06.01 for more information on

catastrophic charity care.)

5. If the answers to the questions are not straight forward and the patient indicates they do not have an ability to pay or indicates they are homeless, refer the patient to the MEP Patient Advocate for further screening.

The FC or hospital advocate will be required to complete the following sections on the **Confidential Medical and Financial Assistance Application**:

- Responsible Party Guarantor
- Spouse
- Homeless Affidavit (if applicable)

The patient will be required to sign the **Attestation of Truth** section in the **Confidential Medical and Financial Assistance Application**. In those cases where the patient is unable to write to complete the application and it is taken verbally by the Financial Counselor or hospital advocate, the FC or hospital advocate must sign the application indicating the following: *Medically unable to sign. Completed by, hospital employee name.*

Office Use Only - To be completed by the Tenet Financial Assistance Program employee.

Or

Financial Counselor:

> *"Mr. or Mrs. _____ thank you for providing the information we need to initiate the application process. One of our Medical Eligibility Program Advocates will be contacting you to verify this information and request additional documentation from you. Is there anything else that I may assist you with? Here is my business card in case you have any questions after you have been discharged, have a nice day."* (Provide MEP contact information to patient.)

The patient will be required to complete the **Confidential Medical and Financial Assistance Application**, and all other applicable forms.

Or

If the patient does not answer "Yes" to any question in section A or his or her income to Federal Poverty Guidelines (FPG) ratio in section B is greater than 200% the hospital advocate or Financial Counselor may use the following script:

> *"I am sorry Mr. or Mrs. _____, based on the information you've provided, it looks like you will not be eligible for any of the medical or financial assistance*

programs I talked to you about. The great news is that you still qualify for the Uninsured Discount. I realize you are concerned with not having sufficient funds to pay for today's treatment but let's discuss how you can make payment on this discount amount."

Or

Financial Counselor:

"Mr. or Mrs. _____ thank you for providing the information we need to initiate the application process. One of our Medical Eligibility Program Advocate will be contacting you to verify this information and request additional documentation from you. In the meantime, the minimum amount of deposit due before you are discharged today is $_____. How will you pay for your services today will this be cash, check or charge?"

Patient response:

"But what if I qualify for one of your programs after all?

Financial Counselor:

"I can imagine your concern Mr. or Mrs. _____, you immediately qualify for the Uninsured Discount Program. But the good news is that if our Medical Eligibility Program later determines that you qualify for any one of our medical or financial assistance programs, we will refund to you any payments you've made today, if there is no patient responsibility amount due."

Uninsured Discount Program

Scenario # 1 – Early Out

Outbound Greeting:

Agent:

"Good morning/afternoon, my name is _____ and I'm calling from the Business Office at _____. May I speak with_____?"

"I'm calling regarding service you received at our facility on _____.

Inbound Greeting:

Agent:

"Thank you for calling the Business Office how I may help you."

Patient:

"I'm calling regarding a statement/ bill I received for services at your hospital."

Agent:

"May I have the account number on the statement?"

Once the caller provides the account number the Business Office Representative will make efforts to identify the caller and determine if the release of information to the caller is appropriate.

Every effort should be made on collecting payment in full on patient balances. If the patient is unable to make payment in full, alternative payment methods will be used in negotiations with the patient.

The Collector is required to negotiate the highest payment and shortest timeframe. Payments may be extended within reasonable limits, depending on the amount owed and according to policy. The table below outlines the payment terms used by Early Out.

Balance	*$0 - $250*	*$251- $500*	*$501 - $1000*	*$1001 - $2500*	*$2501 - $5000*	*$5001 + **
% Down	0%	0%	10%	10%	5%	5%
# of Pmts	4	6	10	12	24	36

*** Admitting Director/DPS/CFO Approval Required**

Uninsured Discount Program

Tenet's Policy & Procedure Uninsured Discount Program

Purpose:
To define Tenet's Uninsured Discount Program Policy & Procedure.

Objectives:
After completing this section, you will be able to describe:

- Location of Tenet's Policy & Procedure for the Uninsured Discount Program
- Tenet's Policy & Procedure for the Uninsured Discount Program

Location of Policy & Procedure:
The Tenet Policy & Procedure for the Uninsured Discount Program, once approved, will be located in the Business Office Procedure Manual (BOPM). The BOPM is located on eTenet, under the Patient Financial Services Corporate Web Page.

Steps to locate Tenet's Policy & Procedure for the Uninsured Discount Program are:

1. Log onto eTenet using your User ID and Password.
2. From the "My eTenet" page, select the Corporate Departments Tab.
3. Click on the link for Patient Financial Services. (Departments are listed in alphabetical order)
4. On the Patient Financial Services Home page, click on "Business Office Procedure" under the section: Business Office Services.
5. Once opened, reference the Table of Contents for the section relating to the Uninsured Discount Program.

Uninsured Discount Program

Figure 6.1

Tenet Health Systems

EXAMPLE

SUBJECT: UNINSURED DISCOUNT PROGRAM-PATIENT PILOT PROGRAM
POLICY #: EMERGENCY ROOM
DEPARTMENT: ADMITTING **PAGE 1 of 3**

ORIGINATED: 7/03

PURPOSE:

1.0 To ensure that all patients whose medical services are not covered by a third party administrator are informed of financial assistance programs made available by the hospital to aid them in honoring any hospital charges incurred during treatment.

2.0 To establish guidelines for the hospital admitting department in the use of the Uninsured Patient Program with various patient types.

3.0 To define the various assistance programs available to uninsured patients.

POLICY:

1.0 Definitions:

1.1 Uninsured Discount Program: Discounted cash rates similar to those established by Non-government insurance plans.
1.2 Medical Eligibility Program (MEP): A means by which the uninsured patient may be screened for linkage to financial aid via government programs.
1.3 Tenet Financial Assistance Program: A program which can aid the uninsured patient in submission of an application for Tenet Financial Assistance Programs.
1.4 Financial Assistance Programs Placard: An informational placard which explains the various financial programs available to the patient in his/her own language (Exhibit 1).
1.5 Uninsured Discount Payment Terms: The form which will list out the agreed on payment arrangements made between patient and hospital advocate under the Uninsured Discount Program (Exhibit 3).
1.6 Confidential Medical and Financial Assistance Application: The application utilized by the hospital to determine whether an uninsured patient is eligible for possible linkage to government programs such as

Medical/caid, or other state or county funded programs, as well as the Tenet Financial Assistance Program (EXHIBIT 4).

1.7 IMaCS-***CarePricer***: The online system utilized to determine the cost of services performed for patient.

PROCEDURE:

1.0 Outpatient Emergency Room Patients

1.1 In adherence to EMTALA regulations and those hospital policies which address the process and flow of registration of ER patients, the screening or obtaining of financial information from the ER patient will occur after the medical screening exam and stabilizing treatment has been performed.

1.2 If the patient is found to be uninsured, the ER hospital designee will give the Uninsured Placard to the patient and answer any questions the patient may have in regards to the placard.

1.3 The Hospital designee will obtain the proper information from the ER clinical staff in order to establish the level of care given to the patient.

1.4 The Hospital designee will perform a primary screen for linkage to government programs utilizing the first eight (8) questions of the Confidential Medical and Financial Screening Assistance Application.

1.4.1 If the patient's answers to the screening questions indicate possible linkage to the MEP, the hospital designee will change the financial class and payer codes to reflect that that the patient is being followed up by the MEP worker and refer the uninsured patient to the MEP worker via:

1.4.1.1 Detailed documentation in the Account Follow-Up System (e.g., PBAR: FUSSA) if the MEP eligibility worker is not available at time of service or prior to the discharge of the patient from the emergency room. MEP will contact the patient via phone and/or mail.

1.4.1.2 The Hospital designee will distribute a copy of the patient face sheet and Confidential Medical and Financial Assistance Application to a designated bucket for the MEP eligibility worker to obtain the next business day.

1.4.1.3 The MEP eligibility worker will contact the patient to complete the screening and application process.

1.4.2 Telephone and documentation in the Account Follow-Up System (e.g., PBAR: FUSSA) if the MEP eligibility worker is available prior to discharge.

1.5 If the patient's answers do not indicate any possible linkage, the hospital designee will again address the uninsured discount program with the patient utilizing set scripting (EXHIBIT 5).

1.6 If the MEP worker is unable to link the patient to any government programs, the MEP worker will again encourage the patient to discuss

the Uninsured discount Program with the Hospital designee.

1.6.1 If the patient is unable to qualify for any programs, the patient's account financial class and payer code are updated to Self Pay/Uninsured.

1.7 The Hospital designee will access the IMaCS-***CarePricer*** in order to obtain the discounted charges for the patient.

1.8 The Hospital designee will offer the uninsured discount program, explaining the discounted charges due.

1.8.1 The Hospital designee will encourage payment at time of service or within 5 days.

1.8.2 If the patient is unable to pay the established discounted rate at time of service, the Hospital designee will fill out the Uninsured Discount Program Payment Terms and list out the terms of the payment arrangement.

1.8.3 The Hospital designee will verify that the patient understands and has correctly completed and signed all forms prior to collecting any monies.

1.8.4 The Hospital designee will clearly document all discount arrangements made in their Account Follow Up System (e.g., PBAR: FUSSA).

1.9 If the patient is discharged prior to the Hospital designee screening him/her or for financial status, the hospital designee will update the account and refer to the ER Quality Control representative to follow up.

1.9.1 If the ER QC is able to reach the patient, he/she will follow a similar process:

1.9.1.1 Screen the patient for third party administrator participation

1.9.1.2 If none, offer the uninsured discount program

1.9.1.3 If unable to pay, screen patient for linkage to the MEP.

1.9.1.4 Refer patient to MEP worker for follow up.

1.9.1.5 Update and document account accordingly.

Uninsured Discount Program

VI. Uninsured Discount Program Glossary of Terms

Purpose:
To define the terms that will be commonly used in reference to the Uninsured Discount Program.

Objectives:
After completing this section, you will be able to define:

- Terms commonly used in reference to the Uninsured Discount Program
- Note: Does not include international patient language

Glossary of Terms:

Term	Term Definition
Uninsured	Any patient without a third party payment source.
Uninsured Discount Program	A program designed by Tenet HealthCare to offer all uninsured patient, meeting the criteria of the program, with discounting that is comparable to non-government discounts.
Medical Eligibility Program (MEP)	A program designed by Tenet HealthCare to offer a means in which the uninsured patients may be screened and assisted in obtaining financial aid from Government Programs.
Tenet Financial Assistance Program	A program which can aid the uninsured patient in submission of an application for the Tenet Financial Assistance Programs.
Tenet Financial Assistance Programs Placard	An informational placard which explains the various financial programs (i.e. Uninsured Discount Program, Medical Eligibility Program, Tenet Financial Assistance Program) available to the patient in his/her own language. (Figure 3.1)
Uninsured Discount Payment Terms	The form which provides a Financial Counselor tool to list the payment arrangement made between patient and (specific facilities) facility advocate under the Uninsured Discount Program. (Figure, 3.2)
Confidential Medical and Financial Assistance Application	The application utilized by the facility to determine whether an uninsured patient is eligible for possible linkage to government programs such as Medicaid/cal, or other state or county funded programs as well as the Tenet Financial Assistance Program. (Figure, 3.5)

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July 22, 2004

VIA HAND DELIVERY, E-MAIL AND FED EX

Mr. Anthony M. Cooke
Majority Counsel, Oversight and Investigations Subcommittee of The House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Re: New York Presbyterian Hospital's Responses to Follow-up Questions

Dear Mr. Cooke:

This letter serves to respond to the questions set forth in the July 14, 2004 letter from Congressman James Greenwood. Congressman Greenwood's questions and New York Presbyterian Hospital's ("NYPH") responses are set forth below.

1. *Please produce for the record a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.*

   NYPH produced its revised Charity Care/Financial Aid Policy to the Subcommittee on May 24, 2004 (*see* NYPH 0001645 – NYPH 0001650). Enclosed please find a copy of NYPH's Policies and Procedures for Collection Agencies and Attorneys (*see* NYPH 0001660- NYPH 0001663). NYPH continues to evaluate its policies and will revise the policies, as needed, on an on-going basis.

2. *If your system has implemented any changes recently to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the planned date of implementation of each such change.*

   NYPH has been in the process of implementing its revised Charity Care/Financial Aid Policy and its Policies and Procedures for Collection Agencies and Attorneys since May, 2004. NYPH will continue to evaluate its charity care and collection policies, and will revise the policies, as needed, on an on-going basis.

3. *Please produce for the record all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients.*

   Enclosed please find training materials related to the implementation of NYPH's revised Charity Care/Financial Aid Policy (*see* NYPH 0001664 – NYPH 0001673).

4. *How are patients made aware of your charity policy and how is the substance of that policy made available to patients, e.g., brochures, postings in the hospital or on the system website?*

   NYPH provides information regarding its Charity Care/Financial Aid Policy to self-pay patients during the patient registration process. Patients are asked to complete an application and to provide documentation related to their financial resources. NYPH's billing statements also contain language that informs patients to contact the Patient Financial Services Department if they are experiencing financial difficulties. The Patient Financial Services Department provides information and applications for charity care/financial aid. NYPH also shares information about this Policy with appropriate community health and human service agencies and other local organizations that help people in need. Finally, NYPH's outside collectors are required to assess a patient's eligibility for financial aid/charity care prior to making a demand for payment.

   NYPH posts information regarding its Charity Care/Financial Aid Policy in the Emergency and Admitting Departments of each of its campuses. This information is also posted in many of NYPH's outpatient clinics.

5. *For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of poverty?*

   NYPH sought to provide larger discounts to those patients who were at or below the Federal poverty level, and to gradually reduce the discount for those patients with incomes up to 300% of the Federal poverty level. NYPH decided upon a 90% discount for patients with incomes at or below 100% of the Federal poverty level. This level of discount allows the patients in greatest need to pay reduced charges. NYPH reduced the discount in 20% increments at 150%, 200%, 250% and 300% of the Federal poverty level to arrive at discounts of 70%, 50%, 30% and 10%, respectively.

   a. *Are there plans to change the discount percentage rates as charges rise?*

   Not at this time, but it may be considered in the future.

6. *The AHA states that in 2002 the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care . . . for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?*

   The amount NYPH receives from state and federal agencies for providing charity care, through DSH funds, bad debt reimbursements and tax breaks is less than the cost to NYPH of delivering charity and uncompensated care. The amount varies by year. In 2003, NYPH received approximately $12 million less than it spent. In 2001, NYPH received approximately $51 million less than it spent.

7. *Did the HHS/OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self-pay patients? What specific further guidance is needed?*

   NYPH appreciates the recent HHS/OIG clarification regarding billing and collections for uninsured patients. The HHS/OIG guidance was very helpful in addressing a number of NYPH's concerns. NYPH has no further questions at this time, although with more experience, further clarification may be needed.

8. *Have you ever reviewed and investigated complaints from patients against any of your collection agencies?*

   Yes. NYPH has received and reviewed two patient complaints. In both cases, the complaints were investigated.

9. *Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse all other means of paying undiscounted charge master rates (except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?*

   Under NYPH's current policy, self-pay patients are counseled regarding Medicaid and other government programs at the time of registration. If a patient is deemed to be potentially eligible for any of these programs, NYPH will assist the patient in the enrollment process. If it is determined that the patient is not eligible for a government program, NYPH will discuss its Charity Care/Financial Aid Policy with the patient, and will provide the individual with an application. Charity care/financial aid is provided to patients with incomes up to 300% of the Federal poverty level. Determinations as to eligibility for charity care/financial aid are communicated to the patient as soon as practicable after the completed application is submitted. NYPH does not require self-pay patients to first exhaust or refuse all other means of payment, such as bank loans or credit cards, prior to assessing a patient's eligibility for charity care/financial aid.

10. The Wall Street Journal had a piece on June 8, 2004 about the collection by New York Presbyterian of certain old debts. Who at New York Presbyterian was aware of and/or authorized pursuit of the bills at issue in the article?

NYPH was not aware that the judgment against Mr. Savinon was still being pursued. Upon learning of Mr. Savinon's case, NYPH reviewed the matter and decided to release the lien and vacate the judgment.

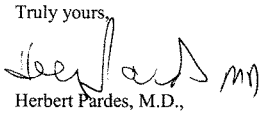
11. Does New York Presbyterian have a contract with the collection agent involved in pursuit of the bills at issue in the June 8, 2004 Wall Street Journal article?

NYPH does not have a contract with the law firm at issue in the Wall Street Journal article. The account was acquired by the law firm as a result of the restructuring of a collection agency utilized by NYPH. NYPH was not aware that the law firm was engaged in collection efforts on any of its patient accounts. NYPH has since asked the law firm to cease collection efforts on behalf of the hospital until such time as NYPH can review the accounts and determine the appropriate course of action.

* * *

If you have any questions regarding NYPH's responses, please do not hesitate to contact Stuart Kurlander of Latham & Watkins at (202) 637-2169.

Truly yours,



Herbert Pardes, M.D.,
President and CEO
New York Presbyterian Hospital

Enclosures

cc: New York Presbyterian Hospital

Stuart S. Kurlander
(202) 637-2169
stuart.kurlander@lw.com

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LATHAM&WATKINS LLP

FIRM / AFFILIATE OFFICES
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August 3, 2004

PRIVILEGED & CONFIDENTIAL

VIA FACSIMILE

Mr. Anthony M. Cooke
Majority Counsel, Oversight and Investigations Subcommittee of The House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Re: New York Presbyterian Hospital's Responses to Follow-up Questions

Dear Mr. Cooke:

Upon further review of New York Presbyterian's (NYPH) July 23, 2004, response to Congressman Greenwood's July 14, 2004 letter, NYPH would like to clarify its response to question six. Please disregard the response contained in NYPH's July 23 letter, and replace it with the following:

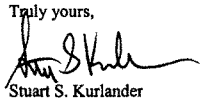
6. *The AHA states that in 2002 the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care . . . for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?*

   The amount NYPH receives from state and federal agencies for providing charity care, through Medicaid Disproportionate Share (DSH) funds, bad debt reimbursements and tax breaks is less than the cost to NYPH of delivering charity and uncompensated care. The amount varies by year. In 2003, NYPH received from the New York State bad debt and charity pool (which is funded through Medicaid DSH) approximately $22 million less than it spent on care related to charity care and bad debt charges. The comparable figure for 2000 is approximately $57 million.

* * *

If you have any questions regarding NYPH's responses, please do not hesitate to contact me at (202) 637-2169.

Truly yours,



Stuart S. Kurlander
of LATHAM & WATKINS LLP

cc: Brad Conway

BILLING AND COLLECTION SERVICES AGREEMENT

This AGREEMENT, dated _____ __, 200__, between The New York and Presbyterian Hospital (NYPH), a New York not-for-profit corporation with offices located at 525 East 68th Street, New York, N.Y. 10021 (NYPH) and _____, a _____ Corporation having an address at _____ (Contractor).

WITNESSETH:

WHEREAS, NYPH desires to retain Contractor's services for billing and collection of NYPH claims for healthcare services provided to NYPH patients, and Contractor desires to provide such services.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is agreed as follows:

SECTION 1. SCOPE OF WORK

Subject to the terms and condition of this Agreement, Contractor shall provide services as described in Appendix A, which is attached hereto and made part of this Agreement. Contractor shall keep and maintain such documents and records as shall be required to verify Contractor's performance under this Agreement, including but not limited to, amounts collected, amounts paid to NYPH and amounts due to Contractor. Contractor shall make such documents and records available to NYPH for inspection upon reasonable prior notice.

SECTION 2. TERM AND TERMINATION.

2.1 Term. The term of this Agreement shall be for an initial period of two (2) years, commencing on the date hereof ("Initial Term"). This Agreement shall be automatically renewed for additional one year periods, each of which shall be hereinafter referred to as "Renewal Term", unless either party provides written notice of non-renewal to the other no later than thirty (30) days prior to the expiration of the Initial Term or the expiration of any Renewal Term thereafter.

2.2 Termination. Either party may terminate this Agreement, with or without cause upon thirty (30) days written notice to the other party. Contractor shall return all NYPH documents and other materials to NYPH, or destroy documents or materials not returned to NYPH, and shall attest to such destruction.

SECTION 3. COMPENSATION.

3.1 Policy. Compensation shall be paid in accordance with all applicable federal, state and local law, regulations, rulings and binding interpretations. For Medicaid claims, it is the policy of NYPH not to base Contractor's compensation on the value or volume of any invoice, the value or volume of the amount of collections, or any percentage or discount of either invoices or collections.

3.2 Payment. Compensation to Contractor for each type of billing and collection service within the scope of work is detailed Appendix B which is attached to and made part of this Agreement. Contractor shall submit to NYPH monthly invoices for amounts due as compensation. NYPH shall pay undisputed invoices within 60 days of receipt.

SECTION 4. COMPLIANCE

4.1 Contractor shall have in place and available for NYPH's review and approval, a compliance plan and active compliance program designed to comply with applicable federal and state law concerning fraud and abuse, including but not limited to anti-kickback and self-referral. NYPH shall have the right to audit and monitor Contractor's compliance program.

4.2 Contractor is aware of the federal False Claims Act, and will not knowingly submit, recommend or cause NYPH to submit any bill to any third party payor, including Medicaid and Medicare, which is false or fraudulent or otherwise in violation of applicable laws, regulations or rules.

4.3 Contractor acknowledges receipt of and agrees to adhere to the NewYork-Presbyterian Hospital Policies and Procedures for Collection Agencies and Attorneys, attached to this Agreement as an Addendum. Failure to adhere to the Policies and Procedures shall constitute a material breach of this Agreement and cause for immediate termination of this Agreement.

SECTION. 5 HIPAA REQUIREMENTS.

5.1 HIPAA Applicability. NYPH is a covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as such must comply with the Administrative Simplification provisions of HIPAA, including the Privacy Standards found at 45 C.F.R. Parts 160 and 164.

5.2 NYPH Use and Disclosure. In order for Contractor to perform its obligations under this Agreement, NYPH intends to disclose certain Protected Health Information (as defined below) of NYPH patients ("PHI") to Contractor and anticipates that Contractor will receive PHI on behalf of NYPH.

5.3 Contractor Use and Disclosure. The parties anticipate that Contractor will be required to use and disclose PHI in order to perform its obligations under this

Agreement. Therefore, Contractor will qualify as a "business associate" under the Privacy Standards.

5.4 Duties of Contractor Regarding Use and Disclosure of PHI

5.4.1 Receipt and Use of PHI. Satisfactory performance of its obligations under this Agreement by Contractor will require Contractor to receive and use Individually Identifiable Health Information that constitutes Protected Health Information ("PHI") obtained from NYPH. Contractor shall not use PHI except as permitted or required by this Agreement or as required by law. Contractor shall use PHI consistent with the Privacy Standards.

5.4.2 "Individually Identifiable Health Information". For purposes of this Agreement, Individually Identifiable Health Information shall mean information that is a subset of health information including demographic information collected from an individual, and that:

(i) is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse.

(ii) relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual; and

(iii) identifies the individual or contains sufficient information to form a reasonable basis to believe the information can be used to identify the individual.

5.4.3 "Protected Health Information" shall mean Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media; or (iii) transmitted or maintained in any other form or medium.

5.5 Disclosure of PHI. Contractor shall not disclose PHI except as permitted or required by this Agreement, or as required by law. Specifically, unless otherwise permitted by this Agreement, Contractor may disclose PHI only (i) for Contractor's proper internal management and administration, or (ii) to carry out the legal responsibilities of Contractor, provided that either of the following conditions are satisfied: (a) the disclosure is required by law; or (b) Contractor obtains reasonable assurances from the person to whom Contractor discloses the PHI that the PHI will be held confidentially, that the information will be used or further disclosed only as required by law or for the purposes for which it was disclosed, and that the person notifies Contractor of any instances where the confidentiality of the PHI has been breached.

5.6 Safeguarding PHI. Contractor shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by this Agreement. Contractor shall maintain an appropriate level of security with regard to all personnel, systems, and administrative processes used by Contractor to transmit, store, process, or otherwise handle PHI. Contractor shall not transmit PHI over any open network unless

the transmission is encrypted or otherwise secured according to the appropriate standard of care. Within thirty (30) days of the date this Agreement is executed by the Parties, Contractor shall inform in writing NYPH of its security measures to protect PHI from improper use and disclosure.

5.7 Third Party Agreements. Under certain circumstances, Contractor may need to enter into agreements with third parties, including subcontractors, in order to satisfy its obligations under this Agreement. Contractor shall require that all of its agents, employees, subcontractors, and Contractors to whom it furnishes any PHI to agree in writing to be bound, and to abide in all respects by, all the obligations of Contractor under this Agreement to protect PHI.

5.8 Reporting of Unauthorized Uses and Disclosures. If Contractor becomes aware of any use or disclosure of PHI by Contractor, its employees, or its agents, that is not provided for in this Agreement, Contractor shall promptly report such violation to NYPH. NYPH shall investigate the unauthorized use or disclosure and Contractor shall cooperate fully with such investigation. In consultation with NYPH, Contractor shall promptly seek to cure or mitigate the unauthorized use or disclosure. If Contractor is unable promptly to cure or mitigate an unauthorized use or disclosure which constitutes a material breach of the Contractor's obligations under this Agreement, notwithstanding any other provision in this Agreement, NYPH shall have the right to terminate this Agreement for cause, to report the matter to the Secretary of the U.S. Department of Health and Human Services, or both.

5.9 Access to Information. Within ten business days of NYPH's written request, Contractor shall provide NYPH with access to PHI in Contractor's possession, if Contractor's information consists of PHI within a Designated Record Set held by NYPH. For the purposes of this Agreement, **"Designated Record Set"** shall mean a group of records maintained by or for NYPH that (i) consists of the medical records and billing records about individuals maintained by or for NYPH, (ii) constitutes the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) is used, in whole or in part, by or for NYPH to make decisions about individuals. For the purposes of this paragraph, the term "Record" means any items, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for NYPH.

5.10 Availability of PHI for Amendment. The parties acknowledge that the Privacy Standards permit an individual who is the subject of PHI to request certain amendments of their records. Upon NYPH's written request, Contractor shall provide NYPH with any PHI contained in a Designated Record Set in Contractor's possession for amendment.

5.11 Accounting of Disclosures. Upon NYPH's written request, Contractor shall make available information to NYPH concerning Contractor's disclosure of PHI for which NYPH needs to provide an individual with an accounting of disclosure as required by the Privacy Standards. For this purpose, Contractor shall retain a record of disclosures of PHI for at least six (6) years from the date of disclosure. Disclosures of

PHI for purposes of treatment, payment or operators of or by NYPH shall not be subject to this accounting requirement.

5.12 Availability of Books and Records. For purposes of determining NYPH's compliance with the Privacy Standards, Contractor agrees to make available to the Secretary its internal policies and procedures relating to the use and disclosure of PHI received from NYPH, or created or received by Contractor on behalf of NYPH.

5.13 Return of PHI at Termination. Notwithstanding the disposition of other documents and materials created by the Parties in performance of this Agreement, upon termination of this Agreement, Contractor shall, where feasible, destroy or return to NYPH all PHI received from NYPH, or created or received by Contractor on behalf of NYPH. Where return or destruction is not feasible, the duties of Contractor under this Agreement shall be extended to protect the PHI retained by Contractor. Contractor agrees not to further use or disclose information for which the return or destruction is infeasible. Contractor shall certify in writing the destruction of the PHI and to the continued protection of PHI that is not feasible to destroy.

5.14 Representations of NYPH.

5.14.1 Obtaining Patient Permission. NYPH represents and warrants that it has obtained patient and individual permissions, consents, or authorizations, required under federal and state law that are necessary for Contractor to receive, use, and disclose PHI as contemplated under this Agreement.

5.14.2 Furnishing Appropriate Patient Notice. NYPH represents and warrants that it has undertaken steps necessary to adequately inform its patients, as required by state and federal law, about the disclosure of PHI to service providers and vendors such as Contractor and use and disclosure of such information by such entities. Such notification shall include, but is not limited to, distribution of a "notice for privacy practices," as this term is defined in the Privacy Standards.

SECTION. 6. MISCELLANEOUS.

6.1 Entire Agreement, Modification. This Agreement constitutes the entire agreement between the parties with respect to the matters set forth herein and may not be amended or modified except in writing signed by all the parties hereto.

6.2 Assignment. This Agreement may not be assigned by either party without the written consent of the other, except that NYPH may assign this Agreement to a successor corporation in the event of a merger, consolidation or transfer or sale of all or substantially all of its assets.

6.3 Notice. Any notice required under this Agreement shall be deemed given when mailed by certified mail, return receipt requested, with a copy sent by regular first class mail, or by overnight delivery by nationally recognized courier, to

the address listed in this Agreement or such other addresses as the parties may designate in writing.

6.4 Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the other provisions hereof, but the remaining provisions of the Agreement shall be construed in all respects as if such invalid or unenforceable provision or provisions were omitted.

6.5 Construction and Governing Law. This Agreement shall be governed by and interpreted exclusively in accordance with the laws of the State of New York without reference to an application of conflict of law principles or provisions.

6.6 Relationship of Parties. The parties hereto acknowledge and agree that this Agreement does not create the relationship of employer and employee between NYPH and Contractor, but rather, that the services to be performed by Contractor hereunder shall be performed by Contractor as an independent contractor. Each of the parties agrees not to hold itself out in any manner inconsistent with or contrary to the terms of this Agreement.

6.7 Waiver. The waiver by either party of noncompliance by the other party of any term or provision of this Agreement shall not be construed as a waiver of any other noncompliance.

6.8 Captions. The captions herein are for convenience and reference only and in no way define, limit or describe the scope or intent thereof, or in any way affect this Agreement.

6.9 Arbitration. In the event a dispute arises under any term or provision hereof, such dispute shall be settled by arbitration in the County of New York, State of New York by and in accordance with the rules then obtaining of the American Arbitration Association. This provision shall not apply to disputes regarding the interpretation of federal or state laws and regulations; nor shall it apply to claims made by third parties against NYPH, Contractor or both.

6.10 Counterparts. This Agreement may be executed in several counterparts, each of which shall be deemed an original, all of which together will constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date and year first above written.

CONTRACTOR	NEW YORK AND PRESBYTERIAN HOSPITAL
By: _____	By: _____

Title: _____ Title: _____

Contractor:

APPENDIX A

Scope of Services

Payors: Medicare _____

Medicaid _____

Commercial _____

Managed Care _____

Self Pay _____

Other _____

Services: Billing _____

Collection _____

Detailed Description of Services:

Contractor:

APPENDIX B

Compensation

For Medicaid and Medicare Claims

Contractor shall be paid a fee of $ _____ for each claim processed.

For Claims Other Than Medicaid and Medicare

Contractor shall be a contingency fee of _____% of amounts collected, less _____ % of any amounts collected by Contractor which must be refunded or repaid to the payor within 180 days of collection.

g:\cap\Billing and Collection Services Agreement

NEW YORK-PRESBYTERIAN HOSPITAL: POLICIES AND PROCEDURES FOR COLLECTION AGENCIES AND ATTORNEYS
JULY 2004

The purpose of these policies and procedures is to promote patient access to quality health care while minimizing bad debt at the New York Presbyterian Hospital ("NYPH"). The promulgation of these policies and procedures will continue to ensure that the debt collection activities undertaken by collection agencies and attorneys on behalf of NYPH remain consistent with the core missions, values, and principles of NYPH.

1. GENERAL PRINCIPLES & GUIDELINES

A. The collection agency (the "Agency") will comply with all applicable federal and state laws and accrediting agency requirements, including, but not limited to, the Fair Debt Collection Practices Act ("FDCPA") the Fair Credit Billing Act, the Consumer Credit Protection Acts, and the Health Insurance Portability and Accountability Act ("HIPAA"). Agency will also comply with NYPH's guidelines on financial aid and charity care.

B. Agency and Outside Counsel will assess the patient's eligibility for government programs and for charity care/financial aid prior to making a demand for payment.

C. Agency will work with the patient to establish a reasonable payment plan.

D. Agency and Outside Counsel will suspend all collection activities associated with a patient account if the patient disputes (in accordance with the appropriate NYPH's dispute resolution procedures) the amount or validity of any outstanding balance. The patient account will remain suspended until NYPH determines that collection efforts may resume.

E. Agency or any lawyer or law firm assisting NYPH or Agency in the collection of an outstanding patient account debt (the "Outside Counsel") may take legal action only upon receiving prior authorization from NYPH.

2. PROCEDURE GOVERNING AGENCY'S RECEIPT OF PATIENT ACCOUNT REFERRALS

A. Agency will send an acknowledgement to NYPH upon receipt of a patient account referral from NYPH. The purpose of the stated acknowledgment is to allow NYPH to reconcile the number of patient accounts referred to the Agency with the amounts received by Agency. Agency will not transfer patient accounts to another Agency, with the exception of accounts being referred for legal action, without NYPH's prior approval.

B. As required under the FDCPA, Agency will send a letter to a patient within three (3) days of receipt of an account referral advising the patient that the Agency is attempting to collect a debt.

3. PROCEDURE GOVERNING THE COLLECTION PROCESS

A. After (or in conjunction with) its initial communication with the patient, Agency will attempt to communicate with the patient to determine why the outstanding balance on the patient's account balance remains unpaid. Agency will adhere to this policy regarding appropriate means of communicating with the patient.

B. Upon contacting the patient, Agency will determine if patient was insured at the time of service (e.g., employer group health plan, no-fault, workers' compensation, Medicare (if patient is over 65 years of age), parents and/or school insurance if patient is a minor, third party liability in the event of an accident).

1. If insurance coverage is identified, follow Agency's internal procedures for billing insurance.
2. If insurance coverage is not identified, determine if patient was eligible for COBRA benefits at the time of service.
   a. If yes, determine ability to reinstate benefits.
   b. If no, proceed to Section C.

C. Agency will determine if patient may be eligible for Medicaid, Family Health Plus, Child Health Plus or other government programs.

1. If patient has coverage that went into effect after the date of service, Agency will determine whether coverage can be made retroactive.

D. If none of the previous steps has been successful, Agency will determine whether patient may be eligible for charity care or financial aid from the hospital.

1. If yes, forward Charity Care/Financial Aid application to patient for completion.
2. If no, proceed to Section E.

E. Agency will conduct a financial profile on the patient and take the following actions, as appropriate:

1. Make demand for full payment,
2. If patient is unable to make payment in full, collector may establish a payment plan. Collector should seek full repayment of the balance within six months. Collector is authorized to extend the repayment period beyond six months if patient's financial profile indicates that extension is appropriate.
3. Accept a settlement if the financial profile indicates that action is appropriate. Settlements for less than 75% of the balance must be approved by a Director of Patient Financial Services, Vice President of Financial Services, or their appropriate designees.
4. Seek alternative payment methods (e.g., credit cards, loans, mortgages) to satisfy debt.

F. Agency will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

I. REFERRAL FOR LEGAL ACTION

A. With respect to those patient accounts for which the foregoing steps are unsuccessful, Agency may refer appropriate accounts to Outside Counsel for possible legal action. Referral of an account should not generally occur until six months after Agency's receipt of the account.

5. GENERAL LEGAL GUIDELINES

A. Outside Counsel will follow all applicable federal and state laws and regulations governing the collection of debts, including, but not limited to FDCPA, FCBA, CCPA, HIPAA and Article 52 of the New York Civil Practice Law and Rules. Outside Counsel will also abide by NYPH's guidelines on financial aid and charity care

B. Outside Counsel will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

C. Outside Counsel will seek NYPH's prior approval before issuing a summons in connection with the collection of an outstanding balance on any patient account.

D. Outside Counsel will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.

E. Outside Counsel will not enforce a judgment against a patient after five years from the date of judgment, without prior approval from NYPH. Similarly, Outside Counsel will not renew a judgment against a patient without prior approval from NYPH.

F. Outside Counsel will not use body attachment to require the patient or responsible party to appear in court.

G. Outside Counsel will conduct judgment evaluations on a case-by-case basis. Electronic "blind" sweeps are not permitted.

H. Outside Counsel will not transfer patient accounts to another collection agency or law firm without prior approval from NYPH.

6. LEGAL SCREENING PROCEDURES

A. Outside Counsel will perform review to ensure that patient has no insurance, and is not eligible for:

1. Medicaid, Family Health Plus, Child Health Plus or other governmental programs; or
2. Financial aid under NYPH's Charity Care/Financial Aid Policy.

B. Outside Counsel will evaluate income, assets, employment data, and any other information indicating ability to pay.

C. Prior to issuing a summons in connection with the collection of an outstanding balance on any patient account, Outside Counsel will complete a Litigation Authorization form, and will forward the form to the Directors of Patient Financial Services, or the Vice President of PFS for approval. Outside Counsel will also provide a history of the account, and a recommendation supporting litigation.

7. POST JUDGMENT PROCEDURES

A. Unless otherwise prohibited by any governing law or regulation, Outside Counsel will contact patient or responsible party by phone at home or place of employment advising him that judgment has been entered. If a telephonic communications is not possible, Outside Counsel should contact the patient or responsible party by mail to inform him of the judgment.

B. When contact is made with the patient or responsible party after a judgment is rendered, Outside Counsel will:

1. Seek payment in full, or
2. Negotiate a written payment plan.

C. If patient is not eligible for government programs or for charity care/financial aid, and no reasonable explanation is made as to why payment cannot be made, Outside Counsel may:

1. Advise patient(s) that judgment will be enforced;
2. Obtain recent credit report;
3. Conduct property search; and/or
4. Confirm place of employment.

D. Outside Counsel may issue Information Subpoenas with or without Restraining Notice to:

1. Major banks;
2. Place of employment;
3. Credit card companies; and/or
4. Mortgage companies.

E. Outside Counsel may issue property execution against patient's bank accounts. If patient contacts Outside Counsel and provides proof of financial hardship as a result of the property execution, Outside Counsel should release the lien.

F. Consistent with New York State law, Outside Counsel may issue income executions on the patient for up to ten percent of the patient's wages. Outside Counsel is not authorized to issue an income execution on a patient's spouse unless a judgment has been obtained against that spouse.

NewYork-Presbyterian

Informational Bulletin # 27-04

May 20, 2004

To: Chiefs of Service
Vice Presidents
Department Heads
Medical Staff
Nursing Service
Key Personnel

Subject: **NYPH Adopts Financial Aid Policy**

NewYork-Presbyterian Hospital has had a long-standing policy to provide financial aid to patients who receive services at NYPH and are in need. Recently, the Board of Directors memorialized our commitment to providing financial aid where appropriate.

The policy applies to hospital inpatient and outpatient services that are deemed medically necessary and that are rendered to uninsured patients residing in our service areas. (The policy generally does not apply to services of physicians or other providers). Before applying for financial aid, patients will be screened for other insurance, assistance, or entitlements, such as Medicaid, Child Health Plus, or Family Health Plus. Patients may request applications for financial aid in our Admitting Departments or the Emergency Departments, or once they receive a bill for services rendered. Patients will complete the applications and submit the forms and other documentation to the hospital for determination of eligibility. We will assist those patients who need help to complete the required financial aid forms and other documentation. Patients who qualify for financial aid may be eligible for discounts, or in some cases free care, depending on family income and size. Financial aid is available for patients whose income falls below 300% of the Federal Poverty Level Guidelines, which are updated annually and adjusted for family size.

It is important that all staff with direct patient contact be aware of the hospital's policy with regard to providing medically necessary health services to uninsured patients lacking financial resources.

For questions, please call Steven Kurz at (212) 297-4440.

Herbert Pardes, M.D.
President and CEO

NEW YORK-PRESBYTERIAN HOSPITAL

FINANCIAL AID POLICY IMPLEMENTATION
MARCH, 2004

NYPH 0001664

New York – Presbyterian Hospital
Financial Aid Policy Implementation
March, 2004

BACKGROUND

- The provision of medically necessary health services to persons in our community who lack resources to pay is part of the charitable mission of New York – Presbyterian Hospital.
- The process for determining patient eligibility for financial aid and collecting debt reflects NYPH's commitment to treating all patients fairly and with dignity and respect.
- NYPH is committed to the comprehensive assessment of individual patient need and to providing financial aid to those qualifying, regardless of age, gender, race, national origin, socio-economic or immigrant status, sexual orientation, or religious affiliation.
- The financial aid policy has been approved by the Board of Directors.

FINANCIAL AID GUIDELINES

- The financial aid policy applies to inpatient and outpatient services rendered to an **uninsured** patient by NYPH and does **not** include services rendered by any other provider.
- The financial aid policy only applies to **medically necessary** services.
- Financial aid will be offered only to patients that reside in the NYPH **service area.**
- Financial aid is not intended to be a substitute for existing government entitlement or other assistance programs. Patients are to be screened for eligibility programs, when appropriate.
- Reduced fee services may be provided to patients whose income falls below 300% of the Federal non-farm poverty guidelines, adjusted for family size.
- NYPH will inform patients regarding the availability of financial aid.
- Patients wishing to apply for financial aid will be required to complete an application for review.
- Exceptions to the above guidelines will be handled on a case-by-case basis.

KEY CONSTITUENCIES

NEW YORK WEILL CORNELL CENTER

- OPERATIONS – William Greene
- ADMITTING – Brenda Sauer
- SOCIAL WORK – Sona Euster
- PAT FINL SVCS – Roseanne Hagan
- PATIENT SVCS – Susan Mascitelli
- AMB CLINICS – Jaclyn Mucaria
  Brian Hale
- LEGAL – Cheryl Parham

NEW YORK – PRESBYTERIAN HOSPITAL/COLUMBIA UNIVERSITY MEDICAL CENTER

- OPERATIONS – Andria Castellanos
- ADMITTING – Kathleen Tomkins
  Kathleen Cullen
  Eladio Cardo
- SOCIAL WORK – Fran Gautieri
- PAT FINL SVCS – Eileen Cottrell
  Elizabeth Daly
- AMB CLINICS – Jaclyn Mucaria
  Lesmah Fraser
- PAT SVCS – Rose Ann Cannon
- LEGAL – Cheryl Parham

PROCEDURAL SUMMARY

- **CLINICS** –
  - Clinics will continue to process patients according to current protocol.

- **INPATIENT/AMBULATORY SURGERY** –
  - patients without insurance will be counseled regarding Medicaid, Family Health Plus, or Child Health Plus. Patients who do not qualify for those entitlements will be given the opportunity to file an application for financial aid.
  - Patients who receive rejections from the above-referenced entitlement programs post-discharge, receive insurance company rejections, or who "fall between the cracks" during the admission process will have the opportunity at any point after discharge to apply for financial aid. Messages on billing statements and/or from follow-up representatives will prompt patients to request financial aid, if appropriate.
  - Patient Financial Services will establish a call center and will counsel patients and handle all non-clinic financial aid applications.
- **OTHER OUTPATIENT** –
  - Patients in this category will generally request aid upon receipt of a billing statement.
  - The Patient Financial Services call center will counsel patients regarding requirements for eligibility and handle as above (inpatients/ambulatory surgery).

APPLICATION PROCESSING/ADHERENCE TO POLICY

- Clinics will process their own applications.
- Applications initiated by the Admitting offices for inpatient and ambulatory surgery patients will be forwarded to designated location for review and disposition.
- All remaining uninsured patients will be serviced by the self-pay follow-up unit. Patients will be counseled regarding entitlement programs. Those that are rejected by those programs will be offered an opportunity to apply for financial aid.
- Uninsured patients that have not qualified for entitlement programs or financial aid will be expected to pay the hospital's charges.
- No case for an uninsured patient will be referred for collection until, and unless, the aforementioned steps have been taken. Referrals for collection may only be made by the Patient Financial Services Department.
- Any subsequent collection or legal activities will be bound by standards set up by NYPH. NYPH will not force the sale of a patient's primary residence to pay for an outstanding debt.

SLIDING SCALE GRID FOR NON-CLINIC PATIENTS

BASED ON 2004 HHS POVERTY GUIDELINES FOR NON-FARM INCOME
UPDATED ANNUALLY

OUTPATIENT VISITS: REDUCTIONS CALCULATED OFF CHARGES.
INPATIENT STAYS: LOWER OF CHARGES OR DISCOUNTED MEDICAID RATE TO APPLY

FAMILY	90% DISCOUNT FOR INCOMES	70% DISCOUNT FOR INCOMES		50% DISCOUNT FOR INCOMES		30% DISCOUNT FOR INCOMES		10% DISCOUNT FOR INCOMES		NO DISCOUNT FOR INCOMES
	100 % FPL									300% FPL
SIZE	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN
1	$9,310	$9,310	$13,965	$13,965	$18,620	$18,620	$23,275	$23,275	$27,930	$27,930
2	12,490	12,490	18,735	18,735	24,980	24,980	31,225	31,225	37,470	37,470
3	15,670	15,670	23,505	23,505	31,340	31,340	39,175	39,175	47,010	47,010
4	18,850	18,850	28,275	28,275	37,700	37,700	47,125	47,125	56,550	56,550
5	22,030	22,030	33,045	33,045	44,060	44,060	55,075	55,075	66,090	66,090
6	25,210	25,210	37,815	37,815	50,420	50,420	63,025	63,025	75,630	75,630
7	28,390	28,390	42,585	42,585	56,780	56,780	70,975	70,975	85,170	85,170
8	31,570	31,570	47,355	47,355	63,140	63,140	78,925	78,925	94,710	94,710
For ea. addtl. person add:	3,180									

SLIDING SCALE FEES FOR CLINIC VISITS
BASED UPON 2004 HHS POVERTY GUIDELINES FOR NON-FARM INCOME
UPDATED ANNUALLY

CATEGORY	A	B		C		D		E		F
VISIT FEE	$40	$50		$60		$70		$80		$165
FED. POV. GUIDLINE %	100%	100% - 150%		150% - 200%		200% - 250%		250% - 300%		> 300%
Family Size Income	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN	< THAN OR =	> THAN
1	$9,310	$9,310	$13,965	$13,965	$18,620	$18,620	$23,275	$23,275	$27,930	$27,930
2	12,490	12,490	$18,735	18,735	24,980	24,980	31,225	31,225	37,470	37,470
3	15,670	15,670	$23,505	23,505	31,340	31,340	39,175	39,175	47,010	47,010
4	18,850	18,850	$28,275	28,275	37,700	37,700	47,125	47,125	56,550	56,550
5	22,030	22,030	$33,045	33,045	44,060	44,060	55,075	55,075	66,090	66,090
6	25,210	25,210	$37,815	37,815	50,420	50,420	63,025	63,025	75,630	75,630
7	28,390	28,390	$42,585	42,585	56,780	56,780	70,975	70,975	85,170	85,170
8	31,570	31,570	$47,355	47,355	63,140	63,140	78,925	78,925	94,710	94,710
For ea. addtl. person add:	3,180									

ANTICIPATED ROLL-OUT SCHEDULE

- Meetings to be held with hospital key constituents March and April, 2004.
- Final changes to forms and procedures expected by week of 5/24/04.
- System changes to accommodate policy expected to be completed by week of 5/24/04.
- Training of call center employees to be completed by week of 5/17/04.
- Revision of patient statements to be completed by week of 4/16/04.
- Revise early-out referral schedule and review other processes that run up against dunning cycles to be completed by week of 4/16/04.
- Legal review of process to be completed by week of 5/24/04.
- Communication with hospital leadership and community organizations – early June.

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Herbert Pardes, MD
President and
Chief Executive Officer

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New York Weill Cornell Center
525 East 68th Street
New York, NY 10021

July 22, 2004

VIA HAND DELIVERY, E-MAIL AND FED EX

Mr. Michael Abraham
Ms. Voncille Hines
U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515

Re: Questions for Herbert Pardes, M.D., President and CEO of New York Presbyterian Hospital

Dear Mr. Abraham and Ms. Hines:

This letter serves to respond to the questions set forth in the July 6, 2004 letter from Congressman John Dingell. Congressman Dingell's questions and New York Presbyterian Hospital's ("NYPH") responses are set forth below.

1. *According to a Wall Street Journal article, dated June 8, 2004, Mr. Nelson Savinon, former patient who received services from NYPH in 1991, learned that a collection agency authorized by NYPH had frozen his bank account because of an unpaid judgment of more than $6,300, including interest. Upon further investigation by New York's Legal Aid Society, it was discovered that NYPH had written off the debt 12 years ago. Furthermore, the final entry on Mr. Savinon's bill read "bad debt credit allowance - $4,492," and the next line read "due from patient, "0." Please explain how this happened, and how it was resolved.*

   Mr. Savinon received inpatient hospital services from NYPH in February 1991 at the former Columbia Presbyterian Hospital. When Mr. Savinon failed to make payment on his bill, Columbia Presbyterian Hospital referred the account to a collection agency. The collection agency was unable to secure payment arrangements, and a lawsuit was filed in 1995 to pursue the unpaid balance. A judgment of $6,800, inclusive of court costs and interest, was rendered against Mr. Savinon in October 1995. For the next several years, the collection agency handling the account periodically searched for assets to satisfy the

judgment, but found none. Without NYPH knowledge, the account was eventually transferred to a successor collections agency. After locating a bank account that contained assets to satisfy the judgment, this successor agency placed a lien on the account. NYPH was not aware of the agency's action. After learning of Mr. Savinon's case, NYPH reviewed the matter and decided to release the lien and vacate the judgment.

As is usual practice, NYPH wrote off the amount of Mr. Savinon's balance as bad debt after obtaining the judgment in 1995. It is NYPH's practice to pursue satisfaction of judgments after the amount is written off as bad debt. Although a debtor may not have sufficient income or assets at the time of judgment, the debtor may gain the financial resources to satisfy the judgment at a later date. Under New York law, a judgment is valid, and may be pursued, for twenty years. NYPH policy is to pursue an outstanding debt for five years.

When NYPH writes off a patient's balance as bad debt, the hospital zeroes out the balance in its internal billing system. This is done for internal accounting purposes.

1a. *Did NYPH receive compensation from the "bad debt and charity care" pool on Mr. Savinon's debt? If the answer is yes, did NYPH report this collection to the administrator of the "bad debt and charity care" pool?*

It is not possible to tell whether NYPH received compensation from the New York Bad Debt and Charity Care Pool on Mr. Savinon's debt, as NYPH receives an aggregate (i.e., non-patient specific) payment from the Pool. This payment represents only a portion of NYPH's bad debt/charity care expense. For example, in 2003, NYPH received reimbursement for only 33% of its stated bad debt/charity care need.

NYPH does not report recoveries on individual patient accounts to the administrator of the Bad Debt and Charity Care Pool. In the event that NYPH collects on an account that has been written off as bad debt, NYPH reconciles such recoveries against its bad debt expense thereby reducing the amount of future distributions from the Pool.

1b. *Does NYPH currently receive compensation for Mr. Savinon's unpaid bill from the "bad debt and charity care" pool administered by New York State? If the answer is yes, why did NYPH, after receiving compensation from the "bad debt and charity care pool" for Mr. Savinon, continue to pursue payment from the patient? Is the policy of NYPH to continue to pursue payment from patients whose bills have been written off and compensated by other funds?*

NYPH does not currently receive compensation for Mr. Savinon's unpaid bill from the New York Bad Debt and Charity Care Pool.

It is NYPH's policy not to pursue payment from patients whose balances have been compensated by other funds, including NYPH's Philanthropic Fund.

1c. Does NYPH notify the pool administrators of the amount of monies eventually recovered from these "bad debt" patients? How is this information reflected in NYPH's records?

As noted above, NYPH does not notify the pool administrators of individual recoveries from "bad debt" patients. However, NYPH reconciles recoveries from these patients against NYPH's bad debt expense. In so doing, the amount of future payments from the New York State Bad Debt Pool is reduced.

Recoveries from "bad debt" patients appear in NYPH's ledger as a credit to the bad debt reserve.

2a. Does NYPH's current bad debt policy preclude the attachment of a bank account if it is the patient's only asset? Do you differentiate by amount of the account? What is NYPH's current bad debt policy concerning attachments and liens for Medicaid-eligible uninsured and underinsured individuals?

NYPH's Policies and Procedures for Collection Agencies and Attorneys limits the type of collection practices that may be used. This policy does not, however, provide for differential treatment based on the level of funds in a patient's bank account, as banks do not inform outside counsel of the amount of funds in the specified account at the time of attachment. In addition, these policies do not preclude the attachment of a bank account if it is the patients' only asset.

NYPH does not currently have a policy concerning attachments and liens for Medicaid-eligible uninsured and underinsured individuals. NYPH instructs its collection agents to assess a patient's eligibility for Medicaid, Family Health Plus, Child Health Plus or other government entitlement programs, as well as to assess eligibility for charity care/financial aid prior to making a demand for payment. If a patient is determined to be eligible for any of these programs, collection efforts cease while the patient's application is pending.

2b. Under what circumstances does NYPH place a lien against a patient's primary residence to pay an outstanding debt? Has NYPH ever forced the sale or foreclosure of a patient's primary residence in order to satisfy a bad debt? What is the hospital's current policy on placing liens on primary residences and foreclosures?

NYPH will place a lien against a patient's primary residence after securing a judgment against the patient. This enables the hospital to collect on the outstanding debt in the event the patient sells the residence. NYPH has never forced the sale or foreclosure of a patient's primary residence. While NYPH's current collection policies do permit outside collectors to place a lien on a patient's primary residence, such policies prohibit the forced sale or foreclosure in order to satisfy a debt.

2c. *Describe in specific terms NYPH's processes and guidelines for determining patient eligibility for receiving Medicaid or charity care/financial aid? At what point are patients told of the availability of these programs?*

NYPH generally assesses, on an individual basis, self-pay patients' eligibility for Medicaid and other government entitlement programs. During the registration process, self-pay patients are asked to provide information regarding their financial resources and the number of individuals in their household. NYPH compares this information to the eligibility requirements established by the State of New York. If the patient is deemed to be potentially eligible, NYPH will assist the patient with the enrollment process.

Eligibility for charity care/financial aid is determined after eligibility for Medicaid and other government programs has been assessed. Patients are asked to complete an application and to provide documentation related to their financial resources. Applicants may be asked to provide the following information/documentation: household income; number of individuals in the household; assets; and tax forms. NYPH will review the information in evaluating the patient's financial situation. NYPH will provide reduced charge care to uninsured applicants with incomes below 300% of the Federal poverty level. Exceptions to these criteria may be authorized by a designated hospital executive.

2d. *Please state specifically the amount of the discount given by NYPH to uninsured individuals whose incomes are at 100%, 200%, 300%, and 400% of the Federal Poverty Level. Is NYPH considering any across-the-board discount to all uninsured persons?*

Inpatients and hospital outpatients with incomes at 100%, 200%, 300% and 400% of the Federal Poverty Level are given the following discounts: 90%, 50%, 10% and 0% respectively. NYPH's outpatient clinics determine patient fees using a sliding fee scale. Clinic patients with incomes at 100%, 200%, 300% and 400% are assessed the following per-visit fee: $40, $60, $80 and $165, respectively.

NYPH is not currently considering an across-the-board discount for uninsured persons. Individuals are uninsured for a variety of reasons, including personal choice. Not all uninsured patients (e.g., international patients) are unable to pay for the medical services that they receive. NYPH believes that discounts tied to income level are more appropriate than across-the-board discounts. Discounts tied to income ensure that those individuals in greatest need receive the highest level of discount, thereby paying the lowest amount.

3. *You submitted to the Subcommittee a document entitled "Customer Service Situation Response Training," which appears to be a training manual for NYPH employees discussing billing problems. What is significant about this document is that customer services representatives are directed to attempt to get payment in full from patients who may be eligible for Medicaid or charity care. Charity is described "as accounts which meet charity guidelines once all other forms of resolution and sponsorship are exhausted." (p.30, emphasis added) Is it the policy of NYPH to attempt to get payment in full or a payment plan for the full amount owed by uninsured patients prior to informing the patient of the availability of Medicaid or charity care or assessing the patient's financial status to determine if they are eligible for Medicaid or charity care. If not, please describe the process by which the patients are informed of financial assistance for their bills.*

It is not NYPH's policy to attempt to obtain payment in full or negotiate a payment plan prior to informing the patient of the availability of Medicaid or charity care/financial aid, and assessing their eligibility for these programs. Under NYPH's current policy, the patient learns of the benefits of Medicaid and other government programs at the time of registration. If a patient is deemed to be potentially eligible for any of these programs, NYPH will assist the patient in the enrollment process. If it is determined that the patient is not eligible for a government program, NYPH will discuss its Charity Care/Financial Aid Policy with the patient, and will provide the individual with an application. Charity care/financial aid is provided to patients with incomes up to 300% of the Federal poverty level. Determinations as to eligibility for charity care/financial aid are communicated to the patient as soon as practicable after the completed application is submitted. NYPH does not attempt to negotiate a payment plan or obtain payment in full prior to informing the patient of the availability of government programs and charity care/financial aid.

In the past, eligibility for charity care from NYPH's Philanthropic Fund (referenced on page 30 of the manual) was assessed after the hospital inpatient received a bill and only if the patient contacted the hospital to explain that he or she was experiencing financial hardship. During this timeframe, customer service representatives were instructed to work with the patient to establish flexible payment arrangements or to settle the account. Charity care from the Philanthropic Fund was reserved only for those patients experiencing financial hardship (i.e., those who could not make any payment on their account). Eligibility for Medicaid and other government entitlement programs, on the other hand, has always been assessed at the point in time in which NYPH learns that the patient is uninsured, which is typically at registration.

The Customer Service Situation Response Training Manual is a dated document. The manual was generated in 2002 and has not been updated to reflect NYPH's current Charity Care/Financial Aid Policy. NYPH is in the process of revising the manual.

4. *Appendix D of the manual (p.26) also states that customer services representatives should attempt to get payment in full, a settlement of the account, or a payment arrangement prior to determining whether the patient is eligible for the Grace Lamb Fund or the Restoration Fund, which are charity funds. Please explain why NYPH makes numerous attempts to get payment in full from uninsured and indigent patients before determining whether they are eligible for charity care? Do these funds pay for the entire hospital bill?*

   As noted above, NYPH routinely assesses a patient's eligibility for Medicaid and charity care/financial aid at the time of registration. NYPH does not attempt to obtain payment in full from self-pay patients prior to this determination.

   NYPH's Philanthropic Fund is used to provide aid to patients experiencing financial hardship. The Philanthropic Fund, which is supported by provide donations, contains approximately three million dollars in available funding on an annual basis. In order to receive monies from the Fund, the patient must submit a letter of hardship which details their financial circumstances, and explains why the patient is unable to pay his or her medical bills. The patient may also be required to submit financial documentation. If the patient is deemed to be eligible, NYPH will forgive the patient's entire balance due to the hospital, subject to the availability of funds. Monies from the Philanthropic Fund are allocated on a first-come, first-served basis. The Grace Lamb Fund and the Restoration Fund are the same as the Philanthropic Fund.

5. *A March 12, 2003 document entitled "Charity Write-off Procedures" states that even when a patient has been identified as a "possible write off to the Charity Restitution Fund," the service representative must still attempt to get a payment settlement on the balance. The patient must then write a "letter of hardship" to NYPH to obtain the write-off. Does that remain the policy today? Why does NYPH continue to attempt to get payment from patients it already knows can't pay?*

   As noted above, NYPH continues to require a patient to submit a letter of hardship in order to receive assistance from the Philanthropic Fund.

   Since the implementation of NYPH's revised Charity Care/Financial Aid Policy, monies from the Philanthropic Fund are primarily used for underinsured patients who are unable to pay their co-insurance, co-payments, or deductibles. Since the Philanthropic Fund contains only a limited amount of money, approximately $3 million a year, NYPH must reserve fund monies for those patients that are truly in the greatest need. Accordingly, in some instances, NYPH may attempt to obtain payment from these patients prior to assessing the patient's eligibility for the Philanthropic Fund in an effort to identify those patients with the greatest need.

6. *Please explain NYPH's procedures to inform self-paying patients who find themselves in need of emergency medical care of available Medicaid or charity care/financial assistance programs. What are the procedures for determining eligibility for Medicaid or charity care/financial assistance programs? Is this information placed in a prominent public location throughout NYPH's facilities?*

   Pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA"), NYPH treats patients experiencing medical emergencies without regard to their insurance status or ability to pay. NYPH bills the patient after he or she is discharged from the hospital. NYPH's billing statements contains language that informs patients to contact NYPH's Patient Financial Services Department if they are experiencing financial difficulties. NYPH's Patient Financial Services will assess the patient's eligibility for Medicaid and other government programs. If the patient is determined to be ineligible, the Patient Financial Services Department will provide the patient with an application for charity care/financial aid.

   The procedures for assessing eligibility for Medicaid and charity care/financial assistance are detailed in our response to question 2(c).

   NYPH posts information regarding its Charity Care/Financial Aid Policy in the Emergency and Admitting Departments of each of its campuses. This information is also posted in many of NYPH's outpatient clinics.

7. *Your written testimony states that NYPH widely disseminates information about its Charity Care/Discount Policy to the communities it serves. How, and to whom, is this information distributed?*

   NYPH shares information regarding its Charity Care/Financial Aid Policy with community health agencies and local organizations that assist individuals in financial need. Specifically, NYPH staff distributes information regarding its policy at community meetings held by these organizations. NYPH has provided such information, for example, to NYP/Columbia Community Health Council, NYP/Weill Cornell Community Health Council, NYP Community Advisory Council, and the Allen Task Force.

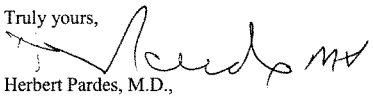
8. *In your testimony you stated that NYPH has written agreements with collection agencies that limit the types of collection practices that may be used. Please provide a copy of that agreement. Does NYPH have an internal process to monitor outside collection agencies to ensure that they adhere to the written agreements?*

Enclosed please find a copy of NYPH's Policies and Procedures for Collection Agencies and Attorneys (*see* NYPH 0001660- NYPH 0001663). Approximately ninety-five percent of NYPH's collections work is performed by Network Recovery Services, a collection agency owned by the hospital. Network Recovery Services adheres to NYPH's Policies and Procedures for Collection Agencies and Attorneys, which limits the types of collection practices that may be utilized. NYPH monitors its outside collectors so as to ensure adherence to NYPH's collection policies.

* * *

If you have any questions regarding NYPH's responses, please do not hesitate to contact Stuart Kurlander of Latham & Watkins at (202) 637-2169.

Truly yours,



Herbert Pardes, M.D.,
President and CEO
New York Presbyterian Hospital

NEW YORK-PRESBYTERIAN HOSPITAL: POLICIES AND PROCEDURES FOR COLLECTION AGENCIES AND ATTORNEYS
JULY 2004

The purpose of these policies and procedures is to promote patient access to quality health care while minimizing bad debt at the New York Presbyterian Hospital ("NYPH"). The promulgation of these policies and procedures will continue to ensure that the debt collection activities undertaken by collection agencies and attorneys on behalf of NYPH remain consistent with the core missions, values, and principles of NYPH.

1. GENERAL PRINCIPLES & GUIDELINES

A. The collection agency (the "Agency") will comply with all applicable federal and state laws and accrediting agency requirements, including, but not limited to, the Fair Debt Collection Practices Act ("FDCPA") the Fair Credit Billing Act, the Consumer Credit Protection Acts, and the Health Insurance Portability and Accountability Act ("HIPAA"). Agency will also comply with NYPH's guidelines on financial aid and charity care.

B. Agency and Outside Counsel will assess the patient's eligibility for government programs and for charity care/financial aid prior to making a demand for payment.

C. Agency will work with the patient to establish a reasonable payment plan.

D. Agency and Outside Counsel will suspend all collection activities associated with a patient account if the patient disputes (in accordance with the appropriate NYPH's dispute resolution procedures) the amount or validity of any outstanding balance. The patient account will remain suspended until NYPH determines that collection efforts may resume.

E. Agency or any lawyer or law firm assisting NYPH or Agency in the collection of an outstanding patient account debt (the "Outside Counsel") may take legal action only upon receiving prior authorization from NYPH.

2. PROCEDURE GOVERNING AGENCY'S RECEIPT OF PATIENT ACCOUNT REFERRALS

A. Agency will send an acknowledgement to NYPH upon receipt of a patient account referral from NYPH. The purpose of the stated acknowledgment is to allow NYPH to reconcile the number of patient accounts referred to the Agency with the amounts received by Agency. Agency will not transfer patient accounts to another Agency, with the exception of accounts being referred for legal action, without NYPH's prior approval.

B. As required under the FDCPA, Agency will send a letter to a patient within three (3) days of receipt of an account referral advising the patient that the Agency is attempting to collect a debt.

3. PROCEDURE GOVERNING THE COLLECTION PROCESS

A. After (or in conjunction with) its initial communication with the patient, Agency will attempt to communicate with the patient to determine why the outstanding balance on the patient's account balance remains unpaid. Agency will adhere to this policy regarding appropriate means of communicating with the patient.

B. Upon contacting the patient, Agency will determine if patient was insured at the time of service (e.g., employer group health plan, no-fault, workers' compensation, Medicare (if patient is over 65 years of age), parents and/or school insurance if patient is a minor, third party liability in the event of an accident).

1. If insurance coverage is identified, follow Agency's internal procedures for billing insurance.
2. If insurance coverage is not identified, determine if patient was eligible for COBRA benefits at the time of service.
   a. If yes, determine ability to reinstate benefits.
   b. If no, proceed to Section C.

C. Agency will determine if patient may be eligible for Medicaid, Family Health Plus, Child Health Plus or other government programs.

1. If patient has coverage that went into effect after the date of service, Agency will determine whether coverage can be made retroactive.

D. If none of the previous steps has been successful, Agency will determine whether patient may be eligible for charity care or financial aid from the hospital.

1. If yes, forward Charity Care/Financial Aid application to patient for completion.
2. If no, proceed to Section E.

E. Agency will conduct a financial profile on the patient and take the following actions, as appropriate:

1. Make demand for full payment,
2. If patient is unable to make payment in full, collector may establish a payment plan. Collector should seek full repayment of the balance within six months. Collector is authorized to extend the repayment period beyond six months if patient's financial profile indicates that extension is appropriate.
3. Accept a settlement if the financial profile indicates that action is appropriate. Settlements for less than 75% of the balance must be approved by a Director of Patient Financial Services, Vice President of Financial Services, or their appropriate designees.
4. Seek alternative payment methods (e.g., credit cards, loans, mortgages) to satisfy debt.

F. Agency will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

4. REFERRAL FOR LEGAL ACTION

A. With respect to those patient accounts for which the foregoing steps are unsuccessful, Agency may refer appropriate accounts to Outside Counsel for possible legal action. Referral of an account should not generally occur until six months after Agency's receipt of the account.

5. GENERAL LEGAL GUIDELINES

A. Outside Counsel will follow all applicable federal and state laws and regulations governing the collection of debts, including, but not limited to FDCPA, FCBA, CCPA, HIPAA and Article 52 of the New York Civil Practice Law and Rules. Outside Counsel will also abide by NYPH's guidelines on financial aid and charity care

B. Outside Counsel will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

C. Outside Counsel will seek NYPH's prior approval before issuing a summons in connection with the collection of an outstanding balance on any patient account.

D. Outside Counsel will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.

E. Outside Counsel will not enforce a judgment against a patient after five years from the date of judgment, without prior approval from NYPH. Similarly, Outside Counsel will not renew a judgment against a patient without prior approval from NYPH.

F. Outside Counsel will not use body attachment to require the patient or responsible party to appear in court.

G. Outside Counsel will conduct judgment evaluations on a case-by-case basis. Electronic "blind" sweeps are not permitted.

H. Outside Counsel will not transfer patient accounts to another collection agency or law firm without prior approval from NYPH.

6. LEGAL SCREENING PROCEDURES

A. Outside Counsel will perform review to ensure that patient has no insurance, and is not eligible for:

1. Medicaid, Family Health Plus, Child Health Plus or other governmental programs; or
2. Financial aid under NYPH's Charity Care/Financial Aid Policy.

B. Outside Counsel will evaluate income, assets, employment data, and any other information indicating ability to pay.

C. Prior to issuing a summons in connection with the collection of an outstanding balance on any patient account, Outside Counsel will complete a Litigation Authorization form, and will forward the form to the Directors of Patient Financial Services, or the Vice President of PFS for approval. Outside Counsel will also provide a history of the account, and a recommendation supporting litigation.

7. POST JUDGMENT PROCEDURES

A. Unless otherwise prohibited by any governing law or regulation, Outside Counsel will contact patient or responsible party by phone at home or place of employment advising him that judgment has been entered. If a telephonic communications is not possible, Outside Counsel should contact the patient or responsible party by mail to inform him of the judgment.

B. When contact is made with the patient or responsible party after a judgment is rendered, Outside Counsel will:

1. Seek payment in full, or
2. Negotiate a written payment plan.

C. If patient is not eligible for government programs or for charity care/financial aid, and no reasonable explanation is made as to why payment cannot be made, Outside Counsel may:

1. Advise patient(s) that judgment will be enforced;
2. Obtain recent credit report;
3. Conduct property search; and/or
4. Confirm place of employment.

D. Outside Counsel may issue Information Subpoenas with or without Restraining Notice to:

1. Major banks;
2. Place of employment;
3. Credit card companies; and/or
4. Mortgage companies.

E. Outside Counsel may issue property execution against patient's bank accounts. If patient contacts Outside Counsel and provides proof of financial hardship as a result of the property execution, Outside Counsel should release the lien.

F. Consistent with New York State law, Outside Counsel may issue income executions on the patient for up to ten percent of the patient's wages. Outside Counsel is not authorized to issue an income execution on a patient's spouse unless a judgment has been obtained against that spouse.

BILLING AND COLLECTION SERVICES AGREEMENT

This AGREEMENT, dated _____ __, 200__, between The New York and Presbyterian Hospital (NYPH), a New York not-for-profit corporation with offices located at 525 East 68th Street, New York, N.Y. 10021 (NYPH) and _____, a _____ Corporation having an address at _____ (Contractor).

WITNESSETH:

WHEREAS, NYPH desires to retain Contractor's services for billing and collection of NYPH claims for healthcare services provided to NYPH patients, and Contractor desires to provide such services.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is agreed as follows:

SECTION 1. SCOPE OF WORK

Subject to the terms and condition of this Agreement, Contractor shall provide services as described in Appendix A, which is attached hereto and made part of this Agreement. Contractor shall keep and maintain such documents and records as shall be required to verify Contractor's performance under this Agreement, including but not limited to, amounts collected, amounts paid to NYPH and amounts due to Contractor. Contractor shall make such documents and records available to NYPH for inspection upon reasonable prior notice.

SECTION 2. TERM AND TERMINATION.

2.1 Term. The term of this Agreement shall be for an initial period of two (2) years, commencing on the date hereof ("Initial Term"). This Agreement shall be automatically renewed for additional one year periods, each of which shall be hereinafter referred to as "Renewal Term", unless either party provides written notice of non-renewal to the other no later than thirty (30) days prior to the expiration of the Initial Term or the expiration of any Renewal Term thereafter.

2.2 Termination. Either party may terminate this Agreement, with or without cause upon thirty (30) days written notice to the other party. Contractor shall return all NYPH documents and other materials to NYPH, or destroy documents or materials not returned to NYPH, and shall attest to such destruction.

SECTION 3. COMPENSATION.

3.1 Policy. Compensation shall be paid in accordance with all applicable federal, state and local law, regulations, rulings and binding interpretations. For Medicaid claims, it is the policy of NYPH not to base Contractor's compensation on the value or volume of any invoice, the value or volume of the amount of collections, or any percentage or discount of either invoices or collections.

3.2 Payment. Compensation to Contractor for each type of billing and collection service within the scope of work is detailed Appendix B which is attached to and made part of this Agreement. Contractor shall submit to NYPH monthly invoices for amounts due as compensation. NYPH shall pay undisputed invoices within 60 days of receipt.

SECTION 4. COMPLIANCE

4.1 Contractor shall have in place and available for NYPH's review and approval, a compliance plan and active compliance program designed to comply with applicable federal and state law concerning fraud and abuse, including but not limited to anti-kickback and self-referral. NYPH shall have the right to audit and monitor Contractor's compliance program.

4.2 Contractor is aware of the federal False Claims Act, and will not knowingly submit, recommend or cause NYPH to submit any bill to any third party payor, including Medicaid and Medicare, which is false or fraudulent or otherwise in violation of applicable laws, regulations or rules.

4.3 Contractor acknowledges receipt of and agrees to adhere to the NewYork-Presbyterian Hospital Policies and Procedures for Collection Agencies and Attorneys, attached to this Agreement as an Addendum. Failure to adhere to the Policies and Procedures shall constitute a material breach of this Agreement and cause for immediate termination of this Agreement.

SECTION. 5 HIPAA REQUIREMENTS.

5.1 HIPAA Applicability. NYPH is a covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as such must comply with the Administrative Simplification provisions of HIPAA, including the Privacy Standards found at 45 C.F.R. Parts 160 and 164.

5.2 NYPH Use and Disclosure. In order for Contractor to perform its obligations under this Agreement, NYPH intends to disclose certain Protected Health Information (as defined below) of NYPH patients ("PHI") to Contractor and anticipates that Contractor will receive PHI on behalf of NYPH.

5.3 Contractor Use and Disclosure. The parties anticipate that Contractor will be required to use and disclose PHI in order to perform its obligations under this

Agreement. Therefore, Contractor will qualify as a "business associate" under the Privacy Standards.

5.4 Duties of Contractor Regarding Use and Disclosure of PHI

5.4.1 Receipt and Use of PHI. Satisfactory performance of its obligations under this Agreement by Contractor will require Contractor to receive and use Individually Identifiable Health Information that constitutes Protected Health Information ("PHI") obtained from NYPH. Contractor shall not use PHI except as permitted or required by this Agreement or as required by law. Contractor shall use PHI consistent with the Privacy Standards.

5.4.2 "Individually Identifiable Health Information". For purposes of this Agreement, Individually Identifiable Health Information shall mean information that is a subset of health information including demographic information collected from an individual, and that:

(i) is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse.

(ii) relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual; and

(iii) identifies the individual or contains sufficient information to form a reasonable basis to believe the information can be used to identify the individual.

5.4.3 "Protected Health Information" shall mean Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media; or (iii) transmitted or maintained in any other form or medium.

5.5 Disclosure of PHI. Contractor shall not disclose PHI except as permitted or required by this Agreement, or as required by law. Specifically, unless otherwise permitted by this Agreement, Contractor may disclose PHI only (i) for Contractor's proper internal management and administration, or (ii) to carry out the legal responsibilities of Contractor, provided that either of the following conditions are satisfied: (a) the disclosure is required by law; or (b) Contractor obtains reasonable assurances from the person to whom Contractor discloses the PHI that the PHI will be held confidentially, that the information will be used or further disclosed only as required by law or for the purposes for which it was disclosed, and that the person notifies Contractor of any instances where the confidentiality of the PHI has been breached.

5.6 Safeguarding PHI. Contractor shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by this Agreement. Contractor shall maintain an appropriate level of security with regard to all personnel, systems, and administrative processes used by Contractor to transmit, store, process, or otherwise handle PHI. Contractor shall not transmit PHI over any open network unless

the transmission is encrypted or otherwise secured according to the appropriate standard of care. Within thirty (30) days of the date this Agreement is executed by the Parties, Contractor shall inform in writing NYPH of its security measures to protect PHI from improper use and disclosure.

5.7 Third Party Agreements. Under certain circumstances, Contractor may need to enter into agreements with third parties, including subcontractors, in order to satisfy its obligations under this Agreement. Contractor shall require that all of its agents, employees, subcontractors, and Contractors to whom it furnishes any PHI to agree in writing to be bound, and to abide in all respects by, all the obligations of Contractor under this Agreement to protect PHI.

5.8 Reporting of Unauthorized Uses and Disclosures. If Contractor becomes aware of any use or disclosure of PHI by Contractor, its employees, or its agents, that is not provided for in this Agreement, Contractor shall promptly report such violation to NYPH. NYPH shall investigate the unauthorized use or disclosure and Contractor shall cooperate fully with such investigation. In consultation with NYPH, Contractor shall promptly seek to cure or mitigate the unauthorized use or disclosure. If Contractor is unable promptly to cure or mitigate an unauthorized use or disclosure which constitutes a material breach of the Contractor's obligations under this Agreement, notwithstanding any other provision in this Agreement, NYPH shall have the right to terminate this Agreement for cause, to report the matter to the Secretary of the U.S. Department of Health and Human Services, or both.

5.9 Access to Information. Within ten business days of NYPH's written request, Contractor shall provide NYPH with access to PHI in Contractor's possession, if Contractor's information consists of PHI within a Designated Record Set held by NYPH. For the purposes of this Agreement, "**Designated Record Set**" shall mean a group of records maintained by or for NYPH that (i) consists of the medical records and billing records about individuals maintained by or for NYPH, (ii) constitutes the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) is used, in whole or in part, by or for NYPH to make decisions about individuals. For the purposes of this paragraph, the term "Record" means any items, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for NYPH.

5.10 Availability of PHI for Amendment. The parties acknowledge that the Privacy Standards permit an individual who is the subject of PHI to request certain amendments of their records. Upon NYPH's written request, Contractor shall provide NYPH with any PHI contained in a Designated Record Set in Contractor's possession for amendment.

5.11 Accounting of Disclosures. Upon NYPH's written request, Contractor shall make available information to NYPH concerning Contractor's disclosure of PHI for which NYPH needs to provide an individual with an accounting of disclosure as required by the Privacy Standards. For this purpose, Contractor shall retain a record of disclosures of PHI for at least six (6) years from the date of disclosure. Disclosures of

PHI for purposes of treatment, payment or operators of or by NYPH shall not be subject to this accounting requirement.

5.12 Availability of Books and Records. For purposes of determining NYPH's compliance with the Privacy Standards, Contractor agrees to make available to the Secretary its internal policies and procedures relating to the use and disclosure of PHI received from NYPH, or created or received by Contractor on behalf of NYPH.

5.13 Return of PHI at Termination. Notwithstanding the disposition of other documents and materials created by the Parties in performance of this Agreement, upon termination of this Agreement, Contractor shall, where feasible, destroy or return to NYPH all PHI received from NYPH, or created or received by Contractor on behalf of NYPH. Where return or destruction is not feasible, the duties of Contractor under this Agreement shall be extended to protect the PHI retained by Contractor. Contractor agrees not to further use or disclose information for which the return or destruction is infeasible. Contractor shall certify in writing the destruction of the PHI and to the continued protection of PHI that is not feasible to destroy.

5.14 Representations of NYPH.

5.14.1 Obtaining Patient Permission. NYPH represents and warrants that it has obtained patient and individual permissions, consents, or authorizations, required under federal and state law that are necessary for Contractor to receive, use, and disclose PHI as contemplated under this Agreement.

5.14.2 Furnishing Appropriate Patient Notice. NYPH represents and warrants that it has undertaken steps necessary to adequately inform its patients, as required by state and federal law, about the disclosure of PHI to service providers and vendors such as Contractor and use and disclosure of such information by such entities. Such notification shall include, but is not limited to, distribution of a "notice for privacy practices," as this term is defined in the Privacy Standards.

SECTION. 6. MISCELLANEOUS.

6.1 Entire Agreement, Modification. This Agreement constitutes the entire agreement between the parties with respect to the matters set forth herein and may not be amended or modified except in writing signed by all the parties hereto.

6.2 Assignment. This Agreement may not be assigned by either party without the written consent of the other, except that NYPH may assign this Agreement to a successor corporation in the event of a merger, consolidation or transfer or sale of all or substantially all of its assets.

6.3 Notice. Any notice required under this Agreement shall be deemed given when mailed by certified mail, return receipt requested, with a copy sent by regular first class mail, or by overnight delivery by nationally recognized courier, to

the address listed in this Agreement or such other addresses as the parties may designate in writing.

6.4 Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the other provisions hereof, but the remaining provisions of the Agreement shall be construed in all respects as if such invalid or unenforceable provision or provisions were omitted.

6.5 Construction and Governing Law. This Agreement shall be governed by and interpreted exclusively in accordance with the laws of the State of New York without reference to an application of conflict of law principles or provisions.

6.6 Relationship of Parties. The parties hereto acknowledge and agree that this Agreement does not create the relationship of employer and employee between NYPH and Contractor, but rather, that the services to be performed by Contractor hereunder shall be performed by Contractor as an independent contractor. Each of the parties agrees not to hold itself out in any manner inconsistent with or contrary to the terms of this Agreement.

6.7 Waiver. The waiver by either party of noncompliance by the other party of any term or provision of this Agreement shall not be construed as a waiver of any other noncompliance.

6.8 Captions. The captions herein are for convenience and reference only and in no way define, limit or describe the scope or intent thereof, or in any way affect this Agreement.

6.9 Arbitration. In the event a dispute arises under any term or provision hereof, such dispute shall be settled by arbitration in the County of New York, State of New York by and in accordance with the rules then obtaining of the American Arbitration Association. This provision shall not apply to disputes regarding the interpretation of federal or state laws and regulations; nor shall it apply to claims made by third parties against NYPH, Contractor or both.

6.10 Counterparts. This Agreement may be executed in several counterparts, each of which shall be deemed an original, all of which together will constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date and year first above written.

CONTRACTOR	NEW YORK AND PRESBYTERIAN HOSPITAL
By: _____	By: _____

Title: _____ Title: _____

Contractor:

APPENDIX A

Scope of Services

Payors: Medicare _____

Medicaid _____

Commercial _____

Managed Care _____

Self Pay _____

Other _____

Services: Billing _____

Collection _____

Detailed Description of Services:

Contractor:

APPENDIX B

Compensation

For Medicaid and Medicare Claims

Contractor shall be paid a fee of $ _____ for each claim processed.

For Claims Other Than Medicaid and Medicare

Contractor shall be a contingency fee of _____% of amounts collected, less _____ % of any amounts collected by Contractor which must be refunded or repaid to the payor within 180 days of collection.

g:\cap\Billing and Collection Services Agreement

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July 20, 2004

The Honorable John D. Dingell
Committee on Energy and Commerce
Room 2322 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Dingell:

Thank you for your follow up request for information of July 6, 2004. Enclosed please find Ascension Health's responses to each question. Please do not hesitate to call if there are any clarifications needed.

I look forward to continuing to work with the Subcommittee Members to assure that uninsured patients are treated with fairness and compassion. Ascension Health's mission emphasizes care for the most vulnerable, and I believe that our policy for billing and collections for the uninsured reflect this deeply held value.

Sincerely,

Anthony R. Tersigni, Ed.D., FACHE
President and Chief Executive Officer

cc: Anthony Cooke
Edith Holleman

Questions for Dr. Anthony Tersigni, COO and Interim CEO Ascension Health
June 24, 2004, Subcommittee on Oversight and Investigations Hearing
"A Review of Hospital Billing and Collection Practices"

As requested by Honorable John D. Dingell, Chairman on July 6, 2004

Question # 1

Do any of your hospitals offer medical credit cards to its patients? What is the interest rate on Ascension's credit cards?

Of the 44 hospitals included in our Data Reporting Group, 43 do not offer medical credit card programs. One hospital implemented a program five months ago to offer a medical card as an alternative to pay their hospital bill on credit at a lower interest rate than bank rates. The hospital subsidizes the program to get a lower interest rate from the bank. The current rate is 9%.

Question # 2

You testified that Ascension places liens on primary residences to recover for unpaid hospital bills. Are these bills at the Charge Master rate plus interest or at some discounted rate? Is Ascension considering changing its policy on placing liens on primary residences? Why or why not?

Under our new policy, Ascension Health prohibits the filing of liens on primary residences for those patients who qualify for charity or financial assistance. Under our System policy, liens would be permitted only for those people that we have determined to have the means to pay.

This is a minimum standard, and many of our hospitals do not, as a practice, file liens. As submitted in our data in October, 2004, 24 of 44 hospitals do not file liens. Those who do so indicate they do so infrequently, and, under our new policy, liens will be filed only in respect to those patients who have been determined to have the means to pay.

Amounts filed in liens for those with means to pay would be hospital debt (at hospital charge). At one of these hospitals, a 6% interest is charged to the balance of the lien, as is permitted by State law. At one other hospital a 4.35% interest rate is charged at the time of judgment.

If we do place a lien on a primary residence as a result of an unpaid bill for a patient with means to pay, our policy states that we will not foreclose on that patient's primary residence.

Question # 3

You stated in your testimony that Ascension's discount policy for uninsured patients with means to pay is pending approval by the Centers for Medicaid and Medicare Services. What is the status of that review? Please attach related documentation.

We met with Mr. Alex Azar, HHS General Counsel and Mr. Tom Barker, Acting Deputy General Counsel for CMS on May 3, 2004 and with Mr. Scott Whitaker, Chief of Staff to the Secretary of HHS, Mr. Dennis Smith, Director of CMS and Mary Kay Mantho, Senior Advisor to the Secretary of HHS on May 4, 2004 to explain our new policy and discuss our concerns. A meeting on May 3, 2004 with Mr. Mark McClellan was cancelled by Mr. McClellan.

The meeting was very helpful, and CMS representatives appeared to understand and agree with our concerns. Mr. Whitaker indicated he would follow up to assist us in addressing this issue.

We were hopeful we would receive guidance before the Subcommittee hearing.

After no response, a follow up phone call to Scott Whitaker on June 24, 2004 indicated that we would need to follow up with Rob Foreman, Director, Office of Legislation for CMS, for clarification.

We are currently working to schedule a meeting with Mr. Herb Kuhn of CMS in August to attempt to resolve the issue. We understand his schedule is not available until mid August.

Question # 4

One of the concerns with hospital billing of the uninsured is that the hospitals offer unreasonable amounts of time (90-180 days) for patients to pay large and unexpected bills before those bills are turned over to a collection agency and the debtor receives a bad credit rating. In your testimony, you stated that patients qualifying for financial assistance are provided with extended payment options. How long would such an option be? What steps has Ascension Health taken to establish reasonable, low-interest or no-interest, longer-term payment plans for uninsured patients?

Our new policy will require all hospitals to provide payment plans if they have not already done so. These payment plans for those needing financial assistance are consistent with our values and our mission to serve the poor.

Financial assistance needs are determined on a case-by-case, facility-by-facility basis. Factors consider medical debt, size of family, and other obligations. The following are two examples of such payment plans provided to patients in our hospitals.

Example # 1 Seton Medical Center, Austin, Texas

Hospital bill	$64,872
Patient annual income	$42,240
Monthly income	$ 3,520
Patient family size	Single
Monthly expenses including insurance, clothing, food, housing, utilities, transportation, loans	$1,731
Monthly available income	$1,789
50% due per month	$ 894
Number of months to pay	36 (Policy is 36 mos max)
Total to be paid for 36 months	$32,184
Amount write-off (50.4%)	$ 32,688

This payment plan would also consider any physician bills due, even though not due to Seton Medical Center. In other words, the payments would be further reduced by an amount to be paid to the physicians (also at a 50% discount).

Example # 2 St. Vincent's Hospital, Birmingham, Alabama

Hospital bill	$ 5,208
Patient annual income	$31,800
Monthly income	$ 2,650
Patient family size	Five

Qualified (:ount	50%
Amount due	$ 2,604
Monthly payment	$ 75
Number of months to pay	35
Total to be paid for 35 months	$ 2,604
Amount write-off (50%)	$ 2,604

Our policy specifies a floor: that payment plans must be provided and that interest must not be charged to patients qualifying for charity or financial assistance. As can be seen above, our hospitals are generous when working with the uninsured. One last note, although our hospitals will utilize collection agencies to follow up with non-responsive patients, many will not report non-payments to credit bureaus.

Question # 5

Do you think that discounting to all uninsured patients, regardless of income, will result in higher collections from the uninsured?

The goal of our policy, Billing and Collections for the Uninsured, is not to increase collections from the uninsured. Our goal is to provide fair and equitable treatment of the uninsured. We have been unable to estimate whether collections from the uninsured will increase, but have not planned for any increased collections.

We currently collect only 5% of our charges on average from the uninsured.

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02108

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LIST OF ATTACHMENTS

by Mark Rukavina, The Access Project

Responses to Questions from the Honorable John D. Dingell and corresponding documentation regarding the June 24, 2004 Subcommittee on Oversight & Investigations hearing entitled **"A Review of Hospital Billing and Collection Practices"**

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1. Mark Rukavina's responses to the five questions from the Honorable John D. Dingell (11 pages)
2. E-mail from Jeff Prescott to Mark Rukavina dated December 16, 2003 (1 page)
3. Letter to Terence van Arkel dated February 18, 2004 (2 pages)
4. E-mail from Mark Rukavina to Jeff Prescott dated March 17, 2004 (1 page)
5. HCA Charity Care and Discount Policy for the Uninsured (1 page)
    a. HCA Procedure for Charity Accounts (12 pages)
6. Letter to Don Chester dated February 18, 2004 (2 pages)
7. E-mail from Mark Rukavina to Steven Campanini dated March 17, 2004 (1 page)
8. E-mail from Steven Campanini to Mark Rukavina dated April 1, 2004 (2 pages)
9. E-mail from Steven Campanini to Mark Rukavina dated April 5, 2004 (3 pages)
10. E-mail from Mark Rukavina to Steven Campanini dated May 6, 2004 (3 pages)
11. E-mail from Steven Campanini to Mark Rukavina dated May 12, 2004 (3 pages)
12. E-mail from Steven Campanini to Mark Rukavina dated May 17, 2004 (1 page)
13. E-mail from Steven Campanini to Mark Rukavina dated May 21, 2004 (2 pages)
14. Tenet's Compact with Uninsured Patients (1 page)

Please note: Mark Rukavina's responses to the five questions from the Honorable John D. Dingell (11 pages) is also being sent via e-mail.

1. You stated in your written testimony that The Access Project tried to facilitate meeting between community leaders in Florida and Tenet and HCA in February 2004 to disseminate information about their financial assistance policies and that Tenet and HCA declined to come. What reason did these hospital chains give for not coming? If you have any documentation of your exchange with Tenet and HCA, please enclose it with your answer.

On February 18, 2004, The Access Project and the Quantum Foundation invited hospitals in Palm Beach County to attend an April meeting to explain their programs to provide assistance to uninsured patients. The Access Project collaborates with the Quantum Foundation on an effort to improve access to health care for low income, uninsured residents of Palm Beach County.

The idea for the meeting came after the American Hospital Association issued guidelines for billing and collection related to uninsured patients that called on hospitals to "make available to the public information on hospital-based charity care policies and other known programs of financial assistance." The AHA encouraged hospitals to have written policies and to share them with appropriate community organizations that assist people in need. It was in the spirit of these guidelines that we invited local hospitals, including Tenet and HCA hospitals, to discuss how Palm Beach County could become a model for informing uninsured residents about financial assistance.

Letters of invitations (see attached) were sent directly to Don Chester at St. Mary's Hospital, a Tenet hospital, and Terence VanArkel at JFK Medical Center, an HCA hospital, as well as to the corporate offices of each system. After sending the letters, The Access Project called the local hospital representatives in early March and sent emails to the corporate

contacts in mid-March to discuss their willingness to participate in the meeting. The local HCA hospital representative agreed to attend but acknowledged that he would need to discuss his participation with others in the corporation. The local Tenet hospital representative said the corporation was in the process of implementing a new policy and that a late-April meeting could work well since they hoped to have more information at that time.

Regarding Tenet, The Access Project learned through a late-March phone conversation and early-April email exchanges (see attached) that they would not attend the meeting. They stated the phase-in of their Compact with Uninsured Patients was in process and that it would be done on a hospital-by-hospital basis in all states but Texas. They expected "it to be fully implemented by June 30th" and felt that they would be in a "better position by July to discuss the program in more detail."

Regarding HCA, we learned shortly before the April 28th meeting that they would not attend. The local representative felt uncomfortable participating in the meeting. We received no response from the corporate HCA representative regarding the Florida meeting. This Palm Beach County interaction only tells part of the story with HCA. The Access Project contacted HCA corporate in October 2003 after seeing reference to the program for uninsured patients in their 3rd Quarter 2003 Earnings Report. We contacted them again in December 2003 after reviewing their website and finding no specific information on their program (see attached). They said the policy had been implemented and that they were "considering posting a version of it on our web site after we have some operational time to ensure that it works as we intend it to. We should have a decision on that around the first of the year." Obviously, we were disappointed that this information was not provided in time for the April 28th Florida meeting.

Three local hospitals and a representative of the American Hospital Association attended the April meeting. Tenet and HCA declined to attend. The following day, on April 29th, an HCA corporate representative called The Access Project to say they were unaware of the meeting in Florida. They said their policy was fully implemented, immediately forwarded a copy of it (see attached HCA documents) to The Access Project and expressed an interest in receiving feedback on their program. They encouraged The Access Project to share the information with interested parties in Palm Beach County, and elsewhere. On May 4th, a Palm Beach County HCA hospital representative contacted The Access Project apologizing for missing the previous week's meeting. He made a commitment to work with The Access Project, the Quantum Foundation and Palm Beach County community groups to inform them of the HCA program.

On May 6th, The Access Project contacted a Tenet corporate representative to see if the hospital system would provide information on its financial assistance program for the uninsured, as well as contact names for their hospitals in Palm Beach County. On May 21st, Tenet responded with a brief description of the Tenet Compact with Uninsured Patients (see attached document and emails) and the names of contacts in each of its hospitals in Palm Beach County.

2. As of this date, do you have any indication that either of these companies has actually implemented their policies in Florida?

HCA informed The Access Project in late April that its policy was fully implemented. Tenet informed us in late May that its policy would be implemented in its Florida facilities by the end of June. We have no systematic way to monitor or evaluate whether this is the case.

This spring, we developed materials and a training on the financial assistance programs available to uninsured residents in Palm Beach County. The materials included information on the Tenet and HCA programs for uninsured patients, as well as the names of the financial service representatives for their hospitals in Palm Beach County.

Two trainings were conducted in Palm Beach County in late May. We heard from several training participants who appreciated receiving the information. They were not previously aware of the particular hospital programs. Since the training, they have referred people to local Tenet and HCA hospitals but have no information on their experiences in attempting to access the programs. Since the training, we have heard one anecdote that may be an isolated incident but which serves to illustrate the difficulty experienced by people when trying to access these assistance programs. In late May or early June, this person inquired about financial assistance at a Tenet hospital for her son. She expressed frustration after speaking with a staff person who was not knowledgeable about financial assistance. She was then transferred to an answering machine where she left a message. As of early July, no one at the hospital has returned the call since she left the message.

3. One of our hospital witnesses submitted testimony referring to problems with getting the uninsured to fill out the forms and provide the information that would get them charity care, Medicaid or discounted care. How significant a problem do you think this is, and do you have any suggestions for improving responses?

The Access Project believes there are currently significant problems in getting the uninsured to complete forms and provide information on charity or discounted care. However, we believe that these problems stem from a lack of clear information on the

programs and the burdensome documentation needed to qualify for them. Hospitals would be well served to examine the work done to improve the enrollment process by Medicaid and State Children's Health Insurance Programs over the past few years. Included in this work has been a simplification of application forms and clarification of the information necessary to make a determination.

Regarding information, several studies have shown that many hospitals fail to notify potentially eligible people about the availability of their financial assistance programs. For example, in 2003 the Public Policy and Education Fund found that of 70 hospitals in New York whose officials were interviewed, only one third could produce written policies describing their indigent care programs. A 2003 study by The Access Project of close to 7,000 uninsured patients who received care in safety-net institutions found that nearly half (48%) said they were never told about the availability of such assistance. This figure rose to 70 percent for those who received care in urban/suburban hospital emergency rooms, and 58 percent of those who received care in rural emergency rooms. Improving uninsured patients' awareness of the existence of hospital financial assistance programs is thus a fundamental step in improving the enrollment process in such programs. An important consideration is the translation of informational materials into languages other than English for patients with limited English proficiency.

Even when patients are aware of financial assistance programs, the documents required for application can be quite confusing. For example, The Access Project recently received information from a Florida hospital on its charity care policy. Included was a form entitled *Information Required For Application For Uncompensated Services* that states patients should "Please bring as many of the following" documents when applying for care:

Most recent Income Tax (1040) Form

Written verification of wage from employer

Forms approving or denying unemployment compensation or worker's compensation

Written verification from public welfare agencies or any governmental agency, which can attest to the patient's income status for the past 12 months

Rent receipt or mortgage payment coupon/voucher

Electric bill

Telephone bill

Gas and water bill

Any other living expenses you may have

If insurance, Medicare or Medicaid exist, bring identification cards

Bank Accounts (hand written on form)

This form illustrates the lack of clear information. It is not obvious whether all of these documents are required.

We have additional examples to describe the various barriers experienced by patients when trying to access financial assistance programs. Our community partners, organizations working with patients who are likely eligible for such programs, provide these examples.

- A hospital in Connecticut requires a Medicaid denial as a prerequisite for applying for charity care. While Medicaid only retroactively covers hospitalizations for three months, the hospital requires a Medicaid denial for all free care applicants, even if their debt is more than three months old (and thus not eligible for payment by Medicaid). The hospital also requires a Medicaid denial for patients with insurance or with income clearly above the Medicaid cut off. Many of the patients who are

ineligible for Medicaid are discouraged from applying by state Medicaid staff because they are obviously ineligible.

- In Illinois, one hospital requires patients to submit, along with a fully completed financial assistance application, a current federal tax form with all supporting documents; mortgage or rent receipts; letters of support if they have no other income; three months of checking, savings, and brokerage account statements; and copies of current credit card statements, utility statements, loan statements, and outstanding medical bills. If an application is submitted without all of the accompanying documentation, patients have only ten days to provide it. According to the hospital, failure to provide the information in that time frame "may result in a denial of your request and your account resuming normal collection process."

One result of the recent negative publicity about hospitals' billing and collections practices is that many hospitals claim that they have improved their processes for notifying and helping people apply for financial assistance programs. It is too early to know in any systematic way whether such changes have occurred on a wide scale.

We encourage hospitals to learn from the work of others. Researchers have long been aware of administrative barriers to enrolling eligible adults and children in Medicaid and the State Children's Health Insurance Programs, and have developed strategies for reducing these barriers. Similar approaches could be applied to hospital financial assistance programs. For example, the Kaiser Commission on Medicaid and the Uninsured recommends the following measures to improve Medicaid/CHIP enrollment:

- Simplify eligibility rules

- Make application forms simpler and shorter
- Allow families to mail in applications
- Expand enrollment office hours
- Increase enrollment sites and assistance in community settings
- Eliminate burdensome verification requirements
- Adopt presumptive eligibility to enroll those who appear to be eligible immediately and allow them to complete the formal process later
- Translate forms into commonly used languages and provide interpreter services to those with limited English skills
- Promote more respectful treatment by enrollment staff
- Work with community-based organizations to conduct outreach and enrollment activities
- Do not require frequent eligibility re-determinations

In Massachusetts, two hospitals have put some of these suggestions into practice by establishing or working closely with programs that proactively screen and help people enroll in all public and private programs, including hospital charity care, for which they may be eligible. In one of the hospitals, all uninsured patients who seek care in the emergency room receive a simply worded flyer that tells them who to contact if they need help paying for their care. Program staff screen the patients for eligibility for any programs that may assist them, help them fill out the paperwork, and explain what documentation is required. When necessary, staff also write support letters or contact staff at other agencies to ease the enrollment process. The directors of both of these programs stress the importance of actively

assisting people through the enrollment process, and reiterate that merely providing packets of information and expecting people to comprehend and comply with complex and differing rules and requirements is not sufficient.

People working with clients who may be eligible for charity care also report that lack of trust can be a major barrier to enrollment, discouraging people from applying for financial assistance. Many patients view hospitals' requests for detailed financial information about their income and assets with distrust, because they fear that the information will be used for collections purposes and may subject them to wage garnishments, liens, and other forms of harassment. Lack of trust exacerbates the level of fear experienced by some patients, especially patients with a mental illness or immigrants with limited English proficiency. The importance of lack of trust as a barrier to enrollment underlines the importance of hospitals working closely with community organizations in creating and implementing financial assistance programs, as these organizations often have established and trusting relationships with those most likely to be eligible for assistance. Community organizations can be extremely useful in conducting outreach about the availability of financial assistance programs and assisting their clients in successfully applying for aid. Many of these organizations currently assist clients in successfully applying for a wide range of programs and services.

4. Currently because of federal and state budget shortfalls, people are being removed from the Medicaid and S-CHIP rolls. What impact will this have on the number of uninsured people?

The number of uninsured people will most certainly increase as federal and state budget shortfalls result in cuts or changes to the Medicaid and State Children's Health Insurance Programs. One recent report from the Kaiser Commission on Medicaid and the Uninsured on the Oregon Health Plan analyzed enrollment in the plan after new premiums and policies were implemented in that state. According to the report, these changes appeared to have resulted in loss of coverage for tens of thousands of poor adults. Enrollment in the group subject to the new premiums fell from 95,700 in February 2003 to 50,938 in October of 2003. This same report found that nearly three-quarters of those no longer enrolled in Medicaid had become uninsured.

Another report issued by Kaiser studied Medicaid changes in Washington State, where immigrants in a Medicaid look-alike program were transitioned into the state's Basic Health Plan. The researchers found that nearly half of the families who lost coverage in the Medicaid look-alike program did not enroll in the Basic Health Plan. Families and outreach workers identified factors such as the initiation of premiums, burdensome documentation requirements and difficulties understanding application materials as barriers to enrollment.

5. You stated that hospitals should be required to provide details on how the Disproportionate Share Hospital payments are used to support services to poor and uninsured patients. How is that handled now, and what changes would you like to see?

Disproportionate share hospitals receive supplemental payments from the federal government in both the Medicaid and Medicare programs. In the Medicare program, whether a hospital qualifies as a DSH hospital is determined by a federal formula, and an adjustment is made to the hospital's Medicare payment rate. In the Medicaid DSH program (the larger of

the two), beyond minimal federal requirements, each state sets its own definition of disproportionate share and determines what supplemental payments will be made to each of the DSH hospitals. The federal government reimburses states for DSH payments at each state's regular Medicaid matching rate.

There is no federal requirement that hospitals use their DSH payments to support particular services or to formally account for their use. This is the case both for Medicaid and Medicare DSH payments. States may choose to impose requirements on hospitals that receive Medicaid DSH payments, but to our knowledge few do so. In Georgia, for example, hospitals that receive DSH funds must provide a certain amount of free or reduced-cost care to low-income, uninsured patients, and they must use 15 percent of their DSH payments to provide primary care. In Massachusetts, DSH payments support the uncompensated care pool, which implies a requirement of providing free or discounted care in exchange for DSH funds. States such as these and a few others are the exceptions, however; the rule is a typically opaque process by which a state allocates DSH funds and sets few if any requirements for their use.

States report annually to CMS on the Medicaid DSH payments (at least half of which are federally reimbursed) that they make to specific hospitals. CMS, of course, also has data on hospital-specific Medicare disproportionate share adjustments. It would not be a policy or administrative burden to require an accounting from hospitals of the use of these funds. Even absent regulatory requirements for how DSH funds should be used, a summary description of, for example, the number of people served, their incomes and health insurance status, and the services they received, would be illuminating to the constituency to which hospitals are ultimately accountable—their own communities.

Mark Rukavina

From: Prescott Jeff - Communications [Jeff.Prescott@HCAHealthcare.com]
Sent: Tuesday, December 16, 2003 10:20 AM
To: 'Mark Rukavina'
Subject: RE: CMS & Uninsured Discounts

The policy has been implemented. We are considering posting a version of it
on our web site after we have some operational time to ensure that it works
as we intend it to. We should have a decision on that around the first of
the year.

-----Original Message-----
From: Mark Rukavina [mailto:rukavina@accessproject.org]
Sent: Monday, December 15, 2003 4:05 PM
To: 'Jeff Prescott (E-mail)'
Subject: RE: CMS & Uninsured Discounts

Jeff, my question remains, have you implemented you policy for discounting
fees for the uninsured patients served by HCA? If so, I would appreciate a
copy of the policy. We check your website regularly and have not seen any
mention of it since you March annoucement.
Regards.
Mark

> -----Original Message-----
> From: Mark Rukavina
> Sent: Thursday, October 23, 2003 1:04 PM
> To: Jeff Prescott (E-mail)
> Subject: CMS & Uninsured Discounts
>
> Jeff, I noticed in your 3rd Quarter 2003 Earnings Report a reference to
> the impact of charity and self-pay discounting care policy changes. Have
> you implemented your policy?
> I also heard mentioned - at a legislative hearing yesterday - a letter
> that you received from CMS regarding your policy for discounting fees
> charged to uninsured patients. Would you be willing to share this letter
> with me?
>
> I look forward to your response. In advance, thank you.
> Mark
>
>
> ::::::::::::::::::::::::::::::::
> Mark Rukavina
> Director
> The Access Project
> 30 Winter Street Suite 930
> Boston, MA 02108
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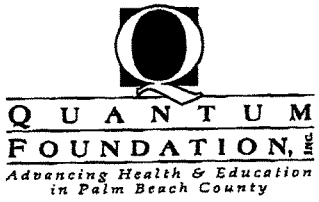

February 18, 2004

Terence van Arkel
JFK Hospital
5301 South Congress Ave.
Atlantis, FL 33462

Cc: Jeffrey Prescott
Media Relations Director
HCA
One Park Plaza, Building 4E
Nashville TN 37203

Dear Mr. van Arkel:

We are writing to you on behalf of The Access Project, a national resource center, and the Quantum Foundation of West Palm Beach, Florida. The Access Project works with community groups and other organizations across the country interested in improving access to health care for vulnerable people. It is currently collaborating with the Quantum Foundation, a grant-making foundation with an interest in improving access to health care and prevention programs, to improve access to health care for low income, uninsured residents in Palm Beach County.

Over the past year, the Quantum Foundation has brought together key health care funders and stakeholders in Palm Beach County to look at ways to improve access to care for uninsured people through coordination of services and expansion of capacity. It has asked The Access Project to facilitate the meetings of this Health Care Coordinating Committee, which are attended by representatives from the State Department of Health, the County Health Care District, the maternal and child health alliance, local hospitals and clinics, and others.

The Access Project previously communicated with HCA to express its interest in helping to clarify your recently announced program to provide discounts to uninsured patients. Along with the Quantum Foundation, we would like to invite you to a meeting of the

Health Care Coordinating Committee in West Palm Beach during the month of April to present information on this program.

The recent release of the American Hospital Association guidelines for hospital billing and collections has again focused attention on the important issue of free or discounted care for the uninsured. As the AHA stated in its guidelines, "hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance." We applaud HCA for developing a program to provide discounts to uninsured individuals. While this represents a positive step toward improving access for uninsured patients, too few people are aware of it. Again, the AHA guidelines encourage hospitals to have "written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs" and to "share these policies with appropriate community health and human services agencies and other organizations that assist people in need." In the spirit of these guidelines, we hope that you will be interested in working with us to publicize your program in Palm Beach County.

We have also invited representatives from Tenet Healthcare Corporation to the meeting to explain its program to provide assistance to uninsured patients. In addition, we have invited representatives from the American Hospital Association and the Florida Hospital Association to discuss how to most effectively encourage the hospitals in Palm Beach County to implement their new charity care guidelines.

We hope that Palm Beach County can become a model for effectively informing uninsured residents about the financial support available to help them pay for their health care. This is an important issue in the County, which has high percentages of low-income uninsured people.

One of us will be contacting you within the next week to explore your interest and discuss your availability to attend this meeting. We believe your participation would be valuable in educating the key healthcare policy makers and administrators on the committee about the new guidelines for providing financial assistance to the uninsured, and that they could provide you with valuable assistance in publicizing the program in the community. With appropriate outreach, we are sure that financial assistance programs can contribute to improved access to care for low-income, uninsured residents of Palm Beach County.

In advance, thank you for your consideration.

Sincerely,

Mark Rukavina
The Access Project

Jeannette Corbett
The Quantum Foundation

Mark Rukavina

From: Mark Rukavina
Sent: Wednesday, March 17, 2004 1:44 PM
To: Jeff Prescott (E-mail)
Subject: April Mtg in Palm Beach County

Jeff, I am following up on a letter dated February 18, 2004 that Jeannette Corbett from the Quantum Foundation and I sent to you. This letter invited you to an April meeting in Palm Beach County where we would like you to present information on your discount program for uninsured patients. I want to inform you that the meeting will take place on either Wednesday, April 21st or Wednesday, April 28th. Would you or some else from corporate be able to attend a meeting on either of these dates?
Mark

Mark Rukavina
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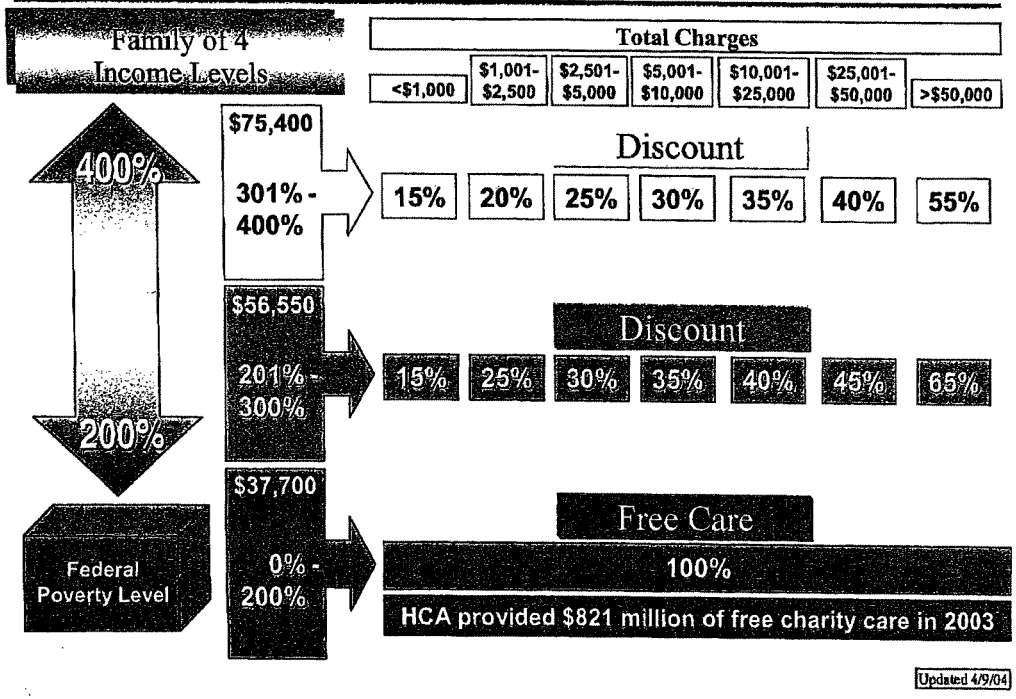
HCA Charity Care and Discount Policy for the Uninsured



HCA

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PAGE: 1	REPLACES POLICY DATED: 01/23/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 10/01/2003	REFERENCE NUMBER: RCOM.PP.COLL.018

SCOPE:
All PAS Registration and Collection areas responsible for requesting and evaluating Income Attestation Forms and supporting documentation obtained.

PURPOSE:
To define the policy for providing the financial relief to charity and uninsured patients receiving non-elective care based on Federal Poverty Guidelines and to establish protocols for the requesting and processing of the Income Attestation Forms and supporting income validation documentation.

POLICY:
Charity discounts will be provided to non-insured patients receiving non-elective care based upon the scale outlined in this document.

Accounts with total charges greater than $5000.00 will be required to have supporting income verification documentation. The preferred documentation will be the most current year's Federal Tax Return. However, if the patient/responsible party is not able to provide this documentation then two pieces of supporting documentation from the following list will be acceptable:

- State Income Tax Return for the most current year
- Employer Pay Stubs for the last six months
- Written documentation from income sources
- Copy of all bank statements for the last three months
- Current credit report

After thorough review of the Income Attestation Form and documented research through Medicaid Eligibility denial or other means, a manager may waive supporting documentation when it is apparent that the patient/responsible party is unable to meet the requirement and clearly meets charity guidelines.

Emergency room visits and accounts with total charges less than $5000.00 will NOT be required to have supporting income verification documentation. The thorough completion of the Income Attestation Short Form will be acceptable for determining charity discount application.

Registrars, Financial Counselors and Collectors should utilize all relevant on-line systems available to gather correct information. All efforts should be documented in a clear, concise and consistent manner in the Collections System. Staff should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all staff. All guidelines set forth by management should be adhered to without exception.

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	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges
Income Level	<$1,000	$1,001 – $2,500	$2,501 – $5,000	$5,001 – $10,000	$10,001 – $25,000	$25,001 – $50,000	>$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

This process will be managed by establishing IPLANS with a Financial Class of 15 for Charity Pending, Charity – 100%, Charity 101% - 200%, Charity 201% - 300% and Charity 301% - 400%. In those instances where state regulations exceed the company policy, additional standard IPLANS will be established. These IPLANS will be attached to standard LOGIDS with the appropriate standard models to calculate the applicable discount and auto post to the account at final bill. These logs will not be worked for discrepancies or any other purpose. Standard procedure codes will be established to use in those instances where the discount must be manually applied. In addition, the collection series (4) Charity Pending Patient Liability and (108) Charity Pending Insurance Liability should be attached to the Pending Charity IPLAN and collection series (208) Self Pay Liability and ( ) Charity Insurance Liability respectively for automated collection tracking for these accounts.

PROCEDURE:

Responsible Party	Action
	Self Pay Inpatient, Outpatient Surgery or Observation Patients
Registrar	Registrar determines if the patient was previously evaluated for potential Medicaid coverage. • If so, apply the Pending Medicaid IPLAN if not previously applied. • If not, complete registration and begin financial counseling process.

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Registrar/Financial Counselor	Determine if this visit is considered elective. • If elective, patient will not qualify for a Charity discount. Collect monies. • If non-elective, continue with Charity discount process.

Registrar/Financial Counselor	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

Registrar/Financial Counselor	Determine if the estimated charges will be greater than $5000.00.
	• Estimated charges greater than $5000.00 will require additional supporting documentation.
	  o Provide the patient/responsible party with:
	  ▪ Charity Introduction Letter (RCOM.FT.XXX)
	  ▪ Income Attestation Long Form (RCOM.FT.XXX)
	  ▪ Income Attestation Long Form Instructions (RCOM.FT.XXX)
	• Estimated charges less than $5000.00 will only require completion of the Income Attestation Short Form. (RCOM.FT.XXX)
	  o Provide the patient/responsible party with:
	  ▪ Income Attestation Short Form (RCOM.FT.XXX)
	  ▪ Income Attestation Short Form Instructions
	• If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.

Registrar/Financial Counselor	Apply Pending Charity IPLAN when Charity forms have been provided to the patient/responsible party.
Registrar/Financial Counselor	Document in Meditech that the Charity Attestation Form was provided to the patient. • If the patient/responsible party returned the form completed, [illegible]

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Registrar/Financial Counselor	document in Meditech that the form was completed and placed for scanning.
	Clinical Outpatient
Registrar/Financial Counselor	Determine if this visit is considered elective. • If elective, patient will not qualify for a Charity discount. Collect monies. • If non-elective, continue with Charity discount process.

Registrar/Financial Counselor	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

Registrar/Financial Counselor	Determine if the estimated charges will be greater than $5000.00.
	• Estimated charges greater than $5000.00 will require additional supporting documentation.
	  o Provide the patient/responsible party with:
	  ▪ Charity Introduction Letter (RCOM.FT.XXX)
	  ▪ Income Attestation Long Form (RCOM.FT.XXX)
	  ▪ Income Attestation Long Form Instructions (RCOM.FT.XXX)
	• Estimated charges less than $5000.00 will only require completion of the Income Attestation Short Form. (RCOM.FT.XXX)
	  o Provide the patient/responsible party with:
	  ▪ Income Attestation Short Form (RCOM.FT.XXX)
	  ▪ Income Attestation Short Form Instructions
	• If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.

Registrar/Financial Counselor	Apply Pending Charity IPLAN when Charity forms have been provided to the patient/responsible party.

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Registrar/Financial Counselor	Document Meditech that the Charity Attestation Form was provided to the patient. o If the patient/responsible party returned the form completed, document in Meditech that the form was completed and placed for scanning.
	Emergency Room Patients
Registrar/Financial Counselor	Determine if patient/responsible party is able to pay estimated charges. • If so, collect monies • If not, determine if patient meets facility Medicaid Eligibility Criteria o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN o If not, continue
Registrar/Financial Counselor	Provide the patient/responsible party with: ▪ Income Attestation Short Form (RCOM.FT.XXX) ▪ Income Attestation Short Form Instructions • If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.
Registrar/Financial Counselor	Apply Pending Charity IPLAN when Charity forms have been provided to the patient/responsible party.
Registrar/Financial Counselor	Document Meditech that the Charity Attestation Form was provided to the patient. o If the patient/responsible party returned the form completed, document in Meditech that the form was completed and placed for scanning.
	PAS Collections – Working from Charity Collection Series
Collector/Support Services	Determine if Income Attestation Form was received. • If not received, evaluate if 14 days have passed since the Pending Charity IPLAN was assigned

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Collector/Support Services	○ If 14 days have passed, remove the Pending Charity IPLAN and send collection letter CHDENY to the patient advising Charity has been denied. ○ If 14 days have not passed, step account 7 additional days. • If received, continue
Collector/Support Services	Determine if total charges are greater than $5000.00 • If so, was supporting documentation received? ○ If yes, continue ○ If no, send collection letter CHDOCR to the patient requesting additional information. ○ Forward to Manager for review and consideration for charity without supporting documentation. • If not, continue
Collection/Support Services	Using the Income Attestation, Manager approval or supporting documentation (if applicable), Federal Charity Guidelines and the Charity Discount Table above to determine if the charity guidelines have been met and at what level the discount should be applied. • If the patient/responsible party does not qualify for any type of charity discount: ○ Send collection letter CHDENY to the responsible party ○ Remove the Pending Charity IPLAN ○ Document the account ○ Place account with NPAS • If the patient/responsible party qualifies for a partial charity discount: ○ Send collection letter CHPRTL to the patient ○ Apply the appropriate Charity IPLAN and reprorate ○ Document the account ○ Place account with NPAS • If the patient/responsible party qualifies for a full charity discount: ○ Send collection letter CHFULL ○ Apply the appropriate Charity IPLAN and reprorate ○ Document the account

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PAS Collections – Working from Correspondence Received

Imaging Staff	Income Attestation or Income Validation received and scanned at the patient account level.
Collector/Support Services	Account is identified

Collector/Support Services	Determine if total charges are greater than $5000.00
	• If so, was supporting documentation received?
	  o If yes, continue
	  o If no, document account
	• If charges are less than $5000.00, continue

Collector/Support Services	Using the Income Attestation, supporting documentation (if applicable), Federal Charity Guidelines and the Charity Discount Table above to determine if the charity guidelines have been met and at what level the discount should be applied.
	• If the patient/responsible party does not qualify for any type of charity discount:
	  o Send collection letter CHDENY to the responsible party
	  o Remove the Pending Charity IPLAN
	  o Document the account
	  o Place account with NPAS

Collector/ Support Services	Determine if account is with a primary or secondary collection vendor or is in bad debt.
	• Account is with a primary or secondary agency or in bad debt:
	  o If the patient/responsible party qualifies for a partial charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Post the manual discount
	  • Document the account
	  o If the patient/responsible party qualifies for a full charity discount:
	  • Send collection letter CHFULL

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Collector/Support Services	• Post the manual discount • Document the account • Account is in current A/R: o If the patient/responsible party qualifies for a partial charity discount: • Send collection letter CHPRTL to the patient • Apply the appropriate Charity IPLAN and reprorate • Document the account • Place account with NPAS o If the patient/responsible party qualifies for a full charity discount: • Send collection letter CHFULL • Apply the appropriate Charity IPLAN and reprorate • Document the account
	Medicaid Eligibility Denied
Collector/Support Services	Medicaid eligibility denial received.
Collector/Support Services	Obtain a copy of the Medicaid eligibility application and supporting documentation. Evaluate for potential charity • Not charity o Document account o Determine if account is with an agency ▪ If yes, no further action needed. ▪ If no, place with NPAS • If potential charity, continue
Collector/Support Services	Determine if account is with a primary or secondary agency or in bad debt. • Account with a primary or secondary agency or in bad debt: o Determine if additional supporting documentation is required • Not Required:

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Collector/Support Services	• If the patient/responsible party qualifies for a partial charity discount: o Send collection letter CHPRTL to the patient o Post the manual discount o Document the account • If the patient/responsible party qualifies for a full charity discount: o Send collection letter CHFULL o Post the manual discount o Document the account • Additional Documentation Required: • Send patient/responsible party collection letter CHDOCR • Document account. • Account is in current A/R: o Determine if additional supporting documentation is required • Not Required: • If the patient/responsible party qualifies for a partial charity discount: o Send collection letter CHPRTL to the patient o Apply the appropriate Charity IPLAN and reprorate o Document the account o Place account with NPAS • If the patient/responsible party qualifies for a full charity discount: o Send collection letter CHFULL o Apply the appropriate Charity IPLAN and reprorate o Document the account • Additional Documentation Required: • Send patient/responsible party collection letter CHDOCR • Apply Pending Charity IPLAN and

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	reprorate • Document account.
	Prior Discharge Requests If the patient/responsible party requests charity discount for discharges prior to October 1, 2003.
Collector/Support Services	Obtain Manager approval for Charity consideration. • Approved, continue • Not Approved, send collection letter CHDENY and document account
Collector/Support Services	Using the Income Attestation, supporting documentation (if applicable), Federal Charity Guidelines and the Charity Discount Table above to determine if the charity guidelines have been met and at what level the discount should be applied.

Collector/Support Services	Determine if account is with a primary or secondary collection vendor or is in bad debt.
	• If yes, determine type of charity:
	  o If the patient/responsible party qualifies for a partial charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Post the manual discount
	  • Document the account
	  o If the patient/responsible party qualifies for a full charity discount:
	  • Send collection letter CHFULL
	  • Post the manual discount
	  • Document the account
	• If not, and account is in current A/R determine type of charity:
	  o If the patient/responsible party qualifies for a partial charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Apply the appropriate Charity IPLAN and reprorate
	  • Document the account

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Collector/Support Services	• Place account with NPAS o If the patient/responsible party qualifies for a full charity discount: • Send collection letter CHFULL • Apply the appropriate Charity IPLAN and reprorate
	Vendor Self-Pay/Charity Flow
Vendor Representative	Patient/Responsible is unable to pay balance.
Vendor Representative	Determine if charity discount has been previously applied. • If previously applied, continue normal collection processes. • If not, continue
Vendor Representative	Determine if charity eligibility was previously denied. • If previously denied, continue normal collection processes. • If not, continue Send patient/responsible party charity documentation with the return address of the applicable PAS: • Income Attestation Short Form for total charges less than $5000.00 • Income Attestation Long Form for total charges greater than $5000.00 • Applicable Income Attestation Instructions • Charity Introduction Letter
Vendor Representative	Document and time account for next follow up. Check for Income Attestation and supporting documentation (if applicable) • If documentation is available, determine if discount has been applied. o Charity discount denied of partial discount applied, continue normal collection process o Full discount applied, account should close and return systematically

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Vendor Representative	o No Discount applied, contact PAS for status
	PAS Daily Review
Collector/Support Services/PARS	On a daily basis, using Clear Access scripts, review all final billed accounts with a Charity IPLAN assigned to ensure that the account is logged and discount is auto posted. (Note: There is a known system bug where changing an non-logged IPLAN to a logged IPLAN, using the collection system, will not apply the account to a log and therefore would not auto post the discount. • If accounts have not been logged then process the appropriate IZ transactions.

REFERENCE:

- Federal Poverty Guidelines
- Income Attestation Short Form
- Income Attestation Short Form Instructions
- Charity Introduction Letter
- Income Attestation Long Form
- Income Attestation Long Form Instructions
- Collection Charity Letters

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www.accessproject.org

February 18, 2004

Mr. Don Chester
St. Mary's Hospital
901 45th Street
West Palm Beach, FL 33407

Cc: Steve Campanini
Director, Media Relations
Tenet Healthcare Corporation
3820 State Street
Santa Barbara, CA 93105

Dear Mr. Chester:

We are writing to you on behalf of The Access Project, a national resource center, and the Quantum Foundation of West Palm Beach, Florida. The Access Project works with community groups and other organizations across the country interested in improving access to health care for vulnerable people. It is currently collaborating with the Quantum Foundation, a grant-making foundation with an interest in improving access to health care and prevention programs, to improve access to health care for low income, uninsured residents in Palm Beach County.

Over the past year, the Quantum Foundation has brought together key health care funders and stakeholders in Palm Beach County to look at ways to improve access to care for uninsured people through coordination of services and expansion of capacity. It has asked The Access Project to facilitate the meetings of this Health Care Coordinating Committee, which are attended by representatives from the State Department of Health, the County Health Care District, the maternal and child health alliance, local hospitals and clinics, and others.

The Access Project previously communicated with Tenet to express its interest in helping to clarify your recently announced program to provide discounts to uninsured patients.

Along with the Quantum Foundation, we would like to invite you to a meeting of the Health Care Coordinating Committee in West Palm Beach during the month of April to present information on this program.

The recent release of the American Hospital Association guidelines for hospital billing and collections has again focused attention on the important issue of free or discounted care for the uninsured. As the AHA stated in its guidelines, "hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance." We applaud Tenet for developing a program to provide discounts to uninsured individuals. While this represents a positive step toward improving access for uninsured patients, too few people are aware of it. Again, the AHA guidelines encourage hospitals to have "written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs" and to "share these policies with appropriate community health and human services agencies and other organizations that assist people in need." In the spirit of these guidelines, we hope that you will be interested in working with us to publicize your program in Palm Beach County.

We have also invited representatives from HCA to the meeting to explain its program to provide assistance to uninsured patients. In addition, we have invited representatives from the American Hospital Association and the Florida Hospital Association to discuss how to most effectively encourage the hospitals in Palm Beach County to implement their new charity care guidelines.

We hope that Palm Beach County can become a model for effectively informing uninsured residents about the financial support available to help them pay for their health care. This is an important issue in the County, which has high percentages of low-income uninsured people.

One of us will be contacting you within the next week to explore your interest and discuss your availability to attend this meeting. We believe your participation would be valuable in educating the key healthcare policy makers and administrators on the committee about the new guidelines for providing financial assistance to the uninsured, and that they could provide you with valuable assistance in publicizing the program in the community. With appropriate outreach, we are sure that financial assistance programs can contribute to improved access to care for low-income, uninsured residents of Palm Beach County.

In advance, thank you for your consideration.

Sincerely,

Mark Rukavina
The Access Project

Jeannette Corbett
Quantum Foundation

Mark Rukavina

From: Mark Rukavina
Sent: Wednesday, March 17, 2004 1:45 PM
To: Steven Campanini (E-mail)
Subject: April Mtg in Palm Beach County

Steve, I am following up on a letter dated February 18, 2004 that Jeannette Corbett from the Quantum Foundation and I sent to you. This letter invited you to an April meeting in Palm Beach County where we would like you to present information on your discount program for uninsured patients. I want to inform you that the meeting will take place on either Wednesday, April 21st or Wednesday, April 28th. Would you or some else from corporate be able to attend a meeting on either of these dates?
Mark

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Mark Rukavina
Director
The Access Project
30 Winter Street Suite 930
Boston, MA 02108
Phone (617)654-9911 X229
Fax (617)654-9922
rukavina@accessproject.org
www.accessproject.org

Mark Rukavina

From: Campanini, Steven [STEVEN.Campanini@tenethealth.com]
Sent: Thursday, April 01, 2004 12:11 PM
To: Mark Rukavina
Cc: Chester, Don
Subject: RE: April Mtg in Palm Beach County

Mark,

Thank you for your invitation to participate in an April meeting to present information about our discount program for the uninsured. We appreciate your offer and would be prepared to provide details about the Compact once it is in place and available in our hospitals. The phase-in will take place on a hospital-by-hospital basis and we expect it to be fully implemented by June 30th. We should talk about arranging a meeting with The Access Project after that.

Meanwhile, I can provide some general information beyond what is what is in the press release. Only last month we announced that we will begin implementing the Compact with Uninsured Patients. Tenet took this action after Tommy Thompson and the Office of the Inspector General issued opinions that nothing in Medicare's billing rules prevents hospitals from offering such assistance to uninsured and underinsured patients who cannot afford to pay their hospitals bills.

Tenet has clearly taken a strong leadership position in the industry with its Compact. Unlike other programs, Tenet's discounts will be available without regard to patient's income. Rather, the Compact offers discounted rates to all uninsured patients who receive treatment in Tenet hospitals, except where prohibited by state law. Specifically, any patient without a third-party source of payment (uninsured) and who meets the criteria of the program will be offered a contractual rate similar to current managed care rates charged by local hospitals. As you know, these rates tend to vary by each hospital.

Tenet's Compact puts in writing other assistance efforts that our hospitals have been making for a number of years. Tenet has been a leader in helping uninsured patients understand and apply for government health care programs, such as Medicaid. Many such patients are often unaware that they are eligible for government programs, and in fact, about 50,000 patients in our hospitals in the last year were qualified for such programs because of the company's efforts under its Medical Eligibility Program.

Uninsured patients who are treated before the Compact is fully implemented will be able to work one-on-one with our staff to determine their ability to pay and to make appropriate arrangements for payment over time.

The Compact will be implemented at all our hospitals -- including the hospitals we are in the process of selling -- except where prohibited by law. Hospitals in Texas will not be allowed to implement the program due to existing state law, and we are in discussions with the State about possible remedies. In Massachusetts, all hospitals, including Tenet's, participate in a statewide Uncompensated Care Fund. The fund does not prevent our hospitals from participating in this Compact, and may mean additional benefit to Massachusetts uninsured.

I hope this information is helpful. We are working through the complexities of implementing the Compact on a case by case basis, and expect to be in a better position by July to discuss the program in more detail.

Best regards,

Steve

Steven Campanini
Director, Media Relations, Corporate Communications
Tenet Healthcare Corporation, Santa Barbara Office
3820 State Street Santa Barbara, CA 93105
Office 805.563.6838 Office Fax 805.563.6871
Cell 805.705.0133
Assistant Meredith Cota 805.563.6873
e-mail steven.campanini@tenethealth.com

-----Original Message-----
From: Mark Rukavina [mailto:rukavina@accessproject.org]
Sent: Wednesday, March 17, 2004 10:45 AM
To: Campanini, Steven
Subject: April Mtg in Palm Beach County

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> www.accessproject.org
>
>

Mark Rukavina

From: Campanini, Steven [STEVEN.Campanini@tenethealth.com]
Sent: Monday, April 05, 2004 1:59 PM
To: Mark Rukavina
Subject: RE: April Mtg in Palm Beach County

Mark - Thanks again for the invitation. However, Tenet, St. Mary's or any other Tenet hospital will not be able participate in a meeting about the Compact prior to the program's implementation.

Perhaps we can talk again in July.

Best regards,

Steven Campanini
Director, Media Relations, Corporate Communications
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e-mail steven.campanini@tenethealth.com

-----Original Message-----
From: Mark Rukavina [mailto:rukavina@accessproject.org]
Sent: Monday, April 05, 2004 10:46 AM
To: Campanini, Steven
Subject: April Mtg in Palm Beach County

Steve, thank you for your response. It appears that you are making progress in terms of your Compact. With regard to the April 28th meeting in Palm Beach, Fl, we hope that you or another representative from Tenet will attend the meeting even though the Compact may not be fully implemented at that time. As we explained in our letter of February 18th, we have also invited representatives from the American Hospital Association, the Florida Hospital Association and other hospitals in Palm Beach County. At this meeting we hope that you and other hospital representatives will explain to a small group of health care leaders from Palm Beach County what Tenet is doing - or planning to do - to assist uninsured patients.
Please contact me directly to confirm your participation in this meeting.
Thank you.
Mark

-----Original Message-----
From: Campanini, Steven [mailto:STEVEN.Campanini@tenethealth.com]
Sent: Thursday, April 01, 2004 12:11 PM
To: Mark Rukavina
Cc: Chester, Don
Subject: RE: April Mtg in Palm Beach County

Mark,

Thank you for your invitation to participate in an April meeting to present information about our discount program for the uninsured. We appreciate your offer and would be prepared to provide details about the Compact once it is in place and available in our hospitals. The phase-in will take place on a hospital-by-hospital basis and we expect it to be fully implemented by June 30th. We should talk about arranging a meeting with The Access Project after that.

Meanwhile, I can provide some general information beyond what is what is in the press release. Only last month we announced that we will begin implementing the Compact with Uninsured Patients. Tenet took this action after Tommy Thompson and the Office of the Inspector General issued opinions that nothing in Medicare's billing rules prevents hospitals from offering such assistance to uninsured and underinsured patients who cannot afford to pay their hospitals bills.

Tenet has clearly taken a strong leadership position in the industry with its Compact. Unlike other programs, Tenet's discounts will be available without regard to patient's income. Rather, the Compact offers discounted rates to all uninsured patients who receive treatment in Tenet hospitals, except where prohibited by state law. Specifically, any patient without a third-party source of payment (uninsured) and who meets the criteria of the program will be offered a contractual rate similar to current managed care rates charged by local hospitals. As you know, these rates tend to vary by each hospital.

Tenet's Compact puts in writing other assistance efforts that our hospitals have been making for a number of years. Tenet has been a leader in helping uninsured patients understand and apply for government health care programs, such as Medicaid. Many such patients are often unaware that they are eligible for government programs, and in fact, about 50,000 patients in our hospitals in the last year were qualified for such programs because of the company's efforts under its Medical Eligibility Program.

Uninsured patients who are treated before the Compact is fully implemented will be able to work one-on-one with our staff to determine their ability to pay and to make appropriate arrangements for payment over time.

The Compact will be implemented at all our hospitals -- including the hospitals we are in the process of selling -- except where prohibited by law. Hospitals in Texas will not be allowed to implement the program due to existing state law, and we are in discussions with the State about possible remedies. In Massachusetts, all hospitals, including Tenet's, participate in a statewide Uncompensated Care Fund. The fund does not prevent our hospitals from participating in this Compact, and may mean additional benefit to Massachusetts uninsured.

I hope this information is helpful. We are working through the complexities of implementing the Compact on a case by case basis, and expect to be in a better position by July to discuss the program in more detail.

Best regards,

Steve

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e-mail steven.campanini@tenethealth.com

-----Original Message-----
From: Mark Rukavina [mailto:rukavina@accessproject.org]
Sent: Wednesday, March 17, 2004 10:45 AM
To: Campanini, Steven
Subject: April Mtg in Palm Beach County

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Mark Rukavina

From: Mark Rukavina
Sent: Thursday, May 06, 2004 4:14 PM
To: 'Campanini, Steven'
Subject: RE: April Mtg in Palm Beach County

Steve, I am sorry that there were no representatives from Tenet at our meeting in Palm Beach County last week. I am hoping that you will provide me with the names of the contact people in each of your hospitals in Palm Beach County who will be working with uninsured patients. We get lots of questions from the groups we are working with in that county and want to be sure that they know who to call should questions arise. This is particularly important given the following quote that I copied from your message below. "Uninsured patients who are treated before the Compact is fully implemented will be able to work one-on-one with our staff to determine their ability to pay and to make appropriate arrangements for payment over time."
Thanks
Mark

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From: Campanini, Steven [mailto:STEVEN.Campanini@tenethealth.com]
Sent: Thursday, April 01, 2004 12:11 PM
To: Mark Rukavina
Cc: Chester, Don
Subject: RE: April Mtg in Palm Beach County

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Mark Rukavina

From: Campanini, Steven [STEVEN.Campanini@tenethealth.com]
Sent: Wednesday, May 12, 2004 10:11 AM
To: Mark Rukavina
Subject: RE: April Mtg in Palm Beach County

[I sent this yesterday but your server kicked it back. Re-sending.]

Mark - We appreciate your efforts in this important area. Our advice is patients should direct billing questions to their hospital. We have patient representatives at each facility who are responsible for confidentially handling patient financial questions.

We continue to encourage patients to work with the hospital directly to resolve financial matters.

Thanks,

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-----Original Message-----
From: Mark Rukavina [mailto:rukavina@accessproject.org]
Sent: Thu 5/6/2004 1:13 PM
To: Campanini, Steven
Cc:
Subject: RE: April Mtg in Palm Beach County

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Mark Rukavina

From: Campanini, Steven [STEVEN.Campanini@tenethealth.com]
Sent: Monday, May 17, 2004 6:52 PM
To: Mark Rukavina
Subject: Palm Beach County request

Mark - I will look into if there is a list we can provide. We're in the process of rolling out the Compact at many of our hospitals, and we are sensitive to distributing information that might change. I'll get back to you by the end of the week.

Best regards,

Steven Campanini
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Assistant Meredith Cota 805.563.6873
e-mail steven.campanini@tenethealth.com

-----Original Message-----
From: Mark Rukavina [mailto:Rukavina@Accessproject.org]
Sent: Thursday, May 13, 2004 10:52 AM
To: Campanini, Steven
Subject: RE: April Mtg in Palm Beach County

Steve, thanks for persevering and re-sending the message. It is good to learn that you have patient representatives at each facility. Again, it would be most helpful if you would provide
a list of names for your hospitals in Palm Beach County. Such a list would enable us to refer patients directly to the proper representative at each facility who would help to resolve their financial matters.
Thanks
Mark

Mark Rukavina

From: Campanini, Steven [STEVEN.Campanini@tenethealth.com]
Sent: Friday, May 21, 2004 1:44 PM
To: Mark Rukavina
Subject: Tenet's Compact with Uninsured Patients

Mark –

I wanted to get back with you on your request for the final written Compact and the patient financial services contacts at each of our hospitals in Palm Beach County. Attached below are a PDF of the Compact and the list of names. We prefer uninsured patients with questions about their invoices are suggested to contact the hospital's billing office in general, and not a specific person, because the individual contact may change and could possibly result in even greater frustration for the patient.

During the course of the last year we have been hesitant to provide details about the proposed Compact because it was not yet in place. However, it is now being rolled out in our facilities in Florida and other parts of the country by the end of June. We recognize the Compact is not a solution to the complexities involving providing care for the uninsured, but we sincerely believe it is a step in the right direction.

I am pleased to learn you will be providing testimony at the O&I hearings. I am currently not planning to attend, but if Tenet is invited we expect to participate.

I hope this information is helpful. Feel free to contact me if there is any additional information we can provide.

Best regards,
Steve

Delray Medical Center
Name: Rosemary Young
Tel: 561-495-3468
Title: Admitting Manager

Good Samaritan Medical Center
Name: Stacy Hannah
Tel: 561- 650 - 6264
Title: Director of Admitting

Palm Beach Gardens Medical Center
Name: Lula Lester
Tel: 561-694-7135
Title: Financial Case Manager

Pinecrest Rehabilitation Hospital
Name: Pam Dunn
Tel: 561-694-7135
Title: Director Case Manager

St. Mary's Medical Center
Name: Mary Barulic
Tel: 561-840-8701

Title: Financial Case Manager

West Boca Medical Center
Name: Michelle Prosper
Tel: 561-883-7040
Title: Financial Case Manager

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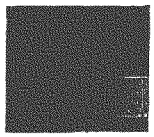


TENET'S COMPACT WITH UNINSURED PATIENTS

- Patients without insurance at Tenet hospitals will be treated fairly and with respect during and after their treatment, and regardless of their ability to pay for the services they receive.

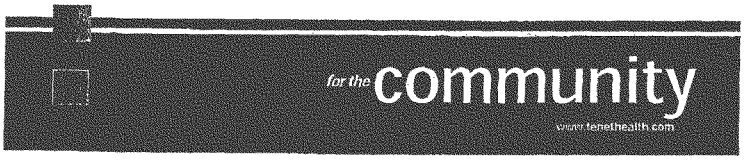
- Tenet hospitals will provide financial counseling to uninsured patients. This will include help in understanding and applying for local, state and federal health care programs such as Medicaid.

- After uninsured patients* receive treatment at Tenet hospitals and are provided with financial counseling, they will be offered discounted pricing for the services provided at rates equivalent to the hospital's current managed care rates, which are substantially discounted from retail or "gross" charges.

- All patients without insurance at Tenet hospitals will be offered reasonable payments and payment schedules and, subject to their acceptance of the offer, will be billed at discounted local market rates. Whenever possible, this will occur before the patients leave the hospital, as part of the financial counseling process.

- Tenet hospitals will not pursue legal action for non-payment of bills against any patient who is unemployed or without other significant income. Before taking legal action for non-payment, our hospitals will assure that the patient is not eligible for any assistance program and does not qualify under the hospitals' charity care policy. Nor will our hospitals pursue legal action if the only recovery available would be to place a lien on the patient's home.

* Patients will not be considered "Uninsured Patients" if they reside outside of the United States and travel to the United States for the purpose of receiving specialized medical care.



NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Herbert Pardes, MD
President and
Chief Executive Officer

Columbia Presbyterian Center
Mailing Address
161 Ft. Washington Ave.
New York, NY 10032
tel 212 305 8000
fax 212 305 8012

New York Weill Cornell Center
525 East 68th Street
New York, NY 10021

July 22, 2004

VIA HAND DELIVERY, E-MAIL AND FED EX

Mr. Michael Abraham
Ms. Voncille Hines
U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515

Re: Questions for Herbert Pardes, M.D., President and CEO of New York Presbyterian Hospital

Dear Mr. Abraham and Ms. Hines:

This letter serves to respond to the questions set forth in the July 6, 2004 letter from Congressman John Dingell. Congressman Dingell's questions and New York Presbyterian Hospital's ("NYPH") responses are set forth below.

1. *According to a Wall Street Journal article, dated June 8, 2004, Mr. Nelson Savinon, former patient who received services from NYPH in 1991, learned that a collection agency authorized by NYPH had frozen his bank account because of an unpaid judgment of more than $6,300, including interest. Upon further investigation by New York's Legal Aid Society, it was discovered that NYPH had written off the debt 12 years ago. Furthermore, the final entry on Mr. Savinon's bill read "bad debt credit allowance - $4,492," and the next line read "due from patient, "0." Please explain how this happened, and how it was resolved.*

   Mr. Savinon received inpatient hospital services from NYPH in February 1991 at the former Columbia Presbyterian Hospital. When Mr. Savinon failed to make payment on his bill, Columbia Presbyterian Hospital referred the account to a collection agency. The collection agency was unable to secure payment arrangements, and a lawsuit was filed in 1995 to pursue the unpaid balance. A judgment of $6,800, inclusive of court costs and interest, was rendered against Mr. Savinon in October 1995. For the next several years, the collection agency handling the account periodically searched for assets to satisfy the

judgment, but found none. Without NYPH knowledge, the account was eventually transferred to a successor collections agency. After locating a bank account that contained assets to satisfy the judgment, this successor agency placed a lien on the account. NYPH was not aware of the agency's action. After learning of Mr. Savinon's case, NYPH reviewed the matter and decided to release the lien and vacate the judgment.

As is usual practice, NYPH wrote off the amount of Mr. Savinon's balance as bad debt after obtaining the judgment in 1995. It is NYPH's practice to pursue satisfaction of judgments after the amount is written off as bad debt. Although a debtor may not have sufficient income or assets at the time of judgment, the debtor may gain the financial resources to satisfy the judgment at a later date. Under New York law, a judgment is valid, and may be pursued, for twenty years. NYPH policy is to pursue an outstanding debt for five years.

When NYPH writes off a patient's balance as bad debt, the hospital zeroes out the balance in its internal billing system. This is done for internal accounting purposes.

1a. *Did NYPH receive compensation from the "bad debt and charity care" pool on Mr. Savinon's debt? If the answer is yes, did NYPH report this collection to the administrator of the "bad debt and charity care" pool?*

It is not possible to tell whether NYPH received compensation from the New York Bad Debt and Charity Care Pool on Mr. Savinon's debt, as NYPH receives an aggregate (i.e., non-patient specific) payment from the Pool. This payment represents only a portion of NYPH's bad debt/charity care expense. For example, in 2003, NYPH received reimbursement for only 33% of its stated bad debt/charity care need.

NYPH does not report recoveries on individual patient accounts to the administrator of the Bad Debt and Charity Care Pool. In the event that NYPH collects on an account that has been written off as bad debt, NYPH reconciles such recoveries against its bad debt expense thereby reducing the amount of future distributions from the Pool.

1b. *Does NYPH currently receive compensation for Mr. Savinon's unpaid bill from the "bad debt and charity care" pool administered by New York State? If the answer is yes, why did NYPH, after receiving compensation from the "bad debt and charity care pool" for Mr. Savinon, continue to pursue payment from the patient? Is the policy of NYPH to continue to pursue payment from patients whose bills have been written off and compensated by other funds?*

NYPH does not currently receive compensation for Mr. Savinon's unpaid bill from the New York Bad Debt and Charity Care Pool.

It is NYPH's policy not to pursue payment from patients whose balances have been compensated by other funds, including NYPH's Philanthropic Fund.

1c. *Does NYPH notify the pool administrators of the amount of monies eventually recovered from these "bad debt" patients? How is this information reflected in NYPH's records?*

As noted above, NYPH does not notify the pool administrators of individual recoveries from "bad debt" patients. However, NYPH reconciles recoveries from these patients against NYPH's bad debt expense. In so doing, the amount of future payments from the New York State Bad Debt Pool is reduced.

Recoveries from "bad debt" patients appear in NYPH's ledger as a credit to the bad debt reserve.

2a. *Does NYPH's current bad debt policy preclude the attachment of a bank account if it is the patient's only asset? Do you differentiate by amount of the account? What is NYPH's current bad debt policy concerning attachments and liens for Medicaid-eligible uninsured and underinsured individuals?*

NYPH's Policies and Procedures for Collection Agencies and Attorneys limits the type of collection practices that may be used. This policy does not, however, provide for differential treatment based on the level of funds in a patient's bank account, as banks do not inform outside counsel of the amount of funds in the specified account at the time of attachment. In addition, these policies do not preclude the attachment of a bank account if it is the patients' only asset.

NYPH does not currently have a policy concerning attachments and liens for Medicaid-eligible uninsured and underinsured individuals. NYPH instructs its collection agents to assess a patient's eligibility for Medicaid, Family Health Plus, Child Health Plus or other government entitlement programs, as well as to assess eligibility for charity care/financial aid prior to making a demand for payment. If a patient is determined to be eligible for any of these programs, collection efforts cease while the patient's application is pending.

2b. *Under what circumstances does NYPH place a lien against a patient's primary residence to pay an outstanding debt? Has NYPH ever forced the sale or foreclosure of a patient's primary residence in order to satisfy a bad debt? What is the hospital's current policy on placing liens on primary residences and foreclosures?*

NYPH will place a lien against a patient's primary residence after securing a judgment against the patient. This enables the hospital to collect on the outstanding debt in the event the patient sells the residence. NYPH has never forced the sale or foreclosure of a patient's primary residence. While NYPH's current collection policies do permit outside collectors to place a lien on a patient's primary residence, such policies prohibit the forced sale or foreclosure in order to satisfy a debt.

2c. *Describe in specific terms NYPH's processes and guidelines for determining patient eligibility for receiving Medicaid or charity care/financial aid? At what point are patients told of the availability of these programs?*

NYPH generally assesses, on an individual basis, self-pay patients' eligibility for Medicaid and other government entitlement programs. During the registration process, self-pay patients are asked to provide information regarding their financial resources and the number of individuals in their household. NYPH compares this information to the eligibility requirements established by the State of New York. If the patient is deemed to be potentially eligible, NYPH will assist the patient with the enrollment process.

Eligibility for charity care/financial aid is determined after eligibility for Medicaid and other government programs has been assessed. Patients are asked to complete an application and to provide documentation related to their financial resources. Applicants may be asked to provide the following information/documentation: household income; number of individuals in the household; assets; and tax forms. NYPH will review the information in evaluating the patient's financial situation. NYPH will provide reduced charge care to uninsured applicants with incomes below 300% of the Federal poverty level. Exceptions to these criteria may be authorized by a designated hospital executive.

2d. *Please state specifically the amount of the discount given by NYPH to uninsured individuals whose incomes are at 100%, 200%, 300%, and 400% of the Federal Poverty Level. Is NYPH considering any across-the-board discount to all uninsured persons?*

Inpatients and hospital outpatients with incomes at 100%, 200%, 300% and 400% of the Federal Poverty Level are given the following discounts: 90%, 50%, 10% and 0% respectively. NYPH's outpatient clinics determine patient fees using a sliding fee scale. Clinic patients with incomes at 100%, 200%, 300% and 400% are assessed the following per-visit fee: $40, $60, $80 and $165, respectively.

NYPH is not currently considering an across-the-board discount for uninsured persons. Individuals are uninsured for a variety of reasons, including personal choice. Not all uninsured patients (e.g., international patients) are unable to pay for the medical services that they receive. NYPH believes that discounts tied to income level are more appropriate than across-the-board discounts. Discounts tied to income ensure that those individuals in greatest need receive the highest level of discount, thereby paying the lowest amount.

3. *You submitted to the Subcommittee a document entitled "Customer Service Situation Response Training," which appears to be a training manual for NYPH employees discussing billing problems. What is significant about this document is that customer services representatives are directed to attempt to get payment in full from patients who may be eligible for Medicaid or charity care. Charity is described "as accounts which meet charity guidelines once all other forms of resolution and sponsorship are exhausted." (p.30, emphasis added) Is it the policy of NYPH to attempt to get payment in full or a payment plan for the full amount owed by uninsured patients prior to informing the patient of the availability of Medicaid or charity care or assessing the patient's financial status to determine if they are eligible for Medicaid or charity care. If not, please describe the process by which the patients are informed of financial assistance for their bills.*

It is not NYPH's policy to attempt to obtain payment in full or negotiate a payment plan prior to informing the patient of the availability of Medicaid or charity care/financial aid, and assessing their eligibility for these programs. Under NYPH's current policy, the patient learns of the benefits of Medicaid and other government programs at the time of registration. If a patient is deemed to be potentially eligible for any of these programs, NYPH will assist the patient in the enrollment process. If it is determined that the patient is not eligible for a government program, NYPH will discuss its Charity Care/Financial Aid Policy with the patient, and will provide the individual with an application. Charity care/financial aid is provided to patients with incomes up to 300% of the Federal poverty level. Determinations as to eligibility for charity care/financial aid are communicated to the patient as soon as practicable after the completed application is submitted. NYPH does not attempt to negotiate a payment plan or obtain payment in full prior to informing the patient of the availability of government programs and charity care/financial aid.

In the past, eligibility for charity care from NYPH's Philanthropic Fund (referenced on page 30 of the manual) was assessed after the hospital inpatient received a bill and only if the patient contacted the hospital to explain that he or she was experiencing financial hardship. During this timeframe, customer service representatives were instructed to work with the patient to establish flexible payment arrangements or to settle the account. Charity care from the Philanthropic Fund was reserved only for those patients experiencing financial hardship (i.e., those who could not make any payment on their account). Eligibility for Medicaid and other government entitlement programs, on the other hand, has always been assessed at the point in time in which NYPH learns that the patient is uninsured, which is typically at registration.

The Customer Service Situation Response Training Manual is a dated document. The manual was generated in 2002 and has not been updated to reflect NYPH's current Charity Care/Financial Aid Policy. NYPH is in the process of revising the manual.

4. *Appendix D of the manual (p.26) also states that customer services representatives should attempt to get payment in full, a settlement of the account, or a payment arrangement prior to determining whether the patient is eligible for the Grace Lamb Fund or the Restoration Fund, which are charity funds. Please explain why NYPH makes numerous attempts to get payment in full from uninsured and indigent patients before determining whether they are eligible for charity care? Do these funds pay for the entire hospital bill?*

   As noted above, NYPH routinely assesses a patient's eligibility for Medicaid and charity care/financial aid at the time of registration. NYPH does not attempt to obtain payment in full from self-pay patients prior to this determination.

   NYPH's Philanthropic Fund is used to provide aid to patients experiencing financial hardship. The Philanthropic Fund, which is supported by provide donations, contains approximately three million dollars in available funding on an annual basis. In order to receive monies from the Fund, the patient must submit a letter of hardship which details their financial circumstances, and explains why the patient is unable to pay his or her medical bills. The patient may also be required to submit financial documentation. If the patient is deemed to be eligible, NYPH will forgive the patient's entire balance due to the hospital, subject to the availability of funds. Monies from the Philanthropic Fund are allocated on a first-come, first-served basis. The Grace Lamb Fund and the Restoration Fund are the same as the Philanthropic Fund.

5. *A March 12, 2003 document entitled "Charity Write-off Procedures" states that even when a patient has been identified as a "possible write off to the Charity Restitution Fund," the service representative must still attempt to get a payment settlement on the balance. The patient must then write a "letter of hardship" to NYPH to obtain the write-off. Does that remain the policy today? Why does NYPH continue to attempt to get payment from patients it already knows can't pay?*

   As noted above, NYPH continues to require a patient to submit a letter of hardship in order to receive assistance from the Philanthropic Fund.

   Since the implementation of NYPH's revised Charity Care/Financial Aid Policy, monies from the Philanthropic Fund are primarily used for underinsured patients who are unable to pay their co-insurance, co-payments, or deductibles. Since the Philanthropic Fund contains only a limited amount of money, approximately $3 million a year, NYPH must reserve fund monies for those patients that are truly in the greatest need. Accordingly, in some instances, NYPH may attempt to obtain payment from these patients prior to assessing the patient's eligibility for the Philanthropic Fund in an effort to identify those patients with the greatest need.

6. *Please explain NYPH's procedures to inform self-paying patients who find themselves in need of emergency medical care of available Medicaid or charity care/financial assistance programs. What are the procedures for determining eligibility for Medicaid or charity care/financial assistance programs? Is this information placed in a prominent public location throughout NYPH's facilities?*

   Pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA"), NYPH treats patients experiencing medical emergencies without regard to their insurance status or ability to pay. NYPH bills the patient after he or she is discharged from the hospital. NYPH's billing statements contains language that informs patients to contact NYPH's Patient Financial Services Department if they are experiencing financial difficulties. NYPH's Patient Financial Services will assess the patient's eligibility for Medicaid and other government programs. If the patient is determined to be ineligible, the Patient Financial Services Department will provide the patient with an application for charity care/financial aid.

   The procedures for assessing eligibility for Medicaid and charity care/financial assistance are detailed in our response to question 2(c).

   NYPH posts information regarding its Charity Care/Financial Aid Policy in the Emergency and Admitting Departments of each of its campuses. This information is also posted in many of NYPH's outpatient clinics.

7. *Your written testimony states that NYPH widely disseminates information about its Charity Care/Discount Policy to the communities it serves. How, and to whom, is this information distributed?*

   NYPH shares information regarding its Charity Care/Financial Aid Policy with community health agencies and local organizations that assist individuals in financial need. Specifically, NYPH staff distributes information regarding its policy at community meetings held by these organizations. NYPH has provided such information, for example, to NYP/Columbia Community Health Council, NYP/Weill Cornell Community Health Council, NYP Community Advisory Council, and the Allen Task Force.

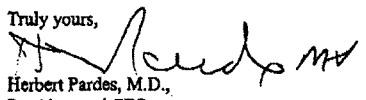
8. *In your testimony you stated that NYPH has written agreements with collection agencies that limit the types of collection practices that may be used. Please provide a copy of that agreement. Does NYPH have an internal process to monitor outside collection agencies to ensure that they adhere to the written agreements?*

Enclosed please find a copy of NYPH's Policies and Procedures for Collection Agencies and Attorneys (*see* NYPH 0001660- NYPH 0001663). Approximately ninety-five percent of NYPH's collections work is performed by Network Recovery Services, a collection agency owned by the hospital. Network Recovery Services adheres to NYPH's Policies and Procedures for Collection Agencies and Attorneys, which limits the types of collection practices that may be utilized. NYPH monitors its outside collectors so as to ensure adherence to NYPH's collection policies.

* * *

If you have any questions regarding NYPH's responses, please do not hesitate to contact Stuart Kurlander of Latham & Watkins at (202) 637-2169.

Truly yours,



Herbert Pardes, M.D.,
President and CEO
New York Presbyterian Hospital

NEW YORK-PRESBYTERIAN HOSPITAL: POLICIES AND PROCEDURES FOR COLLECTION AGENCIES AND ATTORNEYS
JULY 2004

The purpose of these policies and procedures is to promote patient access to quality health care while minimizing bad debt at the New York Presbyterian Hospital ("NYPH"). The promulgation of these policies and procedures will continue to ensure that the debt collection activities undertaken by collection agencies and attorneys on behalf of NYPH remain consistent with the core missions, values, and principles of NYPH.

1. GENERAL PRINCIPLES & GUIDELINES

A. The collection agency (the "Agency") will comply with all applicable federal and state laws and accrediting agency requirements, including, but not limited to, the Fair Debt Collection Practices Act ("FDCPA") the Fair Credit Billing Act, the Consumer Credit Protection Acts, and the Health Insurance Portability and Accountability Act ("HIPAA"). Agency will also comply with NYPH's guidelines on financial aid and charity care.

B. Agency and Outside Counsel will assess the patient's eligibility for government programs and for charity care/financial aid prior to making a demand for payment.

C. Agency will work with the patient to establish a reasonable payment plan.

D. Agency and Outside Counsel will suspend all collection activities associated with a patient account if the patient disputes (in accordance with the appropriate NYPH's dispute resolution procedures) the amount or validity of any outstanding balance. The patient account will remain suspended until NYPH determines that collection efforts may resume.

E. Agency or any lawyer or law firm assisting NYPH or Agency in the collection of an outstanding patient account debt (the "Outside Counsel") may take legal action only upon receiving prior authorization from NYPH.

2. PROCEDURE GOVERNING AGENCY'S RECEIPT OF PATIENT ACCOUNT REFERRALS

A. Agency will send an acknowledgement to NYPH upon receipt of a patient account referral from NYPH. The purpose of the stated acknowledgment is to allow NYPH to reconcile the number of patient accounts referred to the Agency with the amounts received by Agency. Agency will not transfer patient accounts to another Agency, with the exception of accounts being referred for legal action, without NYPH's prior approval.

B. As required under the FDCPA, Agency will send a letter to a patient within three (3) days of receipt of an account referral advising the patient that the Agency is attempting to collect a debt.

3. PROCEDURE GOVERNING THE COLLECTION PROCESS

A. After (or in conjunction with) its initial communication with the patient, Agency will attempt to communicate with the patient to determine why the outstanding balance on the patient's account balance remains unpaid. Agency will adhere to this policy regarding appropriate means of communicating with the patient.

B. Upon contacting the patient, Agency will determine if patient was insured at the time of service (e.g., employer group health plan, no-fault, workers' compensation, Medicare (if patient is over 65 years of age), parents and/or school insurance if patient is a minor, third party liability in the event of an accident).

1. If insurance coverage is identified, follow Agency's internal procedures for billing insurance.
2. If insurance coverage is not identified, determine if patient was eligible for COBRA benefits at the time of service.
   a. If yes, determine ability to reinstate benefits.
   b. If no, proceed to Section C.

C. Agency will determine if patient may be eligible for Medicaid, Family Health Plus, Child Health Plus or other government programs.

1. If patient has coverage that went into effect after the date of service, Agency will determine whether coverage can be made retroactive.

D. If none of the previous steps has been successful, Agency will determine whether patient may be eligible for charity care or financial aid from the hospital.

1. If yes, forward Charity Care/Financial Aid application to patient for completion.
2. If no, proceed to Section E.

E. Agency will conduct a financial profile on the patient and take the following actions, as appropriate:

1. Make demand for full payment,
2. If patient is unable to make payment in full, collector may establish a payment plan. Collector should seek full repayment of the balance within six months. Collector is authorized to extend the repayment period beyond six months if patient's financial profile indicates that extension is appropriate.
3. Accept a settlement if the financial profile indicates that action is appropriate. Settlements for less than 75% of the balance must be approved by a Director of Patient Financial Services, Vice President of Financial Services, or their appropriate designees.
4. Seek alternative payment methods (e.g., credit cards, loans, mortgages) to satisfy debt.

F. Agency will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

4. REFERRAL FOR LEGAL ACTION

A. With respect to those patient accounts for which the foregoing steps are unsuccessful, Agency may refer appropriate accounts to Outside Counsel for possible legal action. Referral of an account should not generally occur until six months after Agency's receipt of the account.

5. **GENERAL LEGAL GUIDELINES**

   A. Outside Counsel will follow all applicable federal and state laws and regulations governing the collection of debts, including, but not limited to FDCPA, FCBA, CCPA, HIPAA and Article 52 of the New York Civil Practice Law and Rules. Outside Counsel will also abide by NYPH's guidelines on financial aid and charity care

   B. Outside Counsel will not report patient's account status to the credit bureaus. Inquiries to the credit bureaus may, however, be made.

   C. Outside Counsel will seek NYPH's prior approval before issuing a summons in connection with the collection of an outstanding balance on any patient account.

   D. Outside Counsel will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.

   E. Outside Counsel will not enforce a judgment against a patient after five years from the date of judgment, without prior approval from NYPH. Similarly, Outside Counsel will not renew a judgment against a patient without prior approval from NYPH.

   F. Outside Counsel will not use body attachment to require the patient or responsible party to appear in court.

   G. Outside Counsel will conduct judgment evaluations on a case-by-case basis. Electronic "blind" sweeps are not permitted.

   H. Outside Counsel will not transfer patient accounts to another collection agency or law firm without prior approval from NYPH.

6. **LEGAL SCREENING PROCEDURES**

   A. Outside Counsel will perform review to ensure that patient has no insurance, and is not eligible for:

      1. Medicaid, Family Health Plus, Child Health Plus or other governmental programs; or

      2. Financial aid under NYPH's Charity Care/Financial Aid Policy.

   B. Outside Counsel will evaluate income, assets, employment data, and any other information indicating ability to pay.

   C. Prior to issuing a summons in connection with the collection of an outstanding balance on any patient account, Outside Counsel will complete a Litigation Authorization form, and will forward the form to the Directors of Patient Financial Services, or the Vice President of PFS for approval. Outside Counsel will also provide a history of the account, and a recommendation supporting litigation.

7. **POST JUDGMENT PROCEDURES**

   A. Unless otherwise prohibited by any governing law or regulation, Outside Counsel will contact patient or responsible party by phone at home or place of employment advising him that judgment has been entered. If a telephonic communications is not possible, Outside Counsel should contact the patient or responsible party by mail to inform him of the judgment.

   B. When contact is made with the patient or responsible party after a judgment is rendered, Outside Counsel will:

1. Seek payment in full, or
2. Negotiate a written payment plan.

C. If patient is not eligible for government programs or for charity care/financial aid, and no reasonable explanation is made as to why payment cannot be made, Outside Counsel may:

1. Advise patient(s) that judgment will be enforced;
2. Obtain recent credit report;
3. Conduct property search; and/or
4. Confirm place of employment.

D. Outside Counsel may issue Information Subpoenas with or without Restraining Notice to:

1. Major banks;
2. Place of employment;
3. Credit card companies; and/or
4. Mortgage companies.

E. Outside Counsel may issue property execution against patient's bank accounts. If patient contacts Outside Counsel and provides proof of financial hardship as a result of the property execution, Outside Counsel should release the lien.

F. Consistent with New York State law, Outside Counsel may issue income executions on the patient for up to ten percent of the patient's wages. Outside Counsel is not authorized to issue an income execution on a patient's spouse unless a judgment has been obtained against that spouse.

HCA

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Jack O. Bovender, Jr., FACHE
Chairman and Chief Executive Officer

July 19, 2004

The Honorable John D. Dingell
Ranking Member
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Dingell:

We have responded to your request for further information following the House Subcommittee on Oversight and Investigation's June 24th hearing on issues surrounding the uninsured. Our representative, Mr. Jim Free, delivered the original to Michael Abraham and Voncille Hines, but I have attached a copy herein for your convenience.

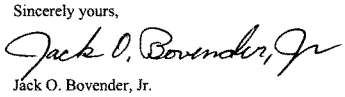
Thank you for your interest in this growing national problem. We believe every individual in this nation should have access to regular preventive and urgent healthcare and we are committed to do our part to help alleviate the enormous burden the cost of that care can create for many individuals. One way to help is to redirect the charges for care of the uninsured to a discounting system more in line with actual costs, and we are hard at work on developing such a system. But an equally important and more long-term solution to this problem is to find a way for every American to be covered by insurance.

As I said in my testimony, it is time for all sectors of the healthcare and business communities to do their part. That includes requiring employers to provide insurance for all employees. We elaborate on this in our answers to your number six question.

However, we should not ignore the responsibility of the individual. Just as every business should be required to offer insurance, either on its own or through a group purchasing coalition, so every employee should be required to accept that insurance and to pay a portion of its cost.

Again, thank you for the opportunity to share our thoughts on this important subject. I am at your disposal to answer any further questions.

Sincerely yours,



Jack O. Bovender, Jr.
Chairman and CEO

Attachment

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable James C. Greenwood, Chairman
Subcommittee on Oversight and Investigations

The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

Response from Mr. Jack O. Bovender, Jr.
Hospital Corporation of America (HCA)
to the Honorable John D. Dingell
regarding the June 24, 2004
Subcommittee on Oversight and Investigation Hearing
Entitled, "A Review of Hospital Billing and Collection Practices"

Question #1
Do any of your hospitals offer medical credit cards to its patients? What is the actual interest rate on HCA's credit cards?

Answer #1
HCA does not have a medical credit card that is offered to its patients. However, HCA does provide interest-free payment plans that can extend up to 5 years.

Question #2
You testified that HCA had implemented its charity and discounting policy in October 2003. This was prior to Secretary Thompson's February 19, 2004 letter to the American Hospital Association, which gave approval to various charity and discount programs. Please explain why HCA did not wait until receipt of that letter and attach any related documentation.

Answer #2
In late fall of 2002, HCA identified an issue of growing numbers of uninsured patients accessing our hospitals. As a result, we began an effort to study the issue and develop a plan. On March 10, 2003, HCA sent a proposed Charity plan to CMS for approval. We received a conditional approval from CMS on June 9, 2003, which instructed us to also submit the plan to our Fiscal Intermediaries for approval. We submitted our plans to the intermediaries and incrementally received their approval over the next several months. In October 2003, we implemented our Charity Care and Financial Discount Policy as described in our testimony. We built our plan in such a way that it met all of the requirements of the Medicare program so we could implement it immediately. When we received Secretary Thompson's letter dated February 19, 2004, it was further confirmation that the plan we had in place met both CMS and OIG criteria. The related documentation you have requested was provided to the O&I subcommittee in August of 2003 but we have attached it again for your convenience.

Question #3
Mr. Rukavina of The Access Project testified that HCA declined to meet with community leaders in Florida to discuss its new charity care and discounting earlier this year. Please explain why HCA did not meet with these community leaders and what outreach you have done since that time to inform the communities in which your hospitals are located of your new policies.

Answer #3
The invitation from The Access Project came to some of our South Florida hospitals, which were embroiled in both a lawsuit with Medical Savings Insurance Company, and a related media campaign waged by Consejo. As a result, these hospitals were somewhat gun-shy about appearing in public for a discussion on billing the uninsured with an advocacy group with which they were unfamiliar. Their reaction was overly defensive, but somewhat understandable in light of what our Florida folks had recently experienced at the hands of Consejo. We should have contacted The Access Project and had a greater discussion with them before dismissing the invitation to participate in the meeting. That was a mistake.

Once we heard a report of the meeting and The Access Project's goals from a colleague at AHA, we realized this organization had good intentions and immediately called Mark Rukavina.

Working with The Access Project, we are optimistic HCA can reach a coalition of local agencies whose mission is to help underserved populations in some of our markets. We have scheduled a conference call with Mr. Rukavina, our President of Financial Services, and heads of Government Relations and Corporate Communications, to develop an agenda for a meeting they will attend with The Access Project and the agencies it recommends. The goal of that meeting will be to establish an ongoing system of communications between local HCA leadership and corresponding agency representatives, to improve access and information about charity care, Medicaid, and other healthcare assistance to those in our communities who are in financial distress.

Question #4
You testified that you are evaluating a discounting plan now that offers all uninsured patients billing at the 95 percentile of your managed care plans. What is the status of this evaluation and when does HCA expect to make a decision on whether to implement this discount or not?

Answer #4
We are currently analyzing data to set the discounting based on PPO managed care rates. We expect to have this analysis complete this summer. Development of the policy, operational processes, educational materials and implementation plan is anticipated to occur in the fall with implementation by year's end.

Question #5
One of the concerns with hospital billing of the uninsured is that the hospitals offer unreasonable amounts of time (90 to 180 days) for patients to pay large and unexpected bills before those bills are turned over to a collection agency and the debtor receives a bad credit rating. What steps has HCA taken to establish reasonable, low interest or no interest, longer term payment plans for uninsured patients?

Answer #5
HCA does not charge interest on patient accounts. Moreover, we have recently changed our processes to allow our patient representatives to extend payment terms for up to 5 years. Prior to this change our patient representatives could establish payment plans for 2 to 3 years. In addition to the no-interest monthly payment plans, we offer assistance to the patient through prompt pay discounting, Medicaid eligibility assistance, and our charity and financial discounting programs.

Question #6
In your written testimony, you stated that all employers should be required to provide health insurance for their employees. How would this be implemented?

Answer #6
An employer-mandated health insurance requirement should apply to all employers over a specified size (e.g., 25 employees). This requirement also should apply to part-time employees (e.g., above 20 hours per week). Small and medium size employers should be allowed to aggregate into insurance purchasing consortia, as advocated by the National Federation of Independent Businesses (NFIB). Self-employed individuals and part-time employees (e.g., less than 20 hours per week) earning above some target level (e.g., $50,000 per year) should have access, and be required to participate, in an insurance product similar to that recommended by the NFIB or be subject to losing certain personal tax deductions.

What constitutes "acceptable" health insurance under such a mandate should be tightly defined. The amount of premium sharing that can be passed on to the employee should be defined and limited to a reasonable amount to ensure it is affordable for lower wage workers. Likewise, the level of permitted deductibles and co-pays should be defined and limited to prevent some employers from trying to gain a competitive advantage by passing on more of the cost of health benefits to their employees.

In addition to employer-mandated insurance, the nation needs a health insurance program to assist the unemployed. COBRA, as presently structured, is not adequate to provide coverage for many employees who have lost their jobs, particularly for the lower wage earners since the premium cost is beyond what they can afford. One possible alternative is a state or federal program funded by an add-on to existing unemployment insurance taxes.

Admittedly, this is a very high level summary of how employer-mandated insurance would look and all issues have not been explored. However, it is clear that a new, bold, and decisive plan to deal with the ever-increasing problem of the uninsured and under-insured is needed and needed now.

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March 10, 2003

VIA FEDERAL EXPRESS

Leslie V. Norwalk
Counselor to the Administrator
Centers for Medicare and Medicaid Services
Office of the Administrator
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Rm. 314G
Washington, DC 20201

Re: HCA Inc.'s Proposed Discount Program For Uninsured Patients

Dear Ms. Norwalk:

We are writing on behalf of HCA Inc. ("HCA") to request the Centers for Medicare and Medicaid Services' ("CMS") concurrence that, under relevant Medicare reimbursement guidance, discounts granted to certain uninsured patients pursuant to the program set forth below will not adversely affect Medicare's view of "customary charges" at HCA's facilities for Medicare payment purposes because such discounts will be considered indigency allowances by CMS.

HCA has been concerned for some time that sick or disabled patients who have no health insurance face catastrophic financial consequences as a result of their medical bills at a time when, in light of their medical state, they are least prepared to bear the financial cost of their care. HCA has developed a financial assistance program that it would like to implement immediately in all of its facilities to provide its most medically and financially needy patients with discounts from standard charges. We set forth below a summary of HCA's proposed program together with our analysis of Medicare's applicable guidance. Based on our review of

[Documentation referred to in Answer #2]

this guidance, we believe that Medicare does not intend that such discounts will adversely affect a facility's usual or customary charges for Medicare payment purposes and we seek CMS' concurrence with our analysis.

While this need for financial assistance has existed for a considerable time, and indeed some HCA facilities already provide charity care to patients with incomes at or below 200% of the federal poverty level ("FPL"), we hope you can promptly provide CMS' concurrence with HCA's approach so that, at least for this subset of the healthcare population, the financial stress that corresponds with patients who have no financial assistance and receive significant medical bills will be alleviated.

I. HCA's Proposed Financial Assistance Program for Uninsured Patients

In an effort expand charity allowances and low-income discounts to its uninsured patients, HCA would like to implement a financial assistance program for uninsured patients based on both their income level and the magnitude of the medical charges they have incurred. This expanded program would only be offered to patients with no health insurance or other state or federal health payor assistance.

Before offering any discount under this program, an HCA facility would verify that *no portion* of the patient's medical services would be paid by any federal or state governmental health care program (*e.g.*, Medicare, Medicaid, Champus, Medicare HMO, Medicare secondary payor), private insurance company, or other private, non-governmental third-party payor source making payment directly to the hospital. This process could begin at admission or registration, but verification of income levels and eligibility determinations may continue for several weeks after discharge. Only when *100%* of the patient's medical services obligation must be paid by the patient personally (or by the patient's family when services have been rendered to a minor) will this discount be offered at the time the first bill is sent to the patient.

As outlined above, there are two components to HCA's proposed financial assistance program for the uninsured, an income based discount and a charge based discount. Under the former, for patients with incomes at or below 200% of the FPL, HCA would treat such patients as charity care patients with no ability to pay.[1] HCA would record its customary charge for these

[1] Several federal programs recognize 200% of the FPL as the upper threshold for eligibility for federal health programs, including the Qualified Disabled and Working Individuals Program. This acknowledgment of eligibility by the federal government at 200% of the FPL formed the basis for HCA to set charity care eligibility at this level for this program. Many states also recognize 200% of the FPL as a benchmark for charity care. In response to those state

patients. However, these patients would be granted a 100% discount from such charges and HCA would not seek to collect such charges. For families with incomes above 200% and up to 400% of the FPL, HCA would offer a sliding-scale discount from its customary charge that reflects both the patient's income and the extent of hospital charges. These additional discounts based on total charges acknowledge that the size of a medical bill can be as important in determining a patient's ability to pay as the patient's income. The charts that describe the level of sliding scale discounts based on income and total charges are included herewith as Attachment A. HCA would only verify income under this program, and use such information to place a patient within a tier of the discount scale based on a comparison of his/her income to some multiple of the FPL for the appropriate family size.

All uninsured patients eligible to receive the expanded allowances under this program will receive bills based on the facility's customary charges. These bills will also reflect the discount to charges in accordance with the guidelines outlined above. Full non-discounted charges will be used for purposes of Medicare cost apportionment.

II. Applicable Medicare Reimbursement Principles

In general, CMS pays providers the lesser of their reasonable costs or customary charges ("LCC") for services furnished to Medicare beneficiaries. *See* 42 C.F.R. § 413.13. A number of services are not subject to the LCC principle, including Part A inpatient hospital services (subject either to the prospective payment system ("PPS") or the rate of increase limits set forth in 42 C.F.R. § 413.40), and Part B hospital outpatient services subject to Outpatient PPS.

The LCC provisions provide meaningful insight into the Medicare program's definition of "customary charges" and how discounts offered to non-Medicare patients may impact a facility's "customary charges" and by extension, Medicare reimbursement. As you know, a facility's charges are also important outside of the LCC context, including, for example, for cost apportionment, cost outlier purposes, and for the recalibration of DRG weights.[2]

Section 413.13 of the Medicare regulations defines customary charges as "the regular rates that providers charge both beneficiaries and other paying patients for the services furnished

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benchmarks, some HCA hospitals already provide charity care to patients whose incomes are at or below 200% of the FPL. HCA now wants to extend this program to all of its hospitals.

[2] HCA does not concede that the concept of customary charges applies outside of the LCC concept to the use of charges in other settings under Medicare. Rather, if the customary charge concept applies in such other settings, the analysis below demonstrates that it is not an impediment to providing needs based assistance to uninsured patients.

to them." Subsection 413.13(e) contemplates reducing a provider's customary charges in certain limited contexts. Specifically, a provider's customary charges would be reduced if the provider either 1) did not actually impose charges on *most of the patients liable for payment on a charge basis*, or 2) failed to make a reasonable effort to collect those charges.[3]

Under 42 C.F.R. § 405.503, the Medicare program recognizes that "token charges for charity patients and substandard charges for welfare and other low income patients" are not considered in determining customary charges. While this section seems to refer to services of physicians and suppliers, the statutory authority cited for this regulation includes the statute outlining the LCC reimbursement principle, 42 U.S.C. § 1395(f)(b). *See* 42 C.F.R. § 405.500. Such token or substandard charges are routinely referred to as "indigency allowances."

Part I of the Provider Reimbursement Manual ("PRM-I") expands on the regulatory definition of "customary charges." It provides that customary charges are those uniform charges listed in a provider's established charge schedule and which are applied consistently to most patients. In order to be considered customary charges, the charges "must actually be imposed uniformly on most patients *and* actually be collected from a substantial percentage of 'patients liable for payment on a charge basis.'" PRM-I § 2604.3 (emphasis added). This provision further provides that patients liable for payment on a charge basis are those individuals *not* otherwise eligible for coverage under Medicare, Medicaid, the Maternal and Child Health Block Grant Program or local welfare programs, or under a private insurance plan, contract or agreement that either is liable for the payment rather than the patient, or alternatively, makes payment directly to the provider on a basis other than charges. *See* PRM-I § 2604.3.B.1. When bad debts constitute the provider's reason for not collecting the charges on its chargemaster, the provider must make reasonable collection efforts (as set forth in PRM-I §§ 310 and 312) for these charges to be considered "customary charges." Please note that indigency allowances are a permissible basis for not collecting charges, and that the full charges for such services are still included in the customary charge calculation.

PRM-I § 2606.2 specifically contemplates how to determine customary charges for providers that utilize a sliding-scale charge structure. It states that when a provider offers care at a reduced charge to patients who are determined to be financially indigent and when the charge is assessed based on the patient's ability to pay, the difference between the provider's full published charges and the charge actually assessed the patient is considered an "indigency

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[3] When a reduction in customary charges is otherwise warranted, the customary charges are reduced in proportion to the ratio of the aggregate amount actually collected from charge-paying, non-Medicare patients to the amount that would have been collected if customary charges had been paid under certain enumerated circumstances. *See* 42 C.F.R. § 413.13(e).

allowance" and not a reduction in customary charges so long as the following conditions are met: a) the provider has a published schedule of its full, non-discounted charges, b) the provider's revenues for patient care are based on application of the published charge schedule, c) the provider maintains written policies for its process of making patient indigency determinations, and d) the provider maintains adequate documentation to support the amount of "indigency allowances" written off.

These provisions interpreting customary charges in the LCC context must be read in accordance with the other Medicare guidance governing charity allowances. PRM-I § 328 outlines that when a provider offers charity allowances, the charges related to the services should be recorded at the full charge amount with the allowance shown as a reduction to revenue. It further provides that the full charges "must be used . . . to apportion costs and in determining customary charges for application of the lower of costs or charges provisions."

III. The Proposed HCA Financial Assistance Program for the Uninsured Should Not Have an Impact on the Customary Charges of HCA Hospitals

First and foremost, under its proposed financial assistance program, HCA hospitals would continue to charge their eligible uninsured patients usual and customary rates from their chargemaster. The discount offered to these patients would not alter, in any way, a hospital's chargemaster nor will any HCA facility be establishing a separate chargemaster for needs based uninsured patients. In fact, all bills sent to uninsured patients will show the hospital's full charges reduced by the applicable discount. As a result, a program giving an uninsured patient a discount on charges would operate in much the same way as an agreement to give a contracting payor a discount on charges. In each instance, the patient and/or payor receives a bill based on full charges, with the charges ultimately subject to some pre-determined discount. Just as a discount to charges offered to a contracting payor does not impact a facility's customary charges, neither would a pre-determined discount offered to patients without medical assistance impact a facility's customary charges.

HCA's proposed financial assistance program does not require an alternative reading of the customary charge guidelines in order to be approved by CMS. The LCC regulation contemplates reducing a provider's customary charges under limited circumstances if the provider either did not impose charges on most of the patients liable for payment on a charge basis or failed to make a reasonable effort to collect these charges. *See* 42 C.F.R. § 413.13(e). PRM-I § 2604.3, in interpreting and expanding upon the LCC regulation, notes that in order to be considered customary, the charges must be imposed uniformly on most patients and actually be collected from a substantial percentage of "patients liable for payment on a charge basis." Together, this regulation and manual provision seem to stand for the proposition that in order to

be considered customary, charges must be imposed on and efforts must be made to collect those charges from a significant percentage of the patients liable for payment on a charge basis.

Furthermore, pursuant to PRM-I § 2604.3.B.3, indigency allowances are a permissible basis for including charges that are not collected from patients liable for payment on a charge basis in "customary charges" under 42 C.F.R. § 413.13(e). The Medicare program explicitly recognizes that minimal or token charges for charity patients (or in the case of the HCA program, patients with incomes at or below 200% of the FPL) or substandard charges for welfare and other low incomes patients (or in the case of the HCA proposed program, patients with income levels above 200% of the FPL and at or below 400% of the FPL) do not impact on customary charge determinations. *See* 42 C.F.R. § 405.503. Furthermore, when indigency allowances are used, the full charge, and not the discounted charge must be used both to apportion costs and to determine customary charges. *See* PRM-I § 328. Importantly, these provisions are silent as to the nature of collection efforts or actual collections that must be achieved before these discounts can be offered. Together, these provisions show that discounts from charges for charity or low-income patients should not impact a facility's customary charges, regardless of the collection efforts utilized or the collection successes achieved.

This conclusion is further supported by PRM-I § 2606.2.D. As outlined above, that section applies to sliding scale charge structures of the type described for HCA's program here and states that the difference between a provider's full charge and reduced charges offered to financially indigent patients based on their ability to pay is an "indigency allowance" and *not* a reduction in customary charges when: a) the provider has a published schedule of its full, non-discounted charges, b) the provider's revenues for patient care are based on its full, non-discounted charges, c) the provider maintains written policies for its process of making patient indigency determinations, and d) the provider maintains adequate documentation to support the amount of "indigency allowances" actually written off.

As referenced above, HCA hospitals have published chargemasters that reflect full, non-discounted charges; these are unaffected by the proposed discount to uninsured patients. Further, HCA determines revenue based on these customary, non-discounted charges. The uninsured discount program will serve as part of the written policy for making patient indigency determinations and the facilities will maintain whatever documentation is necessary to support the actual "indigency allowances" written off. It follows that under PRM-I § 2606.2.D, by implementing this proposed uninsured discount program, HCA facilities will be increasing their indigency allowances but should not be viewed as reducing their customary charges.

* * * *

hooper, lundy & bookman, inc.
HEALTH CARE LAWYERS

As the above discussion shows, we believe that HCA's proposed program of discounting charges to certain needy uninsured patients is consistent with Medicare guidelines for charity and low-income (indigency) allowances and does not impact the HCA facilities' customary charges. HCA is specifically requesting that CMS conclude that discounts based on the income levels and charge levels set forth in Attachment A will be considered indigency allowances that do not have an impact on the calculation of customary charges used for Medicare payment purposes. In light of the importance of this issue and HCA's desire to begin assisting its eligible uninsured patients as soon as possible by implementing this program, your prompt attention to this request would be greatly appreciated. Please contact me should you or anyone at the agency need any additional information to respond to HCA's request.

Sincerely,

John R. Hellow

JRH/sdh

cc: Beverly Wallace, President
Financial Services Group, HCA Inc.

Patricia Lindler, Senior Vice President
Government Programs, HCA Inc.

ATTACHMENT A

HCA
PROPOSED SELF PAY/CHARITY DISCOUNT MATRIX
0-200% OF FPL/CHARITY AND
201-400% OF FPL/UNINSURED DISCOUNT

	Account Balance						
Income Level	**< $1,000**	**$1,001 - $2,500**	**$2,501 - $5,000**	**$5,001 - $10,000**	**$10,001 - $25,000**	**$25,001 - $50,000**	**>$50,000**
0 - 200% of FPL - Charity	100%	100%	100%	100%	100%	100%	100%
200 - 300% of FPL	15%	25%	30%	35%	40%	45%	65%
300 - 400% of FPL	15%	20%	25%	30%	35%	40%	55%

	Family Size							
Federal Poverty Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	$8,860	$11,940	$15,020	$18,100	$21,180	$24,260	$27,340	$30,420
200%	$17,720	$23,880	$30,040	$36,200	$42,360	$48,520	$54,680	$60,840
300%	$26,580	$35,820	$45,060	$54,300	$63,540	$72,780	$82,020	$91,260
400%	$35,440	$47,760	$60,080	$72,400	$84,720	$97,040	$109,360	$121,680

Trevor Fetter
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July 20, 2004

The Honorable John D. Dingell
Ranking Member
United States House of Representatives
Committee on Energy and Commerce
Washington, DC 20515-6115

Dear Mr. Dingell,

Thank you for your letter of July 6, 2004. Enclosed, in question & answer form, are responses to the questions forwarded in that letter. I appreciate working with the committee regarding these important issues.

If you have any additional questions, please contact me at 805-563-7100.

Sincerely,

Trevor Fetter
President and Chief Executive Officer
Tenet Healthcare Corporation

Enclosure

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable James C. Greenwood, Chairman
Subcommittee on Oversight and Investigations

The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

Responses from Mr. Trevor Fetter, President and CEO of Tenet Healthcare Corporation to Questions Dated July 6, 2004 from The Honorable John D. Dingell Regarding the June 24, 2004, Subcommittee on Oversight and Investigations Hearing Entitled "A Review of Hospital Billing and Collection Practices"

1. **Q: Do any of your hospitals offer medical credit cards to its patients? What is the interest rate on Tenet's credit cards?**

   A: Tenet does not offer a medical credit card.

2. **Q: Tenet announced its *Compact with the Uninsured* in January 2003. Included in the policy was a provision granting discounts to all of Tenet's uninsured patients. In February 2004, the Department of Health and Human Services issue a letter from Secretary Tommy Thompson stating that a discount policy for the uninsured and the indigent and the indigent did not violate federal regulations or guidelines. However, it appears that Tenet has not implemented its discount policy "because we wanted to be sure our program complied with all federal and state laws." In how many hospitals and in which states has Tenet fully implemented the discount policies announced in its *Compact with the Uninsured*? When were these discount policies first implemented?**

   A: Tenet's initial rollout of the *Compact with Uninsured* in January, 2003 did not implement the proposed discount program for the uninsured, pending clarification from HHS. At the time the Compact was announced, Tenet sought advisory opinions from the Centers for Medicare and Medicaid Services and from the HHS Office of the Inspector General. Tenet added a proposal to offer discounts to the uninsured based upon managed care-styled pricing, where state law permits, after Secretary Thompson's written clarification on discount programs was issued earlier this year. Tenet's uninsured discount program began in June in several Tenet hospitals and will continue to be implemented through November. Below is the enacted and expected implementation schedule:

   - Alabama in June (1 hospital)
   - New Orleans in June (1 hospital) - Sept (6 hospitals)
   - Florida in July (13 hospitals) - Sept (1 hospital)
   - South Carolina in July (2 hospitals) - Sept (1 hospital)
   - North Carolina in July (3 hospitals)
   - Georgia in July (5 hospitals)
   - Mississippi in Sept (1 hospital)
   - Philadelphia in Sept (5 hospitals)
   - St Louis in Sept (4 hospitals)

- Tennessee in Sept (2 hospitals)
- Nebraska in Sept (1 hospital)
- California by Nov (17 hospitals)

The discount policy will not be implemented in the hospitals Tenet has announced it will be divesting. As previously announced Tenet hopes to conclude its divestitures by the end of this year.

3. **Q: At the June 24, 2004, hearing, you stated that there were regulatory issues in Texas and California that prevented Tenet from implementing discount policies. Please describe these regulatory issues, the status of their resolution, and provide all documentation between Tenet and the states of Texas and California concerning these issues.**

A: 1) Texas. Texas law prohibits charging two different prices for the same service if the higher price charged is based on the fact that an insurer will pay all or part of the price of the service. (Tex. Ins. Code Sec. 522.003). Violation of this law is a Class B misdemeanor and is a "fraudulent insurance act." Tenet inquired with the Texas Department of Insurance regarding whether implementation of managed care style pricing for the uninsured would breach this provision. The Department advised that discounting based solely on the fact that a person is uninsured would not meet the requirements of the statute. The Department did note that an exception to the statute permitted sliding scale discounts based on indigency criteria. Tenet is developing a policy in Texas that will meet the terms of this statute, which may be discounts based on indigency rather than upon uninsured status.

A: 2) California. California law (AB1455) and the California Department of Managed Care recently addressed standards for determining when a licensed plan may be engaging in an unfair claims settlement practice with providers. In the law, the Department sets forth criteria licensed plans must consider when paying for services of a non-contracted provider. The California Healthcare Association has challenged the statute and the ability of the Department of Managed Care to enforce it. That litigation is pending. Until this lawsuit is settled, it is unclear as to how California courts would evaluate the interplay between this statute and Tenet's discount program. Health care providers believe that any discount extended to the uninsured should not substitute for the non-contracted rates under AB1455, but it is not clear whether the Department of Managed Care or the courts will endorse this position. Tenet currently intends to implement a discount program in California based on its interpretation of the applicable state laws and regulations. However, the ultimate resolution of the litigation may affect discount pricing to the uninsured in California by Tenet hospitals and other hospitals in California.

4. **Q: How many hospitals does Tenet own in Texas and California? What percentage of your total number of hospitals is in these two states?**

A: Tenet, as of July 19, currently owns 97 hospitals. In January of 2004, Tenet announced a program to divest several hospitals. This divestiture program is expected to be complete by year end. After the divestitures are complete, Tenet will own 69 acute care hospitals. Seventeen (24%) of the 69 acute care hospitals are in California and 12 (17%) of the 69 acute care hospitals are in Texas.

5. **Q: Describe the implementation plan for the *Compact with the Uninsured*, and what kind of follow-up Tenet is doing to make sure the *Compact* is actually being implemented.**

A: 1) The *Compact with the Uninsured* has 5 primary elements:

- Patients will be treated fairly and with respect, regardless of their ability to pay.
- Hospitals will provide financial counseling to the uninsured.
- Patients will be offered discounted pricing for services provided.
- Patients will be offered reasonable payments and payment schedules.
- Tenet will not pursue legal action for non-payment if the patient is not gainfully employed, eligible for an assistance program, or if the only recovery available is a lien against the patient's home.

A: 2) All elements of the *Compact*, other than discounts for the uninsured, were implemented in 2003. The implementation and follow-up monitoring of the 5 elements is described below:

- **Respect**: Tenet trains self-pay collections staff on the *Compact* and our customer service expectations. As part of our follow-up we actively monitor patient complaints and pursue appropriate disciplinary action.
- **Financial Counseling**: Tenet retrained its admitting and financial counseling staff on appropriate financial counseling under the Compact. Tenet continues to monitor efforts to assist uninsured patients in qualifying for governmental assistance and has seen a significant increase in patients qualified in the past 2 years.
- **Discounted Pricing**: Tenet has moved rapidly this year to implement discounts to the uninsured, including:
  - Development of each hospital's pricing schedule and automated tools for admission/registration staff for calculating discounts.
  - Training the admission/registration staff members and financial counselors on the discounting program.
  - Tenet also monitors claims that are listed as uninsured to ensure that the appropriate discount is applied.
- **Reasonable payments**: Tenet works with uninsured patients to develop payment plans, or where collection is unlikely, to settle accounts as paid in

full for less than the discounted balance owed. Tenet is on track to settle more uninsured accounts in 2004 than in any prior year.

- **Legal Action**: Tenet considers legal action a last resort in the collection process and monitors and evaluates each claim before pursuing legal action. Since the *Compact* was implemented, collection lawsuits against uninsured patients have declined substantially.

6. **Q: Do you expect to collect more or less from the uninsured under these new policies?**

   A: Our hope is that by reducing patient payment amounts and making them more manageable, collections from some patients may increase slightly. However, it is too early to determine the impact that the uninsured discount program will have on overall collections. As we testified in our written submission to the Committee, we believe that the Committee's concerns over billings to uninsured patients will only be adequately and appropriately addressed by increasing the number of insured patients. Providing access to quality, affordable health insurance for all Americans needs to be a priority for this Committee and the Congress.

7. **Q: How quickly do you place an overdue amount with a collection agency?**

   A: Tenet places almost all unpaid accounts with internal collection 120 days after patient discharge, if there has been no positive payment activity on the account.

8. **Q: One of the concerns with hospital billing of the uninsured is that the hospitals offer unreasonable amounts of time (90-180 days) for patients to pay large and unexpected bills before those bills are turned over to a collection agency and the debtor receives a bad credit rating. What steps has Tenet taken to establish reasonable, low-interest or no-interest, longer-term payment plans for uninsured patients?**

   A: We work with our patients to establish payment terms. Tenet's internal guidelines for "time payments" allow for payment plans up to 36 months for larger balances. If these payment terms are established early, and paid timely, they can be interest free. The larger the balance, the longer the payment schedule.

9. **Q: As part of Tenet's settlement with K.B. Forbes, Tenet agreed to use its Washington office to help Mr. Forbes to get public appearances, and to make contributions "from time to time" to pay for Mr. Forbes' "time and expenses." Has your Washington office helped Mr. Forbes get public appearances, and has Tenet or anyone affiliated with Tenet paid Mr. Forbes for his time and expenses or contributed to his organization, Consejo de Latinos Unidos?**

A: Tenet has not entered into any "settlement" with K.B. Forbes. In the Cooperation Agreement and General Release entered into between Tenet and Consejo de Latinos Unidos, however, Consejo is permitted to make efforts to "arrange for K.B. Forbes to speak before various legislative committees, investor groups, etc." The Consejo Agreement states that Tenet will use its "representatives in Washington"[1] to help arrange for K.B. Forbes to speak before these groups, and that "Tenet may, at its discretion, make contributions to Consejo to help Consejo to pay for K.B. Forbes' time and expenses..."

Since the settlement agreement, Tenet has not arranged for K.B. Forbes to engage in any such speaking activities, nor has Tenet made any contributions to Consejo for K.B. Forbes' services.

10. **Q: As part of that settlement, any low-income, uninsured person who contacted Mr. Forbes' organization would get a 70 percent discount from charges at Tenet hospitals. How many uninsured patients have been referred by Consejo?**

A: Not all patients who contact Consejo are referred to Tenet for services. To date Consejo de Latinos Unidos has referred 30 uninsured patients with a total of 52 service visits. Services have ranged from general surgical procedures to chemotherapy and pediatric neurosurgery. The majority of the patient referrals have been from Florida or Southern California.

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1 Tenet does not have a "Washington office," as suggested in this inquiry.

Douglas S. Clarkson
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September 10, 2004

Via Facsimile 202-226-2447
Michael Abraham
Committee on Energy and Commerce
Majority Staff
United States House of Representatives

Via Facsimile 202-225-5288
Voncille Hines
Committee on Energy and Commerce
Minority Staff
United States House of Representatives

Dear Mr. Abraham and Ms. Hines:

This letter responds to Representative Dingell's letter to Mr. Trevor Fetter dated August 30, 2004. In that letter Representative Dingell requested documentation of Tenet's interactions with authorities in the states of Texas and California concerning Tenet's discount policies. No documentation was provided in the original submission because there was no formal correspondence between Tenet and the states of California and Texas. In Texas, Tenet raised its concerns through informal discussions and in a series of personal meetings at the Texas Insurance Commission. In California, clarification of state law and its impact on uninsured discounts was primarily received through a court ruling in a dispute between the California Healthcare Association and the California Department of Managed Healthcare.

Tenet supplements its answers as to each state below.

1. Texas. Representatives of Tenet met with representatives of the Texas Insurance Commission on March 11, 2004 and March 25, 2004. A telephone conference was also held on March 29, 2004. In these meetings Tenet sought to reconcile historical enforcement positions of the Commission as to uninsured discounts with public statements made by the Commissioner of Insurance earlier in the year. There was no further correspondence between Tenet and the Commission clarifying or reconciling the historical positions asserted by the Commission with the public statements made by the Commissioner of Insurance.

On August 20, 2004, the Texas Commissioner of Insurance sent a letter to the Texas Hospital Association regarding his interpretation of the Texas Insurance Code Article 21.79F and its application to uninsured discounts. A copy of this letter is attached. Tenet planned to implement an indigency-based uninsured discount program in Texas prior to receiving this letter. Tenet, along with many other Texas healthcare providers and their professional associations, is currently evaluating this letter and the extent to which it permits indigency-based discount programs to be expanded in Texas.

2. California. At the time of Tenet's original submission, Tenet was evaluating the effect that a new California statute (AB 1455) would have on implementation of an uninsured discount program in California, particularly in light of the fact that the California Healthcare Association had challenged several aspects of the statute and its enforcement in the lawsuit, California Healthcare Association v. Department of Managed Healthcare, Superior Court of California County of Sacramento, Case Number 03CS01643, Department 16. Since that time, a final order and judgment has been entered in that lawsuit. A copy of the order and judgment is attached. With that clarification, Tenet is moving forward to implement a discount program in California.

We appreciate the Committee's participation in the discussion of this important issue and the inclusion of Tenet in that discussion. Thank you.

Sincerely,

Douglas S. Clarkson

DSC/vrd
Enclosures

Texas Department of Insurance
Commissioner of Insurance, Mail Code 113-1C
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-463-6464 telephone • 512-475-2005 fax • www.tdi.state.tx.us

Jose Montemayor

August 20, 2004

Richard Bettis, CAE
President/CEO
Texas Hospital Association
P. O. Box 15587
Austin, Texas 78761-5587

Dear Mr. Bettis:

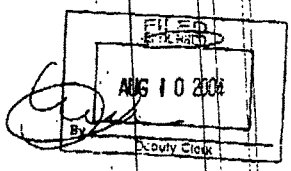
The Texas Department of Insurance has recently received a number of inquiries related to some hospitals' plans to provide a discount program for uninsured patients. I applaud the efforts of these hospitals to make health care more affordable for uninsured Texans. One particular issue that has been brought to my attention when considering discounts for the uninsured is Article 21.79F of the Texas Insurance Code. This statute prohibits intentionally or knowingly charging two different prices for the same product or service when the higher price is based on the fact that an insurer will be paying for all or a part of the product or service. Hospitals are concerned that their efforts to address the needs of uninsured patients may run afoul of this statute and some are, as a result, delaying implementation of their discounts in Texas.

I want to make it clear that the purpose and intent of Article 21.79F is not to prohibit the types of discount programs being considered by some hospitals. Article 21.79F is intended to address providers of goods and services that seek to take advantage of the fact that an insurer is obligated to pay on behalf of a consumer. A hospital's documented plan to provide discounts to the uninsured addresses persons that commonly can not afford to bear the costs of their health care needs. This does not implicate Article 21.79F. I am hopeful that this letter clears up any confusion on this issue and that hospitals continue to move forward with their plans for discounts to the uninsured in Texas.

If you have any particular questions concerning uninsured discounts, please contact Kimberly Stokes, Senior Associate Commissioner of the Life, Health & Licensing Program at (512) 305-7342.

Sincerely,

Jose Montemayor
Commissioner of Insurance



SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

CALIFORNIA HEALTHCARE ASSOCIATION, a California Non-Profit Corporation, Petitioner	
vs.	Department Number: 16
DEPARTMENT OF MANAGED HEALTH CARE, STATE OF CALIFORNIA, Respondent.	Case Number: 03CS01643 **ORDER and JUDGMENT DENYING WRIT OF MANDATE**

ORDER

Petitioner California Healthcare Association (hereinafter "Petitioner") brought a Petition for Writ of Mandate pursuant to CCP section 1085, and requested the Court find invalid certain language contained in Respondent California Department of Managed Healthcare's (hereinafter "Respondent") 2004 regulations, 28 CCR 1300.71 and 28 CCR 1300.71.38 (also referred to as the "AB 1455 regulations"). The Court granted the intervention of California Association of Health Plans (hereinafter "Intervenor"). Intervenor is a non-profit trade association reportedly

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representing twenty-nine (29) member health care services plans who reportedly are affected by, and have a beneficial interest in, the challenged regulations. Having applied its independent judgment and considered the consistency of the regulations to the controlling law, and having considered the reasonable necessity of the regulations, giving due deference to Respondent's expertise in the area, the Court now enters the following ORDER and DENIES the Petition.

The regulations here in question took effect in January, 2004. Petitioner represents medical service providers, as defined in Health & Safety Code section 1345(b) and presents a facial challenge to three provisions of the new regulations, specifically:

> **28 CCR 1300.71(a)(3)(B)** ["Claims Settlement Practices"] defines "Reimbursement of a Claim" as For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:(1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other

aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case.

28 CCR 1300.71(b) [Claim Filing Deadline] (1) Neither the plan nor the plan's capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan or a plan's capitated provider is not the primary payer under coordination of benefits, the plan or the plan's capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.. . . . (4) A plan or a plan's capitated provider that denies a claim because it was filed beyond the claim filing deadline, shall, upon provider's submission of a provider dispute pursuant to section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to Health and Safety Code section 1371 or 1371.35, which ever is applicable, and these regulations.

28 CCR 1300.71.38(d)(1) [Fast, Fair and Cost-Effective Dispute Resolution Mechanism]

/wtw

All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section.. . . . (d) Time Period for Submission. (1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated

provider, neither the plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired.

Evidentiary Issues

The Court sustains the hearsay objections of Intervenor California Association of Health Plan (hereinafter "Intervenor") to paragraph 3 the Declaration of Sherreta Lane in support of the Petition. The Court grants the requests of Respondent and Intervenor for judicial notice of Legislative Counsel's Digest for Assembly Bill No. 1455, Chapter 827, and Rules and Regulations, Department of Health and Human Services, Center for Medicare & Medicaid Services, 42 CFR Parts 412 and 413, Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, Friday, August 1, 2003, published at 68 F.R. 45346, and Table 8A entitled Statewide Average Operating Cost-to-Charge Ratios - July 2002.

Ripeness

Both Respondent and Intervenor have raised the issue of ripeness. The Court has reviewed the facts of the instant case, in light of two cases - Pacific Legal

Foundation v. California Coastal Commission (1982) 33 Cal.3d 158, and Communities for a Better Environment v. California Resources Agency (2002) 103 Cal.App.4th 98.

The issue of ripeness in the context of judicial review of administrative regulations prior to their actual application to the party challenging them is set forth by the California Supreme Court in the case of Pacific Legal Foundation v. California Coastal Commission (supra). In that case, the Court held that whether a case for mandamus relief was ripe for adjudication was whether the issues were sufficiently concrete. Petitioner had challenged guidelines issued by the Coastal Commission, which stated the general policy intended to govern future permit decisions involving the imposition of public access conditions. The guidelines were not mandatory, and did not require the Commission to impose access conditions in any particular circumstances, but allowed the Commission to decide on a case-by-case basis the appropriateness of access exactions.. Under this and similar circumstances, the Supreme Court held courts must consider both whether the issues are sufficiently definite and concrete to allow judicial resolution, and the hardship to the parties of withholding court consideration. (Id. at 172-174.) The Court thus found that the matter was not ripe, that without a precise factual context before it, the Court could not determine whether the Commission had abused its authority by imposing impermissible access conditions upon a particular homeowner, and that the harm to homeowners arose only if and when they

sought to make improvements to their land in the future, at which time they could pursue judicial review of the Commission's actions.

In contrast, the Third District Court of Appeal in Communities for a Better Environment v. California Resources Agency (supra) found that a facial challenge to CEQA guidelines presented a concrete legal dispute ripe for consideration. The guidelines required public agencies to implement them, thus a concrete legal dispute as to whether the guidelines were valid existed (103 Cal.App.4th at 106.)

The present facts are distinguishable from those that the California Supreme Court found not ripe for adjudication in Pacific Legal Foundation, in which the Court would have been required to speculate as to the type of actions that the regulatory agency might impose upon landowners in the future. The facts of the present case are more similar to those of Communities for a Better Environment. The challenged regulations have been in effect since January of this year, and health plans are required to implement them. Health plans are directed to calculate and pay providers the reasonable and customary value of services provided, and to take specific action upon specific facts with regard to deadlines for reimbursement and dispute resolution. (See discussion below.) The Court finds that this controversy is ripe for adjudication.

Standard of Review

Government Code section 11342.2 provides the general standard of review for determining the validity of administrative regulations. This standard has been applied by the courts as a two prong inquiry: first, "the judiciary independently reviews the administrative regulation for consistency with controlling law. The question is whether the regulation alters or amends the governing statute or case law, or enlarges or impairs its scope. In short, the question is whether the regulation is within the scope of the authority conferred; if it is not, it is void. This is a question particularly suited for the judiciary as the final arbiter of the law, and does not invade the technical expertise of the agency." (Communities for a Better Environment v. California Resources Agency (2002) 103 Cal. App. 4th 98, footnotes and citations omitted.) "By contrast, the second prong of this standard, reasonable necessity, generally does implicate the agency's expertise; therefore, it receives a much more deferential standard of review. The question is whether the agency's action was arbitrary, capricious, or without reasonable or rational basis." (Id.)

The Court has reviewed the regulations at issue and the controlling statutes. The purpose of the AB 1455 regulations and the authority of Respondent are set forth in the preamble to AB 1455:

SECTION 1. The Legislature finds and declares the following:

(a) Health care services must be available to citizens without unnecessary administrative procedures, interruptions, or delays.

(b) The billing by providers and the handling of claims by health care service plans are essential components of the health care delivery process and can be made more effective and efficient.

(c) The present system of claims submission by providers and the processing and payment of those claims by health care service plans are complex and are in need of reform in order to facilitate the prompt and efficient submission, processing, and payment of claims. Providers and health care service plans both recognize the problems in the current system and that there is an urgent need to resolve these matters.

(d) To ensure that health care service plans and providers do not engage in patterns of unacceptable practices, the Department of Managed Health Care should be authorized to assist in the development of a new and more efficient system of claims submission, processing, and payment.

(See, Historical and Statutory Notes to Health & Safety Code section 1367.)

The Challenged Provisions

Particularly important to the stated legislative purposes, the AB 1455 Regulations address disputed payment situations, and reform the payment reimbursement process.

28 CCR 1300.71(a)(3)(B)

Petitioner challenges this regulation by labeling it "impermissible rate-setting" beyond the authority of Respondent, inconsistent with the governing statutes, and as being inconsistent with contract law. All parties recognize in their arguments the impact of this definition upon other provisions in the regulations, and particularly when it is necessary for Respondent to determine whether a plan has made timely reimbursement to a non-contracted provider or a provider without a written contract (28 CCR section 1300.71(g)), and when it is necessary for Respondent to determine whether a plan is engaged in an unfair payment pattern. (26 CCR section 1300.71(a)(8).) In applying the two prong test, the Court notes that this regulation only affects those situations in which a health plan disputes the claim for emergency services submitted by a provider without a written contract. Because each non-contract health care service claim is unique upon the facts, the consideration by a plan of the provider's expertise, training, services rendered, location, and other unusual factors as required is appropriate and furthers the legislative purposes.

Respondent has broad authority under the Knox-Keane Act and the AB 1455 regulations. Respondent also articulates a reasonable basis on which to determine whether health plans are abiding by their regulatory payment duties. By setting criteria enabling objective review of claims submitted where there is no written contract, the Department is making the claims billing, processing and payment process more efficient, and has established an initial payment for purposes of applying the claims processing timelines and in determining unfair payment patterns. Without a written contract, and to the extent there are disputes as to amounts billed and or paid, the regulations provide a starting point to determine at least a preliminary payment amount in a reasonable time frame.

The Department is not "dictating a rate" to be paid for any particular service. Petitioner has failed to show how Respondents regulation for claims reimbursement is beyond the scope of its authority or is not reasonably necessary to effect the Departments responsibilities under the law. Thus, the regulation appears consistent with the controlling law and is not arbitrary, capricious or without reasonable or rational basis.

Petitioner's arguments regarding interference with oral contracts is not persuasive nor a necessarily full and complete analysis of the law regarding the enforcement of oral agreements.

<u>28 CCR section 1300.71(b)(1) and (4) and section 1300.71.38(d)</u>

Petitioner challenges the validity of section 1300.71(b)(1) and (4) regarding claims filing deadlines. As argued by Respondent, the payment deadlines are designed to expedite payment to providers and to discourage unfair payment patterns, explicitly within the legislative mandate. Providers wishing to avail themselves of the prompt payment timelines must submit their own claim in a timely manner. Late claims for payment under 1300.71(b) would only be accepted upon a showing of good cause. Petitioner argues that the good cause requirement is a new, higher, and unfair standard that will result in forfeiture of legitimate claims.

Petitioner challenges section 1300.71.38(d) regarding dispute resolution submission and specifically subsection (d), setting a deadline for completion of the process of not shorter than 365 days. Petitioner argues that this regulation could be read as imposing a new, shorter statute of limitations inconsistent with the provisions of the Code of Civil Procedure.

Petitioner misreads these sections. Respondent asserts that these provisions only involve the conduct of the plan and the providers with respect to the Department, and have no effect upon Petitioner's right to seek arbitration or court action over payment claims. Petitioner essentially concedes this in its reply, arguing only that if Respondent is correct, then the regulations should plainly state that they are so limited, to avoid arbitrators or courts from reading the deadlines as absolute. To

the extent that Petitioner's argument is one that the regulations could be misunderstood as setting a binding legal standard for litigation purposes, the issue is not now ripe for adjudication. Moreover, the Court does not interpret the regulations as Petitioner does, and makes a finding discussed in the following paragraph that Petitioner's understanding is in fact not the case. Thus, once again, the challenged regulations do not enlarge or impair or alter or amend the scope of statute or case law and is not arbitrary, capricious or without reasonable or rational basis.

Importantly, all parties agree that the AB 1455 Regulations do not preclude providers from seeking redress outside of the administrative arena, and that the regulatory requirements are not binding upon an arbitrator or a court. Since no party has provided the Court with authority suggesting that the administrative remedies - claim contests and disputes - are mandatory or exclusive, or that the definitions are binding beyond the regulatory processes, there is no legal authority before the Court to suggest that the regulations have an exhaustion requirement that could bar access to the courts. Because Respondent has represented to the Court that such is the case, the Court finds that there is no requirement that a provider must exhaust the provided regulatory processes, using the regulatory definitions, prior to resorting to the courts or arbitration. (See, Opposition brief at p. 5:12-17, dispute resolution process is regulatory mandate that is offered to providers on a voluntary basis, and does not limit or alter individual rights to seek redress of contract disputes through courts or

arbitration; p. 12:18-22, regulations do not dictate the final determination of the amount to be paid to a provider, but set forth methodology that must be used by plans to ensure that reimbursement determinations are not unjust; either party may seek a final determination of the appropriate reimbursement for the specific services provided in court of law or arbitration; see also p. 17:2-4 and 17:26 - 18:1; p. 18:9 - 24 and p. 20:10-15.) As noted, Petitioner states in reply only that if the regulations are not binding on arbitrators or the courts, they should clearly state so. (See Reply at fn.2, pp.3-4 re reasonable value issue; p. 8:12 - 9:3 re good cause requirement, and p. 9:5-16 re 365 day claims dispute deadline.)

Costs are awarded to Respondent and Intervenor pursuant to a properly completed and file memorandum of costs.

Therefore, IT IS ORDERED AND ADJUDGED that the Petition for Writ of Mandate is DENIED. Costs are awarded to Respondent and Intervenor as prevailing parties, prevailing parties should complete and file a timely Memorandum of Costs.

Date: 8/9/04

Honorable JUDY HERSHER,
Judge of the Superior Court of California,
County of Sacramento

CERTIFICATE OF SERVICE BY MAILING

(C.C.P. SEC 1013QA(3))

I, the Clerk of the Superior Court of California, County of Sacramento, certify that I am not a party to this cause, and on the date shown below I served the foregoing ORDER and JUDGMENT DENYING WRIT OF MANDATE by depositing true copies thereof, enclosed in separate, sealed envelopes with the postage fully prepaid, in the United States Mail at Sacramento, California, each of which envelopes was addressed respectively to the persons and addresses shown. I, the undersigned deputy clerk, declare under penalty of perjury that the foregoing is true and correct.

Lloyd A. Bookman, Esq.
Hooper, Lundy & Bookman, Inc.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799

G. Lewis Chartand, Jr., Esq.
Amy Dobberteen, Esq.
980 9th Street, Suite 500
Sacramento, CA 95814

Date: August 10, 2004

D. Ahee, Deputy Courtroom Clerk

CATHOLIC HEALTH INITIATIVES

A spirit of innovation, a legacy of care.

1999 Broadway
Suite 2600
Denver, CO
80202

Phone 303.298.9100
Fax 303.298.9690

July 20, 2004

Representative John D. Dingell
Ranking Member, Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515-6115

Dear Representative Dingell:

As requested I am submitting responses on behalf of Catholic Health Initiatives to the questions you sent in your letter of July 6, 2004 as a follow up to the Subcommittee on Oversight and Investigations hearing entitled "A Review of Hospital Billing and Collection Practices". These responses are being submitted by fax and email as you have requested.

Catholic Health Initiatives remains committed to providing health care to the most vulnerable members of our communities, regardless of ability to pay.

Sincerely,

Kevin E. Lofton

Kevin E. Lofton
President & CEO

cc: The Honorable Joe Barton, Chairman
Committee on Energy and Commerce

The Honorable James C. Greenwood, Chairman
Subcommittee on Oversight and Investigations

The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

**Responses from Mr. Kevin Lofton, President and CEO
Catholic Health Initiatives (CHI)
to the Honorable John D. Dingell regarding the June 24, 2004,
Subcommittee on Oversight and Investigations hearing entitled
"A Review of Hospital Billing and Collection Practices"**

1. Documents from CHI indicate that you are waiting for approval from the Centers for Medicaid and Medicare Services (CMS) to implement a discount policy for all uninsured patients based on what the best-paying payors pay. What is the status of the review by CMS? Please enclose related documentation.

CHI is not presently awaiting formal approval from the Center for Medicaid and Medicare (CMS) to implement a discount policy for all uninsured patients. Kevin Lofton reported in his testimony that CHI leaders had several meetings with Department of Health and Human Services (HHS) staff to discuss charges and discounting parameters in order to better serve our communities.

CHI leaders met with Secretary Tommy Thompson; Mary Kay Mantho, Senior Policy Advisor to the Secretary; Leslie Norwalk, Deputy Administrator, CMS; Herb Kuhn, Centers for Medicare Management; and Lawrence Wilson, Director, Chronic Care Policy Group.

These meetings provided an opportunity to discuss the challenges associated with billing and discounting for the uninsured and underinsured and areas for improvement and simplification. As a follow-up to one of the meetings, the attached Summary of Recommendations **(Attachment I)** was submitted by Catholic Health Initiatives. This was not a formal request for approval, but was offered for further consideration and dialogue.

CHI is appreciative of the guidance issued by CMS ("Questions on Charges for the Uninsured") and the Office of the Inspector General ("Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills") on February 19, 2004. The Open Forum sponsored by CMS and the OIG was also instructive and CHI participated in the Open Forum. CMS actions on proposals of other health care systems will be of interest to CHI as well. As CHI continues to evaluate the needs and concerns of the communities its hospitals serve, particularly the needs of the most vulnerable, it may consider seeking formal guidance from CMS and/or OIG in the future.

2. You stated that since April 2004, CHI has had a policy of not placing liens on primary residences. Many uninsured patients are renters and have small bank accounts as their only asset. What is CHI's policy on attaching or freezing these bank accounts?

Kevin Lofton stated in the hearing of June 24, 2004 that the CHI policy prohibits collection agencies from seeking liens requiring the sale or foreclosure of a primary residence. CHI hospitals may place liens on residences where a lien is required in order to have a claim against an estate in probate.

CHI's Standards and Guidelines **(Attachment II)** do not address every possible patient situation related to collection efforts. Therefore, CHI's policy does not specifically address attaching or freezing bank accounts, but in practice this activity does not occur. Addendum A.11.4 prohibits pursuing any legal action against any patient or patient's

guarantor without the specific approval of a designated hospital or market-based organization (which may be the configuration of more than one hospital in an area) representative who evaluates the circumstances of each individual patient case.

3. Is CHI releasing liens placed on primary residences prior to the April 2004 policy?

CHI hospitals are currently in the process of recalling accounts in collection without activity for more than 150 days and evaluating the release of liens.

CHI hospitals are encouraged and committed to re-evaluate an individual's circumstances and eligibility for charity or discounted care as part of its promise to treat all patients with dignity and respect.

4. Do any of your hospitals offer medical credit cards to its patients? What is the interest rate on CHI's credit cards?

Neither CHI nor its hospitals offer medical credit cards.

5. One of the concerns with hospital billing of the uninsured is that the hospitals offer unreasonable amounts of time (90 – 180 days) for patients to pay large and unexpected bills before those bills are turned over to a collection agency and the debtor receives a bad credit rating. What steps have you taken to establish reasonable, low-interest or no-interest, longer-term payment plans for uninsured patients?

CHI Standards and Guidelines prohibit charging interest of any amount on any account at any time. CHI hospitals offer patients payment arrangements with terms of up to 18 – 24 months for patients seeking payment terms. Patients who are unable to meet their obligations at any point during the 18 – 24 months, or any agreed upon time frame, would be re-evaluated for charity care under CHI guidelines.

6. Do you think that discounting to all uninsured patients, regardless of income, will result in higher collections from the uninsured?

CHI does not think that discounting to all uninsured patients, regardless of income, will result in higher collections from the uninsured. A significant number of uninsured patients are eligible for charity or discounted care because of medical indigency. Most uninsured patients do not have other resources and cannot pay even a discounted bill.

Attachment I

Summary of Recommendations from HHS and CMS Meeting with Catholic Health Initiatives

January 27, 2004

Discount Program for Certain Uninsured Non-Charity Care Patients

A protection would be established to permit hospitals to discount bills for uninsured non-charity care patients who meet the following conditions and circumstances:

1. The class of patients would be established as follows:

    a. 100% of the account balance is the responsibility of the patient/guarantor,

Presumption of Indigency/Charity Care Eligibility

Medicare regulations currently require substantial documentation to justify a patient's qualification for indigency/charity care. Such documentation is frequently not provided by patients who would certainly qualify. The indigency/charity provisions of the Medicare regulations would be clarified to allow the presumption of indigency for persons meeting specified indicators, examples of which are noted below. Under these circumstances it would not be necessary to provide the patient specific documentation required under the current Medicare regulations and eligibility for the hospital's charity care program would be presumed.

Examples of such indicators for presumptive eligibility would include but not be limited to:

- participation in WIC programs;
- residency in a subsidized or affordable housing developments;
- Medicaid eligibility for which the state doesn't pay;
- particular occupations (e.g., migrant farm workers); and
- specific addresses in marginalized locations.

The OIG would determine in advance and publish that such arrangements did not constitute an inducement for referral.

Attachment II

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Definition of Standards and Guidelines

From time to time the Catholic Health Initiatives (CHI) National Finance Group issues financial, accounting and reporting directives to Market-Based Organizations (MBOs). The types of directives issued are as follows:

- *Standards:* MBOs are required to comply with and implement *Standards* on a timely basis. This is the most common type of directive.
- *Guidelines:* MBOs are not required to comply with or implement *Guidelines*. MBOs are encouraged to consider *Guidelines* as leading practices for potential implementation, when practicable.

Purpose of this Section and Effective Dates

- *Purpose:* This section of the CHI *Financial Standards and Guidelines Manual* (FSGM) provides standards for use by MBOs in regard to the management and oversight of MBO staff and third-party collection agents, including self-pay protocols.
- *Effective dates:*
  - **By April 1, 2004:** All written policies and agreements required in Section V of this document must be completed by April 1, 2004. A contract amendment (containing the terms listed in *Addendum A*) must be signed and implemented for every third-party collection agent or the existing contract(s) must be terminated. MBOs are encouraged to seek guidance from the Legal Services Group if there are issues or questions in this regard. Once the written policies and agreements are implemented, they are to be maintained thereafter at all times on a current basis. All future agreements with third-party collection agents must contain the provisions listed in *Addendum A*.
  - **By June 30, 2004:** The standards required in Section IV must be fully implemented throughout the MBO and maintained thereafter at all times on a current basis. To the extent the standards in Section IV impact the completion of the written policies and agreements in Section V, earlier implementation is required by April 1, 2004.

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Specific Topics Addressed in this Section

- Background
- Purpose
- Definitions: third-party collection agent; self-pay balance
- Management and oversight of MBO staff and third-party collection agents, including specific prohibitions
- Required written agreements and policies

Contacts for Questions Related to this Section

Please contact one of the following individuals about this section with questions or concerns:

- Related to technical matters:
  - J. Peter Savini, CHI Vice President, Patient Financial Services (610/594-5102 or at petersavini@catholichealth.net)
- Related to direction regarding the standards:
  - The National Vice President, Financial Services assigned to the MBO
- Related to legal requirements regarding contractual issues:
  - The Legal Services Group member assigned to the MBO

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

I. Background

As a Catholic healthcare provider and as a tax-exempt organization, Catholic Health Initiatives (CHI) is called upon to meet the needs of those who seek health care services in market-based organizations (MBOs). Such needs must be met without regard to a person's ability to pay for services received.

Self-pay patient account balances (i.e., either for uninsured patients or for co-payment / deductible obligations of insured patients) at most MBOs represent a significant and growing percentage of total accounts receivable balances. This economic reality needs to be acknowledged by each MBO, which also is responsible to simultaneously demonstrate respect for human dignity, foster a climate of social justice and acknowledge the full extent of regulatory requirements. Any failure to balance these responsibilities will result in increased costs being unfairly passed to all constituents in the communities served.

It is essential for MBOs to communicate to both MBO staff members and third-party collection agents the collection protocols and tactics that are approved by CHI. The protocols and tactics utilized by MBO staff and third-party collection agents must comply with the CHI standards outlined in this document.

II. Purpose

The purpose of this document is to establish CHI standards for appropriate MBO staff and third-party collection agency protocols and tactics. It is incumbent upon each MBO to take reasonable and immediate steps to ensure that all MBO staff and third-party collection agents consistently follow the collection protocols established through the standards contained in this document. Each MBO needs to ensure that the collection tactics prohibited by the standards contained in this document will not be used either by MBO staff or third-party collection agents.

Each MBO must ensure that consistency is achieved in the definition, communication, distribution and implementation of MBO staff and third-party collection agency protocols and tactics. MBO staff and third-party collection agents must follow the highest standards of ethics and integrity in providing collection services for self-pay balances.

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

III. Definitions

For the purposes of clarity in this document, the following definitions are included:

Third-Party Collection Agent:
A third-party collection agent is an external resource utilized *as a collection agent or as a representative acting in the name of the MBO,* engaged on a contractual basis, for the express purposes of following-up on and potentially collecting any patient accounts receivable balances (e.g., past-due balances, early-out accounts, etc.).

Self-Pay Balance:
A self-pay balance is any accounts receivable balance due from a patient and/or patient guarantor that is (a) a result of health care or other services provided, for which no insurance or other coverage was available, or (b) a balance remaining after all insurance payments have been received.

IV. Management and Oversight of MBO Staff and Third-Party Collection Agents, Including Specific Prohibitions

CHI MBOs, hospitals and other healthcare providers exist to provide health care services to persons in the communities served. The ability of an MBO to serve its patients well requires a relationship with each community that is built on both trust and compassion. This document is intended to strengthen MBO relationships within the communities, reassuring patients and patient guarantors, regardless of the ability to pay, of the provider's commitment to caring.

CHI Standard: Each MBO, in all policies and standards related to patient financial services as defined by CHI standards, shall direct its staff and third-party collection agents to continually assess each patient and patient guarantor's ability to pay or to be determined eligible for financial assistance (i.e., charity care). This Standard shall be applied as follows:

A. In regard to self-pay balances:

1. ***Fair Pursuit.*** Each MBO shall ensure that all patient and patient guarantor accounts are pursued fairly.

2. ***Ethics and Integrity.*** Each MBO shall ensure that all collection activities consistently reflect the highest standards of ethics and integrity.

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

3. ***Reasonable Payment Terms.*** Each MBO shall offer reasonable payment schedules and terms to each patient and patient guarantor with self-pay balances.

4. ***Eligibility for Assistance.*** Each MBO shall perform a reasonable review of each inpatient account, prior to turning an account over to a third-party collection agent and prior to instituting any legal action for non-payment, to assure that the patient and patient guarantor are not eligible for any assistance program (e.g., Medicaid) and do not qualify for coverage through the MBO's charity care policy. After having been turned over to a third-party collection agent, any account that subsequently is determined to meet the MBO's charity care policy shall be returned immediately by the third-party collection agent to the MBO for appropriate follow-up.

B. In regard to third-party collection agents:

1. ***Standards and Scope of Practices.*** Each MBO shall define the standards and scope of practices to be used by third-party collection agents acting on its behalf such that any standards and scope of practices, at a minimum, shall be consistent with the standards contained in this document.

2. ***Board-approved Policy.*** Each MBO shall have a board-approved policy indicating the particular actions consistent with the CHI standards (e.g., garnishments, liens, etc.) that may be pursued by either MBO staff or a third-party collection agent. Such policy shall indicate the circumstances under which each action may be pursued, the designated MBO staff member who may authorize each such action, and the periodic reporting which shall be made to the Board.

3. ***Statement Message.*** Each MBO shall require its third-party collection agents to include a message on all statements indicating that if a patient or patient guarantor meets certain stipulated income requirements, the patient or patient guarantor may be eligible for MBO or other financial assistance programs.

4. ***150-day Limit.*** Only under limited circumstances (i.e., when or if a payment or resolution is expected within 60 days) shall an MBO authorize a third-party collection agent to manage an account beyond 150 days from the date assigned to the third-party collection agent by the MBO.

5. ***Advance Settlement Approvals.*** Each MBO shall instruct its third-party collection agents to seek approval from the authorized and designated MBO staff member before any settlement, as a result of bankruptcy proceedings, shall be accepted.

6. ***Annual Adherence Audit.*** Each MBO or its designee shall be required to audit its third-party collection agents at least annually for adherence to these standards.

C. Specific Prohibitions:

1. ***Unemployed Without Significant Income / Assets.*** No MBO shall pursue any legal action for non-payment of any bills against any patient or patient guarantor who is unemployed and without other significant income or assets.

2. ***Principal Residence.*** No MBO shall pursue any legal action against any patient or patient guarantor by seeking a remedy that would involve foreclosing upon the principle residence of a patient or patient guarantor or taking any other action that could result in the involuntary sale or transfer of such residence, or informing any patient or patient guarantor that he/she may be subject to any such action.

3. ***Cooperating Efforts.*** No MBO shall send any unpaid self-pay account to a third-party collection agent as long as the patient and patient guarantor are cooperating with the MBO in efforts to settle the account balance.

4. ***Collection Tactics.*** Each MBO shall instruct both MBO staff and third-party collection agents that tactics such as charging interest, requiring patients or patient guarantors to incur debt or loans with recourse to the patient's or guarantor's personal or real property assets ("recourse indebtedness") or so-called "body attachments" (i.e., the arrest or jailing of patients in default on their accounts, such as for missed court appearances) are strictly prohibited.

V. Required Written Agreements and Policies

CHI Standard: Each MBO shall develop and maintain written policies and agreements in fulfillment of the appropriate business requirements related to third-party collection protocols as outlined in this document. This Standard shall be applied as follows:

A. ***Adherence to Standards.*** Each MBO shall obtain written agreements from each third-party collection agent to ensure adherence to the standards contained in this document. (See *Addendum A.*)

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

B. ***Core Values and Ethics.*** Each MBO shall require, in written agreements with all third-party collection agents, that the third-party collection agents shall incorporate into the training and orientation of their service representatives the CHI *Mission Core Values* and *Ethics at Work.*

C. ***Authority Related to Debt.*** Each MBO shall implement written policies defining and delineating the circumstances under which, and under whose, authority the debt of any patient or patient guarantor is advanced for collection to the third-party collection agent (i.e., no self-pay balances shall be sent to third-party collection agents as long as a patient or patient guarantor is cooperating in efforts to settle the balance).

D. ***Time and Criteria.*** Each MBO shall implement written policies with specific standards regarding (1) the length of time an account shall be managed by a third-party collection agent and (2) collection standards. These policies shall comply with CHI standards as included herein and in other documents.

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Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Addendum A

I. The parties to this agreement acknowledge and guarantee that the following collection tactics shall be prohibited:

1) Agents charging interest of any amount, on any account, at any time.

2) Seeking a bench warrant or so-called "body attachment" (i.e., seeking or securing the arrest or jailing of patients or guarantors who miss court hearings on their hospital debts).

3) Recourse indebtedness programs, requiring patients to incur debt or loans with recourse to the patient's personal or real property assets.

4) Recourse loans which become the obligation of the MBO upon default by the patient or patient guarantor.

5) Foreclosure upon a patient's/guarantor's principal residence or taking any other action that could result in the involuntary sale or transfer of such residence.

II. The CHI MBO and Agents agree that Agents shall seek approval from the authorized and designated MBO staff member before pursuing any of the following legal proceedings:

1) Garnishing wages, if there is evidence that the patient or patient guarantor has income and/or assets to meet his/her obligation.

2) Subject to the absolute restrictions of paragraph "I (5)" above, placing a lien on the patient's or patient guarantor's home.

3) Taking any legal action against any patient or patient guarantor who is unemployed and without other significant income/assets.

4) Pursuing any legal action against any patient or patient's guarantor not otherwise specifically prohibited above.

HCA

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Jack O. Bovender, Jr., FACHE
Chairman and Chief Executive Officer

July 27, 2004

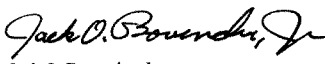
The Honorable James C. Greenwood
Chairman
Subcommittee on Oversight
and Investigations
2125 Rayburn House Office Building
Washington, D.C. 20515-3808

Dear Chairman Greenwood:

Enclosed please find HCA's responses to supplemental questions following the Subcommittee's hearing on hospital billing and collection practices. We have also included a binder of materials that augment these responses.

Thank you again for the opportunity to participate in these important discussions. We commend your efforts on behalf of the uninsured, and we look forward to a time when every individual in America will, through adequate health insurance coverage, have regular access to preventive and urgent care.

Very truly yours,



Jack O. Bovender, Jr.
Chairman and CEO

Cc: The Honorable Peter Deutch, Ranking Member
Subcommittee on Oversight and Investigations

Enclosure

QUESTIONS FOR THE RECORD
TO HCA
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
"A REVIEW OF HOSPITAL BILLING AND COLLECTION PRACTICES"
JUNE 24, 2004

Question One
Please produce for the record a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.

Response
As we have stated in earlier communications, HCA's Charity Care and Financial Discount Policy was initially implemented in October of 2003, and revised in June of this year. Under the tab labeled "Response to Question #1" of the enclosure, you will find a copy of the most recent version of that policy, along with documents that outline our collection practices with respect to uninsured/self-pay patients. Please note that in the case of our Georgia hospitals, our threshold for free care is 250 percent of the Federal Poverty Level, as prescribed by State law.

Question Two
If your system has implemented any changes recently to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change.

Response
The two primary changes made to our policy dated October 2003 regard expansion of the initial charity program to include the underinsured, and the extension of payment arrangements to a period up to five years (the previous plan only provided for payment plans up to three years). In addition, we have simplified the information requirements for qualification (these forms are included in the package under Tab One of the enclosure).

The revised charity and financial discount policy and the new monthly payment restructuring plan were both implemented in June of this year. We are also in the process of implementing changes to point-of-service collection efforts, which include requesting payment (including copays and deductibles) at the time of service.

As we testified before the subcommittee, we are currently in the process of developing a new discounting methodology, which will provide the uninsured a discount for services that is comparable to those, which are provided in our PPO contract agreements. We currently anticipate that our new discounting methodology will be ready for implementation late this year.

Question Three
Please produce for the record all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients.

Response
Attached please find under the tab labeled "Response to Question #3" the materials used in our educational packages for implementation of our charity and financial discount policy. The changes implemented in June 2004 as referenced in answer #2 above, which enable our employees to apply the policy to the underinsured, were built into our ongoing training programs at each Patient Account Service Center. The documents under this tab are consistent with that expansion.

Question Four
How are patients made aware of your charity policy and how is the substance of that policy made available to patients, e.g. brochures, postings in the hospital or on the website?

Response
When a patient who is uninsured cannot pay a bill at one of our facilities, the first thing we do is try to qualify that individual for Medicaid. We believe coverage that offers access to regular care is a better solution than simply achieving a solution for payment for a single occurrence. For those who do not qualify for Medicaid, or for those who have insurance that does not sufficiently cover the expenses of their care, we try to qualify them for charity care or a financial discount under our policy. Our financial counselors discuss the possibility of qualification for charity or discounts with patients on an individual basis. A summary of the material elements of our policy is posted on our website, and will be supported by signs posted in the waiting rooms and lobbies of our facilities in the near future. We also plan to seek input from organizations like The Access Project regarding communications with uninsured patients.

Question Five
For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of property? A. Are there plans to change the discount percentage rates as charges rise?

Response
Our sliding scale is designed for individuals whose annual income is between 201 and 400 percent above the Federal Poverty Level. The discounts were established to try to match the ability to pay with family size, income level and the size of the account balance due. For larger patient bills, the discount was designed to mirror our managed care PPO pricing, e.g.. a 55-65 percent discount on a bill of $50,000 or greater.

We are currently in the process of restructuring our uninsured discount program to ensure greater ability to keep pricing in line with our managed care PPO rates.

Question Six
The AHA states that in 2002 the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care...for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?

Response
In our testimony before the Subcommittee, we stated we had approximately $ 500 million of non-reimbursed costs from treating more than 1 million uninsured in 2003. This number relates only to uninsured patients, not underinsured or bad debts from Medicaid and Medicare patients. HCA's total bad debts in 2003 were in excess of $ 3 billion.

As stated in the June 24th Subcommittee testimony of Herb Kuhn, Director of CMS, "Medicare does not reimburse the bad debts of non-Medicare patients." Accordingly, the approximately $50 million Medicare bad debt reimbursement HCA received in 2003 does not relate to the 1 million uninsured patients we served last year. (Please also note that Medicare only reimburses 70% of bad debts incurred by hospitals from serving Medicare patients.)

With respect to Medicare's DSH program, not all hospitals receive these special payments (approximately 65% of HCA's U.S. hospitals received Medicare DSH payments in 2003), while all treat uninsured patients. There is currently no measure for uncompensated care in the Medicare DSH payment formula. The Medicare DSH payment formula is based upon the percentage of hospital days attributable to Medicare patients in the Federal Supplemental Security Income program and the percentage of days attributable to Medicaid patients. With that understanding, HCA hospitals received approximately $330 million in Medicare DSH payments in 2003.

Even fewer hospitals receive Medicaid DSH payments (approximately 27% of HCA's U.S. hospitals received Medicaid DSH payments in 2003). Medicaid DSH reimbursement has varying designs and purposes on a state-by-state basis, but clearly is not intended to assist all hospitals that treat uninsured patients. HCA hospitals received approximately $103 million in Medicaid DSH payments in 2003.

As an investor-owned hospital system, HCA does not receive "tax breaks". To the contrary, HCA paid over $1.3 billion in federal, state and local taxes in 2003. Over $500 million of these tax payments went to local and state authorities.

Question Seven
Did the HHS/OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self-pay patients? What specific further guidance is needed?

Response
As we move forward with a number of efforts to make our charity care and financial discount policy easier for our patients – both in their awareness and understanding of it, and their ability to qualify – we have identified a number of areas where clarification is needed between recommendations and suggestions from this Committee, and parameters outlined through various communications with CMS.

One example, as noted above in our answer to Question four, is the definition of "advertising" with regard to means by which we would like to inform the public of the existence of our charity care and financial discount policy. If we are prohibited by CMS from "advertising" our policy, what kinds of restrictions does that rule impose on our ability to communicate with people who may need to know about the availability of charity care and related discounts?

Question Eight
Have you ever received and investigated complaints from patients against any of your collection agencies?

Response
Yes. When we review a complaint from a patient we conduct a thorough review of the record of that case, including the call recording data (when available). Once that investigation is complete, we review the findings and conclusions with the patient, and make any necessary process changes with the agency.

As part of our overall effort to make our charity care and financial discount policy easier for our patients who need those considerations, we are also conducting a thorough review of our collections area with regard to communications, customer service, and employee training.

Question Nine
Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse all other means of paying undiscounted charge master rates (except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?

Answer Nine
We request payment at the time of service. If at this time the patient indicates an inability to pay, we will determine if the patient is a candidate for Medicaid. As noted above in answer four, we believe ongoing coverage through a program like Medicaid is a better alternative for the patient, because it allows for ongoing access to the healthcare system, and for the facility, because it provides some government reimbursement to defray the costs of care. If a patient is Medicaid ineligible, we will ask the patient to complete the charity and financial discount application.

There are instances when a patient does *not* tell us they cannot pay the bill and we will attempt to collect from them through a phone call or letter. During such a call, we may ask the patient if they have a credit card or if they can pay the balance through a loan.

We have no desire to collect from patients who are unable to pay, but a key challenge in determining an individual's eligibility for charity or discounted care lies in the communications process. We make every reasonable attempt to gather the information that will help us determine if a patient qualifies for such consideration, but we believe our industry would benefit from assistance with this aspect of the collections process. Reaching underserved populations and obtaining financial information from them is, at best a significant challenge to the process of providing charity and discounted care.

Documentation for Greenwood Response

Table of Contents

Response to Question #1

A. Uninsured Collection Process – Executive Summary
This document provides a summary of HCA's Collection Practices. Detailed explanations are enclosed in sections B – F.

B. Discount Charity Policy

C. Procedure for Discount Charity Policy

D. Financial Assistance Application (English and Spanish)

E. Charity Status Letter (English and Spanish)

F. Collection Practices:
- **F1 NPAS (National Patient Account Services) Operational Procedures and Tool Kit**
- **F2 Work Standards for Primary Collection Agencies**
- **F3 Work Standards for Secondary Collection Agencies**
- **F4 Other Collection Policies Addressing Specific Collection Procedures**

Uninsured Collection Process – Executive Summary

- Patient presents for services
- Request insurance information
- If no insurance exist, ask if patient has the ability to pay
- If no ability to pay, determine if patient is eligible for any state, local or federal programs (e.g. Medicaid, victims of crime, etc.)
- If not eligible for assistance, attempt to have charity form completed
- If form is not completed, continue collection efforts through placement of account with NPAS (National Patient Account Services).

- **NPAS – National Patient Account Services** – NPAS is an internally owned service center that specializes in uninsured collections. Standard collection processes are used for all accounts. NPAS attempts to contact the patient via phone and letters and the following outcomes may occur:
  - Patient responds by paying the bill or establishing agreed upon monthly payment arrangements
  - Patient responds and it is determined they have not previously applied for charity so an application is completed and processed
  - Patient responds and disputes some aspect of the balance due. These are researched and a determination made as to whether an account adjustment is warranted
  - No response from patient or patient responds but is not cooperative in completing the charity application or establishing payment arrangements at which time NPAS will place with a primary agency

  This process typically takes 150 days.

- **Primary Agency** – A primary agency is the first collection agency an account is placed with if we are unable to collect the account through internal means. All agencies are contractually bound to the same work standards. HCA Internal Audit will perform audits on a periodic basis. Also, any patient complaints filed are investigated to ensure the agencies are abiding by the required standards. Primary agency attempts to contact the patient via phone and letters and the following outcomes may occur:
  - Sends required notification letter and places on credit report if no response received in 30 days
  - Patient responds by paying the bill or establishing agreed upon monthly payment arrangements
  - Patient responds and it is determined they have not previously applied for charity so an application is completed and processed
  - Patient responds and disputes some aspect of the balance due. These are researched and a determination made as to whether an account adjustment is warranted

- No response from patient or patient responds but is not cooperative in completing the charity application or establishing payment arrangements at which time primary agency will evaluate for legal action. The evaluation includes verification of home address, determination of liquid assets (e.g. employment verification), determination if balance is suit worthy and review of credit report.
- If legal action is approved a suit is filed by agency attorney. Legal action varies by state due to state requirements. (i.e. some states allow garnishments and others do not.) Also, property liens are not filed on residence unless the home value exceeds $300,000.
- If legal action is not approved because patient does not meet criteria or balance is too low for legal action account is placed with secondary agency.

This process typically takes 150 days.

- **Secondary Agency** – A secondary agency follows work efforts by the primary agency. All agencies are contractually bound to the same work standards. HCA Internal Audit will perform audits on a periodic basis. Also, any patient complaints filed are investigated to ensure the agencies are abiding by the required standards. Secondary agency attempts to contact the patient via phone and letters and the following outcomes may occur:
  - Places on credit report
  - Patient responds by paying the bill or establishing agreed upon monthly payment arrangements
  - Continues to attempt collections periodically for seven years.

HCA

1-B

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Charity Policy for Patients
PAGE: 1	REPLACES POLICY DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PP.COLL.018

SCOPE:
All PAS and Facility areas responsible for requesting and evaluating Financial Assistance Application and supporting documentation obtained.

PURPOSE:
To define the policy for providing financial relief to patients unable to establish partial payments or pay their balance that have received non-elective care and based on Federal Poverty Guidelines and to establish protocols for the requesting and processing of the Financial Assistance Application and supporting income validation documentation.

POLICY:
Charity discounts may be provided to patients receiving non-elective care. The following classes of patients may qualify for a charity discount based on the patient's income and the amount of the patient's charges as outlined in the scale set forth below: 1) Under insured patients (i.e., those patients with some form of third party payer coverage for health care services but such coverage is insufficient to pay the current bill) when indigency is established, and 2) Uninsured patients (i.e., those patients with no third party payer coverage for health care services whatsoever), which have advised that they are unable to pay their account balances. A validation must be completed to ensure that if any portion of the patient's medical services can be paid by any federal, or state governmental health care program (e.g., Medicare, Medicaid, Champus, Medicare secondary payor), private insurance company, or other private, non-governmental third-party payor, that the payment has been received and posted to the account. No charity discount can be applied to any account with any outstanding payer liability.

All Medicare inpatient and outpatient accounts and all non-Medicare inpatient accounts will be required to have supporting income verification documentation. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).

Income Verification:

- For Medicare beneficiaries, in addition to thorough completion of the Financial Assistance Application, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement: State Income Tax Return for the most current year
- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Copy of all bank statements for the last three months

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 2	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

- Current credit report

After thorough review of the Financial Assistance Application and documented research through Medicaid Eligibility processing or other means, a manager may waive supporting documentation on non-Medicare, non-Champus, non-Medicaid, and non-Medicare Secondary Payor accounts only when it is apparent that the patient/responsible party is unable to meet the supporting documentation requirement but clearly meets the Charity guidelines. For non-Medicare and non-inpatient accounts, supporting income verification documentation will NOT be required. For these accounts, the thorough completion of the Financial Assistance Application will be acceptable for determining Charity discount application.

Resource Verification: Medicare Inpatient and Outpatient Accounts Only
Consistent with Medicare requirements, Medicare accounts will be required to provide the most current year's Federal Tax Return or the following supporting documentation to support resource testing:

- Supporting W-2
- Supporting 1099's
- Most recent bank and broker statements listed in the recent Federal Tax Return
- Qualified Medicare Benefits (QMB for inpatient's only)
- Current Credit Report

Registrars, Financial Counselors, Support Services and Collectors should utilize all relevant on-line systems available to gather correct information. All efforts should be documented in a clear, concise and consistent manner in the Collections System. Staff should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all staff. All guidelines set forth by this policy should be adhered to without exception.

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 3	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
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INCOME AND CHARGE BASED DISCOUNT SCALE

	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges
Income Level	<$1,000	$1,001 – $2,500	$2,501 – $5,000	$5,001 – $10,000	$10,001 – $25,000	$25,001 – $50,000	>$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

This process will be managed by establishing IPLANS with a Financial Class of 15 for Charity Pending, Charity – 100%, Charity 101% - 200%, Charity 201% - 300% and Charity 301% - 400%. In those instances where state regulations exceed the company policy, additional standard IPLANS will be established. These IPLANS will be attached to standard LOGIDS with the appropriate standard models to calculate the applicable discount and auto post to the account at final bill. These logs will not be worked for discrepancies or any other purposes since self pay underpayments or overpayments would be identified as they are normally identified today thru our collections series and credit balance reports. On accounts where the charity IPLAN is placed in the secondary or tertiary position, the applicable manual discount will need to be applied. Standard procedure codes will be established to use in those instances where the discount must be manually applied. In addition, the collection series (4) Charity Pending Patient Liability and (108) Charity Pending Insurance Liability should be attached to the Pending Charity IPLAN and collection series (208) Self Pay Liability and (109) Charity Insurance Liability respectively for automated collection tracking for these accounts. For under insured patients, the discount should be applied to total charges and a patient's liability for the co-payment would be limited to that amount. For example: An account's total charges of $10,000 with an insurance payment of $9,000 would leave a remaining patient liable portion of $1,000. According to the patient's Financial Assistance Application, the patient qualifies for a 40% discount. The calculation would be against total charges of $10,000.00 x 40% = $4,000. Since the patient meets only 40% charity discount, it is determined that the patient has the ability to pay $6,000. The

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
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remaining balance of $1,000 is within the patient's ability to pay, the patient would not receive a charity discount.

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

PROCEDURE:

Responsible Party	**Action**
	Inpatient or Medicare Patients

Registrar/Financial Counselor/Eligibility Staff	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

Registrar/Financial Counselor/Eligibility Staff	Provide the patient/responsible party with: o Financial Assistance Application and Letter (RCOM.FT.COLL.628)
Registrar/Financial Counselor/Eligibility Staff	Advise the patient/responsible party of the required supporting documentation.
Registrar/Financial Counselor/Eligibility Staff	If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.
Registrar/Financial Counselor/Eligibility Staff	Apply the Pending Charity IPLAN when Charity forms have been provided to the patient/responsible party.

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 5	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

Registrar/Financial Counselor/Eligibility Staff	Document in Meditech that the Financial Assistance Application Form was provided to the patient/responsible party.
	Non-Medicare and Non-Inpatient Accounts

Registrar/Financial Counselor/Eligibility Staff	Determine if patient/responsible party is able to pay estimated charges.
	• If so, collect monies
	• If not, determine if patient meets Medicaid Eligibility Criteria
	  o If Medicaid Eligibility criteria is met, assign Pending Medicaid IPLAN
	  o If not, continue

Registrar/Financial Counselor/Eligibility Staff	Provide the patient/responsible party the Financial Assistance Application and Letter. • If patient/responsible party completes the form and returns it to the Registrar/Financial Counselor, place form with patient folder documentation for scanning at the PAS.
Registrar/Financial Counselor/Eligibility Staff	Apply Pending Charity IPLAN when the Financial Assistance Application has been provided to the patient/responsible party.
Registrar/Financial Counselor/Eligibility Staff	Document Meditech that the Financial Assistance Application was provided to the patient. NOTE: If the self-pay patient leaves the ER without discussing financial obligations, the account will follow the appropriate Self Pay collection processes.
	PAS Collections – Working Charity Collection Series Accounts
Collection/Support Services Staff	Determine if there is outstanding insurance on the account. • If so, document account • If not, continue

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 6	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

Collection/Support Services Staff	Determine if Financial Assistance Application was received.
	• If not received, evaluate if 14 days have passed since the Pending Charity IPLAN was assigned
	  o If 14 days have passed, remove the Pending Charity IPLAN and send the appropriate Charity denial collection letter to the patient advising Charity has been denied.
	  o If 14 days have not passed, step account 7 additional days.
	• If received, continue

Collection/Support Services Staff	Determine if Medicare or Inpatient account
	• Medicare/Inpatient Account, was supporting documentation received?
	  o If yes, continue
	  o If no, send collection letter CHDOCR to the patient requesting additional information.
	• Non – Medicare/Inpatient Account, forward account to Manager for review and consideration for Charity discount without supporting documentation.

Collection/Support Services Staff	Using the Financial Assistance Application, Manager approval or supporting documentation (if applicable), Federal Charity Guidelines and the Charity Discount Table above to determine if the Charity guidelines have been met and at what level the discount should be applied.
	• If the patient/responsible party does not qualify for any type of Charity discount:
	  o Send the appropriate Charity denial collection letter to the responsible party
	  o Remove the Pending Charity IPLAN
	  o Document the account
	  o Place account with NPAS
	• If the patient/responsible party qualifies for a partial Charity discount:
	  o Send collection letter CHPRTL to the patient
	  o Apply the appropriate Charity IPLAN and reprorate
	  o Apply the appropriate Charity discount manually if

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 7	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

Collection/Support Services Staff	IPLAN is associated with the secondary or tertiary position o Document the account o Place account with NPAS • If the patient/responsible party qualifies for a full Charity discount: o Send collection letter CHFULL o Apply the appropriate Charity IPLAN and reprorate o Apply the appropriate Charity discount manually if the IPLAN is associated with the secondary or tertiary position. o Document the account
	PAS Collections – Working from Correspondence Received Financial Assistance Application or supporting documentation received and scanned at the patient account level. Account is identified
Collection/Support Services Staff	Determine if there is outstanding insurance on the account. • If so, document accounts • If not, continue
Collection/Support Services Staff	Determine if Medicare or Inpatient account • Medicare/Inpatient Account, was supporting documentation received? o If yes, continue o If no, send collection letter CHDOCR to the patient requesting additional information. • Non – Medicare/Inpatient Account, forward account to Manager for review and consideration for Charity discount without supporting documentation.
Collection/Support Services Staff	Using the Financial Assistance Application, Manager approval or supporting documentation (if applicable), Federal Charity Guidelines and the Charity Discount Table above to determine if the Charity

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
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APPROVED:	**RETIRED:**
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Collection/Support Services Staff	guidelines have been met and at what level the discount should be applied.

Collection/Support Services Staff	Determine if account is with a primary or secondary collection vendor or is in bad debt.
	• Account is in Bad Debt – validate that a charity discount has not already been applied.
	  o Previous charity discount applied, document account and notify patient/responsible party.
	  o Only bad debt write off, continue
	• Account is in primary or secondary collection vendor or in bad debt.
	  o If the patient/responsible party does not qualify for any type of Charity discount:
	  • Send the appropriate Charity denial collection letter to the responsible party
	  • Document the account
	  o If the patient/responsible party qualifies for a partial Charity discount:
	  • Send collection letter CHPRTL to the patient
	  • Post the manual discount
	  • Document the account
	  o If the patient/responsible party qualifies for a full Charity discount:
	  • Send collection letter CHFULL
	  • Post the manual discount
	  • Document the account
	• Account is in current A/R:
	  o If the patient/responsible party does not qualify for any type of Charity discount:
	  • Send the appropriate Charity denial collection letter to the responsible party
	  • Remove the Pending Charity IPLAN
	  • Document the account
	  • Place account with NPAS
	  o If the patient/responsible party qualifies for a partial

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 9	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

Collection/Support Services Staff	Charity discount: • Send collection letter CHPRTL to the patient • Apply the appropriate Charity IPLAN and reprorate • Document the account • Place account with NPAS o If the patient/responsible party qualifies for a full Charity discount: • Send collection letter CHFULL • Apply the appropriate Charity IPLAN and reprorate • Document the account
	Medicaid Eligibility Denied
Collection/Support Services Staff/Eligibility Staff	Medicaid eligibility denial received.
Collection/Support Services Staff/Eligibility Staff	Obtain a copy of the Medicaid eligibility application and supporting documentation.
Collection/Support Services Staff/Eligibility Staff	Evaluate for potential Charity • Not Charity o Document account o Determine if account is with an agency ▪ If yes, no further action needed. ▪ If no, place with NPAS • If potential Charity, continue
Collection/Support Services Staff	Determine if account is with a primary or secondary agency or in bad debt. • Account is in Bad Debt – validate that a charity discount has not already been applied. o Previous charity discount applied, document account and

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 10	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
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Collector/Support Services	notify patient/responsible party. o Only bad debt write off, continue • Account with a primary or secondary agency or in bad debt: o Determine if additional supporting documentation is required • Not Required: • If the patient/responsible party qualifies for a partial Charity discount: o Send collection letter CHPRTL to the patient o Post the manual discount o Document the account • If the patient/responsible party qualifies for a full Charity discount: o Send collection letter CHFULL o Post the manual discount o Document the account • Additional Documentation Required: • Send patient/responsible party collection letter CHDOCR • Document account. • Account is in current A/R: o Determine if additional supporting documentation is required • Not Required: • If the patient/responsible party qualifies for a partial Charity discount: o Send collection letter CHPRTL to the patient o Apply the appropriate Charity IPLAN and reprorate o Document the account o Place account with NPAS • If the patient/responsible party qualifies for a full Charity discount: o Send collection letter CHFULL

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
PAGE: 11	**REPLACES POLICY DATED:** 10/01/2003
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/01/2004	**REFERENCE NUMBER: FSG.PP.COLL.018**

Collection/Support Services Staff	○ Apply the appropriate Charity IPLAN and reprorate ○ Document the account • Additional Documentation Required: • Send patient/responsible party collection letter CHDOCR • Apply Pending Charity IPLAN and reprorate • Document account.
	Prior Discharge Requests If the patient/responsible party requests Charity discount for discharges prior to October 1, 2003.
Collector/Support Services	Obtain Manager approval for Charity consideration. • Approved, follow appropriate steps above. • Not approved, send the appropriate Charity denial collection letter and document account.
	Extenuating Circumstances There may occurrences of extenuating circumstances where the patient/responsible party is not able to complete the Financial Assistance Application and/or provide supporting documentation and resource testing cannot be completed or where the medically indigence of the patient is determined by the medical debt outweighing 25% of the patient/responsible party's annual income as outlined by state requirement/policy. In those circumstances, a manager may make the decision to waive the required documentation provided that all attempts to obtain additional information are documented clearly or perform additional resource testing to validate the need for charity. Some of the following could be considered extenuating circumstances:
Collector/Support Services	• **Undocumented Residents or Homeless** - Patients identified as an undocumented residents or homeless through ○ Medicaid Eligibility screening ○ Registration process ○ Discharge to a shelter

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DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Charity Policy for Patients
PAGE: 12	REPLACES POLICY DATED: 10/01/2003
APPROVED:	RETIRED:
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Collection/Support Services	o Clinical or Case Management documentation o Attempt to run a credit report may be considered for a charity discount if an attempt to complete the Financial Assistance Application was documented and a manager has reviewed and approved a policy exception. • **Patient Expiration** - Patients that expire and research determined through family contact and/or courthouse records that an estate does not exist and was documented, may be considered for a charity discount with the manager's review and approval for a policy exception. • **Medically Indigent** – Based upon state guidelines or requirements the patient/responsible party meets the medically indigent status, a charity discount may be applied after the manager completes a resource testing process for the patient/responsible party.
	Vendor Self-Pay/ Charity Flow
Vendor Representative	Patient/Responsible is unable to pay balance.
Vendor Representative	Determine if Charity discount has been previously applied. • If previously applied, continue normal collection processes. • If not, continue
Vendor Representative	Determine if Charity eligibility was previously denied. • If previously denied, continue normal collection processes. • If not, continue
Vendor Representative	Send patient/responsible party Charity documentation with the return address of the applicable PAS: • Financial Assistance Application (FSG.FT.638)
Vendor Representative	Document and time account for next follow up.
Collection/Support Services/PARS Staff	Check for Financial Assistance Application and supporting documentation (if applicable) • If documentation is available, determine if discount has been

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DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients
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Collection/Support Services Staff	applied. o Charity discount denied of partial discount applied, continue normal collection process o Full discount applied, account should close and return systematically o No Discount applied, contact PAS for status
	PAS Daily Review
Logging Staff/Bad Debt Specialist	On a daily basis, using Clear Access scripts, review all final billed accounts with a Charity IPLAN assigned in the primary insurance position to ensure that the account is logged and discount is auto posted. (Note: There is a known system bug where changing an non-logged IPLAN to a logged IPLAN, using the collection system, will not apply the account to a log and therefore would not auto post the discount. • If accounts have not been logged then process the appropriate IZ transactions. Accounts with the Charity IPLAN assigned in the secondary or tertiary insurance positions will not auto post the contractual and will require manual adjustments. **Medicare Charity Write Offs** Medicare Charity Write offs are to be maintained in a separate Medicare Bad Debt Log and the appropriate reclass journal entries will be made in accordance with policy FSD.PARS.PP.009

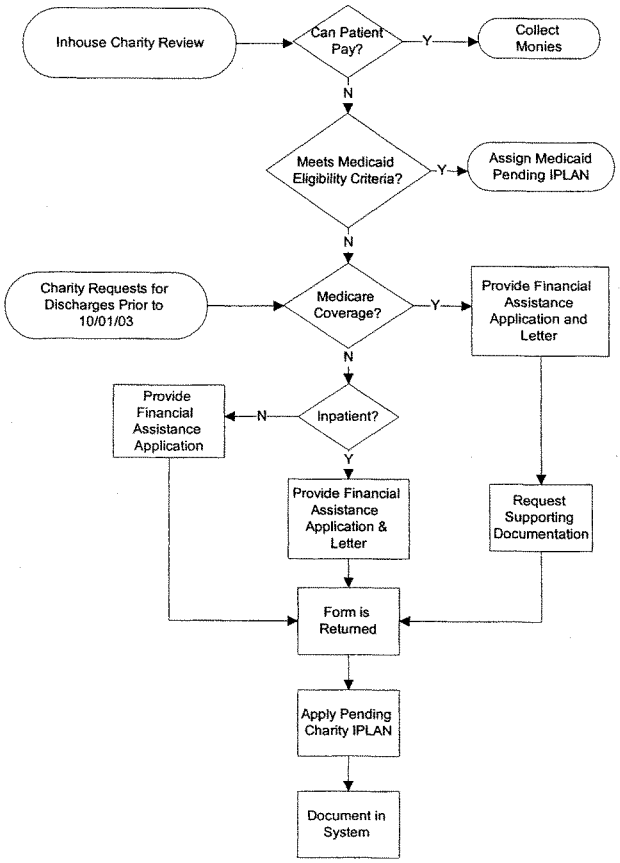
REFERENCE:

- Federal Charity Guidelines, FSG.COLL.FT.606
- Financial Assistance Application, FSG.COLL.FT.638
- Collection Charity Letters, FSG.COLL.MF.804
- PARS Medicare Bad Debt and Recovery Logs, FSD.PARS.PP.009

HCA 1-C

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Discount Charity Policy for Patients
PAGE: 1	REPLACES FLOW DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PF.COLL.018

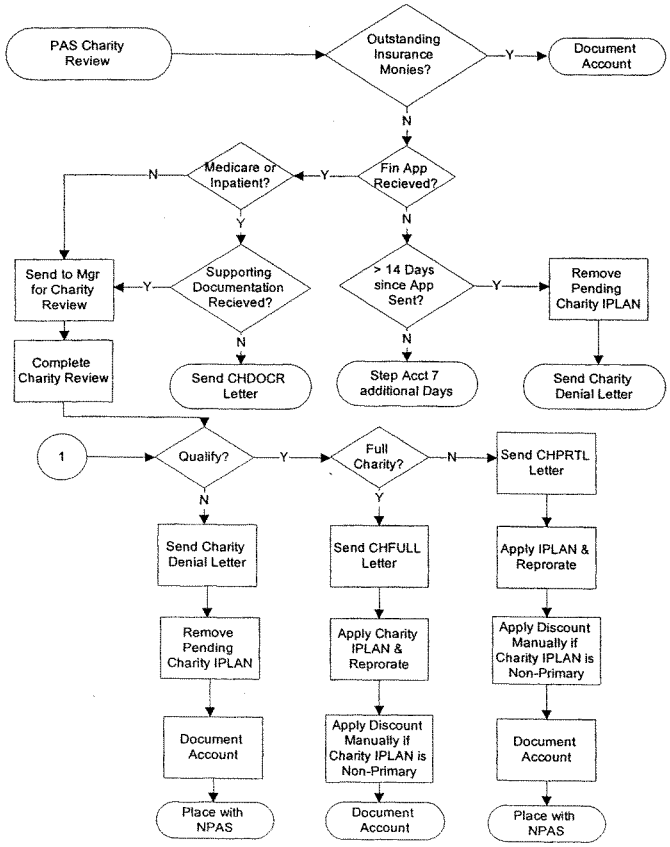
Page 1- Initial Charity Request Flow



HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Discount Charity Policy for Patients
PAGE: 2	REPLACES FLOW DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PF.COLL.018

Page 2- PAS Collections- Working Charity CS Accts



HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Discount Charity Policy for Patients
PAGE: 3	REPLACES FLOW DATED: 10/01/2003
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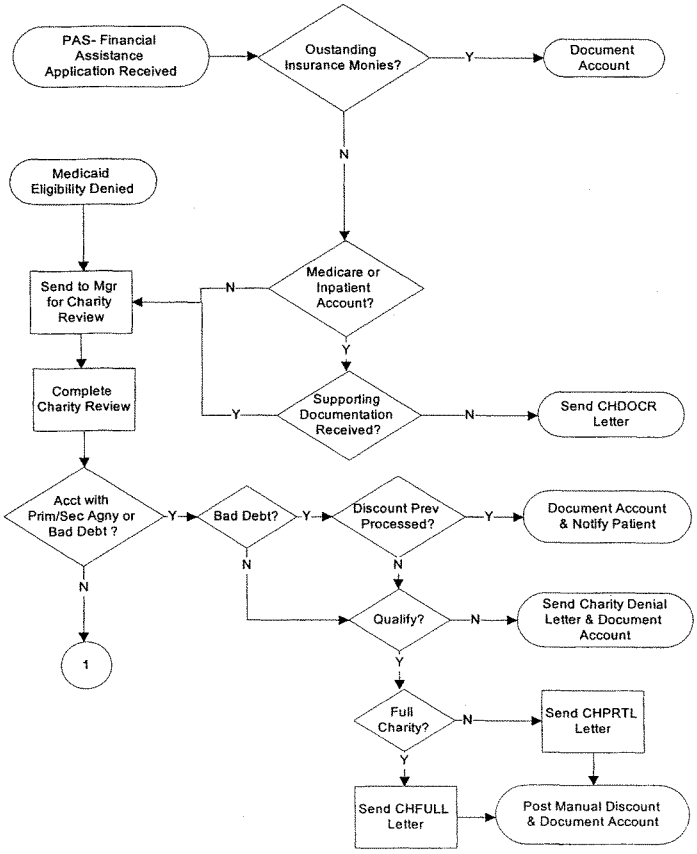
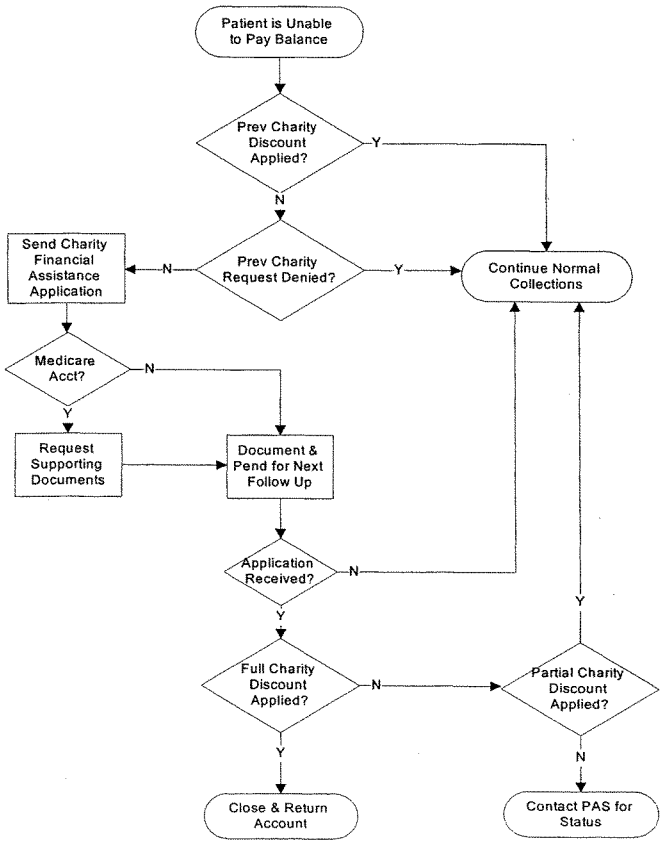
Page 3- PAS Collections- Working from Correspondence Received



HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Discount Charity Policy for Patients
PAGE: 4	REPLACES FLOW DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PF.COLL.018

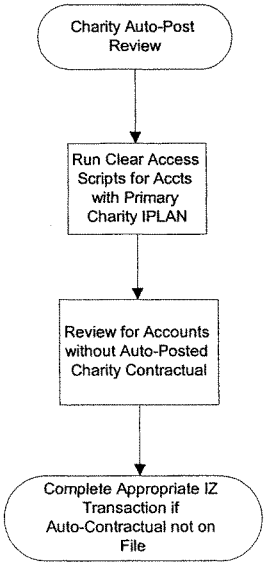
Page 4 - Vendor Self-Pay Charity Flow



HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Discount Charity Policy for Patients
PAGE: 5	REPLACES FLOW DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PF.COLL.018

Page 5- PAS Daily Review of Auto-Posted Charity Discount



1-D

Dear Patient/Responsible Party.

We are providing this application, because you may qualify for our ***Financial Assistance Program.***

To be eligible for the program, you must have applied for Medicaid, State or Local Assistance and have been denied, because you do not meet the requirement for an application.

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application within fourteen (14) days of receipt.

Inpatient Visits: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months

Medicare Patients: If you are covered by Medicare, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any of the documents listed below.

Supporting W-2
Supporting 1099's
Most recent bank and broker statements
Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Remember if you return this form your bill may be included in our Financial Assistance Program

FSG.FT.COLL.638

FINANCIAL ASSISTANCE APPLICATION

Hospital Name_____ Account Number_____
Patient Name_____ Social Security Number_____
Responsible Party Name_____ Social Security Number_____

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Name (First, Middle and Last Name if different than Patient)	Age

Employment (Patient/Responsible Party)

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Spouse Employment

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Other Income

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bond, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other State/County Assistance? _____
If yes and known, Case Number_____ Date Applied_____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature_____ Date_____

Estimado paciente o parte responsable:

Le enviamos este formulario, pues usted podría calificar para nuestro ***Programa de Asistencia Financiera.***

Para ser elegible, a usted se le debe haber negado el Medicaid, o cualquier asistencia estatal o local porque no cumple los requisitos de solicitud.

El formulario adjunto sólo tiene relación con las cuentas hospitalarias, y no incluye otras facturaciones que usted tenga que pagar, como atención médica, radiología, servicio de ambulancia, etcétera.

Si desea que le consideremos para asistencia total o parcial, **usted debe llenar** el Formulario de Asistencia Financiera. La parte responsable **deberá firmar al pie del documento,** y enviarnos el formulario completo dentro de los catorce (14) días posteriores a haber recibido la planilla.

Visitas Ambulatorias: Si usted fue admitido en el Hospital como paciente ambulatorio, es necesario que nos suministre su **más reciente Declaración de Impuestos Federales,** como documentación de apoyo. Si usted no realizó declaración de impuestos, indique la razón, e incluya dos de los documentos relacionados a continuación:

Declaración de Impuestos Estatales
Talones de pago de su empleador
Declaración escrita de sus fuentes de ingresos
Copias de todos los estados de cuenta de su banco durante los últimos tres meses

Pacientes de Medicare: Si usted es beneficiario de Medicare, es necesario que nos suministre su **más reciente Declaración de Impuestos Federales,** como documentación de apoyo. Si usted no realizó declaración de impuestos, indique la razón, e incluya dos de los documentos relacionados a continuación:

Documentos / Formulario W-2
Documentos / Formularios 1099
Estados de cuentas bancarias y de acciones más recientes
Beneficios del Medicare para los que califica

Si por alguna razón no puede entregarnos la información solicitada, incluya una declaración escrita explicando las causas por las cuales no puede hacerlo.

Permítanos diez (10) días hábiles para la realización de nuestro proceso de revisión. Le notificaremos por carta nuestra decisión. Si tiene alguna pregunta o preocupación, no dude en contactar nuestro Servicio al Cliente en cualquier momento que estime conveniente.

Recuerde que si nos devuelve el formulario, su cuenta médica pudiera ser incluida en nuestro Programa de Asistencia Financiera

SOLICITUD DE ASISTENCIA FINANCIERA

Nombre del Hospital_____ Número de Cuenta_____
Nombre del paciente_____ Número de Seguro Social (SSN)_____
Nombre de la parte responsable_____ Número de Seguro Social (SSN)_____

Dependientes en el núcleo familiar

(Incluye a la/el esposa/o, hijos menores de 18 años, y las demás personas registradas como dependientes en su declaración de impuestos)

Nombre (Nombre, Segundo Nombre y Apellido si no es el del paciente)	Edad
	____
	____
	____

Situación laboral (Paciente/Parte Responsable)

Empleador_____ Pago por hora_____ Horas semanales de trabajo_____
Ingreso actual bruto semanal, mensual o anual (antes de la deducción de impuestos) _____
Si está desempleado, última fecha de trabajo_____

Situación laboral del cónyuge

Empleador_____ Pago por hora_____ Horas semanales de trabajo_____
Ingreso actual bruto semanal, mensual o anual (antes de la deducción de impuestos)_____
Si está desempleado, última fecha de trabajo_____

Otros ingresos

	Paciente	Cónyuge
Seguro Social		
Pensiones		
Desempleo		
Compensación del trabajador		
Beneficios VA		
Ingreso por rentas		
Acciones, Bonos, 401K		
Dividendos/Intereses		
Manutención infantil		
Pensión alimenticia		
Otros		

¿Ha solicitado los beneficios del Medicaid o cualquier otra asistencia estatal/del condado? _____
En caso positivo, Número de Caso_____ Fecha de solicitud_____

Yo, el que suscribe, certifico que la información arriba relacionada es verdadera y exacta hasta donde llegan mis conocimientos. Comprendo que la información suministrada será objeto de verificación. En el proceso de revisión se solicitará un informe de crédito para verificar la información suministrada en esta solicitud. Entiendo que la falsificación de la información ofrecida puede poner en peligro la consideración de mi caso para el programa. Además, entiendo que debo solicitar para recibir cualquier asistencia disponible y posible para pagar esta cuenta hospitalaria antes de completar este formulario, con el fin de poder calificar como beneficiario de este programa de ayuda financiera.

Firma:_____ Fecha: _____

FSG.FT.COLL.638

1-E

Charity Discount Full

CHFULL

```
\
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that an charity discount has\
been applied to the account listed on this letter.  The account is now\
considered closed.\
\
If you have any questions or concerns, please contact us at the number\
listed below.\ Thank you for choosing @131\
for your healthcare needs.\
\
\
Sincerely,\
\
\
\
@041\
@048\
\
\
\
```

Charity Discount Partial

CHPRTL

```
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that a partial charity\
discount has been applied to the account listed on this letter.  The\
remaining account balance of $ @081 is due now. Payment may be made by\
check, money order or credit card. In addition, payment may be made\
through the Internet at our web address @028.  If you are paying by check,\
please include your account number on the check.\
\
If payment has been made since the date of this letter, please disregard\
this request. Thank you for choosing @131\
for your healthcare needs.  If you have any questions or concerns, please\
contact us at the number listed below.\
\
\
Sincerely,\
\
\
\
@041\
@048\
\
\
\
Credit Card Authorization\
\
When paying by credit card, check the appropriate card and complete\
the information below.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Card Number: ____________________________________________________\
Expiration Date: ________________________________________________\
Signature of Cardholder: ________________________________________\
Payment: $_______________________________________________________\
\
\
```

Charity Discount Denied - Federal Poverty Guidelines

```
\
\
\                                                          CHDFPG
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Account Balance: @013\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that your charity\
discount request has been denied due to income exceeding the Federal\
Poverty Charity Guidelines.\
\
The account balance @013 is due now. Payment may be made by check,\
money order or credit card. In addition, payment may be made through the\
Internet at our web address @028.  If you are paying by check, please\
include your account number on the check.\
\
If payment has been made since the date of this letter, please disregard\
this request. Thank you for choosing HCA @131\
for your healthcare needs.  If you have any questions or concerns, please\
contact us at the number listed below.\
\
\
Sincerely,\
\
\
\
@041\
@048\
\
\
\
Credit Card Authorization\
\
When paying by credit card, check the appropriate card and complete\
the information below.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Card Number: ____________________________________________________\
Expiration Date: ________________________________________________\
Signature of Cardholder: ________________________________________\
Payment: $_______________________________________________________\
\
\
```

Charity Discount Denied – Missing Documentation

```
\                                                                    CHDOCR
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Account Balance: @013\
Service Date: @016 - @017\
\
\
Dear @052:\
\
Thank you for providing the Financial Assistance Application.\
However, we need some additional supporting documentation to determine\
your qualification.  Please provide your Federal Income Tax Return\
for the most current year or two of the following documents:\
\
   •  State Income Tax Return for the most current year\
   •  Employer Pay Stubs for the last six months\
   •  Written documentation from income sources\
   •  Copy of all bank statements for the last three months\
   •  Current credit report\
\
To continue the charity discount process, the required supporting\
documentation must be returned within seven (14)days of the date on\
this letter. If you have any questions or concerns, please contact us\
at the number listed below.\
\
Sincerely,\
\
\
\
@041\
@048\
\
\
```

Charity Discount Denied – Financial Assistance Application

```
\                                                          CHDFAA
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Account Balance: @013\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that your charity\
discount request has been denied due to the Financial\
Assistance Application not being received.\
\
The account balance @013 is due now. Payment may be made by check,\
money order or credit card. In addition, payment may be made through the\
Internet at our web address @028.  If you are paying by check, please\
include your account number on the check.\
\
If payment has been made since the date of this letter, please disregard\
this request. Thank you for choosing HCA @131\
for your healthcare needs.  If you have any questions or concerns, please\
contact us at the number listed below.\
\
\
Sincerely,\
\
\
\
@041\
@048\
\
\
\
Credit Card Authorization\
\
When paying by credit card, check the appropriate card and complete\
the information below.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Card Number: ____________________________________________\
Expiration Date: ________________________________________\
Signature of Cardholder: ________________________________\
Payment: $_______________________________________________\
\
\
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Charity Discount Denied – Income Validation

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\                                                          CHDIVD
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Account Balance: @013\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that your charity\
discount request has been denied due to missing income validation\
documentation.\
\
The account balance @013 is due now. Payment may be made by check,\
money order or credit card. In addition, payment may be made through the\
Internet at our web address @028.  If you are paying by check, please\
include your account number on the check.\
\
If payment has been made since the date of this letter, please disregard\
this request. Thank you for choosing HCA @131\
for your healthcare needs.  If you have any questions or concerns, please\
contact us at the number listed below.\
\
\
Sincerely,\
\
\
\
@041\
@048\
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\
Credit Card Authorization\
\
When paying by credit card, check the appropriate card and complete\
the information below.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Card Number: ____________________________________________________\
Expiration Date: ________________________________________________\
Signature of Cardholder: ________________________________________\
Payment: $_______________________________________________________\
\
\
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Charity Discount Denied - Other

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\                                                          CHDOTH
@091\
\
\
@052\
@053\
@055 @057\
\
\
Facility Name:  @131\
Patient Name: @002\
Account Number: @011\
Account Balance: @013\
Service Date: @016 - @017\
\
Dear @052:\
\
This letter is being sent to notify you that your charity\
discount request has been denied due to the following reason:\
\
@081_____\
\
The account balance @013 is due now. Payment may be made by check,\
money order or credit card. In addition, payment may be made through the\
Internet at our web address @028.  If you are paying by check, please\
include your account number on the check.\
\
If payment has been made since the date of this letter, please disregard\
this request. Thank you for choosing HCA @131\
for your healthcare needs.  If you have any questions or concerns, please\
contact us at the number listed below.\
\
\
Sincerely,\
\
\
\
@041\
@048\
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\
\
Credit Card Authorization\
\
When paying by credit card, check the appropriate card and complete\
the information below.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Card Number: _____\
Expiration Date: _____\
Signature of Cardholder: _____\
Payment: $_____\
\
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Uninsured Charity Discount Full
Letter Name: SPCHFULL

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@091\
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\
@052\
@053\
@055 @057\
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\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @52:\                                                          \
Esta carta es enviada para notificarle que una reduccion de beneficencia sin\
seguro ha sido aplicada a su cuenta. Su cuenta es este momento esta\ cerrada.\
\
Si tiene alguna pregunta o problema, porfavor de llamar a el siguiente numero.\
Gracias por su preferencia @131 para el cuidado de su salud.\
\
\
Sinceramente,\
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@041\
@048\
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Uninsured Charity Discount Partial
Letter Name: SPCHPRTL

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@091\
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@052\
@053\
@055 @057\
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\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @52:\
\
Esta carta le es enviada para notificarle, que una reduccion parcial de\
beneficencia sin seguro, ha sido aplicada a la cuenta mencionada en esta\ carta.
El balance que le queda de $____(@081)___, se le vence ahora.  Puede\ hacer su
pago por medio de cheque personal, money order o targeta de credito.\ Tambien
puede hacer su pago por medio de la Internet a la siguiente direccion\ @028. Si
va a pagar por medio de cheque, porfavor escriba su numero de cuenta\ en el
cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
\
\
@041\
@048\
\
\
\
Autorizacion para pagar con tarjeta de credito\

\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\

[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: ____________________________________________\
Numero de Cuenta: ____________________________________________\
Fecha de Caducidad: ____________________________________________\
Firma:____________________________________________\
Cantidad: $____________________________________________\
\
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Uninsured Charity Discount Denied - Federal Poverty Guidelines
Letter Name: SPCHDFPG

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@091\
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@052\
@053\
@055 @057\
\
\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado (a)@052:\
\
Esta carta es para notificarle que su solicitud de beneficencia sin seguro le\
ha  sido negada porque sus ingresos sobrepasan el Indice de Pobreza Federal.\
\
El balance de la cuenta @013 se le vence ahora.  Puede hacer su pago por medio\
de cheque personal, money prded o tarjeta de credito.  Tambien puede hacer su\
pago por medio de la Internet a la siguiente direccion @028.  Si va a pagar\ con
cheque, porfavor escriba su numero de cuenta en el cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
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\
@041\
@048\
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\
Autorizacion para pagar con tarjeta de credito\
\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: ____________________________________________________\
Numero de Cuenta: ____________________________________________________\
Fecha de Caducidad: ____________________________________________________\
Firma:____________________________________________________\
Cantidad: $____________________________________________________\
\
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Uninsured Charity Discount Denied – Missing Documentation
Letter Name: SPCHDOCR

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@091\
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@052\
@053\
@055 @057\
\
\
Nombre Del Hospital: @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @052:\
\
Gracias por proveer su Formulario de Testificacion de Ingresos para una\
reduccion de beneficencia sin seguro. Necesitamos pruebas adicionales para\
determinar su qualificacion. Por favor envie su mas reciente Declaracion\
Federal de Inpuestos, o dos copias de los siguientes documentos.\
\

- Declaracion de Inpuesto Estatal de el ano mas reciente\
- Talon de cheque de su sueldo por los ultimos seis meses\
- Prueba en escrito de otros Recursos economicos\
- Copia de los estados de cuenta bancaria por los ultimos tres meses\
- Copia reciente de su Reporte de Credito\

\
Para continuar con el proceso de su Solicitud de reduccion de beneficencia sin seguro, necesitamos que nos remita la informacion aqui requerida, en un periodo de (7)siete dias ha partir de la fecha de esta carta. Si tiene alguna\
pregunta o problema porfavor de llamar a el siguiente numero.\
\
\
Sinceramente,\
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@041\
@048\
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Uninsured Charity Discount Denied – Income Attestation Form
Letter Name: SPCHDIFM

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\
@091\
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@052\
@053\
@055 @057\
\
\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
Facility Name:  @131\
\
\
Estimado(a) @052:\
\
Esta carta es para notificarle que su solicitud de reduccion de beneficencia\
sin seguro le ha sido negada porque el Formulario de Testificacion de Ingresos\
no ha sido recivido.\
\
El balance de la cuenta @013 se le vence ahora.  Puede hacer su pago por medio\
de cheque personal, money prded o tarjeta de credito.  Tambien puede hacer su\
pago por medio de la Internet a la siguiente direccion @028.  Si va a pagar\ con
cheque, porfavor escriba su numero de cuenta en el cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
\
\
\
@041\
@048\
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\
Autorizacion para pagar con tarjeta de credito\
\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: ____________________________________________________\
Numero de Cuenta: ____________________________________________________\
Fecha de Caducidad: ____________________________________________________\
Firma:____________________________________________________\
Cantidad: $____________________________________________________\
\
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Uninsured Charity Discount Denied – Income Validation
Letter Name: SPCHDIVD

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\
@091\
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\
@052\
@053\
@055 @057\
\
\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @052:\
\
Esta carta es para notificarle que su solicitud de reduccion de beneficencia sin
seguro ha sido negada porque no incluyo la documentacion de verificacion de
ingresos.\
\
El balance de la cuenta @013 se le vence ahora.  Puede hacer su pago por medio\
de cheque personal, money prded o tarjeta de credito.  Tambien puede hacer su\
pago por medio de la Internet a la siguiente direccion @028.  Si va a pagar\ con
cheque, porfavor escriba su numero de cuenta en el cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
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\
\
@041\
@048\
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\
\
Autorizacion para pagar con tarjeta de credito\
\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: ____________________________________________________\
Numero de Cuenta: ____________________________________________________\
Fecha de Caducidad: ____________________________________________________\
Firma:____________________________________________________________\
Cantidad: $____________________________________________________\
\
\
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```

Uninsured Charity Discount Denied - Insurance
Letter Name: SPCHDINS

```
\
@091\
\
\
@052\
@053\
@055 @057\
\
\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @052:\
\
Esta carta es para notificarle que su solicitud de beneficencia sin seguro le\
ha sido negada porque la aseguranza cubrio esta visita.\
\
El balance de la cuenta @013 se le vence ahora.  Puede hacer su pago por medio\
de cheque personal, money prded o tarjeta de credito.  Tambien puede hacer su\
pago por medio de la Internet a la siguiente direccion @028.  Si va a pagar\ con
cheque, porfavor escriba su numero de cuenta en el cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
\
\
\
@041\
@048\
\
\
\
Autorizacion para pagar con tarjeta de credito\
\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: ____________________________________________\
Numero de Cuenta: ____________________________________________\
Fecha de Caducidad: ____________________________________________\
Firma:____________________________________________\
Cantidad: $____________________________________________\
\
```

Uninsured Charity Discount Denied - Other

Letter Name: SPCHDOTH

```
\
@091\
\
\
@052\
@053\
@055 @057\
\
\
Nombre Del Hospital:  @131\
nombre Del Paciente: @002\
Numero De Cuenta: @011\
Fecha De Servicio: @016 - @017\
\
\
Estimado(a) @052:\
\
Esta carta es para notificarle que su solicitud de reduccion de beneficencia\
sin seguro ha sido negada porque la siguiente razon:\
\
@081_____\
\
El balance de la cuenta @013 se le vence ahora.  Puede hacer su pago por medio\
de cheque personal, money prded o tarjeta de credito.  Tambien puede hacer su\
pago por medio de la Internet a la siguiente direccion @028.  Si va a pagar\ con
cheque, porfavor escriba su numero de cuenta en el cheque.\
\
Si ud mando su pago, antes de que esta carta fuera enviada, porfavor ignore\
esta notificacion.  Gracias por preferir @131 para el cuidado de su salud.\
Si tiene alguna pregunta o problema por favor de llamar a el siguiente numero.\
\
\
Sinceramente,\
\
\
\
@041\
@048\
\
\
\
Autorizacion para pagar con tarjeta de credito\
\
Para pagar con tarjeta de credito, marque el tipo de tarjeta, y complete la\
siguiente informacion.\
\
[ ] Visa            [ ] American Express\
[ ] MasterCard      [ ] Discover\
\
Nombre en Tarjeta: _____\
Numero de Cuenta: _____\
Fecha de Caducidad: _____\
Firma:_____\
Cantidad: $_____\
\
\
\
```

NATIONAL PATIENT ACCOUNT SERVICES

Operational & Procedural Toolkit

National Patient Account Services, Inc.
400 South 4th Street • Suite 500
Phone (502) 572-3120 • Fax (502) 572-3150

Last Revised Date: 07/01/2004

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Overview of NPAS

History/Background

National Patient Account Services (NPAS) began operations as the Central Collections Department (CCD) in 1980. CCD functioned as a "Pre-Primary Collection Agency" collections group for 18 Humana CBO Hospitals. This group was expanded over the next 2 years to include all Humana Hospitals.

The original CCD group collected private pay delinquent accounts, typically greater than 70 days from discharge. Accounts deemed uncollected were then forwarded to an outside primary collection agency. Accounts were cycled through primary and salvage units and then were scheduled for return to the hospital. Subsequently, they were turned over to the hospital's primary collection agency.

In 1988 two additional collection groups were added to the delinquent group: Central Insurance Follow-up Services (CIFS) and Central Patient Account Services (CPAS).

CIFS worked pending insurance accounts (typically non-governmental) that were unpaid after 75 days from date of final bill.

Originally NPAS worked accounts with no insurance after 55 days from discharge, and accounts previously identified as insurance after 40 days from insurance payment or denial. This group was a first attempt at an "early-out" type of collection effort. This group's goals were to ensure all insurance had been identified, there were no billing problems, when and how the patient would pay the balance due or to determine the account was not collectable at an early stage. However, this follow-up was not aggressive.

Current Overview

In 1994 it became apparent that the collection needs of the hospitals had changed. In order to address these needs and to improve overall collections at a reduced cost, HCA's Group Operation Management defined a new strategy. The basics of this strategy are defined as:

- Refocus hospitals' internal efforts on the 20% of accounts consisting of large balance insurance and Medicare/Medicaid Accounts
- Remove the burden from the hospitals for the 80% of accounts that consists of self-pay, certain/designated insurance accounts, and outpatient accounts
- Redesign the former Humana/Galen Central Collections group as an Internal Early Out Vendor

The first redesign/conversion/expansion effort began in September 1994 and continued through 1995. The former Galen Hospitals began using the Early-Out Placement options in October 1994. The installation of new collection software to handle the new type of business (and additional volume) began in November 1994 and continued through June of 1995. Pilots were successfully completed using former Galen hospitals' placements and with former HCA hospitals in January/February 1995. All existing hospitals' accounts were converted to new collection and predictive dialing software in June 1995.

A new complete site was opened in Bedford, Texas in 1996. At present, this site is fully staffed.

The Louisville, KY and Bedford, TX sites currently serve all HCA hospitals and provide certain collection services to Lifepoint. The Louisville, KY center expanded over the years and currently includes more than 450 work stations. The Bedford, TX site currently includes approximately 250 workstations.

The strategy was refocused further, beginning in 1999, with a second redesign and with HCA's move to Revenue Service Centers (PASs). CPAS changed its name to National Patient Account Services (NPAS) in September 2000 in following the naming of the RCOM Service centers. The new strategy and redesign addressed improvements pertaining to the management of self-pay and small balance accounts. Per the RCOM directive NPAS now receives all self-pay accounts at the time of discharge.

In an attempt to address customer complaint issues and to improve quality, NPAS added a new call recording system in July 2000. All calls are presently recorded. This allows us to review and address any issues that may arise. In addition, the recordings provide NPAS with a coaching tool that allows us to improve our customer service and collection performance.

NPAS maintains a stringent quality review process that includes review of monthly call recordings on each CSP. To ensure that NPAS continues to provide, the utmost in customer service, cost efficiency, collections and compliance per HCA, NPAS guidelines, the following monthly audits are conducted: systems, processes, account handling efficiency, messages sent to the PAS/hospital, quality reviews performed by managers on CSPs, or by special request (i.e., HIPAA & Charity).

CONTACT INFORMATION

Louisville, KY Office

Location:
500 Kaufman-Straus Building
400 South 4th Ave.
Louisville, KY 40201

Mailing Address:
P.O. Box 1021
Louisville, KY 40201

General Phone/Fax Numbers:
Main Switchboard: 800-222-0049
Fax: 877-405-6032
Toll Free # for PAS/Hospitals only - 800-422-2714
Toll Free # for PAS/Hospitals to give to GN/PT only - 800-944-1859

Hours of Operations

Mon. - Thurs.	8:00am - 10:00pm
Friday	8:00am - 9:30pm
Saturday	9:00am - 1:00pm

(Eastern Standard Time)

Executive & Director Management - Louisville, KY

Curtis Warfield	Chief Executive Officer	502-572-3101
Joe Shutts	Chief Operating Officer	502-572-3199
Garett Jackson	Chief Financial Officer	502-572-3283
Joe Dickerson	Director, Insurance Department	502-572-3274
Tom Rogers	Director, Private Pay Department	502-572-3158
Sherri Harbsmeier	Director, Human Resources	502-572-3284
Charlie Schuhman	Director, Client Services	502-572-3219
Barry Swanson	Director, Training & Education	502-572-3149
Paula Hahnert	Director, IT&S	502-572-3124

Client Support Managers	Respsonsibility By Division	Local Number	Toll Free Number
Lisa Duncan	Mid America, Delta, San Antonio	502-572-3251	877-588-9144
Jon Hanks	Far West	502-572-3240	877-588-9132
Marquita McKune	East Florida, West Florida, North Florida	502-572-3109	877-588-9131
Bill Sutton	Gulf Coast, Continental, North Texas	502-572-3309	877-588-9147
Robert Wordlow	Central Atlantic, Southeast, Health Midwest, Life Point, Triad	502-572-3308	877-588-9145

Bedford, TX Office

Location:
3600 Harwood Road, Suite B
Bedford, TX 76021

Mailing Address:
P.O. Box 99008
Bedford, TX 76095

General Phone/Fax Numbers:
Main Switchboard: 817-819-1916
Fax: 877-405-6032
Toll Free # for PAS/Hospitals only - 800-422-2714
Toll Free # for PAS/Hospitals to give to GN/PT only - 800-944-1859

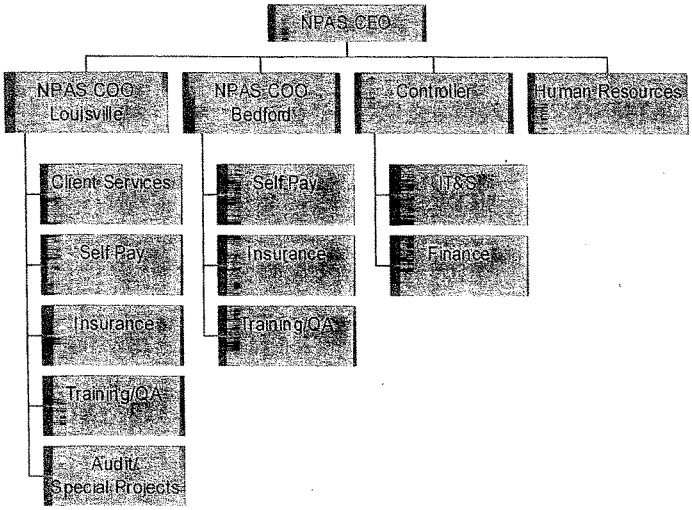
Hours of Operations:

Mon. - Thurs.	8:00am - 10:00pm
Friday	8:00am - 9:30pm
Saturday	9:00am - 1:00pm

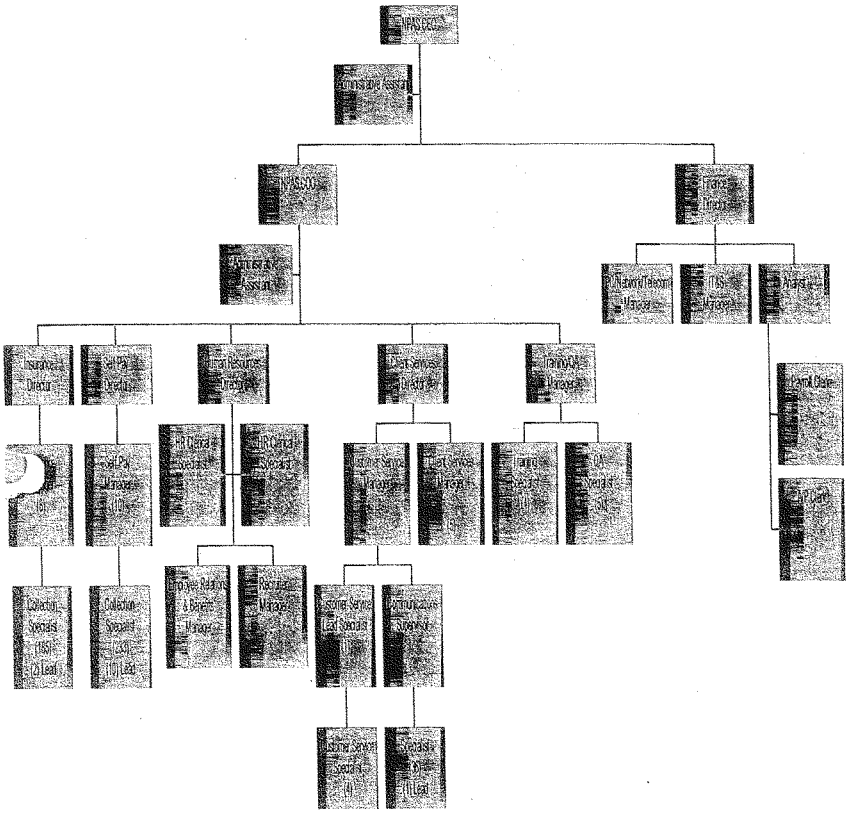
(Central Standard Time)

Executive & Director Management - Bedford, TX		
Debra Machos	**Chief Operating Officer**	**817-358-8001**
Steve Teddy	**Director, Insurance Department**	**817-358-8012**
Gina Broussard	**Director, Private Pay Department**	**817-358-8011**

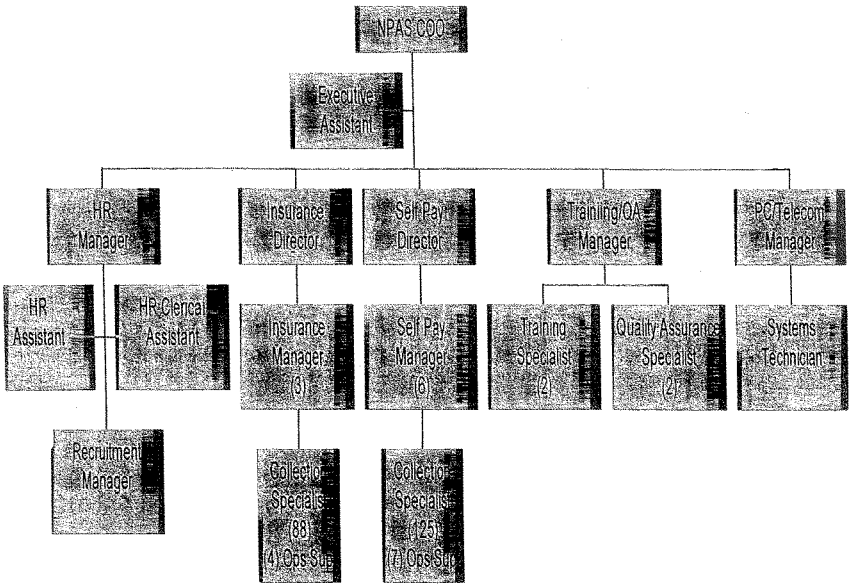
ORGANIZATIONAL CHART



NPAS Louisville



NPAS Bedford



Standard Placement Parameter

A standard set of parameters has been established for all hospitals/PASs to follow, which allows flexibility in the type, dollar amount, and age of the accounts that can be placed. The following are these parameters:

ALL SELF-PAY ACCOUNTS

- All balances (minimum balance $10.00)
- At time of discharge/final bill (standard)
- 1 day from insurance payment (prior insurance)

ALL COMMERCIAL PPO INSURANCE PAYORS (at discretion of hospital/PAS)

- Minimum balance $10.00 to $1,000
- Maximum balance over $1,000 set by hospital
- 35 days from final bill date (standard)

WORKER'S COMPENSATION (at discretion of hospital/PAS)

- Minimum balance $10.00
- 35 Days from bill date (standard)

CHAMPUS (at discretion of hospital/PAS)

- Minimum balance $10.00
- 35 Days from bill date (standard)

HMO (at discretion of hospital/PAS)

- Minimum balance $10.00
- 35 Days from bill date (standard)

DELINQUENT OR TROUBLED INSURANCE/CLEAN-UP OF OLD ACCOUNTS (At discretion of hospital/PAS and agreement and approval of NPAS COO)

- All sweeps should be reviewed with NPAS prior to placement
- Balances set by Hospital
- Insurance greater than 40 days from bill date

PA Masterfile Settings

To forward accounts to NPAS, the hospital should set their profile or master file based upon the standard parameters. These profiles and master files control the timing and selection of the accounts for placement with NPAS (see following section titled "PA Masterfile General Instructions").

Early-Out Program: Establishment/Maintenance

Hospitals using Patient Accounting (PA) should contact Customer Support in Information Systems, with details pertaining to the initial master file set-up and use of the auto transfer (interface) mechanisms of the system (see following section titled "Early-Out Agency Placement") Customer Support Phone #: 800-265-8422.

Placements and Data Transfer

Once an account is flagged by the collection system to place as an Early Out, the placement notification is communicated electronically to NPAS automatically on the following day. All changes to demographic information, payment transactions, adjustment transactions and comments entered into the PAS/hospital's collection system before and after placement will be automatically transmitted electronically to NPAS. Likewise, changes to demographics, and collection comments entered by NPAS personnel will be electronically communicated to the hospital and will automatically update the PAS/hospital's collection data within 24 hours (after nightly downloads are complete).

Work Effort and Time Frame

NPAS' goal is to resolve/liquidate early-out placements within 120 days of placement. The average time of an account placement at NPAS is typically less than 60 days for Insurance placed accounts and less than 80 days for Private Pay placed accounts. The work effort for both Insurance and Private Pay accounts is designed around resolving the account with each contact whether it's the first contact or the last. In most instances, the account will be liquidated, regular monthly payments established, pending insurance payment date scheduled, or the account scheduled for return to the hospital within 90 days of placement. Obviously, payment resolutions, legal/liability cases, and some insurance resolution may extend beyond 120 days. A control feature also has accounts set to cycle out of NPAS after 140 days based on a standard mainframe masterfile setting.

PA MASTERFILE – General Instructions

Financial Systems Update

For further information, contact Customer Support (CS) (800) 265-8422

DATE June 9, 2000

TO Chief Financial Officer
Business Office Manager
Data Processing Coordinators
Hospital Director Information Services

FROM Stephen Meyer
Financial System Product Support

SYSTEM Patient Accounting

TOPIC Patient Accounting Early-out Program

CONTENT New early-out agency placement functionality has been developed for Patient Accounting. Early-out processing is intended to alleviate accounts based on account balance and/or financial class criteria. Through early-out processing, facilities can place accounts that would not be advantageous to work internally. While early out is available to all HCA facilities, it may not be appropriate for all facilities.

Instructions on how to set up Master Files and a general overview of early out are contained in the following pages.

Coordination with your Group or Regional Office and Financial Operations is required prior to placement with a preferred vendor.

Early-Out Agency Placement

HCA hospitals or any Lifepoint hospital placing accounts with NPAS do not need a signed contract before placing accounts, as NPAS is a subsidiary of HCA.

Patient Accounting's early-out placement feature enables your hospital to automatically identify accounts that could be effectively handled by an outside agency – an agency that acts on behalf of your facility. In fact, the employees at the early-out agency should act as if they represent your hospital. Early out provides you with more flexibility in your collection efforts. For example, your staff might spend the same amount of time collecting on a relatively small account that they would spend on a large dollar account. Early out is not intended for bad debt accounts.

Early-out processing automatically identifies accounts that should be placed with an early-out agency based on financial class and account balance (placement by patient type will be a future enhancement), regardless of tracking. So, an account can be placed

with an early-out agency even if insurance has not yet been released. Placement can also be directed through the Collection Series Master File regardless of the financial class. Guidelines for when an account goes to an early-out agency are determined based on contract criteria and defined in various master files.

Early-out placement is available for both Collection and non-Collection system sites.

Note: for Collection System sites the information that is completed for early-out agencies in the FAGNY Master File on the Collection system must match exactly as entered in the Collection Agency Master on host.

Accounts that are placed with early-out agencies can automatically be placed with primary agencies, bad debt, or assigned through the agency assignment feature on Patient Accounting when placement days have expired with the early-out agency.

Agency range 770-799 is defined by corporate and agencies are assigned based on the satisfactory completion interface criteria for Patient Accounting.
Current agencies include:

770 AC/NCO (NSURE)
771 NPAS (National Pat Account Svcs, Louisville, KY)
772 MFS (NCO (Facs)

How Early-Out Placement Works

Evaluation for early-out placement can begin as early as final bill. At final bill, the system checks the financial class of the account (as determined by the primary insurance plan or the default financial class of 99 for accounts without insurance). The account's financial class is then cross-referenced to the Financial Class Master (figure 1) on host. If early-out parameters are established in the referenced financial class (early-out days and agency) the account is flagged with the appropriate information.

Note: It is imperative that the parameters in the financial class master not be established until the day placements are to begin.

Figure 1

```
        UNIT NUMBER: 0000 0000 - MUSIC CITY MEMORIAL
             ACTION:_            I-INQUIRY    C-CHANGE
          FIN CLASS: 99
 ---------------------------------------------------------------------------
FINANCIAL CLASS DESC:  SELF      SELF-PAY_____________________
UB92 WARNINGS/ERRORS:__              EARLY-OUT INDICATORS
BAD DEBT W/O ACCOUNT:_______         DAYS:_40
I/P BAD DEBT RECOVERY:______         AGENCY CODE: 771
O/P BAD DEBT RECOVERY:______         INPATIENT:_
I/P PROVIDER NUMBER:_____________    OUTPATIENT:_
O/P PROVIDER NUMBER:___________      EMERGENCY:_
                                     SURGERY:_
*****
Early-out Indicators:
Days = Days from final bill to evaluate for early-out placement, creates early-out date.
Agency Code = Collection Agency associated number from the 770-799 range.
Inpatient = (for future use)
Outpatient = (for future use)
```

Emergency = (for future use)
Surgery = (for future use)
** System currently requires an entry of at least one "Y" in one of the patient type fields.

(Example using parameters in Figure 1: Self-pay account final bills on 01/01/00, system cross references the Financial Class Master and calculates the early-out date to be 02-10-00.)

The early-out date will be displayed on the COLL screen of online patient inquiry in the EOUT DT field (figure 2).

Figure 2

```
===============COLLECTION INFORMATION SCREEN 1===============
 PREV SER:  42   PREV STEP:11    01/19/00        ACTY IND:     ACTY NO: 77
CURR SER:  42   CUR STEP:  11    01/21/00              ACTY IND: L     ACTY NO: 77
NEXT ACT: 02/01/00     LST PAY:                    .00  OVERDUE:    652.00
EOUT DT: 02/10/00     LST STM: 01/28/00     2,250.00   CUR DUE:       .00
AGE CAT: 31-60            STMS:   3                  TOT DUE:       652.00
BD TYPE: NA
GUAR NO:              GUAR NM:
DT LINK:               DT UNLINK:
ARRG/DATE: NONE   FREQ:          EST DUE:       .00    MIN DUE:       .00
```

Collection system sites will view the early-out date and agency on the patient inquiry screen in the EO Date/Agy fields. If an account does not meet early-out financial class criteria, the fields will be set to default values of 99-99-99 for date and 999 for agency (figure 3).

Figure 3

```
COL/HIS   DATE   STA   ACTIVITY: Patient Inquiry            ASSUME-DATE: 09-12-99
CS R5.2 03-14-00 0002  TRACK     MANUAL-REF: UG 3-0-1      ACH
NEXT/PREV= Pkt or Guar UP/DOWN=Bill Thru _
P/N       9662897    DOE JOHN
P/N    9662897          SSN 333-45-6777          Admit Date 02-21-99 Disc Date 02-21-
99
Pat DOE JOHN                                     PType E     FC   5   G/N
Rsp DOE JOHN
Adr RT 2 Box 57                                  P-Ins 400-02  SHAW
Adr                                              Amt Due        107.40  Pd
C&S NASHVILLE     TN                             CS 11 6 CONTROLLER_TRF NOT E
ZIP 37322-0000     Phone (615) 555-4194SD 09-13-99 WTD 08-30-99 Desk       7

Total Charges       134.25                  S-Ins
ActBal       134.25  PatDue     26.85             Amt Due                Pd
Last Pat Pay                Date                  CS
CS   71 2 INSURANCE HAS NOT PAID       SD        WTD          Desk
EO Date/Agy/Hold 99-99-99 999 N        T-Ins
DLY            Last Stmt Date 09/10/99            Amt Due             Pd
Due/Begin            Amt                          CS
Total Combined Bal                                SD         WTD          Desk
```

Once the early-out date has been reached, the system references the accounts financial class to the Financial Class Master to determine with which early-out agency to place the account. If an agency exists, it compares the overall account balance to the parameters established in the collection Agency Master File on host. The Collection Agency Master contains two different sets of min/max dollar levels (MIN AMT1/MAX AMT1 and MIN AMT2/MAX AMT2). Fields MIN AMT1/MAX AMT1 will be used in evaluating those accounts that have **no** insurance liability outstanding. Fields MIN AMT2/MAX AMT2 will be used in evaluating those accounts that *have* insurance liability outstanding.

Note: If the financial class of the account changes prior to early-out placement, the early-out date will be recalculated based on the agency's day's parameter set up in the new financial class from system date. For example, if a financial class change was made on 01-06-00 and the agency day's field is 40, the new early-out date would be 2-15-00. It does not calculate the new early-out date from final bill date plus agency days.

Collection system sites will establish these parameters in the FAGNY Master File on Collections.

If there is NO insurance liability on the account and the overall account balance is equal to or greater than MIN AMT1 and less than or equal to MAX AMT1 in the Collection Agency Master (figure 4), the account is placed with the appropriate agency.

If there is insurance liability outstanding on the account and the overall account balance is equal to or greater than MIN AMT2 and less than or equal to MAX AMT2 in the Collection Agency Master, the account is placed with the appropriate agency.

If there is NO insurance liability on the account and the account balance is less than MIN AMT1, the account is moved to series 985 (agency default). If the account balance is greater than MAX AMT1, and again there is no insurance liability, the account will continue to process in the assigned patient collection series.

If there is insurance liability on the account and the account balance is less than MIN AMT2 or greater than MAX AMT2, the account will remain tracking in the assigned patient and insurance collection series.

Figure 4

```
UNIT NUMBER: 0000    0000 - MUSIC CITY MEMORIAL
   ACTION: I        I-INQUIRY   A-ADD   C-CHANGE   D-DELETE
AGENCY CODE: 771
-------------------------------------------------------------------------------------------------
---------------------------
AGENCY TYPE: E
      NAME: MISCELLANEOUS EARLY-OUT        SHORT: MEO
ADDRESS ONE: 2555 PARK PLAZA            PHONE: 615 - 555 - 1212
ADDRESS TWO:                                    CONTACT: MARY JONES
CITY, STATE: NASHVILLE, TN
      ZIP: 37202 - ____

MIN AMT1: 00005.00          MIN AMT2: 00010.00  START DATE: 1999 01 01  CCYY MM
DD
MAX AMT1: 99999.99 MAX AMT2:   1000.00      END DATE: 2004 12 31  CCYY MM DD
```

PLACEMENT DAYS: 010 PYMT PROC CD: 000027 COLLECTION PAYMENT
NEXT PLACEMENT: 605 PAYMENT %: 100
PRELIST DAYS: 002

****
MIN AMT1 = Minimum transfer amount for accounts without insurance liability.
MAX AMT1 = Maximum transfer amount for accounts without insurance liability.
MIN AMT2 = Minimum transfer amount for accounts with insurance liability.
MAX AMT2 = Maximum transfer amount for accounts with insurance liability.
NEXT PLACEMENT = Valid entries for this field include any primary (corporate or hospital defined) agency, bad debt (990), or 000 (to use the Agency Assignment Master File). This allows the system to automatically transfer accounts appropriately after placement days have expired.

Note: The MIN AMT1 and MIN AMT2 values should be at least $.01 greater than your SMALL BALANCE debit amount.

If the account meets all of the parameters established in the various master files, the account information is then transferred nightly through the TCP/IP network to the assigned agency. Updated account information and bill requests are also sent for accounts previously placed.

Placement activity (new placement, cancel, transfer, deletions) are reported on the Collection Agency Activity Report (AGNY:AGNY01).

Likewise, early-out agencies can send transactions to host through the TCP/IP network. These transactions update demographic, employment, and insurance information. Transactions to update collection notes are also sent (figure 5) and reflect being sent from an external agency. Any rebill (Detail, UB92, or 1500) request entered for an "early out" will be sent automatically to the early-out agency regardless of who ordered it, hospital or agency. These bills are identified on the Bills Generated Report (BILL:BILL16).

Figure 5

```
COL/HIS   DATE   STA   ACTIVITY: FILE TRACK            ASSUME-DATE: 03-15-00
CS R5.2 03-15-00 6015  TRACK     MANUAL-REF: UG 3-0-1     MCM
=========================================================================
============
NEXT-> Forward PREV->Backward EXIT-> _

=========================================================================
============
P/N            1212121  BEECH SANDY            Ins  -  Adm-Date 12-19-99
Pat  BEECH SANDY                        Desk    1 JOE COLLECT ClSub Dt
RESP  BEECH SANDY                       Unit SDS   SAME DAY SURGERY  Type S
Adr 1000 WEST EDGEWATER                       CS  771  1 Accounts placed with
agency
Adr                                     Pckt       SD 06-07-99 WTD 00.00 06-14-99
C&S MIAMI  FL                                 DLY         Est   Balance         175.29
ZIP 12541-0000 Phone (615)555-1212 Arrange Due-Date Arrange Amt Net Balance
SSN  330-27-0001  Sub Un      FC 5                                          175.29
G/N            GNam                GNet              GBal
```

```
=================================================================
============
T Not-Date Time Desk   Field/Note
EX 03-03-99 1039    701 External   PER COMMENTS PATIENT ONLY
EX 03-03-99 1039    701 External  OWES $158.89
```

Collection System site will receive transaction from the early-out agencies through the daily host interface (RDAT:DATCSD).

An account remains with the early-out agency for the number of placement days defined in the Collection Agency Master File or until the account is paid in full, manually recalled or canceled. If a payment or payments are made on the account, and the total of all payments received in a single day meets or exceeds the payment percent (Payment %) in the host Collection Agency Master, when compared to the adjusted turnover amount, the placement days start over. If the payment percent is not met, the placement days keep counting from turnover date.

Collection system sites will enter the payment percent (Payment %) in the % of Bal = Payment to Reset Days field in the FAGNY Master File on the Collection System.

How to Evaluate For Early-Out Placement

One way an account can be processed to an early-out agency, as discussed earlier, is through the use of the parameters in the Financial Class Master on the host. The second would be through the use of an early-out prompt in the Collection Series/Step Master on the host (Collection System sites will use prompts in FCS Master File). Another would be the entry of a financial transaction against the account. The last would be the changing of the account's financial class.

Non-collection system sites could opt to use the prompts in the Collection Series/Step Master (figure 6) to evaluate accounts for placement in conjunction with the Financial Class Master or by itself. *Early-out prompts are to be defined in the patient series.*

Note: The early-out indicators in the Collection Series/Step Master on the Host or the FCS master on the Collection System should not be established until the day placements are to begin to the early-out agency.

Figure 6

```
        UNIT NUMBER: 0000 MUSIC CITY MEMORIAL
           ACTION: I    I-INQUIRY   A-ADD   D-DELETE
COLLECTOIN SERIES: 005
 COLLECTION STEP: 01     TO DELETE A SERIES, STEP MUST = 99
-------------------------------------------------------------------------------------
SERIES DESCRIPTION: COMMERCIAL INSURANCE PATIENT PT
      SERIES TYPE: P     INITIAL STEP DAY: 0
-------------------------------------------------------------------------------------
   ACTIVITY                  ACTIVITY                                NEXT
ST I1 NO1 I2 NO2-------------------DESCRIPTION----------------  DAYS SER/ST
01 N 000   000 NO ACTIVITY                                 007    005 02
02 E 770 M 001 EARLY-OUT PLACEMENT                         014    005 03
L 012    000 COMMERCIAL INSURANCE 8 WKS     007    005 04
04 L 077    000 CONTROLLER ACTION NOT TAKEN                007     005 04
```

(Example using figure 5): An account is final billed on 01-01-00 in the amount of $1000.00. Primary insurance receives $900.00 in liability and the patient $100.00. The financial class of the account does not have early-out parameters defined. The insurance liability is assigned to the insurance collection series and the patient liability is assigned to the patient collection series, in this case series 5. The account steps into step 1 upon final bill due to initial step day being 0. On 01-08-00, the account steps out of step 1 into step 2. As the account enters step 2, the system reads the first activity indicator one (I1) of "E" (early-out evaluation). The next step in processing is to read the activity number one (NO1) of "770". The agency master is then cross-referenced to compare the account balance with either the MIN/MAX1 OR MIN/MAX2 levels (in this case MIN/MAX2 due to insurance liability outstanding). If the account falls between the MIN/MAX levels, the account will be transferred to the appropriate agency during nightly processing. If the account does not fall between the MIN/MAX levels and balance/liability is such that the account will continue to step (see paragraphs 1 and 2 on page 4) the system will then perform activity indicator two (I2) and activity number (NO2).

The only time activity indicator number two (I2) and activity number two (NO2) are valid entries is if activity indicator number one (I1) and activity number one (NO1) is equal to "E" and a valid early-out agency.

The early-out activity indicator can be used in multiple steps. This will permit the system to reevaluate the account balance in every step for early-out placement if the account did not qualify previously.

Collection system sites would modify their patient collection series by entering a valid early-out agency in the Early-Out Agency field in the appropriate FCS (figure 7) and entering a "Y" under the "E" (early-out) field in the desired step.

Figure 7

```
COL/HIS DATE    STA ACTIVITY: COLLECTION SERIES    ASSUME-DATE: 09-12-99
CS R5.2 03-15-00 0002 FCS     MANUAL-REF: MFM 2-4-1 ACH
=========================================================
============
CS 71 PATIENT WITH COMMERCIAL INSURANCE          Type P Init Step Day 0
                                                Early-Out Agency    775
## Letter   E A Act# Desk Days Step CS ## Description
__ _______ _ _ ___ _________ ___ ___ __ ____________________________________
 1          M 999          42  35  71  2  THANK YOUFOR USING MUSIC CITY
 2            M   56          28   21  71  3   INSURANCE HAS NOT PAID THIS B
 3                              0   21  71  4   PHONE CALL TO GN
 4          Y M     7          21   14  71  5   YOUR ACCOUNT IS SERIOUSLY PA
 5                               0    7   00  0  REVIEW FOR PRIMARY PLACEMENT
```

(Example using figure 7): The account will process through steps 1 - 3 accordingly. When the account steps into step 4 during PDSTEP, the Collection System will perform the same evaluation as the host (example using figure 6 on previous page).

The early-out indicator can be used in multiple steps. This will permit the system to reevaluate the account balance in every step for early-out placement if the account did not qualify previously.

Early-Out Parameters Set Up in the Financial Class Master & Collection Series

Both, Host Financial Class Master and the Collection Series/Step Master may be utilized for early-out placements. Both Host and Collection systems will base early-out placement according to which early-out parameter is reached first. Example of this would be if an account final bills on 01/01/00, the financial class master has 2/10/95. However, if at final bill there was patient liability and the initial step day is 0 (step immediately), the account will begin stepping in the patient series. If through stepping, the patient portion reaches a step where there is an early-out parameter defined prior to the system generated early-out date and the account balance falls between the MIN/MAX levels, the account would be placed at that time. If your days in the financial class master were forty, but the first early-out prompt in the series master is before forty days, accounts could be placing earlier then expected.

Preventing Placement with an Early-Out Agency

(Once parameters have been established)

To keep an account from placing with an early-out agency a couple of processes could be followed:

1) Do not use early-out parameters in the Financial Class Master due to the financial class parameters being "global" to all accounts with that financial class. The Collection Series/Step Master must then drive the placement of the accounts. Placing the account into a series that has no early-out parameters established would keep the account from being evaluated.
2) You can place the account on hold from an early-out vendor. Non-collection facilities can enter a "C" transaction with a field code of "EOUT" and new data field of "Y". Collection sites can enter the hold indicator in the patient maintenance activity. These accounts will appear on the Delayed Accounts Report.

Note: If the Financial Class Master is going to be used to drive early-out placements, and currently accounts with those financial classes are set up in "administrative hold" series, a type 1 payment or financial class change will cause an early-out date to be calculated and subsequent placement of the account regardless of what series it was in. In order to produce a report of those accounts in the special series and individually place the early-out processing on hold as previously described. On the Collection System produce a RACCOUNT report using option 2 (collection series), or for non-collection system sites produce a Patient Accounting Custom Report.

Re-Evaluation of Accounts

There will undoubtedly be accounts in the hospital's accounts receivable that may need to be turned over to an early-out agency. Through payments, financial class changes, and possibly the collection series stepping, older accounts will be placed once associated Master Files have been built.

Financial transactions prior to agency placement will cause the host to re-evaluate the account for early-out parameters in the Financial Class Master. If the Financial Class Master has parameters defined for the account's financial class, the system will generate an early-out date equal to system date. The date will update the EOUT DT field on the COLL screen of Online Inquiry and EO Date/Agy fields of the Collection System. A zero payment will also cause the account to be re-evaluated.

Financial Class changes prior to agency placement will also cause the host to re-evaluate the account for early-out placement. If the account at final bill is in a financial class that does not have early-out parameters set up and then is changed to one that does, an early-out date equal to system date plus the "days" parameter will be generated. This date will also update the EOUT DT field on the COLL screen of Online Inquiry and EO Date/AGY fields of the Collection System. If an account has a financial class change to a financial class that has no parameters established, a default date of 99-99-99 is created and the respective fields updated.

Likewise, if an account does not meet early-out criteria initially, but reaches a collection series step where its balance is evaluated for placement, it could be placed at that time.

As you can see, many factors can impact when an account could be evaluated for early-out placement. The thorough understanding of the various master files that impact placement is essential.

Manual Placement of Accounts

Either through HBOSS's AGENCY activity, a free form "C" transaction with a field code of AGNY, or with the Collection System's APLAC activity, you can manually place an account with early out. By using the manual placement options available, the MIN/MAX levels associated with the account can be bypassed. Therefore, an account with an overall balance greater than the MAX1/MAX2 levels could be placed, or an account with an overall balance less than the MIN1/MIN2 levels could also be placed.

Accounts Not To Place with an Early-Out Agency

Accounts with financial arrangements, GN accounts, GN linked accounts, zero balance accounts, and credit balance accounts cannot be placed with an early-out agency.

As long as an account has current financial arrangements (series 900-903) the account is not eligible for placement. However, once the account is in a delinquent status (series 590-593) placement can occur.

GN accounts cannot be placed with an early-out agency. Errors will appear on the Daily Batch Report the following day if accounts are placed manually through the collection system. If the Collection System is being used, the system will give an error indicating that associated accounts must first be unlinked. If the GN's account attempts to place through stepping, the GN account will appear on the Incomplete Agency/Bad Debt Transfer report. The GN account then continues to step in its own series.

If a linked account attempts to go to early out, the system changes the early-out date to all 9's.

Recalling/Canceling an Account From Early-Out

Using HBOSS's AGENCY activity, a "C" transaction with a field code of AGNY, or using the Collection System's APLAC activity an account can be recalled or canceled from an early-out agency just as primary or secondary accounts have in the past.

The system will automatically recall accounts from early-out agencies when their placement days are expired and places with a primary agency or bad debt as defined in the Collection Agency Master.

When an account that was placed with outstanding insurance liability is recalled insurance will be released with a status code of "E". The account will then appear on the Agency Prelist (AGNY:AGNY10) for the specified number of prelist days in the Collection Agency Master File. Collection system sites will view accounts on the RSEC report. After primary agency, bad debt, or through the Agency Assignment as the next placement field indicates in the Collection Agency Master. Manual cancels/recalls will not release insurance; therefore, to place an account after manually canceling/recalling an account, insurance would have to be released prior to primary agency/bad debt placement. The collection system will give users a warning of "all insurance liability will be released" when placing an account with a primary agency after manually recalling from an early-out agency.

Account Statement Consideration

It is possible that an account can be placed with an early-out agency without the patient receiving an account statement from the hospital.

Currently, at the time of final bill, if there is no patient liability, and the information statement prompt in the host Statement Options Master File is set to "N", a patient will not receive a statement. Once there is patient liability, the Collection Series Master determines when the initial account statement should be produced.

Given an example where a commercial insurance is tracking at 100% at final billing, and the information statement prompt is set to "N", no information statement will be produced. When the primary insurance pays, the financial transaction will cause the system to generate an early-out date (if the account is not already placed with an early-out agency). This date is equal to current system date; the account will be placed with current nightly processing. *Collections will receive the date in the daily interface file (RDAT:DATCSD) and the placement will be formatted during the next nights processing.* Due to the placement taking place on the same date when the account could be moving into the first step of a Collection Series where a statement may be designated to be produced but the statement is never generated.

To ensure that a statement will always be produced prior to an account being sent to early-out agency, all early-out placements must be based on the Collection Series Master and not the Financial Class Master (i.e., the early-out parameters would have to be blank in the host Financial Class Master **or** the Information Statement prompt in the host Statement Options Master File is set to "Y").

ACCOUNT SWEEPS

DATE	January 8, 1996
TO	Chief Financial Officer Business Office Manager Data Processing Coordinators Hospital Director Information Services
FROM	Stephen Meyer Patient Accounting Applications Development
SYSTEM	Patient Accounting
TOPIC	Patient Accounting Agency Inventory Sweep
BENEFIT	A new enhancement known as Agency Inventory Sweep ("Sweep") has been developed for Patient Accounting. The Sweep's purpose is to provide Patient Accounting facilities with the ability to reduce their account inventory according to criteria established by them on an as needed basis. This enhancement will improve the rate at which aged accounts can be placed with an agency (early-out or primary) when the facility designates a portion of their accounts receivable that needs external intervention or when placements are just beginning with a new agency. Due to the impact of a Sweep on the account inventory of a facility, it will be controlled at a Host Master File level and should have very limited users with access.
CONTENT	The following pages include how to allow access, screen samples, valid criteria entry, examples of data batches created by the Sweep, and examples of Sweeps. Additional documentation regarding the Sweep can be found in the Patient Accounting Master File Manual Section 7.
DISTRIBUTION	Business Office Managers please distribute to addressees

Agency Inventory Sweep

The philosophy behind the AGENCY INVENTORY SWEEP ("Sweep") functionality for Patient Accounting is to provide the hospitals with the ability to reduce their account inventory according to criteria established by them on an as needed basis.

This functionality will improve the rate at which aged accounts can be placed with an agency (early-out or primary) when the facility designates a portion of their accounts receivable that needs external intervention or when placements are just beginning with a new agency.

Through the completion of the AGENCY INVENTORY SWEEP screen, the facilities will designate by patient type (I, O, E, or S), discharge date or final bill date (date range or age range), financial class (up to five per Sweep), collection series (up to five per Sweep for non-collection sites), and account balance, which accounts should be considered for the "Sweep". These criteria can be used individually or in conjunction with each other. If multiple Sweep criteria are selected, only accounts with an account status of 'AR' (accounts receivable) or 'AX' (account reestablished for follow up) are eligible. Accounts that currently have a status of 'AR' but have previously been recalled from an agency will not be eligible. If an individual account has been put on hold from early out, it will be excluded from the Sweep to either an early out or primary.

Facilities will be able to complete one AGENCY INVENTORY SWEEP screen per day. Modifications will be permitted throughout the day, however, the criteria as defined at processing time (approximately 10:00 p.m.) will be used in determining which accounts to select.

The AGENCY INVENTORY SWEEP screen has a double verification check. Once the screen has been completed, the user will press <ENTER> then a second prompt will appear asking the user to "PRESS ENTER TO COMPLETE AGENCY SWEEP REQUEST OR "Y" TO CANCEL". At the second prompt the user can either press <ENTER> to continue, F3 to exit, or "Y" and <ENTER> to inactivate any Sweep criteria previously entered.

Upon nightly processing, a batch will be created by Patient Accounting with a batch label of "IS01; AGY SWEEP" for the current processing date. This batch will be viewable the following day under Online Transaction Maintenance. Any rejections from the batch that appear on the Daily Batch Report (CONT:CONT01) should be worked as a normal facility batch with errors. Review all rejections for appropriateness and possible correcting re-entries (see Possible batch rejection examples section).

Due to the amount of accounts that a Sweep could impact, it is recommended that a Patient Accounting Custom Report be created and printed using criteria that would be used in a potential Sweep prior to actually performing the Sweep. There is no automatic reversal of a Sweep; therefore it is critical that the user entering the Sweep criteria be aware of all potential accounts that may be included in the Sweep. Accounts placed through the sweep that the user did not want to be placed will have to be canceled using a C; patient number; AGNY; X transaction for non-Collection sites or canceling the placement on the Collection System through the APLAC activity.

Assigning Security

The Security Administrator for the facility should assign security on a very limited basis to the Sweep. The following steps (1-5) show where the security resides to give access for the Sweep activity:

Sweep Screens

1

```
++
| |
| HOSPITAL ONLINE SYSTEMS MENU |
| |
++
1. PATIENT ACCOUNTING
2. GENERAL ACCOUNTING
3. SAIS
4. PAYROLL/BENEFITS/HUMAN RESOURCES
5. TRANSACTION MAINTENANCE
6. STATISTICS
7. SECURITY

MENU SELECTION: __ ACCESS ID: _____ ACCESS CODE:
```

2

```
HOSPITAL ONLINE SECURITY SYSTEM DATE: 122095
ACTION: _ MAINTENANCE MENU SE01

USER/UNIT: _____
ACCESS ID: _____

1. INQUIRE/MAINTAIN BY ID
2. INQUIRE/MAINTAIN BY APPLICATION
3. COPY SECURITY SETUP
4. MAINTAIN ACCESS CODE/DESCRIPTION
5. VIEW SECURITY OPTIONS
6. REQUEST REPORT

ENTERCONTINUE F3EXIT
```

3

```
HOSPITAL ONLINE SECURITY SYSTEM DATE: 122095
INQUIRE/MAINTAIN BY ID SE02

USER:
PLEASE ENTER THE FOLLOWING TO RESTART SEARCH
```

```
ACCESS ID: _________ DISPLAY ALL IDS: N

APPLICATION/ACTIVITY:
_________V_____________________________________
ACTION ACCESS ID ACCESS CODE DESCRIPTION GRANTED
S ABC ABC123 MANAGER, THE




MORE...
DDELETE SSELECT (CHG OR INQ) F3EXIT F7PREV F8NEXT F9-
CANCEL
```

4

```
HOSPITAL ONLINE SECURITY SYSTEM DATE: 122095
INQUIRE/MAINTAIN BY APPLICATION SE03

USER:
ACCESS ID: CODE: DESC: MANAGER, THE
ACTION APPLICATION/ACTIVITY ACCESS GRANTED
C PATIENT ACCOUNTING  MASTER FILES Y
_ PATIENT ACCOUNTING  MASTER FILES CORP
_ PATIENT ACCOUNTING  ONLINE CASHIERING
_ PAY/BEN/HRS  COL/HCA BENEFITS
_ PAY/BEN/HRS  GLOBAL EMPLOYEE MAINT
_ PAY/BEN/HRS  HTI BENEFITS
_ PAY/BEN/HRS  HTI BENEFITS  CORP MAINT
_ PAY/BEN/HRS  HUMAN RESOURCES
_ PAY/BEN/HRS  ONLINE PAYROLL
_ PSYCH REPORTING
_ QMIRS STATISTICS MAINTENANCE
_ QMIRS STATISTICS MAINTENANCE  CORP
_ SAIS
MORE... CCHANGE DDELETE IINQUIRE F3EXIT F7PREV F8NEXT F9-
CANCEL
```

5

```
HOSPITAL ONLINE SECURITY SYSTEM DATE: 122095
MAINTAIN SECURITY SE04
USER:
```

```
ACCESS ID: CODE: DESC: MANAGER, THE
ADD ADD CHG. CHG. DEL DEL INQ INQ
PATIENT ACCOUNTING  MASTER FILES SEN SEN SEN SEN
UPDATE
CARRIER PROFILE (Y/N) Y
ALERT EDIT MASTER (Y/N) Y
ELECTRONIC RA (Y/N) Y
DEPARTMENT MAINTENANCE (Y/N) Y
AGENCY INVENTORY SWEEP (Y/N) Y



DATE ADDED: 112691 DATE UPDATED:
MORE...
F3EXIT F7PREV F8NEXT
```

Access to Sweep

Once security has been given to a user, to enter the Agency Inventory Sweep, the user will need to logon as follows on a **Host** session (steps 1-5):

1

```
HCA CORPORATE SYSTEMS GROUP

_ EXIT (PF01)
_ HOSPITAL ONLINE SYSTEMS (PF04)
_ MAIL (PF08)
_ 1995 GL CLOSING SCHEDULE (PF09)
_ TECHNICAL REPOSITORY (PF10)
_ HUMANA INSURANCE (PF11)
_ R/DARS PRODUCTION SYSTEM (PF12)

Command:
_____________________________________________________
_______
```

2

HOSPITAL ONLINE SYSTEMS MENU

1. PATIENT ACCOUNTING
2. GENERAL ACCOUNTING
3. SAIS
4. PAYROLL/BENEFITS/HUMAN RESOURCES
5. TRANSACTION MAINTENANCE
6. STATISTICS
7. SECURITY

MENU SELECTION: __ ACCESS ID: _____ ACCESS CODE:

F3EXIT

3

ACTIVITY: __

MASTER FILES
2. PATIENT ACCOUNTING INQUIRY
3. LOGGING
4. CUSTOM REPORTING
5. DATABASE/CASEMIX REPORTING
6. CASHIERING
7. INSTITUTIONAL CONTRACTS

4

```
UNIT NUMBER: _____
ACTIVITY: __

MAINTENANCE: INQUIRIES:
1. HOSPITAL PROFILE 50. ACCOMODATION CODE 62. LOG ID
2. COLLECTIONS 51. ROOM/BED 63. SUBUNIT CODES
3. UB82/UB92/1500 OPTIONS 52. NURSE STATION 64. PHYSICIAN
CODES
4. TIER PRICING 53. BILL CODES 65. PHYSICIAN GROUP ID
5. CASHIERING PROFILE 54. BILL EDITS 66. REFERRAL
MANAGEMENT
6. PAYMENT LINK MASTER 55. INS DENIAL CODES 67. G/L
ACCOUNT
7. INSURANCE PAYMENT LINK 56. SERVICE CODES 68. PROCEDURE
CODES
8. CARRIER ID 57. DEPARTMENT CODES
9. BILLING/ALERT EDITS 58. REVENUE CODES
10. ELECTRONIC RA 59. DEMO CATEGORIES
11. CORPORATE IPLAN 60. INSURANCE PLANS
12. DEPARTMENT CODES 61. EMPLOYER CODES
13. REVENUE CODES
F1HELP F3EXIT
```

5

```
UNIT NUMBER: 8918 8918  UNIX MEMORIAL
ACTIVITY: __


1. COLLECTION ACTIVITY
2. COLLECTION AGENCY
3. AGENCY ASSIGNMENTS
4. AUTO WRITEOFF
5. COLLECTION SERIES/STEPS
6. AGENCY INVENTORY SWEEP





F1HELP F3EXIT
```

Performing A Sweep

Note: It is recommended that a Patient Accounting Custom Report be created and printed prior to performing a Sweep. Use the same criteria for the Custom Report that would be used in the Sweep. A sweep cannot automatically be reversed after it has been performed.

The Agency Inventory Sweep will allow the user to enter criteria to limit their sweep to specific accounts. The more criteria entered, the more limited the sweep, the fewer accounts potentially being place to an early-out or primary collection agency. The following are fields in which criteria can be entered to limit the Sweep and the valid entries accepted in each field:

PAT TYPE
I/P = Inpatient (Including I and IB patient types)
O/P = Outpatient (Including O, OR, ORV, and OV patient types)
E/R = Emergency (Including E, ER, ERV, and EV patient types)
SURG = Surgical Outpatients (Including S, SR, SRV, and SV patient types)
Enter a "Y" for each patient type to be included in the Sweep. To include all patient types, either enter "Y" to all patient types or leave all patient types blank.

DISCH DT
Enter a "D" to use a Date Range or "A" to use an Age Range, which an accounts discharge date must fall within.

BILL DT
Enter a "D" to use a Date Range or "A" to use an Age Range, which an accounts final bill date must fall within.
Either the DISCH DT **or** the BILL DT can be entered.

AGE RANGE
If an "A" was entered in either the DISCH DT or BILL DT fields, enter an age range from either the discharge date or final bill date of the accounts wanted to be included in the Sweep. The age range is real time aging not Patient Accounting aging, therefore, the age range does not have to be in 30-day increments. Valid entries would be 000-999.

DATE RANGE
If a "D" was entered in either the DISCH DT or the BILL DT fields, enter a date range from either the discharge date or the final bill date of the accounts wanted to be included in the Sweep. Valid entries can either be entered in mmddyy or yymmdd format.

FIN CLASS
Up to five financial classes per Sweep can be entered. Valid entries would be 01-15 and 99.

SERIES
This option is only available to those Patient Accounting facilities that do not use the HCA Collection system for account follow-up. Up to five patient/insurance collection series per Sweep can be entered. Valid entries would be 001-599.

ACCOUNT BALANCE
Enter in whole dollars the range in which the overall account balance must fall to be included in the Sweep. If the range is left blank, Patient Accounting will default to 0000000 - 9999999.

AGENCY
Enter either an early-out or primary (corporate or hospital) agency where the accounts are to be placed. The agency entered must be active in the Host Collection Agency Master. Sweeps to corporate primaries can only be performed on Fridays. Before a Sweep can be performed to an early-out agency, an agreement must be in place with the agency (See the Early Out Agency Placement Section).

Sweep Screens

The first time the Sweep screen is accessed, the screen will appear as follows:

```
PAT TYPE: I/P _ O/P _ E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: _ BILL DT: _

AGE RANGE...: ___-___
DATE RANGE..: _________-_________

FIN CLASS...: __ __ __ __ __

SERIES......: ___ ___ ___ ___ ___

ACCOUNT BALANCE: _______-_______
AGENCY......: ___
CANCEL......: _

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F1-HELP F3-EXIT
_____________________________________
```

After entering the screen and creating a valid Sweep, the screen will change to reflect that there is an "active" Sweep established for the current day's processing.

```
PAT TYPE: I/P Y O/P Y E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: D BILL DT: _

AGE RANGE...: ___-___
DATE RANGE..: 010195-033195

FIN CLASS...: 05 01 __ __ __

SERIES......: ___ ___ ___ ___ ___

ACCOUNT BALANCE: 0000000-9999999
AGENCY......: 770 ARTRAC
```

CANCEL.....: _ ****ACTIVE****

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F3-EXIT

After the effective date of the sweep has passed, when reentering the screen the "active" flag will display "inactive".

PAT TYPE: I/P Y O/P Y E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: D BILL DT: _

AGE RANGE...: ___-___
DATE RANGE..: 010195-033195

FIN CLASS...: 05 01 __ __ __

SERIES.....: ___ ___ ___ ___ ___

ACCOUNT BALANCE: 0000000-9999999
AGENCY.....: 770 ARTRAC
CANCEL.....: _ ****INACTIVE****

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F3-EXIT

If <ENTER> is pressed on the screen, and a second <ENTER> is pressed to verify the selection criteria, the Sweep will now be active for the current date and the "inactive" flag will be changed to "active".

PAT TYPE: I/P Y O/P Y E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: D BILL DT: _

AGE RANGE...: ___-___
DATE RANGE..: 010195-033195

FIN CLASS...: 05 01 __ __ __

SERIES.....: ___ ___ ___ ___ ___

ACCOUNT BALANCE: 0000000-9999999
AGENCY.....: 770 ARTRAC
CANCEL.....: _ ****ACTIVE****

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F3-EXIT

Entry of the collection agency number will automatically display the associated name for the agency from Collection Agency Master.

Sample Sweeps

#1

PAT TYPE: I/P Y O/P Y E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: D BILL DT: _

AGE RANGE...: ___-___
DATE RANGE..: 010194-123194

FIN CLASS...: 05 01 __ __ __

SERIES.....: ___ ___ ___ ___ ___

ACCOUNT BALANCE: 0000150-9999999
AGENCY.....: 770 ARTRAC
CANCEL.....: _ ****ACTIVE****

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F3-EXIT

This Sweep will select:

1. Any account that has a current status of 'AR' or 'AX', and has not been previously recalled from an agency.
2. Any account that has a patient type of 'I', 'IB', 'O', 'OR', 'OV', or 'ORV'.
3. Any account that has a discharge date greater than or equal to 01/01/94 and less than or equal to 12/31/94.
4. Any account that has a financial class of 05 or 01.
5. Any account that has a total account balance equal to or greater than $150.00 and less than or equal to $9,999,999.00.

Any account must meet **all** of the Sweep selection criteria. Any account that did meet the Sweep selection criteria would be placed with agency 770-Artrac during nightly processing.

#2

PAT TYPE: I/P _ O/P _ E/R _ SURG _
(FINAL BILLED ONLY)

DISCH DT: _ BILL DT: A

AGE RANGE...: 365-730
DATE RANGE..: _____-_____

FIN CLASS...: __ __ __ __ __

SERIES.....: 010 020 011 015 150

ACCOUNT BALANCE: 0001000-0010000
AGENCY.....: 600 HOSPITAL PRIMARY
CANCEL.....: _ ****ACTIVE****

VERIFY SELECTION CRITERIA
ENTER-CONTINUE F3-EXIT

This sweep will select:

1. Any account that has a status of 'AR' or 'AX', and has not previously been previously recalled from an agency.
2. All patient types ('I', 'IB', 'O', 'OR', 'OV', 'ORV', 'E', 'ER', 'EV', 'ERV', 'S', 'SR', 'SV', or 'SRV'. Remember, all patient type fields blank means all patient types to be included
3. Any account which has a final bill date equal to or greater than 365 days and less than or equal to 730 days from **today's** date.
4. Any account that has either a patient or insurance series (payors 1, 2, or 3) equal to 010, 020, 011, 015, or 150.
5. Any account that has a total account balance greater than or equal to $1,000.00 and less than or equal to $10,000.00.

Any account must meet **all** of the Sweep selection criteria. Any account that did meet the Sweep selection criteria would be placed with agency 600-Hospital Primary during nightly processing.

NPAS Notification Of Sweeps

In order to ensure the staffing needs are meet at NPAS, NPAS requests the following information is provided before a PAS/hospital performs a Sweep. This information should be e-mailed to the appropriate Client Support Manager.

1. What type of accounts will be included in the sweep (insurance tracking, FC99, etc)?
2. What will be the number and dollar of the accounts swept?
3. What will be the balance range of accounts swept: under $1,000, $1,000-$10,000; and over $10,000?
4. What will be the average balance of accounts swept?
5. What will be the range of discharge dates (months and years) of accounts swept?
6. Have any statements been sent (what timeframe) and has any follow-up has been done (what timeframe) since the statements have been sent?
7. When will the accounts be placed?
8. If a settlement is going to be offered by the hospital, what accounts are to be included in the settlements: i.e., all accounts, all self-pay accounts, we recommend not offering settlements unless the accounts are 60 days old or older from date of discharge (Settlement discussion should be initiated by the facility, not the CSM).

Nightly Processing / Non-Collection Facilities

Patient Accounting will create the following transactions for those accounts meeting all of the criteria established in the Sweep: C; patient number;AGNY;Axxx (where xxx equals the agency number defined in the Sweep).

If the agency defined in the Sweep is a hospital or corporate primary, an I;Z; patient number; insurance plan;RELS line will be created for all insurance plans that have a status of "M" (payment(s) posted but still tracking liability) or blank (still tracking

liability).

If an account has previously been placed on hold from early out the account will not be included in the Sweep (regardless if the agency specified in the Sweep is an early-out agency or primary agency).

Early out and hospital primary agency placements will be placed the night of the Sweep. Corporate primary agencies will place only on Friday nights (only time the Sweep will allow entry of a corporate primary).

Nightly Processing / Collection Facilities

Patient Accounting will create the following transactions for those accounts meeting all of the criteria established in the Sweep: C;patient number;AGNY;Axxx (where xxx equals the agency number defined in the Sweep).

If the agency defined in the Sweep is a hospital or corporate primary, an I; Z; patient number; insurance plan; RELS line will be created for all insurance plans that have a status of "M" (payment(s) posted but still tracking liability) or blank (still tracking liability).

Also, a S; N; patient number; ACCOUNT EVALUATED FOR EARLY-OUT; IS line will be created.

Due to the C;AGNY transaction being passed through to the Collection System, any Sweep will take two days to complete. Patient Accounting must receive a C;DMND;A from the Collection System. On the day of the Sweep, Patient Accounting will process the Sweep request, create transactions and pass them to the Collection System in the RDAT:DATCSD file. Upon stepping (PDSTEP) accounts will be placed with the appropriate agency and the proper C;DMND;A will be formatted back up to Patient Accounting.

If the Sweep is going to a corporate primary, the Collection System will hold the placement until the next Friday's date. Therefore, since the Sweep will only allow entry of a corporate primary on a Friday, once the Sweep is processed, the C; patient number; AGNY; Axxx will pass to the Collection System and the placement will be held until the next Friday.

*****Note: It is <u>critical</u> that if the agency specified in the Sweep is a Corporate defined primary (only allowed on Fridays) that the Assume Date on the Collection System when PDTRAN is performed is the next day's date (Saturday). Therefore, if you were performing a Sweep to a corporate primary on Friday, January 5 (01-05-96) prior to setting up PDTRAN on Friday night, logoff of the Collection System and log back on using the assume date of Saturday, January 6 (01-06-96). Failure to perform PDTRAN with Saturday's date will cause placements due to the Sweep to reject on the batch report on Saturday night.***

Sample Batches / Non-Collection Facilities

Sweep to a hospital primary. Note the I; Z releases for insurances that had a status of either "M" or spaces (still tracking liability without any prior payments).

```
$IS01;AGY SWEEP 01 ;B;19940603
C;000000344254;AGNY;A600
I;Z;000000344254;02501;RELS
I;Z;000000344254;02401;RELS
C;000000344969;AGNY;A600
```

I;Z;000000344969;02401;RELS
C;000000347611;AGNY;A600
I;Z;000000347611;04444;RELS
@;;00000007;;00000000;00000000

Sweep to early-out agency. Accounts can be placed to early-out agencies with insurance still tracking, therefore no I;Z transactions are formatted.

$IS01;AGY SWEEP 01 ;B;19940604
C;000008012370;AGNY;A770
C;000009000059;AGNY;A770
C;000009000605;AGNY;A770
@;;00000003;;00000000;00000000

Sample Batches / Collection Facilities

Sweep to hospital primary. Note the S;N transactions for Collection sites that are not formatted for non-Collection sites. Also, note the I;Z releases for insurances that had a status of either "M" or spaces (still tracking liability without any prior payments).

$IS01;AGY SWEEP 01 ;B;19941201
C;000004189406;AGNY;A601
S;N;000004189406;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
C;000004195726;AGNY;A601
S;N;000004195726;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
I;Z;000004195726;10103;RELS
C;000004202747;AGNY;A601
S;N;000004202747;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
@;;00000007;;00000000;00000000

Sweep to early-out agency. Accounts can be placed to early-out agencies with insurance still tracking, therefore no I;Z transactions are formatted.

$IS01;AGY SWEEP 01 ;B;19941128
C;000003223601;AGNY;A772
S;N;000003223601;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
C;000004196019;AGNY;A772
S;N;000004196019;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
C;000007136561;AGNY;A772
S;N;000007136561;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
C;000007139834;AGNY;A772
S;N;000007139834;ACCOUNT EVALUATED FOR EARLY-OUT ;IS
@;;00000008;;00000000;00000000

Possible batch rejection examples:

<u>C lines for early-out agencies:</u>
ACCOUNT LINKED
GUAR ACCOUNT
ARRG ON ACCOUNT
ALREADY PLCD
ACCOUNT <= SBAL

<u>C lines for primary agencies:</u>
INS TRACKING

NO CLAIM DT2
NO CLAIM DT3
ARRG ON ACCOUNT
ALREADY PLCD
ACCOUNT<=SBAL

Due to the order of processing of Patient Accounting, INS TRACKING, NO CLAIM DT2, and NO CLAIM DT3 errors will appear only when an account selected for the Sweep to the primary agency has a primary insurance still tracking at the time of the Sweep.

New Placements

Accounts that are placed to an early-out or primary agency will appear on the Collection Agency New Activity Report (AGNY:AGNY01) in the New Placements section.

```
EFF DATE: 12/05/94 AGNY:AGNY01 #08918 8918  UNIX MEMORIAL COID: 34222
PAGE 1
COLLECTION AGENCY NEW ACTIVITY
NEW PLACEMENTS
PATIENT NO PATIENT NAME RESP PARTY ADDR1 CITY STATE FC DSCH DATE
SUB# PYMT DT INS DUE
RESP PHONE RESP PARTY NAME RESP PARTY ADDR2 ZIP PT TRNOVR DT AGE
PYMT AMT PAT DUE
RESP SSN CURRENT BAL
AGENCY: 770 ARTRAC
AGENCY Type: E

731469001143 EDWARDS THOMAS 1 LIL PUMPKIN LANE MUSIC CITY 99 12/01/94
0.00
6153212131 EDWARDS THOMAS 37202 O 12/05/94 4 0.00 29.50
546451313 29.50
TOTAL NEW PLACEMENTS/AGENCY 770: 1 TOTAL INS DUE: .00 TOTAL PAT DUE:
29.50 TOTAL PLACEMENT AMT: 29.50
```

In addition to the accounts appearing on the Collection Agency New Activity Report the AGNY screen of Online Patient Accounting will also reflect that the account was placed by the Sweep:

```
PAT INQUIRYAGENCY UNIT: 8918 FILE DATE: 10/08/94 REFER: 3131
==================================================
============================
PAT NUM: 4213954 PT: S ADM: 06/12/94 FBIL: 06/12/94 BAL: 286.65
PAT NAME: SMITH JOHN FC: 13 DIS: 06/12/94 PHYS: 3430 ROOM: STAT: CA
==============================AGENCY
INFORMATION==============================
EARLY-OUT ------------
AGENCY CODE/DESC: 772 MFS SWEEP
ORIG TRNOVR AMT/DT: 286.65 09/30/94
CHGS SINCE TRNOVR: .00
ADJ/ALLOW AMT/DT: .00
PAYMENT ADJ/DT: .00
ADJ TRNOVR AMT: 286.65
INS/PAT TRNOVR AMT: .00 286.65
```

```
|
AGENCY PAYMENTS: .00 % RCVY: 000 % RCVY:
OTHER PAYMENTS: .00
LST AGY PYMT AMT/DT: .00
AGE TRNOVR/AGNY: 110 8
RECALL AMT/DT: .00

ENTERCONTINUE F1HELP F3EXIT F12LINK ACT: AGNY
```

BALANCING PROCESS

Daily Procedures

Downloads verify that the records received match the total provided in the trailer record. Operations will verify that the download runs each day. The download will not complete unless a file is received on the AS400. NPAS Data Control logs, reviews, and files the download reports for each day. Significant error messages are researched. If reports are not generated, the Systems Manager is notified.

Weekly Procedures

NPAS relies on a weekly balancing process to ensure that the Intelec (NPAS System) and the hospital patient accounting system remain in balance. The balancing process is performed on the first workday of each week. All accounts are extracted from Intelec (NPAS System) and all accounts placed with NPAS are extracted from PA and Meditech B/AR. The files are transferred to host. The Intelec (NPAS System) file is split into PA and Meditech files. The individual files are then compared to the hospitals' extracts at an account level. The balancing process generates files reflecting the following discrepancies:

- File 1 – Accounts active in Intelec (NPAS System) which the hospital does not show as placed (missing on hospital extract)
- File 2 – Accounts hospital shows as placed which are not in Intelec (NPAS System) (missing in Intelec (NPAS System))
- File 3 – Accounts which both sources show as placed, but where the balance of the account is different
- File 4 – Accounts which are in balance in total, but where the amount prorated to the patient is different
- File 5 – Accounts which are in balance in total, but where the proration for the individual insurance differs
- File 6 – Accounts closed in Intelec (NPAS System) which continue to show as placed by the hospital

After researching cause of discrepancies, they are handled in the following manner:

- File 1 – Accounts are closed on Intelec (NPAS System)
- File 2 – Check download files to determine if placement data was sent. If located, the data is downloaded. Otherwise, report is sent monthly to the hospital.
- File 3 – Balancing adjustment is posted to the account.
- File 4 – No action taken.
- File 5 – No action taken.
- File 6 – On a quarterly basis, accounts that have remained on the file for 3 consecutive weeks are reported to the hospital for the hospital to correct.

The totals are recorded in the data set R:/Intelec (NPAS System)/Balstat99 where 99 indicate the year.

DELAY DATES ON PA

The purpose of setting the delay date is to extend the date on which PA will automatically recall an account. **It does not mean that accounts will be held until that date, which is a common misunderstanding**. The delay date will be extended by NPAS when it's determined by the PAS/hospital or NPAS that payment on an account will be delayed past the 140-day standard recall date parameter. This would also include an account set up on regular monthly payments. Accounts have the potential to remain at NPAS anywhere from 1 – 140+ days. Actions taken or information received on accounts will determine how long an account remains active at NPAS.

If regular monthly payments are set up on an account, NPAS will set the date to the final payment date with an extra 2 months added. The additional 2 months is to allow time for the final notice process if the GN defaults on the last payment. Sometimes accounts with small balances having a delay date that extends past what would be reasonable for that account's balance could be seen. This is a result of the account being linked with a larger balance account and the regular monthly payments are being made for all the linked accounts.

The recall date may also be extended by 90 days from the current date in situations such as (but not limited to) account re-bill, request for EOB, request for information from the hospital, insurance will pay, promise to pay in full by GN, or hospital requests hold. The recall date may also be extended by 60 days on accounts placed as insurance when the balance is made patient responsibility if the account is already 75 days from placement. The CSPs do not actually decide when the recall date should be reset in any of these cases. The smart codes used by the CSPs are set up to automatically apply smart code 896 or 897, which, if necessary, sends the transaction to host to reset the recall date.

The process of resetting the recall date was implemented as a result of concerns of our client hospitals that accounts where regular monthly payments are being made or other potential to pay were being sent to the agencies. They were sent because PA automatically recalled the accounts. Most hospitals were not working their agency pre-list and were not sending them to NPAS to work. Due to the volume of accounts, it really wasn't feasible for NPAS to manually process all the pre-lists. This new process has essentially eliminated all complaints of accounts being inappropriately recalled.

Posting Adjustments & Payments

NPAS is **not able** to post any adjustments or payments to the PA system. Intelec (NPAS System) only receives payments that the hospital, PAS, or lock box posts to the system. As a result, it is necessary for NPAS to forward all payments to a designated payment address. In the case that an adjustment needs to be posted, reversed, or altered in any way, NPAS will message the PAS/hospital with all pertinent information and ask that the PAS/hospital complete the adjustment and then notify NPAS via message when the adjustment has been posted (See "Messaging Process" section for details).

CHANGES TO I-PLANS & PRORATIONS

NPAS is also unable to change the proration or the I-Plan on an account. Once an account is placed with NPAS, the proration will remain the same on the Intelec (NPAS System) system, regardless of any changes made by the PAS/hospital. In order for the hospital/PAS to keep up with proration changes, it will be necessary for the hospital/PAS to observe payments and change the proration on an account at the time that a payment is posted. If the hospital changes an I-plan on the PA system, this change will transfer to Intelec (NPAS System).

There are certain circumstances where NPAS will notify the hospital that the proration and/or I-plan need to be changed. In these cases, the hospital/PAS must review the facts to ensure that a change in proration is warranted, prior to recording an actual change.

Follow up w/IT&S
When NPAS receives new insurance information that was not previously recorded on the account, or when the current insurance information is changed, NPAS will send a one line message to the PAS/hospital on the NPAS01 report (see Communication/Messaging Process section for further explanation) stating "+ FYI-REVIEW IPLAN CHG +". This informs the PAS/hospital that it is necessary to change and review both the I-plan and possibly the proration.

When NPAS receives a denial from an insurance company, NPAS sends a one line message to the PAS/hospital on the NPAS01 report (see Communication/Messaging Process section for further explanation) stating "+ FYI-INSURANCE DENIAL +". This informs the hospital that the proration tracking to one of the insurance companies on file needs to be released. The notes should indicate further which insurance company sent the denial. The remaining proration can then be moved to the patient or a secondary or tertiary insurance company.

These changes allow the hospital to maintain accuracy in their reports and records to the degree that such accuracy is possible. NPAS cannot guarantee that the hospital will be informed of every change in I-plan or proration, but this process is designed to improve accuracy over current methods.

NPAS SYSTEMS CAPABILITY

Functional Overview

SOFTWARE

Intelec (NPAS System), our collection software provides the flexibility and functionality to support an unlimited number of clients, users, and services. The system is functionally complete and will meet all reporting and interfacing requirements. The system is fully customized and can be easily modified. Intelec (NPAS System) is "on-line" and transaction results are reflected as information, entered by the CSP. All required updates are reported back electronically, in batch, to the hospital system the following day.

ELECTRONIC TRANSFER/INTERFACES

Placements, payments, adjustments, demographic changes, CSP notes/comments and returns are electronically communicated between the hospital collection system and the NPAS system. This interface and communication link was developed using the Patient Accounting (PA) collections system in conjunction with the Collection System, or the Meditech B/AR system. This eliminates most of the manual effort and time consuming activities of communication between the PAS'/hospitals' business offices and NPAS.

Intelec (NPAS System) Work Screen

The system provides unique CSP work screens for both insurance and private pay collections for use by the collection staff. From these screens, the CSP is able to set regular monthly payments, access history files, enter relevant comments, modify information, recommend cancellation, and generate letters to GNs and insurance letters to third party payors. The system maintains a running history of each account. In addition, each CSP has on-line access to the hospitals' mainframe collection system, which is referred to on a limited basis and only when appropriate.

Letters

NPAS' system has the capability for CSPs to flag accounts for "on demand" specific letter requests, as well as the capability to set up letter series which are automatically requested under predetermined management prescribed circumstances and time intervals. Daily, the system reviews outstanding letter requests and produces a letter when necessary or requested. Although CSPs do have some latitude as to which a letter should be sent, the vast majority of letters are predefined by the system. (See "Letters Utilized by NPAS" section for sample copies).

Data Updates

The system retains a record of all collection activity; skip trace attempts, written and verbal contact with the debtor or third party, payment information, and other pertinent data. This information is recorded on the Intelec (NPAS System) system and is updated daily. All information is also passed back to the hospitals' Patient Accounting System.

The CSP receives individual account data on-line and attempts to collect the amount due. From an initial work screen, the CSP has the ability to set up promises for payment, set up regular monthly payment resolutions, access history files, enter comments on debtors, modify debtor information, cancel and return accounts to the client, send various letters, transfer accounts to skip trace, and request that an account be billed.

Payment Processing

All payments are directed to the Pas/hospital or designated lock box by including the hospitals or designated lock box address on our letters. Each day all payment activity is electronically transferred from the hospital's Patient Accounting system to NPAS during nightly batch. There is no need for the PAS/hospital to send NPAS a manual payment listing.

Billing and Rebilling

The system allows for identification and the direction to a specific work group, accounts requiring billing or rebilling. The billing department has the capability of printing imaged bill reprints from AVDM/DEI systems for PAS accounts. Non-PAS account bills are requested from the Patient Accounting system. These billings are printed in Nashville, shipped to Louisville, modified if necessary, and billed by the department. (See "Billing Process and Expectations" section for bills that NPAS cannot process).

If the hospital needs to request a re-bill on an account that is placed with NPAS, the re-bill needs to be requested off of the mainframe application (not HBOSS). There is a destination indicator on this screen in which the hospital would enter an "N" if the hospital wants to receive the bill. **DO NOT** requests the re-bill off of HBOSS if you want the bill to be sent to the hospital.

Hardware

NPAS is currently using a new state-of-the-art IBM AS/400 computer. This machine, located in Louisville, is on-line to the host computers in Nashville thereby facilitating the ease of electronic interfacing. The system has the capacity to handle all future expansion plans. The AS/400 is supported by an IBM 6408 line printer, and a "mirroring" DASD is used for backup. The CSPs use PC work stations connected to the AS/400 via an intranet and are capable of autodial, as well as on-line access to the hospital's mainframe collection data. All PCs are configured according to the PAS standard with slightly modified software to account for operational differences.

NPAS maintains its own AT&T Definity G3R phone systems to ensure reliability, immediate access to voice and data lines, and flexibility to modify services to address the needs of the collection environment.

Contact Series

Contact Series have been developed in order to ensure certain collection actions take place on accounts. They are system automated actions and are generally time initiated following actions taken by a CSP, a previous system action, or in some cases, when no action has occurred and time since the last action occurred warrant further activity. This provides assurance that collection activity is being performed on a continual basis. These series are constantly monitored and adjusted based on business volumes.

Recording System

NPAS implemented a call recording system in July 2000. This system records all incoming and outgoing phone calls with the exception of accounts worked in the Client Services Department or any calls transferred to a supervisor or manager. The call recording system allows NPAS to ensure that the highest quality of customer service is

provided to each customer. It allows NPAS to determine the validity on GN/patient complaints. NPAS maintains call recordings for 90 days. Call recordings are available upon request.

This system also has a Quality Call piece, which allows us to complete a Quality Review while listening to the call. (See Quality Review Section for more details.)

Predictive Dialer

Realizing the value of volume calling to maximize debtor contact, NPAS has used a Predictive Dialer System since 1993. Predictive Dialers are especially effective in resolving small balance insurance and private pay accounts. These efficiencies are achieved, in part, by assigning an account to a CSP only as contact is made, which allows the CSP to either discuss the details of the account with a GN/patient, or leave a message with a person or answering machine on every account worked. The Predictive Dialer has proven to be significantly more productive and less costly than more traditional approaches to working these accounts.

Currently, private pay accounts less than $1,500 and commercial insurance accounts that are less than $1,000 utilize the Predictive Dialer to the degree at which the CSPs working these accounts do not have an opportunity to review all of the details, especially comments entered into the notes screen until contact is made with the GN/patient on all inbound and outbound calls.

Advancements made in Predictive Dialer Technology have enabled CSPs working Private pay accounts with balances greater than $1,500, commercial insurance accounts with balances greater than $1,000, and all specialty accounts such as Worker's Comp, Champus, PPO and HMO accounts the ability to review accounts before initiating contact with the GN/patient or insurance company. All CSPs are trained to quickly recognize the status of the account and to focus on using good customer service skills to successfully resolve the account.

The Predictive Dialer technology also allows for protection against time zone calling errors. NPAS follows the legal calling hours of 8 a.m. to 9 p.m. EST, with any time zone considerations before a call is made.

HIPAA - Privacy Policy

Introductory Terminology

DRS-Designated Record Set. All patient medical information maintained by the covered entity. This includes medical, payment and billing records. PHI and IHI of the DRS.

AOD-Accounting of Disclosure. An individual has a right to an accounting of disclosures (AOD) of PHI by a covered entity.

Payment-Activities undertaken to obtain or provide reimbursement for health care. This includes billing and collections.

FPO-Facility Privacy Officer

Authorization- A form that must be completed by the patient to authorize release of information.

PHI- Protected Health Information. Individually Identifiable Health Information (IIHI) for a patient.

Covered Entity- Any entity bound by HIPAA law such as a hospital, an insurance company, physician's office, clearinghouse or self-administered fund like TPA.

Business Associate- a party performing services on behalf of HCA/NPAS but not employed by the organization (credit bureaus, vendors, Medifax and Shred-It).

What is it?
- Health Insurance Portability and Accountability Act of 1996

Why is it important?
- Establishes patient rights and privacy controls.
- Establishes a common set of standards and requirements about how to use and protect patient information.
- Improves the efficiency and effectiveness of the healthcare system.

Who is affected at NPAS?
- Every employee of NPAS is affected and must protect patient health information.

In order to become compliant with the HIPAA law, NPAS has instituted specific policies to safeguard protected health information (PHI). The NPAS specific policies are defined to support compliance with the law. PHI is individually identifiable health information relating to physical or mental condition of an individual, provision of health care to an individual or payment for health care provided to an individual. Individually identifiable health information (IIHI) is a subset of PHI and includes demographic information.

Protected Health Information (PHI) includes but is not limited to:

PHI

Health plan beneficiary number	Name
Account number	Address including street, city, county, zip code and equivalent geocodes
Certificate/license number	Names of relatives
Any vehicle or other device serial number	Name of employers
Web Universal Resource Locator (URL)	Birth date
Internet Protocol (IP) address number	Telephone numbers
Finger or voice prints	Fax Numbers
Photographic images	Electronic e-mail addresses
Any other unique identifying number, characteristic, code	Social Security Number
	Medical record number

How is NPAS required to protect PHI?

- NPAS is required to ensure that a verbal verification process is completed before the call can proceed. In some cases, a written authorization form must be completed by the patient, returned to the PAS/hospital, and documented in the account notes before PHI can be released.
- Upon verification only necessary information may be released. CSPs may not discuss PHI with those people who cannot complete the verification process.

When Speaking To	Requirement
Attorney	The patient must provide a signed authorization form before the account can be discussed with an attorney.
Payment Purposes Question: Asked to all except covered entities and the Patient or GN.	CSPs should ask if the person is able to discuss the account for payment purposes prior to the verbal verification process.
Outbound Calls: All people EXCEPT the patient or GN.	A verbal verification process is required. Part of the process is NPAS policy and not law.
Inbound Calls: ALL Inbound Callers	A verbal verification process is required. Part of the process is NPAS policy and not law.

Patient Privacy Protection

Only individuals with a legitimate **"need to know"** may access, use or disclose **protected health information** (PHI). This includes all activities related to payment and medical treatment. CSPs may only disclose the **minimum information necessary** regarding the account for payment purposes.

*Payment purposes can include determining eligibility, collections, gathering insurance information, billing, and justification of charges, pre-certification/pre-authorization. The definition of payment for HIPAA purposes is "activities undertaken by a health care provider to obtain reimbursement for the provision of health care." The NPAS verification procedure is designed to limit release of the information for "payment purposes." Payment purposes can include determining eligibility, collections, gathering insurance information, billing, and justification of charges. NPAS will only disclose the **minimum information necessary** regarding the account for payment purposes after verification.

Do not share protected health information (PHI) with anyone who doesn't have a need to know or is not authorized. Limit the disclosure of PHI to the minimum necessary information.

Consequences of Non-Compliance

Civil
If failure to comply with transaction standards.
$100 fine per occurrence; up to $25,000 per year.

Criminal
If health plans, providers and clearinghouses that knowingly and improperly disclose information or obtain information under false pretenses.
Penalties higher for actions designed to generate monetary gain.
Up to $50,000 and one year in prison for obtaining or disclosing protected health information.
Up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses".
Up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

NPAS
Progressive discipline through NPAS policies

Speaking to an attorney

The patient must complete the authorization form and return it. NPAS cannot speak to an attorney until authorization is complete and has been received and documented (Except in the case of bankruptcy). When the form has been returned and reviewed for accuracy, documentation will be placed in the notes.

If an attorney is encountered on a call and an authorization form is not on file, do the following:
State: "I am sorry, due to patient privacy we are unable to discuss the account until authorization has occurred."

NPAS CSPs encounter this situation in regard to handling attorneys. When a release of information is not on file, calls should be handled in the following ways:

An attorney calls in and the account **is** in a final notice series, NPAS should tell the attorney to have the GN call the facility.

An attorney calls in and the account is **not** in final notice series, NPAS will advise the attorney to have the GN call into NPAS. NPAS will not negotiate payments, release bills, etc to the attorney.

Calls from GN/Patient when attorney is handling

When the GN has retained an attorney and NPAS must conduct follow-up, an authorization form must be on file in order to speak to an attorney.

If an attorney calls NPAS the account may not be discussed (Except in the case of bankruptcy) unless there is a note in the system that the attorney authorization form is on file.

If the attorney authorization form is on file, CSPs should perform the standard verification process before discussing the account with the attorney.

Verification Process

NPAS will verify the following information to complete the verification process:

Last four digits of the **patient's** Social Security Number.
Patient's complete Date of Birth.
Patient's **Complete** mailing address listed on the account.

These three items must be verified before discussing the account with someone. NPAS can only use alternate verification if one of the items listed above is not listed on the system.

Alternate Verification Process

In order to release information a **minimum of three items** must be verified.
Example
*Last four digits of SS# **verified**, DOB not on the system, use the primary list for the third item.*
*Last four digits of SS# **and** DOB not on the system, use primary list, then secondary list to equal three items.*
Last four digits of SS# not on the system, DOB verified, primary list items not on the system, use secondary list to equal three items.
• When the last four digits of the social security number and date of birth of the patient are **on the system, both** must be provided. The third item should be selected from the primary list below.
• If the last four digits of the social security number and/or date of birth are **not** on the system, use the list of items below for verification:

Primary
- The Complete address of the patient must be verified first.
- Account Number
- Insurance Carrier Name
- Insurance Policy Number

If the above items are not available, use these following secondary verification items:
Secondary
- Original Balance
- Current Balance
- DOS/Discharge date

If proper verification cannot be accomplished via the guidelines above, NPAS **will not speak to the person.**

Once verification has occurred:
The following information is examples of what may be discussed to the extent it is need to secure payment:

Guarantor/Patient Name
Guarantor/Patient Social Security Number
Patient Date of Birth
Patient Account Number
Patient Case Number
Patient/Guarantor Phone Numbers
Patient/Guarantor Street Address Information
Insurance Carrier Name
Insurance Coverage Number
Admit / Discharge Date (Dates of Service)
Facility Name
Total Charges
Current Account Balance
Payments
Adjustments
Insurance Deductibles
Insurance Co-Pays

*At the conclusion of the call note who was verified and that the call was for payment purposes.

The following information should never be released to anyone:
Diagnosis
Procedure
Facility Type (EX: Rehab, Psychiatric, etc.)

The following information should only be given if the patient or guarantor specifically requests it.
Doctor's name (due to Physician Specialty)
Patient type or service type

Speaking to a covered entities
A covered entity is defined as an HCA hospital or surgery center that is part of the HCA Company. A covered entity is also an insurance company, physician's office, clearinghouse or self-administered fund like TPA. When calling covered entities and business associates, NPAS should expect to respond to the company's verification policies. In the same way, NPAS should verify inbound callers from these two groups. NPAS should verify a total of **three** primary pieces of patient information.

Follow the standard verification process.

*It is not necessary to ask if the call is for payment purposes.

Speaking to business associates
A business associate is defined as a party performing services on behalf of HCA/NPAS but not employed by the organization (credit bureaus, vendors, Medifax and Shred-It). These associates have signed a business associates agreement.

Follow the standard Verbal Verification Process

Requests for billing
A person who has completed the verbal verification process (or when a written authorization form is or file), may request additional information like a UB, IB or summary bill. Follow this procedure:

NOTE:
NPAS may **not** change addresses for callers other than the GN/patient, if the purpose is for billing.

NPAS should tell the requestor that the process is usually complete in 10 days but could take up to 30 days. Requests **must** be met within 30 days, an additional 30 days is acceptable under the HIPAA law, if the FPO notifies the patient in writing.

Handling Inbound Calls
There will be times when the caller will not know the name of the patient. CSPs should give the caller the first initial of the patient's first name. If this does not help identify the patient, CSPs can then give the patient's name.

In cases where NPAS must look up the account, care should be taken to protect PHI.

Inbound Call (Patient or GN)
NPAS will explain that there is a federal law protecting health information. There are several pieces of information that must be verified before I can discuss the matter. At that point NPAS will proceed with verification.

Inbound Call (NOT the patient or GN)
NPAS will ask the person if they are calling to discuss the account for payment purposes? If the answer is yes, *NPAS will explain that there is a federal law protecting health information. There are several pieces of information that must be verified before I can discuss the matter. At that point NPAS will proceed with verification.*

Outbound call (Speaking to people other than the GN/patient)
There will be times when the caller will not know the name of the patient. NPAS should give the caller the first initial of the patient's first name. If this does not help identify the patient, NPAS can then give the patient's name.

A party has answered the telephone and has asked, the nature of the call.
NPAS will state the following:
My name is *(CSP's name)* and I'm calling on Behalf of the business office for FACILITY regarding a
business matter. For quality purposes, this call may be recorded.

Attempt to leave a message. If the party requests further information:
NPAS will state the following:
"There is a federal law protecting health information. There are several items that must be verified before I can discuss the matter." "Are you able to discuss the account for payment purposes?"

If the party does not want to discuss the account for payment purposes, offer to leave a message. If the party indicates that he/she has information that will help NPAS resolve

the account, the account will be documented with that information. NPAS will not discuss any PHI with the party unless the party agrees to verification.

If the party does not want to discuss the account for payment purposes, proceed to verification.

Handling Associated Accounts (Inbound)
A caller might not be aware of associated accounts. If the caller is not the patient or GN and the patient listed on the associated account is different than the patient being discussed on the call, don't bring up the associated account. If the caller **asks** about the associated account verify the other patients information.

Handling Closed Accounts
Informing callers that an account is closed and not being handled by NPAS is permitted without verification. NPAS can also supply the telephone number to the PAS/facility to the caller.

Receiving compliment/complaint letters
NPAS receives complaint and compliment letters from patients and guarantors. Occasionally that information will be distributed or posted (to compliment the CSP involved). If this information is posted or distributed, the PHI will be removed or concealed.

Accidental disclosures of PHI
If NPAS discloses PHI to an unauthorized person/party, the following actions will take place:
Complete an AOD form immediately after disclosure to be given to a manager.
The manager should forward that information to the Facility Privacy Officer. The FPO will forward the information to the hospital for documentation.

Documentation of Accidental disclosures
Document that name of the person who received the information, why and what was disclosed. Here's an example of good documentation: *"Cld GN at # her sister provided. Lady who answered adv she was the GN so I adv her of DOS & Bal. After I had done so she adv she had not been to that hosp. She verf her DOB for me and it did not match."*

If this happens, an AOD form should be completed and given to a member of management.

An example of an AOD:

Release of PHI to Law Enforcement
If a police department calls for payment purpose concerning an account of an employee, the person calling is subject to verification.

Transferring Calls
The transferring CSP should remain on the line to tell the person receiving the call whether HIPAA verification has been completed and why the call is being transferred.

GN or PT gives telephone to another party
In the event that a GN/PT states that another party handles the bills and wants to hand the phone to that person, please follow this procedure:

On an outbound, if the GN/PT states that another party handles the bills and hands the phone off to that person, NPAS does NOT have to authorize/verify that person.

On an inbound call, if the GN/PT has been verified and the GN/pt states another party handles the bills, there is no need to authorize/verify the other party. However, in the event that no verification process has occurred, either the GN/pt or the other party would have to complete the verification process.

In both cases, NPAS must clearly note **who** the CSP discussed the account with and that the **GN/PT gave permission** to speak to that person. The CSP should discuss the minimum necessary to resolve the account.

A future inbound call from the party that was given permission to discuss the account would still require authorization/verification. A future outbound would not require verification of that party **if the notes state verbal permission was received by the GN/PT on a previous call.** Documentation is essential.

If the phone is simply taken away from the GN/PT and permission has not been properly obtained, verbal permission would have to be obtained from the GN/PT before discussing the account.

Other ways to protect PHI:

• **Do not** leave PHI information visible on a desk, in box or other receptacle (Each person is responsible for securing PHI at the close of a shift).

• **Do not** leave PHI visible on a computer screen, when not in use.

• **Shred all** documentation that will not be filed or stored that contains PHI.

• **Do not** email PHI outside of the HCA network.

• **Ensure** that collection notes are accurate and concise; notes are subject to PHI disclosure.

• Printed items containing PHI should be secured from the printer **immediately**.

The following requests may be made by patients but cannot be handled by NPAS. NPAS will refer the patient to the hospital FPO.
Right to Request Confidential Communications
Patients have right to request confidential communications by alternative means or to alternative locations. Acceptable alternative means include mail and telephone (not fax, e-mail or internet).
System changes are in progress to notify NPAS when a patient has requested confidential communications. If an account has been noted for confidential communication, it cannot be linked with another account. Description code CN will appear in the description code field.
This message should be received via green sheets from the facility. The request must be noted clearly on the account.

Notice of Privacy Practices
Each company-affiliated facility must provide adequate Notice of Privacy Practices to patients. Providers must inform patients the rights with respect to PHI as well as the facility's legal duties. Patient must acknowledge receipt of the notice. If a patient

requests a copy of this information, refer the caller to the hospital's main number or web site.

Patient requesting a record of PHI
Patients have right to inspect and obtain a paper copy of PHI that is contained within the designated record set. There are some exceptions and the facility may deny a request under certain circumstances. Requests must be made in writing. If a request for medical records is made, refer the patient to medical records at hospital.
If a portion of the designated record set (DRS) is **clinical** (i.e., medical records, ER notes), the GN should be referred to the hospital. The patient should speak with **Health Information Management. The facility will require the person to submit the request for clinical information in writing.** If the request is something **other than clinical** (EOB) then the caller should be referred to the PAS who will requires only a verbal request. If the **request is an IB**, then NPAS will provide the IB only to the address that is on the account.
Continue collection activities on accounts regardless of what is being requested.

Right to Amend
Patients have right to have the facility amend (add to, never change) PHI that is contained within the designated record set for as long as the information is maintained by the facility. The facility may deny request. If a request to amend is made, the patient must send a written request to facility FPO (facility privacy officer). Notify the patient that the hospital's FPO will approve/deny the request within 60 days of receiving the request.

Right to Request Confidential Communications
Patients have right to request confidential communications by alternative means or to alternative locations. Acceptable alternative means include mail and telephone (not fax, e-mail or internet).
System changes are in progress to notify NPAS when a patient has requested confidential communications. If an account has been noted for confidential communication, it cannot be linked with another account.
If confidential communications have been requested, description code CN will be used to designate this request. CSPs should only communicate with the patient in these cases and correspondence should only be sent to the confidential address. Skip trace should not be done on confidential addresses. Address changes to accounts with confidential communications can only be done with written permission from the patient.

Right to Request Privacy Restrictions
Patients have right to request restriction of certain uses and disclosures of PHI that is contained within the designated record set. If a request is received, tell the patient to submit the request in writing to the hospital FPO. HCA does not expect this to be an issue.

HIPAA – Security

(Link under construction)

SUMMARY OF OPERATIONS

Insurance - Account Handling – General Overview

New insurance accounts are placed daily with NPAS and are added daily to the scheduling module. Accounts are evenly and randomly distributed among CSPs to optimize the efficiency of any one CSP or group of CSP's performance for any one hospital. Random distribution also allows NPAS to provide good customer service and collection recoveries equitably to all hospitals.

Accounts are placed at NPAS by first searching for monies prorated to the insurance Iplan/field. If monies are found in the insurance Iplan/field of the PA system, the account will place as an insurance account and follow the insurance cycles. Insurance cycles generally pursue the insurance company's portion of the balance first, and then pursue the patient's portion. Accounts placed, as "insurance" will remain classified as an insurance account even after an insurance payment is received and there remains a balance that is due from the GN. All monies collected from the accounts that are classified "insurance" will be reported on the NPAS Monthly Performance Reports under insurance recoveries.

If money is found prorated to an insurance Iplan/field, then the financial class (FC) and balance size of the placement are reviewed and placed as follows:

Specialty Units

- FC 04 - Workman's Compensation (W/C) accounts regardless of balance size will be placed into the W/C unit
- FC 06 - Champus accounts regardless of balance size will be placed into the Champus Unit
- FC 07 - HMO accounts with balances under $1000 will be placed in the Small Balance HMO Unit and balances over $1000 will be placed in the Large Balance HMO Unit. In the HMO cycle no contact is made with the GN unless additional information is needed to resolve the account, or until a clear determination has been made that the GN owes the remaining balance.
- FC 08 - PPO financial class accounts are considered a commercial financial class and treated the same as other commercial business with placements on the dialer or ownership units depending on the balance of the account. These cycles balance-bill and pursue patients for the balances owed.
- NPAS offers a restricted cycle for PPO business, similar to the HMO financial class cycle, for those situations in which the PAS/Hospital elects for NPAS not to balance bill and pursue the GN/patient for payment. Contact is not made with the GN unless additional information is needed to resolve the account, or until a clear determination has been made that the GN owes the remaining balance. If a restricted PPO cycle is a better option than a commercial cycle, an e-mail or call to a Client Services Manager is necessary.

Non - Specialty Units

- Commercial insurance accounts are accounts that do not fall into the financial classes listed in the specialty units stated above. Commercial accounts with a balance less than $1,000 are worked in a dialer-pooled environment (worked by multiple CSP's), with NPAS relying upon the GN's involvement to resolve the pending insurance claim. Accounts with a balance greater than $1,000 are worked in ownership units (accounts assigned to more experienced CSP's). The CSP's performs direct follow up with the insurance company and utilizes the GN's involvement as needed.

Multiple scenarios can be encountered when working insurance accounts. Standard follow up with the insurance company or GN will occur every 7 to 10 days until payment is received from the insurance or the balance is determined to be GN responsibility. All problems or requests for information (i.e., no claim on file, medical records, authorization codes, etc.) are resolved by means of NPAS' efforts, including working with the insurance company, GN and/or the PAS/hospital.

NPAS utilizes various tools to expedite the process in obtaining insurance payments. The primary methods used include telephone contact, online verification and various letter options that are made available to secure payment. The letters are tailored to the specific type of insurance in which follow up is being performed. All ranges of insurance dollars are collected by NPAS.

NPAS does not process or follow up on Medicare or standard Medicaid accounts. If Medicare/Medicaid is placed as primary and have monies prorated to the I-plan, then NPAS' systems will automatically close/return accounts back to the PAS/hospital. However, follow up will be done if an account is a secondary insurance placement after Medicare.

NPAS has the capability to limit collection activity to the insured's company when contact with the insured is not allowed (i.e., in some states, worker's compensation, HMO and some PPO payors).

*If a private pay account is placed in error in an insurance cycle, the account will initially follow an incorrect contact series; resulting in collection efforts being delayed, and recoveries possibly being impacted.

Account Handling – Private Pay – General Overview

As accounts are placed at NPAS our system first searches for monies prorated to an Iplan/insurance field. If there are no monies in the Iplan/insurance fields of the PA system, the account will place as a private pay account and follow the private pay cycles. The account will remain in the Private Pay Department and be reported on the NPAS Monthly Performance Reports as Private Pay recoveries, even if subsequent insurance is found and collected.

Dialer accounts generally make up 80 % of the NPAS work volumes and are automatically scheduled to be worked everyday until a contact is made or an appropriate status code is entered. Accounts are prioritized based on age, dollar amount and time zone.

New private pay placements (balances over $1,500) are added daily to the scheduling module and are evenly and randomly distributed among CSPs to optimize the efficiency of any one CSP or group of CSP's performance for any one hospital. Random distribution

also allows NPAS to provide good customer service and collection recoveries equitably to all hospitals.

Once telephone contact has been made it is NPAS' objective to resolve all patient account balances in the shortest amount of time possible. NPAS CSPs are to seek payment in full through various avenues but may schedule regular payments that are within the company established guidelines. Each PAS/hospital will have the choice of selecting one of three regular payment options per hospital for NPAS to follow when GNs resolve balances with regular payments. (See "Payment Resolution Procedure & NPAS Settlement Policy" sections for details.)

Pure Self Pay Accounts

Accounts that are pure self-pay (Financial Class 99) at discharge are placed with NPAS on the day after the final bill date. The CSPs have various tools at their disposal to work the accounts and to attempt to make contact with the GN. The first priority is to make personal contact via phone. The CSPs can set a predetermined timeframe (A.M., Mid-Day, P.M.) to contact the GN when first attempts at contact were not successful. If a CSP does not make contact on the first attempt, a letter is sent informing the GN that the account has been referred for collection follow-up. The account continues to schedule regularly to allow the CSP to continue trying to reach the GN/patient by phone. The CSPs working accounts with balances greater than $1,500 have several letter options to assist them in making contact with the debtor or confirming payment agreements, etc. CSP's working accounts with balances less than $1,500 do no have the ability to select letters. The system will send out the appropriate letter, depending upon where the account is within the contact series.

*If an insurance account is placed in error in a private pay cycle, the account will initially follow an incorrect contact series; resulting in collection efforts being delayed, and recoveries possibly being impacted.

Account Handling – Special Situations

Deceased

When learning the GN/patient is deceased NPAS should, before any questions are asked, express sympathy for the situation. A description code may appear on the account indicating the patient is deceased but this is not always the case. Handling of the account will depend on whether or not the person to whom NPAS is speaking wishes to continue the conversation. If the conversation continues several variables are involved.

If it has been less than 30 days since the date of death and the party does not wish to speak at this time, NPAS should express sympathy for the loss and advise the party that a call will be returned at a later date. The account will be documented with the date of death and a follow up date will be scheduled 30 days from the date of death. If it has been less than 30 days, a letter is sent out requesting the needed information.

If it has been less than 30 days since the date of death and the party is willing to speak at this time or if it has been more than 30 days since the date of death NPAS will obtain the following seven pieces of information:

- Date of death?
- Is there a surviving spouse? If so, obtain the name.
- Is there an estate? If so, who is the executor?
- Is there an attorney involved? If so, obtain all attorney information.
- Is there any other insurance? If so, populate the insurance contact screen with the information and handle appropriately.
- Are there any additional funds to help pay the balance? If so, pursue for payment following NPAS standard guidelines.

If there is no estate, no means of payment and the spouse is not legally obligated to pay, NPAS will express sympathy for the loss and obtain the seven pieces of information (listed above). The account will be closed back to the PAS/hospital, as the account is deemed uncollectible according to NPAS' processes.

If there is no estate, no means of payment and the spouse is legally responsible to pay, NPAS will express sympathy for the loss and attempt to establish a pay down resolution plan that is feasible for the spouse and is within NPAS' standard guidelines. If the spouse is unwilling to make payment or cannot meet the guidelines, the final notice speech will be stated. The account will be documented accordingly and a message will be sent to the PAS/hospital to change the name to the spouse so that a final notice letter can be sent. A final notice letter will not be sent until the name has been changed.

If an estate is involved NPAS will express sympathy for the loss and obtain executor information so that follow up can be made with the executor. If the executor is the attorney an attorney authorization form must be obtained. If no deceased information is available, NPAS will follow up with the probate court for the county in which the GN lived to determine if an estate has been filed with the court. If the probate court wants to charge a fee to find out if there is an estate, NPAS will message the PAS/hospital and ask to be advised. NPAS will not pay the fee. If the estate is in probate court or the account cannot be resolved NPAS will message the PAS/hospital and ask to be advised.

If an attorney is involved because the GN is deceased NPAS will contact the attorney and verify when the estate will be settled. If the estate will be settled within 30 days follow

up with the attorney will continue. If the estate will not be settled within 30 days an attempt will be made to find out when the estate will be settled and the account will be returned to the PAS/hospital.

If insurance is involved, NPAS will express sympathy for the loss and either update the insurance information so a claim can be billed or follow up with the insurance company until the claim is paid.

Special Notes:

- The husband is always responsible for his deceased wife medical bills regardless of the state that they reside in.
- The wife is only held responsible for her deceased husband's medical bills in Community Property States (listed below). However, there are exceptions.

  In some states court rulings have held that the husband and wife are equally responsible for medical bills. For example, in the state of Florida, the law prevents the pursuit of the spouse of a deceased patient for a balance unless the spouse signed for services. When dealing with spouses in these states, great care is to be used during the call. NPAS should, if asked, indicate the account would be returned to the hospital for handling once all information is secured. Since NPAS is not aware how the hospital will collect the balance, assumptions should not be made or conveyed to the spouses. If a spouse volunteers to resolve the balance, NPAS will accept the offer, document the account and take the appropriate action to get the account resolved.

Community Property States:
Alaska
Arizona
California
Idaho
Louisiana
Nevada
New Mexico
Puerto Rico
Texas
Washington
Wisconsin
Indiana

Bankruptcy

When NPAS is informed that a GN has filed bankruptcy and HCA is listed as a creditor, the following information will be obtained:

- Chapter filed-7 or 13
- Date the bankruptcy was filed
- Attorney's name
- Attorney's telephone number
- Bankruptcy case number
- Reviewer- could be someone at the attorney's office or court house
- Credit Review- date of the first creditors meeting
- Amend Date: date if the original filing as been amended
- Name of Judge or court -enter the name of the judge or court location

If NPAS is successful in obtaining all of the above information the account will be closed back to the PAS/hospital. If there are other active accounts, those accounts will also be documented and closed back to the PAS/hospital.

If only a portion of the information is obtained, additional follow up will be made with the attorney. In this case, an attorney authorization form is not required if an attorney is involved due to bankruptcy.

If a notice has been sent to the PAS/hospital, the account will be documented. If a notice has not been sent to the PAS/hospital, NPAS will request that the notice be sent to the NPAS office.

If the GN is unable to provide the attorney name and telephone number, a request will be made for the GN to call back with the attorney information.

If the GN states that bankruptcy has not yet filed or if HCA is not listed as a creditor NPAS will continue to pursue for payment.

Attorney Accounts

NPAS will accept attorney information for the following reasons: (1.) balances is over $1500 for private pay accounts or the balance is over $1000 for insurance accounts, (2.) Bankruptcy, (3.) Deceased, (4.) Worker's Comp Dispute, and (5.) Lawsuit filed against the HCA facility.

NPAS will not accept attorney information for the following reasons: (1.) third party liability (i.e., auto accident), (2.) civil matters (i.e., divorce, child custody agreements), (3.) quality-of-care suits filed against the physician.

Attorney follow up will only be performed if an authorization form is on file and noted in the system. An exception could be made for deceased accounts.
Once NPAS is made aware that a GN is suing a HCA facility, attorney contact information and attorney authorization would be obtained. A message would also be sent to the PAS/hospital requesting advise on how to proceed.

NPAS does not accept attorney information for third party situations, such as, the GN has an attorney due to an auto accident or the GN is suing a neighbor for injuries sustained at a party. If the GN has an attorney for a reason such as this:

- Request a good faith payment within NPAS guidelines
- If the GN agrees, set up the balance resolution plan on the appropriate payment options screen.

<u>If the GN has an attorney and the balance is over $1,000 (INS) $1,500 (PP), do the following:</u>

- Advise the GN that before NPAS can speak to an attorney, written authorization must occur
- Obtain the attorney information and document the account notes
- Request a good faith payment, if GN agrees to a payment access the appropriate payment screen
- If no good faith payment is secured, GN will be pursued for the balance

If there is an attorney involved due to Workman's Compensation and Worker's Compensation has denied the claim:

- Send the GN a attorney authorization form to be completed and returned to the respective PAS/hospital
- If attorney authorization form is received at the PAS/hospital, NPAS will call attorney's office to see when case will be settled. If the case is in litigation and no hearing set, account will be closed back to the respective PAS/hospital. If the case is in litigation and a hearing has been set within the next 30 days, account will be placed on hold pending outcome of hearing. If outcome is determined to be insurance responsibility, will allow time for claim to be processed. If outcome is determined to be GN responsibility NPAS will pursue the GN for the balance.

- If attorney authorization form is not received at the PAS/hospital:
  - 1st review second attorney authorization form sent to GN.
  - 2nd review call GN / POE to advised attorney authorization form not received, verify address that is listed is correct. If address is incorrect, update the system with correct address, and send additional attorney authorization form. If address is correct, advise attorney authorization form must be completed and returned to the PAS/hospital.
  - 3rd review if Las Vegas, Tampa, or Orange Park PAS, release balance to GN. If an adjustment needs to be put back on the account, NPAS must message PAS to add back on. Once complete, reroute / recode account to Dialer or Preview according to guidelines listed above. Additional attempts will be made for all other Pass/hospitals to follow up with the GN or POE to obtain the attorney authorization form. After significant number of attempts, a message will be sent to the PAS/hospital to advise how to proceed.

If attorney requests that we hold for Lien or Letter of Protection (LOP):

The attorney will be advised that NPAS does not accept liens. Letters of Protection are accepted only if a guarantee of payment in full within 90 days can be made. Otherwise, good faith payments (within hospital guidelines) are needed to hold the account (except for state-regulated workman's compensation).

If attorney advises that a Letter of Protection or Lien is on file with the hospital:

NPAS will ask for a copy to be faxed. Once received the document will be reviewed and check for a signature. If the LOP or Lien was signed message will be sent to the PAS/hospital requesting to be advised on whether to hold the account, or pursue for payment. If there is no signature, the attorney will be contacted and advised that there is no signature. At this point a request for good faith payments would also be made.

If attorney requests we follow-up with the GN for a monthly solution:

- The attorney will be advised that NPAS cannot follow-up with the GN once we have been referred to the attorney or the attorney contacts our office. If the attorney refuses to follow-up with the GN advise the attorney that the account will be final noticed.
- If the hospital notes indicate that they have received a request from the attorney for an itemized bill, the account should be handled as GN responsibility.

When following up with an attorney for the status of a case that is not one of the five reasons NPAS would except attorney information:

- Contact the attorney's office to see when case will be settled. If the case will not be settled within in the next 30 days and it is not due to worker's compensation, bankruptcy, deceased, or suing the hospital, ask the attorney to follow up with the GN for good faith payments. If the attorney sets up good faith payments (within hospital guidelines) the appropriate payment will be established. If attorney states GN cannot or will not set up good faith payments, give the Attorney Final Disposition Speech.
- If the attorney is not available, see if someone else can give the status of the case. If no one else can give the information required, leave a message.
- If on the next review, the attorney has not responded to the previous message, and is not available, leave a second message.
- On the third review, if there has still been no response, and the attorney is still not available, leave a message but stipulate that if a response is not received within a week, the account will be closed and may be placed with a collection agency.
- Hospitals in South Carolina require hospital review; accounts are closed back in protected status. In South Carolina, the above referenced procedure should not be used for accounts where the attorney is handling due to one of the 5 exceptions. Continue to hold those accounts until a response is received unless otherwise advised.

Verifying New or Updated Insurance Information

On a routine basis NPAS will obtain new or updated insurance information from a GN/patient. In these cases the insurance will need to be billed or rebilled. As a standard process NPAS will make contact with the insurance company to verify that the insurance information is accurate before any attempts are made to bill the claim.

Because of the difficulties in being able to make contact with insurance representatives, Private Pay Service Units hold for 3 minutes, 3 minutes, 7 minutes and then indefinitely. Insurance Service Units hold for 3 minutes, 3 minutes, 5 minutes and then indefinitely. Preview Units follow the same number of attempts, but use discretion relative to hold times. Research conducted at NPAS shows that more contacts are made with the insurance companies following this approach instead of remaining on hold with no time limits imposed during the 1st attempt.

Final Notice

Accounts are final noticed for the following reasons:

- GN can't pay. If the GN/patient offers to pay a dollar amount that is below guidelines the account will be documented with the requested payment amount.
- GN refuses to pay.
- The balance is less than $2,000 and the GN/patient speaks a language other than English or Spanish. Throughout the collection process these GN/patients are encouraged to seek interpretive assistance.
- The GN refuses to assist in resolution of account.
- GN requests that they not be called again and the balance is GN responsibility.
- GN does not respond to three consecutive messages that have been left and the balance is GN responsibility. Private Pay FC99 balances greater than $3,00 and, Private Pay Co-pay and deductible balances greater than $1,500, NPAS leaves 5 consecutive messages. If there is no response from the GN after 5 attempts, and the balance is the GN's responsibility, then account is final noticed. Insurance balances greater than $1,000, NPAS leaves 3 consecutive messages. If there is no response

- GN is in Jail (See GN is in Jail section for details.)
- GN is out of the country, GN cannot be reached, and it is not known when the GN will return (See GN is out of the country section for details.)
- The GN has an Attorney for third party litigation and refuses to make good faith payment and the reason for the attorney is not due to one of five reasons: balance is over $1500 for private pay accounts or the balance is over $1000 for an insurance accounts, Bankruptcy, Deceased, Worker's Comp Dispute, and Lawsuit filed against the HCA facility

Third Party Liability Cases

As a standard process NPAS will not pursue third party payers. Possible situations would include auto accidents, civil matters (i.e., divorce, child custody agreements, etc.), and quality-of-care suits filed against the physician. NPAS will also not bill another person's third party commercial health insurance or homeowner's insurance policy. Under these circumstances NPAS considers the GN to be responsible for the balance and would request for the GN to make good faith payments based on PAS/hospital payment guidelines. If the GN refuses to setup any type of resolution on the account, the account will be final noticed.

If NPAS contacts the third party insurance company for balances greater than $1,500 and the insurance company states that the account will be paid within 30 days and the insurance company will pay the hospital directly, then NPAS will hold the account. If the insurance company states they do not know when the account will be paid and /or they are paying the GN directly, NPAS will pursue the GN for payment.

GN is in Jail

If NPAS is informed that the GN is in jail, CSPs verify if the GN will be released/available within seven days. If the GN will be released/available within seven days, the account is placed on hold and a call back is scheduled. If the GN will not be released/available within seven days, the account will be final noticed and will cycle to the next primary agency after 30 days.

GN is Out of the Country

Preview, W/C & Champus Accounts:
Insurance and private pay follow up will be conducted on accounts within Canada. Attempts will be made by phone and by mail to contact the GN and/or insurance company. If there is no response and the balance is less than $7,000 accounts will be closed and placed with the next primary agency. If there is no response due to invalid demographic information (bad home phone & address), and the balance is greater than $7,000 accounts will be routed to the Skip Trace Unit. If valid demographics are obtained, accounts will be handled accordingly. If contact is made and NPAS is informed that the GN will be available within seven days, a call back will be scheduled. If valid demographics are not obtained, accounts will be closed to the next primary agency, as NPAS deems these accounts uncollectible.

PPO & Dialer Accounts:
The Dialer does not have the capability of dialing phone numbers that is outside of the United States (U.S.). Accounts in the PPO Unit or on the Dialer with numbers that are outside of the U.S. will be routed to the Bad Phone Unit where limited attempts to verify or obtain a valid phone number is made. If research returns the same phone number, an attempt will be made to contact the GN. If contact is made with the GN, then the account will be handled accordingly. If contact is made and NPAS is informed that the GN will be available within seven days, a call back will be scheduled. If the GN will not

account will be handled accordingly. If contact is made and NPAS is informed that the GN will be available within seven days, a call back will be scheduled. If the GN will not be available within seven days, the account will be closed and placed with the next primary agency.

If research obtains a different phone number, the account will be routed back to the PPO Unit or Dialer for follow up.

GN does not speak English

If the GN/patient speaks Spanish the account would be transferred to a Spanish-speaking unit so that the appropriate follow up can take place. If the GN/patient speaks another language other than Spanish and English, and the balance is greater than $2,000, an interpretive service will be provided.

GN requests a Non-Recorded Line

NPAS routinely records all outgoing and incoming telephone calls with the exception of any management, supervisor lines or CSP's working in the Client Services Department. The GN/patient is always informed that the call will be recorded. If the GN/patient requests that the call not be recorded, NPAS has the ability to turn off the call recording for that particular call.

GN inquires about the services received

Anytime a GN/patient has specific questions about a procedure or treatment, NPAS will explain that they have reached a centralized business office of the hospital, and we are unable to discuss the details of the services received. NPAS can provide information that would include the date of service, the doctor's name, type of service (i.e., ER, outpatient, etc.) and balance information. Because the CSP's at NPAS do not have any medical background or training, additional medical related information will not be discussed or provided. If the GN/patient requests more details an itemized statement would be sent. If the GN has remaining questions after receiving the itemized bill, the GN would then be referred to the PAS/hospital.

GN is in Distress

If during the duration of any call made to a GN/patient, it becomes apparent that the GN/patient is in distress (i.e., the GN/patient speaks of harming themselves or others), the NPAS CSP's are instructed to notify a member of management. In turn, the member of management will inform the appropriate Client Support Manager so follow up can take place with the PAS/hospital and/or the GN/patient.

Calling The GN's Place Of Employment

When attempting to make telephone contact with a GN/patient NPAS will always first attempt to contact the GN using the home telephone number listed. If the home telephone number is missing, invalid or contact cannot be made using the home telephone number, the place of employment telephone number will be used. NPAS emphasizes care to be taken when attempting to contact the GN at their place of employment. If the GN requests no contact at their place of employment, the place of employment's telephone number will be removed for any and all active accounts at NPAS.

to NPAS a copy (front and back) of the cancelled check. Once received the document would be forwarded to the PAS/hospital for review. If the check has not cleared their bank or posted to the account and the check was mailed over 20 days ago, NPAS will verify the hospital and address where the payment was sent. A request would be made of the GN to place a stop payment and reissue another check.

If NPAS is informed that an insurance payment has been sent, the check has cleared and the account doesn't reflect a posted payment, then a copy (front and back) of the cancelled check would need to either mail or fax to NPAS. Once received, the document would be forwarded to the PAS/hospital for review. If the check has not cleared and the check was mailed over 20 days ago NPAS will verify the hospital and address where the payment was sent. A request would be made to place a stop payment and reissue another check.

If the insurance company states that payment will be made, NPAS will document the account with the following information: date of payment, amount of payment, check number, adjustments, patient responsibility, insurance representatives' name and telephone number.

Accounts are monitored every 7 to 12 days to ensure that the payments or cancelled checks are received. Additional follow up will be made with the insurance company, the GN or the PAS/hospital, if the payment does not post or if a copy of the cancelled check is not received within a reasonable timeframe.

Legal Action

If legal action appears to be the most appropriate means of action in order to resolve an account, the account will be returned to the hospital for turnover to an outside agency. NPAS does not use or employ attorneys. If the PAS/hospital determines prior to sending an account to NPAS that legal action should be the immediate course of action, the PAS/hospital should by-pass placing the account with NPAS and send it directly to an attorney or Primary Collection Agency.

GN Calls On A Closed Account

NPAS is unaware of the activity that may take place on accounts that are closed or become inactive. To avoid the communications or erroneous information, the GN/patient is referred back to the PAS/hospital.

Replaced Accounts

NPAS utilizes a number of standard processes and collection flows for each type of account that is placed. Anytime an account is replaced, the collection flow starts all over again. The collection efforts will not resume where they ended.

Recreated Accounts

Are similar to replaced accounts. Accounts will be worked according to how they are placed (i.e., insurance or private pay). If an account is placed at NPAS without an original balance (original balance is shown as $0) but has a current balance, the CSPs will review the entire account's notes for possible notation of the original balance. If no original balance is found in the notes, associated accounts will be reviewed to see if the account was previously closed from NPAS. If no associated accounts are found, the CSP will check Mainframe for the account's original balance. If the original balance for the account is not found in any of those areas, the CSP will message the PAS/hospital for the

original balance. Follow-up cannot be done with an insurance company without an original balance.

Medicaid At NPAS - General Overview/Account Handling

As a standard process NPAS does not bill or follow up with any Medicaid account. Any account with Medicaid insurance tracking should not be placed at NPAS. Medicaid accounts tracking insurance with IPlans within the restricted range (00100 – 08099) will be automatically closed back to the PAS/hospital. NPAS does have the ability to verify Medicaid eligibility through Medifax. If it is determined that the GN/patient is eligible for benefits, and the service provided will be covered by Medicaid, the account will be documented with all of the necessary billing information and closed back to the respective PAS/hospital so that Medicaid can be billed. If the GN/patient is not eligible for benefits or the account is not billable (per information obtained from Medifax) the GN would be pursued for the balance.

When accounts are placed at NPAS as private pay the GN may inform NPAS that they have applied for Medicaid. NPAS will attempt to obtain an application number. If the application number is not available NPAS will request a letter from the social worker stating that a Medicaid application is on file and the GN is awaiting approval. In most cases, NPAS will continue to pursue the account as a self-pay account until the GN can confirm that Medicaid has been approved.

Government Health Insurance Programs For Children

Most states have programs for insuring children who do not qualify for Medicaid and have no insurance coverage. Examples include; CHIP (Children's Health Insurance Program), CMS (Children's Medicaid Services), Florida Healthy Kids, Peachcare in Georgia, Texas Children's Health Plan, and Nevadacare Kids. NPAS does not bill or follow up with any of these types of Government Health Insurance Programs. If the GN/patient informs NPAS that they are covered under one of these types of programs, a request would be made for the GN/patient to fax or mail a copy of the insurance card. Once the insurance card is received the account would be closed back to the PAS/hospital to bill the account. In some cases, NPAS may call the insurance company to verify coverage.

Medicare At NPAS - General Overview/Account Handling

As a standard process NPAS does not bill or follow up with any Medicare account. Any account with Medicare insurance tracking should not be placed at NPAS. Accounts tracking insurance under a Medicare Iplan will be automatically closed and returned to the PAS/hospital.

If a GN/patient informs NPAS that they have Medicare, the account will be documented with the Medicare insurance information and will be closed back to the PAS/hospital so that Medicare can be billed.

CALL SCRIPTS (Insurance and Private Pay Scripts)

OPENING SPEECH:

Hello, Mr./Ms. **GN's Last Name**. *My name is* **CSP's Full Name**, *and I'm calling on behalf of the business office for* ***Name of Hospital***. *We would like to thank you for choosing* **Hospital's Name** *as your provider of medical services. For quality purposes, this call may be recorded. We appreciate the opportunity to serve you. The current balance of your hospital account is* **$ Amount** *for services provided to* **Patient's Name** *on* **Date of Service**. *Do you have any insurance information that will help us to get the balance paid?*

Special Notes:

- ***If additional insurance information is found the insurance will be billed and the account will be placed on hold for 20 days, pending a response from the insurance company.***
- ***If there is no additional insurance information the balance is deemed to be GN responsibility and payment will be requested***
- **If the GN does not agree to pay normal standard collection methods will be used.**

WHEN LEAVING A MESSAGE ON AN ANSWERING MACHINE:

This message is for **GN's Name**. My name is **CSP's Full Name.** I'm calling from a centralized business office for **Name of Hospital** regarding a business matter. Please return this call at **Phone Number,** Monday through Friday, 8:30 a.m. through 9:30 p.m. EST. When you return the call, you may not reach me, but any representative will be happy to assist you. Thank you.

WHEN LEAVING A MESSAGE With a Third Party:

For your information, I should advise you that for quality purposes, this call may be recorded. This message is for **GN's Name**. *My name is* **CSP's Full Name.** *I'm calling from a centralized business office for* **Name of Hospital** *regarding a business matter. Please return this call at* **Phone Number**, *Monday through Friday, 8:30 a.m. through 9:30 p.m. EST. When you return the call, you may not reach me, but any representative will be happy to assist you. Thank you.*

Special Note

This is all that can be said when leaving a message. Never refer to why you are calling, or offer any other information. However, if leaving a message with a person, and they insist on knowing who you are, state the name of the company is "HCA".

WHO is NPAS?:

We are Patient Account Services. We function as an extension of the hospital's business office, however, at a different location than the hospital.

IN BOUND CALL FOR INSURANCE ACCOUNTS:

Insurance follow up Services, this is **CSP's Full Name**. *How may I assist you?*

IN BOUND CALL FOR PRIVATE PAY ACCOUNTS:

Patient Account Services, this is **CSP's Full Name.** *How may I assist you?*

FINAL NOTICE – (if the balance is over $50):

At this time, I will have to send you a final notice giving you ten days to pay in full. If the account is not paid within that time, your account will be referred to a collection agency, and it will be reported to a credit bureau without further notice.

FINAL NOTICE (if the balance is under $50):

At this time, I will have to send you a final notice giving you ten days to pay in full. If the account is not paid within this time, we will have to return it to the hospital for possible placement with an agency.

ATTORNEY FINAL DISPOSITION SPEECH (under $1,000 for insurance accounts and under $1,500 for private pay accounts):

Due to the size of the account, we do not hold for litigation, and since you have informed me that you have an attorney, I cannot send you a final letter at this time; however, I will be closing your account back to the hospital for possible placement with an agency.

Charity (Eligible):

Based upon the information provided, you may qualify for financial assistance. We will send a form with instructions for you to complete. You will have 7 days from the date the letter is issued to return the documentation to us for review. Please allow 10 days for the review to take place.

Charity (Not Eligible):

Based upon the information provided, you do not qualify for financial assistance. At this time we will hold your account for 10 days so that you may contact us to make payment. At the end of 10 days, if the account is not paid, we will final notice the account and it may be placed with a collection agency.

Department/Unit Descriptions

Insurance Dialer Accounts

Accounts with a balance less than $1000, still tracking insurance, utilize the Predictive Dialer so that contact can be made with the GN/patient to enlist their help in resolving the pending insurance claim. The Insurance Dialer Unit has the ability to receive incoming calls and can only make outgoing calls to the GN. When attempting to make telephone contact with the GN, the home telephone number is utilized first. If the home telephone number is invalid or if one is not provided, the predictive dialer would attempt to contact the GN at the place of employment if a phone number is provided.
This unit does not have the ability to send messages to the PAS/hospital. *(For additional information about the Predictive Dialer see NPAS System Capability.)*

Private Pay Dialer Account

Accounts with a balance less than $1,500, with no insurance tracking, utilize the Predictive Dialer so that contact can be made with the GN/patient to reach a balance resolution. The Private Pay Dialer Unit has the ability to receive incoming calls and can only make outgoing calls to the GN. When attempting to make telephone contact with the GN, the home telephone number is utilized first. If the home telephone number is invalid or if one is not provided, the predictive dialer would attempt to contact the GN at the place of employment if a phone number is provided.

This unit does not have the ability to send messages to the PAS/hospital. *(For additional information about the Predictive Dialer see NPAS System Capability.)*

Service Units (Insurance & Private Pay)

The Service Units support the Dialer Units. Accounts are routed to the Service Units from the Dialer Units when additional follow up is required, such as, verifying new or updated insurance information, when no payment has been posted (i.e., insurance EOB or GN's copy of cancelled check), or obtaining additional information that would help resolve the accounts. The Service Units send messages to the PAS/hospital on behalf of the Dialer Units base on information received from the insurance company or GN that would be used to resolve the accounts.

Preview Units (Insurance & Private Pay)

These are "ownership" units staffed by more experienced CSP's. These units are populated with accounts greater than $1,000 still tracking commercial insurance and private pay accounts with balances greater than $1,500. Accounts are "previewed" by a CSP prior to a call being placed, which is not available for the Predictive Dialer environment. Accounts are automatically scheduled for follow-up, but the CSP's make the decision as to what type of follow up is warranted (i.e., a call is placed and/or a letter is sent to the GN, place of employment, attorney, insurance company or any number of other alternatives). In addition, these units can send messages to the PAS/hospitals based on information received from the insurance company or GN that would be used to resolve the accounts.

Large Balance Unit

This unit is staffed with our most experienced CSPs and is worked in a "Preview" or ownership environment. Only accounts greater than $10,000 are included in this specialized unit and each account is reviewed every 5 to 10 workdays.

Final Chance Unit

This unit works Dialer accounts where the GN is willing to pay but is unable to meet the minimum monthly payments. Although the accounts have been final noticed, one last attempt is made to contact the GN and establish a payment resolution plan by extending the monthly payments up to 60 months. The objective is to set the highest monthly payment resolution possible. If a payment resolution plan is unable to be reached, the final notice will stand and accounts will cycle to the next primary agency.

Worker's Comp Unit

This Unit functions in a "Preview" or ownership environment with no balance size restrictions. This unit only works accounts placed with a financial class type of 04 and the balance is prorated to insurance. If NPAS finds new Worker's Comp insurance, the account would be transferred to this unit to be worked. Both state and non-state regulated accounts are worked in this unit. Before follow up can begin the W/C Unit will ensure that the following four pieces of information are listed in the account; (1.) date of injury, (2.) name of employer and telephone number, (3.) if accident report was filed, (4.) name, address, phone number of Worker's Compensation carrier. If any of these four pieces of information is missing NPAS will contact the GN's POE to obtain this information. If these four pieces of information are not missing, follow up will begin by contacting the Worker's Compensation carrier to obtain status of the claim. If the insurance carrier needs additional information, NPAS would follow up with the employer or hospital (i.e., medical records) depending upon what additional information is needed to resolve the account. Follow up cycle is continued until the claim is paid or denied. The W/C insurance is recognized as the primary insurance.

Tricare (Champus & VA) Unit

This Unit functions like a Preview Unit with no balance size restrictions. This unit only works accounts placed with a financial class type of 06 and the balance is prorated to insurance. If NPAS finds new Champus insurance, the account would be transferred to this unit to be worked.

HMO Large Balance (over $1,000) Unit

This Unit functions like a Preview Unit by only working accounts with balances above $1,000, and the account was placed with a financial class type of 07 with the balance prorated to insurance. If NPAS finds new HMO insurance, and the balance is above $1,000, the account would be transferred to this unit to be worked. This unit works directly with the insurance to resolve pending insurance claims or identify a balance as GN responsibility. The GN can be contact only to request their help in resolving the pending insurance claim. The GN can only be billed when the balance is identified as GN responsibility.

HMO Small Balance (under $1,000) Unit

This Unit functions like a Preview Unit by only working accounts with balances less than $1,000, and the account was placed with a financial class type of 07 with the balance prorated to insurance. If NPAS finds new HMO insurance, and the balance is below

$1,000, the account would be transferred to this unit to be worked. This unit works directly with the insurance to resolve pending insurance claims or identify a balance as GN responsibility. The GN can only be contacted to request their help in resolving the pending insurance claim. The GN can only be billed when the balance is identified as GN responsibility. Accounts worked in this unit have a short follow up cycle consisting of 65 days. Once the follow up cycle ends, and there has been no resolution on the account, the account will automatically close back to the PAS/hospital. The PAS/hospital may then choose to replace the account with NPAS.

PPO Units

The PPO Unit functions as a support unit of the Insurance Department, which is a combination of the Service and Dialer Units. This unit only works accounts placed with a financial class type of 08 and the balance is prorated to insurance. If NPAS finds new PPO insurance while in another unit other than PPO, the account will remain in that respective unit until the account is resolved. Accounts are resolved by following up with the insurance company, GN, or sending messages to the PAS/hospitals based upon information that was obtained from the insurance company or GN.

Spanish Unit

NPAS maintains both Insurance and Private Pay Dialer and Preview Units that are staffed with Spanish Speaking CSPs. These units are located in the Bedford, Texas NPAS office and follow a similar criteria used by the regular Insurance and Private Pay Dialer and Preview Units.

Billing Department

NPAS has the capability to automatically request a reprint of any bill for PA hospitals and reprint an imaged bill for PAS facilities that scan documents into AVDM and/or ON-BASE systems. This eliminates the need, in most cases, of additional communications with the business office. Certain government payors (i.e., Medicaid) will need to be referred back to the hospital for possible assistance, should this type of an insurance payor be identified.

NPAS has the capability to update insurance information in Collections and Meditech Systems for PAS's who have granted NPAS access to their specific Collections/Meditech Systems.

The NPAS Billing Department has the ability to rebill primary payors and/or bill or rebill secondary payors with the exception of Medicaid and Medicare. NPAS will rebill secondary insurance after the primary payor denies or pays, when it is properly identified. Once an account is identified as needing to be rebilled, the account is routed to the Billing Department. If PA paper billings are needed (especially for hospitals not in a PAS) these bills are printed in the Nashville Corporate office and shipped to Louisville. Limited modifications can be made to the paper bills if necessary prior to being billed.

Skip Trace Unit

This unit is designed to locate and obtain valid demographic information on accounts in which NPAS has deemed the demographic information to be invalid. If the NPAS system detects either a value of 0 or repeated seven digits of the number "nine" and an incomplete address or no address while searching the demographic fields, accounts are routed to this unit. (Accounts must have a bad address and telephone number before the system will route accounts to this unit.)

As accounts are worked by the CSPs and it has been determined that the telephone number and/or the address is invalid then the accounts are manually routed to this unit.

This unit only works accounts with balances greater than $1,500. Actions taken to locate valid demographic information would include a combination of automated letters, local calls, Directory Assistance, Finder, and on-line "look-up" service for new telephone numbers and addresses. Full Credit Bureau Reports would only be used for balances greater than $5,000. AT&T translation service for all languages is used when necessary but, only for accounts with a balance greater than $3,000. This unit also handles out of country accounts for balances over $3,000.

Bad Phone Unit

This unit is designed to support the Dialer and PPO Units when the Predictive Dialer detects an invalid or non-working phone number. Attempts are made to verify or obtain a valid/working phone number so accounts can be routed back to the appropriate unit so that collection efforts may resume by telephone contact.

Private Pay Contracts Unit

This unit manages those accounts that have been setup on a payment resolution plan prior to placement at NPAS or where the payments fall below the payment guidelines. Any other account that has been setup on a payment resolution plan by another unit, will remain in that unit until the account is paid in full or the GN defaults on the payments.

Medicaid Unit

This unit manages and reviews any account that has been identified as having Medicaid insurance or other government insurance that needs to be billed. Medifax will be utilized to verify Medicaid. If the GN/patient is eligible for Medicaid and the service provided is billable to Medicaid, the account is closed back to the PAS/hospital so that Medicaid can be billed. If the GN/patient has other government insurance that needs to be billed, and eligibility can be verified by review of the medical card, then these accounts will be closed back to the PAS/hospital so the account can be billed. *(For additional information see the "Medicaid at NPAS" section.)*

IBIP Unit

This unit performs the posting of all credit and debit card payments obtained at NPAS for those hospitals in which NPAS has IBIP access. Credit and debit card payment information obtained by NPAS is entered into a temporary screen that prevents credit and debit card information from becoming a permanent part of the account. This information is downloaded into a special report the next day and is provided to the IBIP Unit. The IBIP Unit maintains a 2 to 3 day turn-around time in getting all credit and debit card payments processed.

Client Services Department

This department handles the Customer Service Complaint Line, messages sent from the PAS/hospital, and additional communications.

The Customer Service Complaint Line handles calls from the GN/patients who are not satisfied with the progress on their account or have a complaint against a process, procedure or situation at NPAS or the PAS/hospital. NPAS logs all complaints received by

the GN/patients or PAS/hospital. Client Services enterers and maintains complaints that are entered/stored in the Customer Service Database.

All messages sent to NPAS are reviewed by Client Services with the appropriate actions being taken (i.e., setup payment resolution plan or place account on hold) at the time of review. If the unit managing the account needs to take an action on the account, Client Services will mark the account for immediate review.

Accounts are sometimes routed to Client Services from other units due to no response received from a PAS/hospital during the standard messaging series (2 messages and 1 fax). In situations where NPAS is unable to more forward with account resolution (i.e., account balance needs to be adjusted or no audit results) Client Services will initiate additional follow up with the PAS/hospital via telephone, e-mail, or fax. Accounts that are in Client Services will assume an outstanding status until the message has been responded to and answered appropriately.

Stat Requirement Per Unit

Each CSP, depending upon the type of collection call being made, is asked to work a minimum number of accounts to maintain productivity and ensure quality of work. The goals are set on well-developed historical trends and support both productivity and good customer service. The goals are reviewed any time there are changes in work methods and whenever statistical trends in the achievement of minimum goals indicate a possible need for an adjustment. If dollar collection recoveries exceed predetermined levels, collection CSPs earn monthly incentives. These levels are adjusted monthly based on the dollar collections needed at current inventory levels to meet recovery collection percentage goals. An additional discretionary incentive will be awarded to those CSPs who earn a monthly bonus. The discretionary portion of the monthly bonus is based upon the use of good customer service skills, quality of job performance according to NPAS' policy and procedure and generally how well the rep represented HCA to our patients/customers.

Specific production requirements by unit are outlined below:

Stat Requirements Per Unit/Department	# Of Accounts Worked Per Day
Insurance Predictive Dialer Accounts	128
Private Pay Predictive Dialer Account	164
Service Unit	100
Preview Unit Insurance	101
Preview Unit Insurance (Spanish)	101
Preview Unit Private Pay	134
Preview Unit Private Pay (Spanish)	125
Large Balance	132
Worker's Comp Unit	102
Champus Unit	150
HMO Large Balance (over $1,000) Unit	101
HMO Large Balance (under $1,000) Unit	101
PPO Units	101
Billing Department (Imaging) on average	136
Billing Department (Itemized Bills - paper) on average	375
Billing Department (Account review) on average	675
Billing Department (UB92s) on average	263
Skip Trace	154
Contracts Unit	90
IBIP Unit	180
Client Services (Messages from PAS/hospital)	473
Client Services (Complaint Line)	53
Client Services (Account review/Communication Que)	188
Client Services (Incoming Faxes/Netmoves)	90

Messaging Process

Overview/Message Categories

Y message
uidelines web toolk.

ACCOUNT NOTE ABBREVIATIONS

ABBREVIATIONS (Revised 12/20/99)

ABBREVIATION	FOR	ABBREVIATION	FOR
?	QUESTION	ID	IDENTIFICATION
2ND INS	SECONDARY INSURANCE	INFO	INFORMATION
ACCT	ACCOUNT	INS	INSURANCE
ADDRS	ADDRESS	LM	LEFT MESSAGE
ADDTNL	ADDITIONAL	LM/RCRDR	LEFT MESSAGE RECORDER
ADJ	ADJUSTMENT	LTP/A	LONG TERM P/A
AMEX	AMERICAN EXPRESS	LTR	LETTER
AMT	AMOUNT	M/R	MEDICAL RECORDS
AOB	ASSIGNMENT OF BENEFIT	MCAID	MEDICAID
APGY	APOLOGY	MCARE	MEDICARE
ATTN	ATTENTION	MEOB	MECICARE EOB
ATTY	ATTORNEY	MNTH	MONTH
AUTH	AUTHORIZATION	MSG	MESSAGE
BAL	BALANCE	MSTR CD	MASTER CARD
BCBS	BLUE CROSS/BLUE SHIELD	NCOF	NO CLAIM ON FILE
BNKRPT	BANKRUPTCY	NL	NO LISTING
BOM	BEGINNING OF MONTH	NLE	NO LONGER EMPLOYED
BZ	BUSY	NS	NO ANSWER
CBO	CENTRAL BUSINESS OFFICE	O/P	OUT PATIENT
CK	CHECK	OBTN	OBTAIN
CL BK	CALL BACK	P/A	PAYMENT ARRANGEMENT
CLD	CALLED	PCP	PRIMARY CARE PHYSICIAN
CLM	CLAIM	PD	PAID
CMT	COMMENTS	PEOB	PRIMARY EOB
CO	COMPANY	PHYS	PHYSICIAN
COB	COORDINATION OF BENEFITS	PIF	PAID IN FULL
COINS	CO-INSURANCE	PLS	PLEASE
CORRES	CORRESPONDENCE	PMT	PAYMENT
CPAS	COLUMBIA PATIENT ACCOUNT SERVIC	POE	PLACE OF EMPLOYMENT
CUST SERV	CUSTOMER SERVICE	PP	PRIVATE PAY
D/A	TELEPHONED DIRECTORY ASSISTANC	PPO	PREFERRED PROVIDER ORG.
DECSD	DECEASED	PT	PATIENT
DED	DEDUCTIBLE	RECV	RECEIVED
DFLT	DEFAULT	REF	REFERAL
DISC	DISCOUNT	REP	REPRESENTATIVE
DISCVR	DISCOVER	REQ	REQUEST
DOB	DATE OF BIRTH	RESPON	RESPONSIBILITY
DOS	DATE OF SERVICE	SAU	SERVICE UNIT
DX	DIAGNOSIS	SC	SMART CODE
EOB	EXPLAINATION OF BENEFIT	SD	SAID
EOM	END OF MONTH	SNT	SENT
EOMB	EXPLANATION OF MECICARE BENEFITS	SOC	SHARE OF COST
EOW	END OF WEEK	SPAN	SPANISH
ER	EMERGENCY ROOM	SS#	SOCIAL SECURITY NUMBER
F/N	FINAL NOTICE	STTD	STATED
F/U	FOLLOW-UP	STTLMNT	SETTLEMENT
FWD	FORWARD	SUPR	SUPERVISOR
G-LINES	GUIDELINES	TATTY	TELEPHONED ATTORNEY
GN	GUARANTOR	THX	THANKS
HCP	HUMANA	TT	TALKED TO
HMO	HEALTH MAINTENANCE ORG.	UB	UNIFORMED BILL
HOSP	HOSPITAL	VRFY	VERIFY
HUSB	HUSBAND	W/C	WORKMANS COMP
I/P	INPATIENT	W/O	WRITE OFF
IB	ITEMIZED BILL	WF	WIFE
		WK	WEEK
		WRK	WORK
		WRNG#	WRONG #

DO NOT USE THESE KEYS IN INTELEC NOTES ~ { } [ ] | (bar) ` (backwards tick) ; (semi-colon) and \ (backslash)

Payment Resolution Procedure

It is NPAS' objective to resolve all patient account balances in the shortest amount of time possible. NPAS CSPs are to resolve accounts by extending in order the various payment resolutions to the GN, listed in the payment recipe. Those guidelines will be monitored through an automated process.

Payment Recipe

1. Payment in full, check by phone
2. Payment in full, credit or debit card
3. Half now, half in 30 days
4. Largest monthly installments, or negotiating until the minimum monthly payment is reached as outlined in the payment tier options noted below
   Special notes:
   - *The following units have the ability to extend monthly payments up to 60 months. The objective is to set the highest monthly payment resolution possible. The minimum monthly payment would not fall below $25.00.*
     Insurance - $1,000 & up (balance must be GN responsibility)
     Private Pay Preview- $1,500 - $10,000
     Large Balance - $10,000 & up

   - *Private Pay Dialer and Insurance Dial Accounts (balance is GN responsibility) where the GN is willing to pay but is unable to meet the minimum monthly payments. Such accounts will be final noticed and routed to the Final Chance Unit where one last attempt will be made to establish a payment resolution plan by extending the monthly payments up to 60 months. If a payment resolution plan can't be reached, the final notice will stand and the account will cycle to the next primary agency.*
5. Settlement (extended as a last resort)
6. If no agreement to pay, screen for HCA Uninsured Standard Charity (only for participating hospitals)
7. Final notice if no agreement to pay can be established (using option 1 to 5) and non-participation in HCA Uninsured Standard Charity program

Advanced Negotiation Techniques (ANT)

CSPs may attempt to resolve accounts by determining alternative money sources that may be available to a GN. Negotiating alternative money sources requires the CSPs to use good judgment and present these suggestions in a helpful manner.

Examples are as follows:

- Loans from banks or credit unions.
- Ask the GN to review their current verbal agreements with doctors, dentists, or any other medical providers in an attempt to re-arrange or reprioritize schedules to meet NPAS minimum guidelines
- Borrowing against their retirement plans/401K Plans, or from family/friends
- Cashing in vacation time
- Discontinuing cable television or cell phone.
- Income tax refunds
- Ask the GN if there are any vehicles paid for that could be used as collateral for a loan, selling assets (i.e., property, vehicles, recreational equipment, etc.), liquidation of stocks, bonds, family heirlooms, etc.

Payment Tiers for Monthly Payment Resolution Process

The payment tier options for each PAS/hospital are listed below. The PAS/hospital has the option to standardize the payment tiers for all hospital(s) in their PAS/hospital, or they may choose any one of the three payment tiers below for any of the facilities in their PAS/hospital.

Payment Resolution Tier A Most Aggressive	
Balance Due	**Minimum Monthly Payment**
$10 - $75	$25
$76 - $250	Divide by 3
$215 - $500	$75
$501 - $1,200	$100
$1,201 & above	Divide by 12

Payment Resolution Tier B Moderately Aggressive	
Balance Due	**Minimum Monthly Payment**
$10 - $150	$25
$151 - $250	Divide by 6
$251 - $350	$50
$351 - $500	Divide by 7
$501 - $900	$75
$901 - $1,000	Divide by 12
$1,001 - $2,400	$100
$2,401 & above	Divide by 24

Payment Resolution Tier C Least Aggressive	
Balance Due	**Minimum Monthly Payment**
$10 - $60	$15
$61 - $180	$20
$181 - $300	Divide by 9
$301 - $360	$30
$361 - $600	Divide by 12
$601 - $900	$50
$901 - $12,00	Divide by 18
$1,201 - $1,800	$75
$1,801 - $3,000	Divide by 24
$3,001 - $4,500	$125
$4,501 & above	Divide by 36

Payment Resolution & Default Process

System generated reminder letters are mailed 15 days before the regular payment is due. In the event a GN defaults on a payment promise, a system generated default letter is sent 5 days after the regular payment was due and the account is scheduled for a call 10 days later. Collection CSPs ask that the GN make up the missed payment after the first default. If the GN is unable to make up the missed payment, the regular payment agreement may be reset one time. The GN is advised that a second consecutive default (two full payments in arrears) will require that the missed payment(s) be made up. If the GN is unable to make up the missed payment(s) a final notice will be sent and the account will cycle to the next primary agency.

LINKING/UNLINKING

NPAS has the ability to link accounts manually. While the accounts are linked at NPAS, they still remain separate accounts at the hospital. Only accounts that have a Private Pay balance and the accounts are for the same hospital can be linked. Accounts placed as insurance pending are only linked when the balance due is determined to be patient's responsibility and the GN requests that they be linked so that a regular monthly agreement can be established.

Accounts are linked for the following reasons:

- The GN can set up a payment resolution plan for multiple accounts and make only one monthly payment.
- The GN does not receive several calls in one day/evening
- The GN does not receive multiple letters
- Accounts needing to be re-billed can all be sent to the billing department

PAS/Hospital Setting up Payments Prior to Placement

NPAS has the ability to accept monthly payment agreements from the Patient Accounting System (PA). This enhancement is available for non-Collection System facilities. Collection System facilities must have version 6.3 loaded before this functionality will work.

When a GN has agreed to make regular payments, the PAS/hospital may enter the agreement information and then have the system forward/place the account to NPAS. All information (payment amount, frequency, and start date) will automatically be loaded and establish the account on regular monthly payments with NPAS. The new agreement frequency for NPAS arrangements will be "C".

These accounts will be automatically placed in a regular payment agreement-monitoring unit at NPAS called the Contracts Unit. The system will automatically monitor payment activity and only schedule accounts to be reviewed when in default.

The cost associated with this new agreement functionality will be the same as with any other private pay accounts with NPAS, in that it is a direct cost allocation of NPAS expenses.

This functionality offered by NPAS will relieve the PAS/hospital staff of the burden of monitoring and completing follow-up on patient regular payment accounts. The PAS/hospital may also establish payments on accounts previously placed with NPAS. The PAS/hospital can establish agreements by informing NPAS through the messaging series, contacting the Client Service Department or the respective Client Support Manager.

Host Based Follow-Up Facilities

NPAS monthly financial arrangements can be established by entering an "F" transaction on a patient's account with a frequency of "C".

Trans Code	Patient Number	Estimated Amount Due	Maximum Amount Due	Statement Frequency	Statement Start Date	Note Due Date
F	R/O 12-N	O/O 7-N	O/O 5-N	O/O 1-A	O/O 8-N	O/O 8-N

Example: F; 123456; 20;C; 19970201
In this example, we would be establishing a $20.00 NPAS monthly financial arrangement that would begin on February 1, 1997.

- NPAS arrangements (payment resolutions) are only **monthly.** NPAS does not accept or establish bi-weekly, semi-monthly, or note arrangements.
- NPAS arrangements can be changed by entering subsequent "F" transactions with new arrangement information with a C frequency.
- NPAS Arrangements cannot be established on pre-admitted (will reject for INV PRE ARRG), GN, or GN linked accounts (both will reject for INV FRQ LINK).
- NPAS Arrangements cannot be established on accounts with a current "note" arrangement (will reject for NOTE DUE DT).

Master Files
In order for the NPAS arrangements functionality of Patient Accounting to work properly, the following master files must be established:
Host Collection Agency Master File

The NPAS Collection Agency Master File (Agency #771) must be established on the Host.

```
SYSTEM:MSTR/MS14 ACTIVITY: COLL AGENCY DATE: 02/04/97 REFER: MFM 3-6-1
=========================================================
=======================
UNIT NUMBER: 09999     9999 - QUALITY HOSPITAL
   ACTION: I     I-INQUIRY    A-ADD    C-CHANGE
AGENCY CODE: 771
-------------------------------------------------------------------------
AGENCY   TYPE: E
     NAME: NATIONAL PAT ACCOUNT SVCS        SHORT: NPAS
ADDRESS ONE: 500 KAUFMAN-STRAUS BLDG       PHONE: 615 - 572 - 3199
ADDRESS TWO: 400 SOUTH 4TH AVE.          CONTACT: JOE SHUTTS
CITY, STATE: LOUISVILLE, KY
ZIP: 40202 - ____
MIN AMT1: 00010.00   MIN AMT2: 01000.00   START DATE: 1994 01 01   CCYY MM
DD
MAX AMT1: 99999.99   MAX AMT2: 05000.00    END DATE: 1999 12 31   CCYY MM
DD
PLACEMENT DAYS: 140  PYMT PROC CD: 999771  NPAS PAYMENT
NEXT PLACEMENT: 749
  PRELIST DAYS: 014
F1-HELP   F3-EXIT F7-PREV AGENCY F8-NEXT AGENCY F12-CANCEL
```

Patient Accounting Processing

The following "rules" apply when Patient Accounting receives an "F" transaction with a "C" frequency:

- The account cannot be in a pre-admit status, cannot be a GN or GN linked account, and cannot have a current "note" arrangement. All of these conditions will cause the "F" transaction with a frequency of "C" to reject on the Daily Batch Report.
- Patient Accounting will validate the financial class at the individual patient account level with the corresponding financial class in the Host Financial Class Master File. If the Host Financial Class Master File contains an early out agency other than 771 or spaces the transaction will reject on the Daily Batch Report.
- If outstanding insurance liability exists (i.e., patient due does not equal account balance), the account will be directed to series 901 (monthly arrangements) but will maintain the "C" frequency. The following Host COLL screen illustrates this scenario:

```
PAT INQUIRY-COLLECTIONS   UNIT: 09998   FILE DATE: 01/26/95    REFER: 3-16-1
==============================================================
===================
 PAT NUM: 329960     PT: I  ADM: 11/19/91  FBIL: 01/08/92   BAL:   26,975.85
 PAT NAME: JONES JOHN  FC: 01 DIS: 12/21/91  PHYS: 0978   ROOM: 312B  STAT: AR
=========================COLLECTION INFORMATION
SCREEN1====================
  PREV SER: 999   PREV STEP:  1   01/11/95   ACTY IND: L   ACTY NO: 999
  CURR SER: 901   CURR STEP:  1   01/12/95   ACTY IND: M   ACTY NO: 994
  NEXT ACT: 02/12/95      LST PAY:                .00  OVERDUE:     .00
   EOUT DT:              LST STM: 01/12/95    26,975.85  CUR DUE:    11.00
   AGE CAT: OVR 360          STMS: 4                  TOT DUE:    11.00
   BD TYPE: NA
   GUAR NO:              GUAR NM:
   DT LINK:            DT UNLINK:
   ARRG/DATE: MINM 02/12/95 FREQ: C EST DUE:          .00  MIN DUE:  2000.00
ENTER-CONTINUE F1-HE F3-EXIT F8-NEXT F12-LINK                    ACT: AGNY
PRESS F8 TO DISPLAY LLECTION INFORMATION SCREEN2
```

Due to an outstanding insurance liability, the account is placed to series 901 (minimum monthly) but retains the frequency of "C"

- The "C" frequency arrangement will act as though it is an "M" (monthly) arrangement. Patient Accounting will generate statements to the patient monthly based on the arrangement start date.
- Once all outstanding insurance liability has been resolved and patient due is equal to the total account balance, the account will be placed to agency series 771 (NPAS) and the account will be placed to NPAS. The arrangement information will be passed to NPAS as well so they may continue the arrangement cycle.

```
PAT INQUIRY-COLLECTIONS   UNIT: 09998   FILE DATE: 01/26/95    REFER: 3-16-1
==============================================================
===PAT NUM: 329960     PT: I  ADM: 11/19/91  FBIL: 01/08/92   BAL:   26,975.85
PAT NAME: JONES JOHN  FC: 01 DIS: 12/21/91  PHYS: 0978   ROOM: 312B  STAT: AR
=========================COLLECTION INFORMATION
SCREEN1====================
  PREV SER: 901   PREV STEP:  1   01/11/95   ACTY IND: L   ACTY NO: 999
  CURR SER: 771   CURR STEP:  1   01/12/95   ACTY IND: M   ACTY NO: 994
  NEXT ACT: 03/01/96      LST PAY:                .00  OVERDUE:     .00
   EOUT DT:              LST STM: 01/12/95    26,975.85  CUR DUE:    11.00
   AGE CAT: OVR 360          STMS: 4                  TOT DUE:    11.00
   BD TYPE: NA
   GUAR NO:              GUAR NM:
   DT LINK:            DT UNLINK:
   ARRG/DATE: MINM 02/12/95 FREQ:  EST DUE:          .00  MIN DUE:     .00
ENTER-CONTINUE F1-HE F3-EXIT F8-NEXT F12-LINK                    ACT: AGNY
PRESS F8 TO DISPLAY LLECTION INFORMATION SCREEN2
```

Once insurance liability has been released, the account will be placed to NPAS, series 771, and the next action date will be calculated based on account balance divided by arrangement amount multiplied by thirty days pause thirty days then added to the arrangement start date.

- If the facility utilizes the Financial Class Master to calculate an early out date, and an early out date is reached, the account with insurance still tracking will be placed to series 771 and the account will be placed to NPAS. The arrangement information will be passed to NPAS as well so they may continue the arrangement cycle.
- If no insurance liability exists, the account will be directed to agency series 771 and placed to NPAS immediately. The arrangement information will be passed to NPAS as well so they may begin the arrangement cycle.
- Upon placement to NPAS, the account's next step date will be calculated as the total account balance divided by the arrangement amount multiplied by thirty days plus thirty days then added to the arrangement start date. An example would be a NPAS arrangement established on January 1, 1997 in the amount of $20.00 on a $200.00 account balance: (200.00/20.00 = 10x30 = 300+30 = 330 added to arrangement start date of January 1, 1997 would give a next step date of approximately December 1, 1997. This calculation will insure that accounts will not be systematically recalled from NPAS prior to the financial arrangement being completed.
- Due to the user stating through the "F" transaction that the account should be placed to NPAS when eligible, both minimum and maximum dollar placement ranges in the Collection Agency Master File are ignored, any early out hold indicators are ignored, and any patient type omitted in the Financial Class Master File (by answering "N") would be included.
- After the initial "F" transaction has been entered with a frequency of "C", subsequent "F" transactions can be entered to modify the arrangement amount. If the account has already placed to NPAS, the transaction will not update the Host but will pass directly to NPAS in the interface.

Collection System Facilities

NPAS monthly financial arrangements can be established by entering a FREQUENCY of "C" in the ARRANG activity.

- NPAS Arrangements are only **monthly** arrangements. NPAS does not accept or establish bi-weekly, semi-monthly, or note arrangements.
- Only "C" frequency arrangements will be formatted to NPAS for follow-up.

```
COL/HIS   DATE     STA ACTIVITY: ARRANGEMENTS          ASSUME-DATE: 02-06-97
CS 6.3 02-06-97 0001 ARRANG   MANUAL-REF: 8-8-1       QH
==============================================================
===
==============================================================
===
P/N          1999999 DOE JOHN
Admission Date      03-21-94
System Date         02-06-97
Pat Estimated        756.00
Net Balance         756.00
Arrangement Type       MINM
Arrangement Date    02-06-97
Payment Amount          100
Frequency                C
Stmt Start Date     02-06-97
Note Due Date
```

In this example, we would be establishing a $100.00 NPAS monthly financial arrangement that would begin on February 6, 1997.

- The system will not allow the user to place GN or GN linked accounts on NPAS arrangements.

```
COL/HIS   DATE     STA  ACTIVITY: ARRANGEMENTS          ASSUME-DATE: 02-06-97
CS 6.3  02-06-97  0001  ARRANG   MANUAL-REF: 8-8-1       QH
==============================================================
======================
* ERROR 3323 * GN linked account cannot be a "C" frequency! PRESS ACK KEY
==============================================================
======================
  P/N G       3273101 DOE MICHAEL

 Admission Date      04-05-94
 System Date         02-06-97
 Pat Estimated          0.00
 Net Balance        4,060.85
 Arrangement Type       MINM
 Arrangement Date    02-06-97
 Payment Amount          10
 Frequency                C
 Stmt Start Date
 Note Due Date
```

GN Account Indicator.
Same *Error 3323 will be given
if account is a GN linked
account (indicated with a "L")

If another early out collection agency has been assigned to the account through the Host Financial Class Master File, the system will not allow a NPAS arrangement to be established.

```
COL/HIS CS R6.3  STA:  06011  ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
====================
P/N 9594791        DOE ELIZABETH          Facility  9999  QUALITY HOSPITAL
Rsp DOE ELIZABETH            SSN 888-22-3333 Admit 09-14-93 Dsch 09-14-93 FC  1
Adr 1111 MAIN ST S           Desk       1 CS   2   2 ADMIN HOLD OKAY? NOT RESO
Adr APT 1                  BdAdr N   Ptype E   SD 02-13-97 WTD 00.00 02-06-97
C&S ANYWHERE        TN        G/N              EOD 99-99-99 Agy 770     Hold N
Zip 55666-0000   Ph (555)111-2222     Arrg Amt              Lst Stmt 07-24-94
Lst Pt Pay             09-03-94    BdDebt NA Fbill 09-17-93 Delay
Ttl Chg      724.05   Bal       84.51   Pt Due       84.51   Pd
Ttl Cmbd Bal P 1 84.51 Dlq Ins - Dsk
Pri 500-02P COMMERCIAL INS            CS
Due              Pd      639.54    SD         WTD              Dly
Sec                            Grp
Due              Pd              Ph (   )   -            Claim Sub
Ter                            Pol#                      Ins'd
Due              Pd              TAuth                     AccDt
----- Financial Transactions ------------------ Notes ---------------------
09-03-94 000010 1
10-15-93 000402 1        123.96-
10-15-93 000502 5        515.58-
09-14-93 000105 6         45.00
Early out agency 770 assigned by the
Host Financial Class Master
```

```
COL/HIS   DATE    STA   ACTIVITY: ARRANGEMENTS          ASSUME-DATE: 02-06-97
CS R6.3 02-06-97  6011  ARRANG    MANUAL-REF: UG 8-8-1       QH
==============================================================
====================
* ERROR 3321 * "C" frequency invalid per assigned early-out! PRESS ACK KEY
==============================================================
====================
  P/N          9594791 DOE ELIZABETH
  Admission Date      09-14-93
  System Date         02-06-97
  Pat Estimated         84.51
  Net Balance           84.51
  Arrangement Type      MINM
  Arrangement Date    02-06-97
  Payment Amount           10
  Frequency                 C
  Stmt Start Date
  Note Due Date
```

The system will not allow NPAS arrangements to be established if collection agency 771 is not established in the FAGNY Master File.

If the current early out hold indicator is "Yes or "S", when the NPAS arrangement is established the early out hold indicator will be set to "N".

```
COL/HIS CS R6.3  STA:  06011  ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
================================================================
==
P/N 3281487        DOE MARY              Facility  9999  QUALITY HOSPITAL
Rsp DOE MARY                SSN 755-55-5555 Admit 03-25-94 Dsch 03-26-94 FC  1
Adr 50 PINE CIRCLE           Desk     20 CS 200  0 MEDICARE PATIENT LIABILIT
Adr                       BdAdr N   Ptype I   SD 99-99-99 WTD 00.00 99-99-99
C&S ANYWHERE TN              G/N              EOD 99-99-99 Agy 999     Hold S
Zip 55443-0000   Ph (555)346-7356    Arrg Amt                Lst Stmt
Lst Pt Pay              04-14-94    BdDebt NA Fbill 04-04-94 Delay
Ttl Chg     8,231.30  Bal     8,231.30    Pt Due                Pd
Ttl Cmbd Bal P   2 8,231.30       Dlq Ins 100-02  MEDICARE Dsk       1
Pri 100-10  MEDICARE                CS  100  5 MGR-MC NOT RESOLVED/TRANSFER
Due     7,535.30    Pd              SD 04-05-97 WTD       02-13-97 Dly
Sec 100-02 MEDICARE                 Grp                MEDICARE
Due       696.00    Pd              Ph  (000)000-0000       Claim Sub 04-04-94
Ter                            Pol# 555121212A            Ins'd P
Due              Pd              TAuth                    AccDt
----- Financial Transactions ----------------- Notes ----------------------
04-14-94 000065 1
04-04-94 FBILL  6      8,231.30
Early out indicator. Values can be "N", "Y" or "S".
```

```
COL/HIS    DATE   STA   ACTIVITY: ARRANGEMENTS            ASSUME-DATE: 02-06-97
CS R6.3  02-06-97 6011  ARRANG    MANUAL-REF: UG 8-8-1     ACH
================================================================
==
* INFO 3330 * Early-Out Hold will be set to "N"!            PRESS ACK KEY
================================================================
==
  P/N          3281487   DOE MARY

  Admission Date      03-25-94
  System Date         02-06-97
  Pat Estimated          0.00
  Net Balance        8,231.30
  Arrangement Type        MINM
  Arrangement Date    02-06-97
  Payment Amount           10
  Frequency                 C
  Stmt Start Date
  Note Due Date
```

Master Files
In order for the NPAS arrangements functionality of Patient Accounting to work properly, the following master files must be established:

Host Collection Agency Master File
The NPAS Collection Agency Master File (Agency #771) must be established on the Host.

```
SYSTEM:MSTR/MS14   ACTIVITY: COLL AGENCY     DATE: 02/04/97  REFER: MFM 3-6-1
==============================================================================
====================
UNIT NUMBER: 09999   9999 - QUALITY HOSPITAL
   ACTION: I      I-INQUIRY   A-ADD   C-CHANGE
AGENCY CODE: 771
------------------------------------------------------------------------------
AGENCY TYPE: E
     NAME: NATIONAL PAT ACCOUNT SVCS          SHORT: NPAS
ADDRESS ONE: 500 KAUFMAN-STRAUS BLDG          PHONE: 615 - 572 - 3199
ADDRESS TWO: 400 SOUTH 4TH AVE.            CONTACT: JOE SHUTTS
CITY, STATE: LOUISVILLE, KY
ZIP: 40202 - _____

MIN AMT1: 00010.00   MIN AMT2: 01000.00   START DATE: 1994 01 01   CCYY MM DD
MAX AMT1: 99999.99   MAX AMT2: 05000.00    END DATE: 1999 12 31   CCYY MM DD
PLACEMENT DAYS: 140  PYMT PROC CD: 999771  NPAS PAYMENT
NEXT PLACEMENT: 749
  PRELIST DAYS: 014


F1-HELP F3-EXIT F7-PREV AGENCY F8-NEXT AGENCY F12-CANCEL
```

Collection System Collection Agency Master (FAGNY)
The NPAS Collection Agency Master File must be established on the Collection System using the same parameters as the Host.

```
COL/HIS   DATE     STA    ACTIVITY: AGENCY            ASSUME-DATE: 02-06-97
CS R6.3   02-06-97  6011   FAGNY MANUAL-REF: MFM 2-2-1    QH
==============================================================
===================
==============================================================
===================
 Agency    771
        NPAS Type E

 Name     NATIONAL PAT ACCOUNT SVCS
 Name
 Adr      500 KAUFMAN-STRAUS BLDG
 Adr      400 SOUTH 4TH AVE.
 C&S      LOUISVILLE KY
 ZIP      40202-    Ph (615)572-3199 Ext
 Contact  JOE SHUTTS

 Minimum Transfer          1000.00  Max Bal to Early Out   5,000.00
 Self Pay Minimum            10.00  Self Pay Maximum      99,999.99
 % of Bal = Payment to Reset Days 100  Placement Days            140
 Agency Transfer              749  Prelist Days              14
```

Host Financial Class Master
Upon receipt of the "F" transaction, if the arrangement frequency is a "C", Patient Accounting will validate the individual patient account financial class against the Host Financial Class Master. If the Financial Class Master that corresponds to the patient's account financial class contains an early out agency other than 771 or spaces, the "F" transaction will reject on the Daily Batch Report (CONT:CONT01) for INV FOR EOUT. This **does not** mean that you must have agency 771 established in your Financial Class Master File, if the "Agency Code" field is blank (spaces) the transaction will accept. This **does** mean that if you use more than one early out vendor according to financial class, if you attempt to establish a NPAS arrangement for a financial class that contains an early out agency other than 771 (i.e., 770, 772, 773, 774, 775) the transaction will reject.

Since the Collection System will have the account in either 771 or 901, the correction for the rejected transaction would be to validate that the facility is using NPAS for financial arrangements. If so, then maintenance to the Host Financial Class Master File should be performed to enter either 771 or spaces. Allow the rejected transaction to recycle and the transaction will post correctly.

```
SYSTEM:MSTR/MS15  ACTIVITY: FINANCIAL CLASS  DATE:  02/04/97  REFER: MFM4-6-1
==================================================================
====================

   UNIT NUMBER: 09999   9999 - QUALITY HOSPITAL
      ACTION: I      I-INQUIRY  C-CHANGE
    FIN CLASS: 99
-----------------------------------------------------------------------
 FINANCIAL CLASS DESC: SELF   SELF-PAY
                          EARLY OUT INDICATORS
 BAD DEBT W/O ACCOUNT: 00110090                  DAYS:  25
I/P BAD DEBT RECOVERY: 00595200               AGENCY CODE:  771
O/P BAD DEBT RECOVERY: 00595200                INPATIENT:   Y
 I/P PROVIDER NUMBER: _____                     OUTPATIENT:   Y
 O/P PROVIDER NUMBER: _____                      EMERGENCY:   Y
                          SURGERY:   Y
F1-HELP F3-EXIT F7-PREV FIN CLASS F8-NEXT FIN CLASS F12-CANCEL
```

Must be 771 or spaces for "F" line with "C" frequency to accept.

Collection System / Patient Accounting Processing of the NPAS Arrangement

The following "rules" apply when a NPAS arrangement is established on the Collection System and when Patient Accounting receives an "F" transaction from the Collection System with a "C" frequency:

- Patient Accounting will validate the financial class at the individual patient account level with the corresponding financial class in the Host Financial Class Master File. If the Host Financial Class Master File contains an early out agency other than 771 or spaces the transaction will reject on the Daily Batch Report.
- If outstanding insurance liability exists at the time the arrangement is established, the account will be placed to series 901 (minimum monthly), however a frequency of "C" will be passed to the Host. The Host will act upon the "C" frequency as though it was an "M" frequency (i.e., sending out statements every thirty days).
- Once insurance is released, the account will be placed to NPAS for arrangement follow-up. The following screens illustrate this scenario:

```
COL/HIS CS R6.3  STA: 06014  ACTIVITY: File Track      MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
================================================================
==
P/N        7307728 DOE JOANNA              Facility 9999 QUALITY HOSPITAL
Rsp DOE JOANNA              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC  1
Adr 1111 OAKBROOK RD        Desk      20 CS 200  0 MEDICARE PATIENT LIABILIT
Adr                         BdAdr N   Ptype O   SD 99-99-99 WTD 00.00 99-99-99
C&S ANYWHERE        TN        G/N              EOD 99-99-99 Agy 999    Hold N
Zip 51543-0000   Ph (555)151-9289    Arrg Amt                Lst Stmt
Lst Pt Pay                     BdDebt NA Fbill 04-14-94 Delay
Ttl Chg      598.50  Bal       598.50    Pt Due  ______________   Pd
Ttl Cmbd Bal P   5     1,309.85      Dlq Ins 100-02  MEDICARE        Dsk 1
Pri 100-02  MEDICARE                CS  100  5 MGR-MC NOT RESOLVED/TRANSFER
Due      478.80   Pd              SD 04-05-95 WTD       03-22-95 Dly
Sec 545-01  TNCARE - BC/BS TN        Grp                MEDICARE
Due      119.70   Pd              Ph   (000)000-0000       Claim Sub 04-14-94
Ter                          Pol#  555555555A            Ins'd P
Due                Pd              TAuth                  AccDt
----- Financial Transactions ------------------ Notes ----------------------
04-11-94 680024 6        598.50
```

Insurance liability is outstanding

```
COL/HIS    DATE     STA   ACTIVITY: ARRANGEMENTS          ASSUME-DATE: 02-06-97
CS R6.3   02-06-97  6014  ARRANG   MANUAL-REF: UG 8-8-1      QH
================================================================
====================
* INFO 1014 * Record was ADDED! PRESS ACK KEY
================================================================
====================
  P/N          7307728 DOE JOANNA
  Admission Date      04-11-94
  System Date         02-06-97
  Pat Estimated        0.00
  Net Balance        598.50
  Arrangement Type        MINM
  Arrangement Date      02-06-97
  Payment Amount            10
  Frequency                  C
  Stmt Start Date       02-06-97
  Note Due Date
```

NPAS monthly arrangements established.

```
COL/HIS CS R6.3  STA:  06014  ACTIVITY: File Track          MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
===================
P/N        7307728 DOE JOANNA              Facility  9999  QUALITY HOSPITAL
Rsp DOE JOANNA              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC 1
Adr 1111 OAKBROOK RD          Desk       8 CS  901   0 MONTHLY ARRANGEMENT
Adr                      BdAdr N   Ptype O   SD 99-99-99 WTD 00.00 99-99-99
C&S ANYWHERE      TN          G/N              EOD 99-99-99 Agy 999    Hold N
Zip 51543-0000   Ph (555)151-9289     Arrg Amt        10.00   Lst Stmt
Lst Pt Pay                        BdDebt NA Fbill 04-14-94 Delay
Ttl Chg       598.50  Bal       598.50    Pt Due                Pd
Ttl Cmbd Bal P   5     1,309.85      Dlq Ins 100-02  MEDICARE        Dsk 1
Pri 100-02  MEDICARE                CS  100  5 MGR-MC NOT RESOLVED/TRANSFER
Due       478.80    Pd              SD 04-05-95 WTD       03-22-95 Dly
Sec 545-01  TNCARE - BC/BS TN        Grp                MEDICARE
Due       119.70    Pd              Ph  (000)000-0000       Claim Sub 04-14-94
Ter                            Pol# 555555555A           Ins'd P
Due              Pd
----- Financial Transactions
04-11-94 680024 6        598.50
```

Due to insurance liability remaining account is place to series 901

```
COL/HIS CS R6.3 STA:  06014 ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
===================
P/N 7307728        DOE JOANNA              Facility  9999  QUALITY HOSPITAL
Rsp DOE JOANNA              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC  1
Adr 1111 OAKBROOK RD          Desk      23 CS  771   0 NATIONAL PAT ACCOUNT SVCS
Adr                      BdAdr N   Ptype O   SD 02-06-97 WTD 00.00 99-99-99
C&S ANYWHERE        TN       G/N              EOD 99-99-99 Agy 999    Hold N
Zip 51543-0000   Ph (555)151-9289    Arrg Amt        10.00   Lst Stmt
Lst Pt Pay                        BdDebt NA Fbill 04-14-94 Delay
Ttl Chg       598.50  Bal       100.00    Pt Due        100.00   Pd
Ttl Cmbd Bal P   10     2,619.70     Dlq Ins   -                Dsk
Pri 100-02S MEDICARE                CS
Due              Pd              SD        WTD              Dly
Sec 545-01 TNCARE - BC/BS TN         Grp
Due              Pd              Ph  (   )   -          Claim Sub
Ter                            Pol#                     Ins'd
Due              Pd              TAuth                    AccDt
----- Financial Transactions ----------------- Notes ---------------------
02-07-97 000010 1        498.50
```

Once insurance liability has been released, the patient series will change to 771 and be set to step the next PDSETP.

```
COL/HIS CS R6.3 STA:  06014 ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
====================
P/N 7307728        DOE JOANNA              Facility  9999  QUALITY HOSPITAL
Rsp DOE JOANNA              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC  1
Adr 1111 OAKBROOK RD        Desk      23 CS  771   1 NATIONAL PAT ACCOUNT SVCS
Adr                    BdAdr N    Ptype O   SD  12-07-97 WTD 00.00 99-99-99
C&S ANYWHERE        TN       G/N              EOD          Agy 999    Hold N
Zip 51543-0000   Ph (555)151-9289    Arrg Amt                Lst Stmt
Lst Pt Pay                      BdDebt NA Fbill 04-14-94 Delay
Ttl Chg       598.50  Bal       100.00    Pt Due        100.00   Pd
Ttl Cmbd Bal P  10     2,619.70      Dlq Ins    -                 Dsk
Pri 100-02S MEDICARE                CS
Due              Pd              SD        WTD              Dly
Sec 545-01 TNCARE - BC/BS TN        Grp
Due              Pd              Ph  (   )   -          Claim Sub
Ter                            Pol#                     Ins'd
Due              Pd              TAuth                     AccDt
----- Financial Transactions ------------------ Notes ----------------------
02-07-97 000010 1        498.50
```

Upon stepping, the next date was calculated as the account balance ($100.00) divided by the arrangement amount ($10.00) multiplied by 30 days plus thirty = 330 days to payment
in full; added to the current assume date of 02/06/97 = 12/06/97.

If the facility utilizes the Financial Class Master to calculate an early out date, and the early out date is reached after the NPAS arrangement has been established, but prior to the insurance liability being released, the account with insurance liability still tracking will be placed to series 771 and the account will be placed to NPAS. The arrangement information will be passed to NPAS as well so they may continue the arrangement cycle. The following screens illustrate this scenario:

```
COL/HIS CS R6.3  STA: 06014 ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
====================
P/N 7307729        DOE JOSEPH              Facility  9999  QUALITY HOSPITAL
Rsp DOE JOSEPH              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC  1
Adr 1111 OAKBROOK RD        Desk      20 CS 200  0 MEDICARE PATIENT LIABILIT
Adr                    BdAdr N   Ptype O   SD 99-99-99 WTD 00.00 99-99-99
C&S ANYWHERE        TN       G/N              EOD 02-06-97 Agy 771      Hold N
Zip 51543-0000   Ph (555)151-9289    Arrg Amt                Lst Stmt
Lst Pt Pay                      BdDebt NA Fbill 04-14-94 Delay
Ttl Chg       598.50  Bal       598.50    Pt Due _____          Pd
Ttl Cmbd Bal P   5     1,309.85      Dlq Ins 100-02  MEDICARE        Dsk       1
Pri 100-02  MEDICARE                CS  100  5 MGR-MC NOT RESOLVED/TRANSFER
```

```
Due      478.80    Pd            SD 04-05-95 WTD       03-22-95 Dly
Sec 545-01  TNCARE - BC/BS TN      Grp              MEDICARE
Due      119.70    Pd            Ph  (000)000-0000       Claim Sub 04-14-94
Ter                            Pol#  555555555A           Ins'd P
Due              Pd            TAuth                    AccDt
----- Financial Transactions ------------------ Notes ----------------------
04-11-94 680024 6       598.50
```

Early out date calculated by the Host Financial Class Master.

Insurance liability is outstanding.

```
COL/HIS    DATE   STA   ACTIVITY: ARRANGEMENTS          ASSUME-DATE: 02-06-97
CS R6.3 02-06-97 6014   ARRANG   MANUAL-REF: UG 8-8-1      QH
==============================================================
===================
* INFO 1014 * Record was ADDED! PRESS ACK KEY
==============================================================
===================
 P/N         7307729 DOE JOSEPH
Admission Date      04-11-94
System Date         02-06-97
Pat Estimated          0.00
Net Balance          598.50

Arrangement Type        MINM
Arrangement Date    02-06-97
Payment Amount          100
Frequency                C
Stmt Start Date     02-06-97
Note Due Date
```

NPAS monthly arrangements established.

```
COL/HIS CS R6.3  STA: 06014 ACTIVITY: File Track        MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==============================================================
===================
P/N 7307729        DOE JOSEPH              Facility  9999  QUALITY HOSPITAL
Rsp DOE JOSEPH              SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC  1
Adr 1111 OAKBROOK RD         Desk       8 CS 901   0 MONTHLY ARRANGEMENT
Adr                      BdAdr N   Ptype O   SD 99-99-99 WTD 00.00 99-99-99
C&S ANYWHERE        TN       G/N              EOD 99-99-99 Agy 771    Hold N
Zip 51543-0000   Ph (555)151-9289    Arrg Amt        100.00   Lst Stmt
Lst Pt Pay                       BdDebt NA Fbill 04-14-94 Delay
Ttl Chg       598.50  Bal       598.50    Pt Due              Pd
Ttl Cmbd Bal P   5     1,309.85      Dlq Ins 100-02  MEDICARE              Dsk 1
Pri 100-02  MEDICARE                CS  100  5 MGR-MC NOT RESOLVED/TRANSFER
```

Due 478.80 Pd SD 04-05-95 WTD 03-22-95 Dly
Sec 545-01 TNCARE - BC/BS TN Grp MEDICARE
Due 119.70 Pd Ph (000)000-0000 Claim Sub 04-14-94
Ter Pol# 555555555A Ins'd P
Due Pd Tauth AccDt
----- Financial Transactions
04-11-94 680024 6 598.50

Due to insurance liability remaining account is placed to series 901.

COL/HIS CS R6.3 STA: 06014 ACTIVITY: File Track MANUAL-REF: UG 3-0-1
Maint mEmo Let Not Fin Claim Reqst Both meDi _
F3=Patient Inquiry
==========
==========
P/N 7307729 DOE JOSEPH Facility 9999 QUALITY HOSPITAL
Rsp DOE JOSEPH SSN 555-16-5656 Admit 04-11-94 Dsch 04-11-94 FC 1
Adr 1111 OAKBROOK RD Desk 8 CS **771 1 NATIONAL PAT ACCOUNT SVCS**
Adr BdAdr N Ptype O **SD 09-07-97 WTD 00.00 99-99-99**
C&S ANYWHERE TN G/N EOD 99-99-99 Agy 771 Hold N
Zip 51543-0000 Ph (555)151-9289 Arrg Amt 100.00 Lst Stmt
Lst Pt Pay BdDebt NA Fbill 04-14-94 Delay
Ttl Chg 598.50 **Bal 598.50 Pt Due** Pd
Ttl Cmbd Bal P 5 1,309.85 Dlq Ins 100-02 MEDICARE Dsk 1
Pri 100-02 MEDICARE CS 100 5 MGR-MC NOT RESOLVED/TRANSFER
Due **478.80** Pd SD 04-05-95 WTD 03-22-95 Dly
Sec 545-01 TNCARE - BC/BS TN Grp MEDICARE
Due **119.70** Pd Ph (000)000-0000 Claim Sub 04-14-94
Ter Pol# 555555555A Ins'd P
Due Pd Tauth AccDt
----- Financial Transactions
04-11-94 680024 6 598.50

Due to the early out date (02/06/97) being reached, the account with insurance still tracking would be placed to NPAS.

Upon stepping, the next step date was calculated as the account balance ($598.50) divided by the arrangement amount ($100.00) multiplied by 30 plus thirty = 210 days to payment in full; added to the current assume date of 02/07/97 = 09/07/97.

Due to the user establishing a "C" frequency arrangement in the ARRANG activity, both minimum and maximum dollar placement ranges in the Collection Agency Master File are ignored and any early out hold indicators would have been overridden at the time of arrangement establishment.

After the initial NPAS arrangement has been established in the ARRANG activity, subsequent changes can be entered in the ARRANG activity to modify the arrangement amount. If the account has already placed to NPAS, the transaction will not update the Host, but will pass directly to NPAS in the interface.

NPAS Settlement Policy

PURPOSE:
To recover money on private pay accounts.

POLICY:
In the event that all other solutions are exhausted, NPAS will occasionally issue settlement offers. Settlement amounts will be 20% a single account or on linked accounts where the balance(s) is equal to or less than $999.99, and 25% on a single account or on linked accounts were the balance(s) is equal to or greater than $1000. This solution is a last resort and should be viewed as the last step to resolve the account balance before charity is offered for applicable hospitals or a final notice is issued. Settlements will only be offered on the patient due portion of accounts. Accounts placed from HCA hospitals will be eligible for this offer. Settlements should be presented during the call as a one-time only offer. If the GN fails to pay the full settlement amount within 20 days of the offer being extended or the GN only makes partial payment of the settlement, the full balance will be due. However, there are exceptions to this timeframe that may warrant additional time for payment to be received. In instances where NPAS judges that acceptance of a settlement over a 25% reduction is merited, NPAS will advise the Chief Financial Officer/Designee of the individual PAS/hospital of the specifics and request authorization for settlement. *Accounts placed from Lifepoint and Triad hospitals will continue to receive a standard 15% settlement on balances over $1000 and no settlement on balances under $1000.*

For example: A total balance of $1100 would reduce to a settlement amount of $825 (1100.00 x .75 = $825.00) a total balance of $425 would reduce to a settlement amount of $340 (425.00 x .80 =$340.00).

PROCEDURES:
CSPs are strongly urged to secure the payment by check by phone. If this is not available, CSPs then offer payment by credit/debit card. If the credit/debit card payment option is not available a payment request will be made by check or money order via mail or pay directly at the hospital.

Settlements paid by credit card:
If payment is secure by credit card, the appropriate information will be obtained and processed according to procedures for IBIP or non-IBIP hospitals.

IBIP Hospitals:

- Accounts are routed to the NPAS credit card que where the information is loaded into IBIP. Confirmation of the payment is received immediately however, the payment will generally post to the account within 24 to 36 hours after being entered into IBIP
- The account will be scheduled for a 4-day follow-up to ensure that the settlement payment is posted and the remaining balance is adjusted to reflect a zero balance.
- If the PAS has not adjusted the remaining balance at the 4-day review, the credit card CSP will close the account back to the hospital indicating that the balance is a discount, and noting the account with all appropriate information.

Non –IBIP Hospitals:

- A daily report is generated and sent to the non-IBIP hospitals.
  The hospital will post the credit card payment secured by NPAS.

- The account will be scheduled for a 10 to 12 day follow-up to ensure that the settlement payment is posted and the remaining balance is adjusted to reflect a zero balance.
- If the hospital has not adjusted the remaining balance at the 10 to 12 day review, the credit card CSP worker will close the account back to the hospital indicate that the balance is a discount, and noting the account with all appropriate information.

Settlements paid by check, money order or cash:
If the CSP is unable to pay the settlement by credit card, but can pay by other means (i.e., check or money order) the CSP will document the account and a letter will be sent to the GN/patient showing the settlement portion owed. GN/patient will be advised that the payment is due within 20 days of the settlement offer.

Special Notes:
- If no payment is received within 20 days of a settlement offer being extended, (for balances less than $999.99) NPAS **may** attempt to contact the GN. If no payment is received within 20 days of a settlement offer being extended, (for balances greater than $1000.00) NPAS **will** attempt to contact the GN.
- Settlement offers will be honored if payment is received within 35 days from the offer being extended. The additional 15-day window is not communicated to the GN. The process was put into place because of potential posting delays with Regulus.
- If no payment is received within 35 days of the settlement offer being extended the account will be final noticed.

Miscellaneous Settlement Information:
- If the GN refuses a settlement offer the account will be final noticed and documented to show that the GN did not accept the settlement.
- If the GN asks to call back because time is needed to discuss this with a spouse or other family member, NPAS will allow 2 days for a call back. However, it is explained that if there is no call back, a final notice will be sent.

Charity At NPAS - General Overview/ Account Handling

There are four general conditions that must exist in order for NPAS to be able to screen for Charity. (1.) The hospital must be participating in the HCA Charity Process. (2.) The account must be strictly private pay with no insurance, with the exception of accounts with insurance denials or not eligible at the time of service. (3.) The date of discharge must be after October 1, 2003 or later as other non-participating hospitals elect to join the HCA Charity Program. (4.) All other attempts to secure payment from the GN must be exhausted.

NPAS will screen for charity when it has been determined that the GN is unable to pay the account in full or make payments within the payment guidelines. Charity screening at NPAS begins by asking two questions: (1.) How many members are in the household? (2.) What is the total gross family income for the past 12 months? If eligibility is established NPAS will forward an Attestation form (charity application) to the GN to be filled out and returned to the PAS/hospital with in 10 days. After the attestation form has been sent the account will be held for twenty days. PAS/hospital will make the determination if the GN is eligible. If an account is approved for a partial charity discount, NPAS will pursue the GN for the remaining balance after the account has been adjusted. If the PAS/hospital denies the application, NPAS will final notice the account. If the GN has questions as to the reason for the denial, NPAS will refer the GN to the PAS provided the hospital is in a PAS. NPAS will not hold an account while the GN disputes the decision without good faith payments based on the payment guidelines. If the account is approved for 100% charity, NPAS will close the account back to the PAS/hospital.

In situations where the GN claims they did not receive an application, NPAS will verify the GN's address and send a second application. NPAS will only send a charity application to the same GN two times. If a GN requests a charity application a third, time NPAS will decline the request and proceed with attempting to establish a payment resolution on the account. If the GN is unable to pay the account in full or make payments within the payment guidelines the account will be final noticed. The GN will be referred to the hospital if they still insist on obtaining an attestation form.

If a GN states they sent in an application less than ten days ago, NPAS will hold the account an additional 10 days. If the attestation form is not received within 10 days, NPAS will contact the GN informing him/her of such. The account will then be placed on hold for 15 days. At the end of 15 days the account will be final noticed if the attestation form has not been received.

In general, if a GN requests other associated accounts be included for charity but those accounts are already set up on payments, NPAS will request that the GN continue to make payments. If the GN cannot continue to make payments, NPAS will request a letter stating that they are unable to complete their commitment. The GN will be instructed to add all account numbers to the attestation form.

If the PAS/hospital has started the charity process, prior to placing accounts with NPAS, the accounts should be held at the PAS/hospital until the GN is denied or the accounts are adjusted to the correct balance.

Disputes At NPAS - General overview and Account Handling

The policy at NPAS for acceptable disputes is always to request that the dispute be put in writing. When a letter of dispute (LOD) is requested from the GN, directions will be given to forward the LOD to NPAS. Upon receipt of the LOD the account is noted and the information is forwarded to the PAS/hospital. The account is put on hold until NPAS receives a response from the PAS/hospital. The PAS/hospital determines the validity of the dispute and how it will be handled. Once NPAS receives a response from the PAS/hospital, the follow up process will proceed based on the instructions from the PAS/hospital.

Due to system limitations, NPAS is unable to determine the validity on certain types of disputes. Examples would include situations where the GN is disputing that certain services were not provided or disputes the quality of care provided. NPAS will never imply to a GN that the balance could be adjusted for this type of dispute. Disputes on the services received by the patient can sometimes be resolved by sending the GN an itemized bill.

If a GN disputes a balance owed after the insurance makes a payment, the GN will be referred back to their insurance company to obtain an EOB. If the GN has an EOB that shows a different balance owed, NPAS will follow up with the insurance to verify the correct GN responsibility. Based upon the information obtained from the insurance company NPAS will either continue to pursue the GN for the current balance or request a copy of the EOB from the insurance company. If a discrepancy exist with how much the GN owes and what NPAS is pursing for, the PAS/hospital will be messaged with the details, requesting that an adjustment be made to correct the balance owed by the GN.

Examples of disputes that are **not** forwarded to PAS/Hospital would include:

- Charges are to high
- GN states that the wait in the emergency room was to long, so left before being treated. (If a person signs for services, a bill will be generated. Especially if the triage nurse obtained the person's vital signs and assessed the condition of the patient.)
- Ex-spouse is responsible for bill. (Whoever signed the patient in is responsible for payment.)
- The GN disputes the Medicare non-covered drug charges.
- GN is dissatisfied with the food quality (tasted bad).
- If the GN claims they agreed to pay less than the charges begin pursued for. This is not a valid dispute unless documentation or the name of a contact at the facility can be provided.

NOTE: These are just several examples of invalid disputes, while these items can be documented in the notes as reasons the GN is dissatisfied, these are not reasons for the GN to submit a letter of dispute.

NPAS Complaint Resolution Policy

SCOPE: All complaints received from the PAS, facilities, GNs or patients will be entered into the Customer Service Database for the purpose of complaint resolution and reports.

PURPOSE: To ensure the timely review and resolution of complaints.

POLICY: Review and determine the validity of controllable complaints for quality and training purposes. Document complaints, inquiries and compliments for the purpose of reporting to NPAS Management and PAS/Hospitals.

Notification & Documentation CSMs Managers/Supervisors Customer Service FPO	Hospitals/PASs notify CSMs who research the complaint, provide a response, and document the complaint in the Customer Service Database. Managers and Supervisors take escalated calls from patients/GNs and refer complaints to the Customer Service Department for logging in the Customer Service Database. Customer Service Professionals (CSP) in the Client Services Department take calls from patients/GNs and document complaints, inquiries and compliments in the Customer Service Database. The FPO receives AODs, researches the issue, reports findings and refers the information to a Customer Service Professional for entry into the Customer Service Database. As needed, the FPO may contact the customer.
Determination of Validity Quality Assurance (1 business day)	Quality Assurance Specialist retrieves controllable complaints (complaints related to a CSP) from the Customer Service Database daily. Validity is determined by reviewing account notes, listening to the call recording and reviewing pertinent information in the Customer Service Database. Reviewer's findings and suggestions are entered into the Complaint Resolution Form, which is forwarded to the Manager/Supervisor for review with the CSP.
Complaint Coaching Review NPAS Management (2 business days)	Manager/Supervisor receives the Complaint Resolution Form for review of the complaint with CSP. Valid complaints and "T" code training opportunities must result in the call recording being played for the CSP. Complaints on management personnel are reviewed according to the NPAS chain of command. After the complaint review/coaching, the reviewer completes the Complaint Resolution Form and returns it to Quality Assurance within two business days.
Disputes NPAS Management (6-8 days)	An NPAS Manager previews the complaint form/call before the complaint coaching session. If an NPAS Manager disagrees with a validity determination, the dispute process must be initiated. The dispute process occurs within 6-8 business days, depending on the level of approvals required (see Disputes for detail). At the end of the dispute process, the manager/ supervisor has 2 days to review or present to the CSP.
Reporting Daily	**Daily** HIPAA FPO Reports **Weekly**

Weekly Monthly Quarterly Yearly/Annually	Complaints by CSP (Month to Date) Complaints by Department (Month to Date) Complaint Call Analysis (Month to Date) Complaint Validity Report (Month to Date) Compliments (Month to Date) Training Issues (Month to Date) **Monthly** Complaints by CSP (Month to Date) Complaints by Department (Month to Date) Complaints by Responsible Party Complaint Detail Report (for previous month) Complaint Detail by PAS (for previous month) Complaint Call Analysis (Month to Date) Complaint Validity Report (Month to Date) Compliments (Month to Date) Complaint Tracking Log Report Training Issues (Month to Date) **Quarterly** Advanced Negotiations Training Analysis Report Complaint Validity Report (Directors and COOs) Complaint Tracking Log (Directors and COOs) **Yearly/Annually** Complaints by CSP (Year End) Complaint Call Analysis (Year End) Complaints by Department (Year End) Complaints by Responsible Party (Year End)

Process Detail

Notification/Documentation

There are three different means by which complaints can be brought to NPAS' attention. They include the Customer Service line, the Manager of the Customer Service Professional (CSP) who takes an escalated call at the request of the GN, and when the facility forwards complaints to NPAS.

When complaints are received on the Customer Service line, the Client Services CSP logs the complaint into the Customer Service database. When a supervisor or manager takes an escalated call and receives a complaint about a CSP, the details should be emailed to the Client Services Supervisor or their designee. The Client Services Supervisor or their designee will log the complaint on the database. The email must include the case number, the account number, the GN's name, and the exact nature of the complaint. When facility complaints are received by NPAS, the person receiving the complaint will log the information on the database.

Complaints are categorized in the following manner:

• NPAS CSP (Controllable or "C" call category complaints referenced by "Patient" – complaints generated by patients dissatisfied with services provided by NPAS; and "Client" – complaints generated from a PAS/facility dissatisfied with NPAS processes. It is important to note a PAS/facility can submit a complaint on behalf of the patient and the complaint will be deemed a patient complaint.

• Complaints regarding specific NPAS processes (NPAS process or "P" call category complaints, such as balance resolution guidelines).
• Complaints with the hospital experience ("H" call category complaints, such as quality of care complaints). As requested, the appropriate CSM can send a complaint summary to each PAS/facility on a monthly basis.

In the course of researching the validity of each complaint, errors that are unrelated to the original complaint may be discovered. These are training opportunities that serve as "mini-audits". For example: while researching a complaint on CSP "A" if an error is found that is unrelated to the original complaint, either made by CSP "A" or by CSP "B", these unrelated training opportunities are logged as "T" codes in the Customer Service Database. "T" codes do not result in disciplinary action unless extenuating circumstances exist as determined by the Operations Manager of the CSP.

A complaint will be valid (see page 7 for categories), invalid or tagged call unavailable but will always be recorded as a complaint. However, in the event that a complaint is brought to NPAS' attention as a result of an action that occurred more than 90 days ago, it will be Call Type "Training Issue", the Call Category will be a T-code, and it will be recorded and handled as a training opportunity."

At the facility's request the Client Support Manager (CSM) can email the location (see Call Recording Maintenance) of the call for review. When warranted, an apology letter and/or phone call are provided to the patient.

Call Unavailable

In instances where calls are unavailable, the QA Specialist will mark the complaint as "call unavailable" and notate the details of the inaccessible call in the call resolution section. The QA Specialist will then forward the complaint form to the appropriate manager for review. Upon review, the manager will coach the CSP on details of the complaint.

Because the recording cannot be used to substantiate validity or initiate disciplinary action, the Manager should handle coaching details of the complaint with the same gravity as a valid complaint.

Determination of Validity

Within one business day of the complaint being logged in the database, the Quality Specialist assesses the complaint validity. This assessment is based on factors such as respectfulness, tone of voice, call management skills and proper account handling procedures. Once the validity of the complaint has been determined, the complaint is routed to the appropriate manager of the CSP who then reviews the complaint with the CSP as appropriate. If necessary, the manager/supervisor takes disciplinary action (see Disciplinary Action process).

Complaint Coaching Review

The Manager/Supervisor has two days to complete the complaint review. The Complaint Resolution Form and call recording will be previewed prior to the complaint coaching session. If the Manager/Supervisor agrees with the validity decision, the complaint is reviewed with the CSP. If not, the manager/supervisor initiates the dispute process (see Disputes). After the complaint coaching, the Manager/Supervisor completes the electronic Complaint Resolution Form and returns it to the Quality Specialist. The manager is required to maintain a hard copy of the signed CSP Complaint Resolution Form for documentation purposes.

All valid complaints and all "T" code training opportunities must result in the call recording being played for the CSP. While it is required that an invalid complaint be presented to the CSP, it is not necessary to conduct a meeting. The manager or supervisory may choose to do so at their own discretion. A copy of the complaint must be provided to the employee to make them aware that there was a complaint filed against them, but that it was determined to be invalid.

The complaint review/coaching process provides an opportunity to give the CSP constructive feedback and ensures the NPAS clients of the real commitment to on-going improvement and dedication to the highest customer service standards. There is no more important management function than supporting the CSPs in their professional development as it relates to their ability to provide excellent Customer Service while maintaining their production targets.

Disputes

If there is disagreement on the validity of a complaint, managers/supervisors should document the reason for the dispute and provide supporting documentation from training materials or memos. Complaints on management personnel are reviewed according to the NPAS chain of command.

At the discretion of each COO, the manager/supervisor may need to forward the dispute to the Director for review. If so, the dispute and documentation should be forwarded to the Director within three days of receiving the complaint. The Director will review the complaint and all additional documentation within two days to determine if the dispute will continue. If the Director disagrees with the validity, the dispute and all additional documentation will be forwarded immediately to the Quality Specialist. If the Director agrees with the validity of the complaint, the manager will have two days to review the complaint with the CSP and return the completed Complaint Resolution Form to the Quality Specialist. If Director review is not required, the Manager/Supervisor should forward the dispute and documentation directly to the Quality Specialist within three days of receiving the complaint.

The Quality Specialist has one day from receipt of the dispute to review the documentation and to evaluate the validity decision. If validity is overturned after reviewing the new information, the Customer Service Database is updated and the complaint is returned to the manager who has two days to present the invalid complaint to the CSP. If the Quality Specialist upholds the validity of the complaint, the disputed complaint, the call recording and supporting documentation are sent back to the manager/supervisor. If there is still disagreement on the validity of a complaint, managers/supervisors should document the reason for the dispute and provide supporting documentation from training materials or memos. Complaints on management personnel are reviewed according to the NPAS chain of command.

At the discretion of each COO, the manager/supervisor may need to forward the dispute to the Director for review. If so, the dispute and documentation should be forwarded to the Director within three days of receiving the complaint. The Director will review the complaint and all additional documentation within two days to determine if the dispute will continue. If the Director disagrees with the validity, the dispute and all additional documentation will be forwarded immediately to the Quality Specialist. If the Director agrees with the validity of the complaint, the manager will have two days to review the complaint with the CSP and return the completed Complaint Resolution Form to the Quality Specialist. If Director review is not required, the Manager/Supervisor should forward the dispute and documentation directly to the Quality Specialist within three days of receiving the complaint.

The Quality Specialist has one day from receipt of the dispute to review the documentation and to evaluate the validity decision. If validity is overturned after reviewing the new information, the Customer Service Database is updated and the complaint is returned documentation will be forwarded to the Director of Client Services or designee for final review. Within two days of receipt of the escalated dispute, the Director of Client Services or designee will review the documentation and make a final validity determination.

Once a decision has been reached, the Director of Client Services or designee will notify the Manager, Director (if applicable) and the Quality Specialist of the final outcome. The Quality Specialist will then update the Complaint Resolution Form and forward it to the Manager by the following business day for review with the CSP. The Manager has two business days to return the completed complaint to the Quality Specialist.

If a CSP disputes the validity of the complaint, the reason must be documented and supporting documentation from training materials or memos with any other pertinent material should be provided. The dispute is forwarded to their manager for review within two days. The manager will review the complaint within 2 days and determine if the dispute will continue. If the validity remains, the CSP is notified.

If the CSP still contends that the dispute is valid and has supporting evidence he/she should request a meeting with his/her Director to discuss the complaint. The manager should notify the Quality Specialist via email. If the Director agrees with original validity ruling, the CSP, the Manager and the Quality Specialist are notified and the dispute ends. If the Director disagrees with the validity determination, it will be submitted to the Quality Specialist. The Quality Specialist will review the dispute and either overturn the initial validity determination or forward it to the Director of Client Services or designee for a final validity determination. Failure to comply with the dispute process will result in a default to the Quality Specialist's original determination.
Disciplinary Process
During any rolling 12-month calendar period, any event deemed by the manager to be an unacceptably performed customer service related event is subject to the following disciplinary action:
Valid Patient Complaints:
2nd Valid Complaint – Verbal Warning**
3rd Valid Complaint – First Written Warning at time of offense**
4th Valid Complaint – Final Written Warning**
5th Valid Complaint – Justification for termination at time of offense

Valid Client Complaints:
3rd Valid Complaint – Verbal Warning**
5th Valid Complaint – First Written Warning**
7th Valid Complaint – Final Written Warning**
9th Valid Complaint – Justification for termination

Note:
If multiple client complaints of the same nature are received prior to the first complaint being reviewed with the CSP, the multiple complaints are counted as one offense.

Invalid Complaints (Patient and Client):
There will be no disciplinary action for invalid complaints.

Invalid complaints will be reviewed by Client Services on a monthly basis and managers will be made aware of their respective CSP's with elevated numbers.

Training Opportunities (Patient and Client):
There will be no disciplinary actions for training opportunities. Repeated errors of the same type may result in disciplinary action at the manager's discretion. The manager of a CSP with 3 or more training opportunities documented in one month will receive a Multiple Training Opportunities Report. The report will document the training Opportunities logged during the month. The manager will review the Multiple Training Opportunities Report with the CSP and email the report back to Client Services stating that the training opportunities have been addressed. A Multiple Training Opportunities Report will be provided to the appropriate director.

Disputes of Training Opportunities (Patient and Client):
Training opportunities, which are disputed by either the Manager or CSP, will follow the same process as a disputed complaint.

Call Types

C = Controllable complaints (CSP)	**I = Inquiries**
P = Process complaints	K = Kudos
H = Hospital complaints	
T = Training opportunities	

Category Code	Category Description	Category Code	Category Description	Category Code	Category Description
C01	COLLECTOR RUDE	H21	CUST SERV COMPLAINT ON HOSP REP	P18	MULTIPLE CALLS RECEIVED
C02	COLLECTOR HUNG UP	H22	TOTAL CHARGES (NON-COVERED) NOT BILLED BY HOSPITAL	P19	MINIMUM PAYMENT GUIDELINES UNSATISFACTORY
C04	COLLECTOR WOULD NOT GIVE NAME	H23	ACCOUNT NOT DISCUSSED PER HIPAA GUIDELINES	P20	GN RECEIVED CALL AT WORK
C05	COLLECTOR WAS OVER ZEALOUS ON COLLECTIONS EFFORT	H24	HIPAA VIOLATION -- PHI DISCLOSED	P21	ACCESS TO ACCOUNT INFO DENIED TO INDIVIDUAL
C06	COLLECTOR FAILED TO OFFER HELPFUL INFORMATION	H25	CALL TRANSFERRED BY FACILITY	P22	COLLECTORS UNAVAILABLE TO TAKE CALLS
C07	COLLECTOR MADE ERROR IN HANDLING ACCOUNT	I01	HOSPITAL NEEDS/PROVIDES INFORMATION	P24	OTHER PROCESS RELATED COMPLAINT
C09	COLLECTOR PROVIDED INCORRECT INFORMATION	I02	GN HAS MCAID AND/OR MCARE--PROVIDING INFO	P26	UNTIMELY WORKING OF ACCOUNT
C10	MISCELLANEOUS COLLECTOR COMPLAINT	I03	SETTLEMENT OFFER	P27	DIALER HUNG-UP ON GN OUTBOUND CALL
C11	COLLECTOR VERBAL SKILLS ARE POOR	I04	PT/GN CALLED ABOUT ACCOUNT INFORMATION	P28	COMPLAINT. WANTS DIFFERENT SETTLEMENT OFFER
C12	INCORRECT USE OF Y MESSAGE	I05	INS CALLED ABOUT ACCOUNT INFORMATION	P29	NPAS SWITCHBOARD COMPLAINTS

C13	COLLECTOR SPOKE W PERSON OTHER THAN GN	I06	INACTIVE ACCOUNT	P33	NO SUPERVISOR AVAILABLE TO TAKE CALL
C15	NO CALLBACK FROM SUPERVISOR/MANAGER	I07	GN WANT TO LINK ACCOUNTS/SET UP P/A OR PIF	P35	ACCOUNT NOT DISCUSSED PER HIPAA GUIDELINES
C16	HIPAA GUIDELINES IMPROPERLY FOLLOWED	I08	PT/GN REQUEST I/B OR STATEMENT	P36	HIPAA VIOLATION -- PHI DISCLOSED
C17	HIPAA VIOLATION -- PHI DISCLOSED	I09	PT/GN REQUEST CHARITY APP OR APP STATUS	T02	OVERZEALOUS COLLECTION EFFORTS
H01	INSURANCE NOT BILLED	I10	GN PROVIDED INFORMATION	T03	SCRIPTS NOT FOLLOWED
H03	CHARGES DISPUTED	K01	PROFESSIONAL	T04	RUDENESS
H04	BALANCE DISPUTED	K02	GOOD FOLLOW UP	T05	INTONATION/CONVERSATION QUALITY UNSATISFACTORY
H05	LATE CHARGES WERE NOT BILLED	K03	VERY HELPFUL	T06	ENUNCIATION POOR
H06	NO LETTER RECEIVED	K04	GOOD CUSTOMER SERVICE	T07	COURTESY NOT OBSERVED
H07	HOSPITAL BILLING PRACTICES UNSATISFACTORY	P01	INSURANCE NOT BILLED	T08	INCORRECT USE OF Y MESSAGE
H10	FAILURE TO POST PAYMENT PROPERLY	P05	ACCOUNT MADE PATIENT RESPONSIBILITY	T09	INCORRECT ROUTING OF CALL
H11	FAILURE TO POST INS DISCOUNT PROPERLY	P06	DISSATISFIED WITH LETTER CONTENT	T10	INCORRECT SMART CODE USE
H12	HOSP PLCD ACCOUNT PRIOR TO 25/35 DAY	P07	CONSISTENT PAYMENTS. ACCOUNT CYCLED TO AGENCY	T11	FAILURE TO ACT ON NOTES APPROPRIATELY
H13	ACCOUNT WENT TO AGENCY-HOSP RECALLED	P08	ACCOUNT CYCLED TO AGENCY (NOT RECALLED)	T12	ERROR IN HANDLING OF ACCOUNT
H14	HOSP PLACED ACCOUNT W/ INCORRECT PRORATION	P12	GN UPSET ABOUT MESSAGE LEFT ON RECORDER	T13	FAILED TO OFFER OPTIONS FOR SOLUTION
15	NO RETURN CALL FROM HOSPITAL	P13	GN UPSET OVER TIME OF DAY CALL WAS RECEIVED	T14	PROVIDED INCORRECT INFORMATION
H16	ACCOUNT NOT RESOLVED AS AGREED BY HOSPITAL	P14	GN UPSET ABOUT BEING CALLED	T15	SPOKE W UNAUTHORIZED PERSON
H17	HOSP CARE UNSATISFACTORY	P15	LATE CHARGES NOT BILLED	T16	MISCELLANEOUS TRAINING ISSUES
H18	MISCELLANEOUS HOSP RELATED COMPLAINT	P16	I/B OR STATEMENT REQUESTED - NOT RECEIVED	T17	HIPAA GUIDELINES IMPROPERLY FOLLOWED
H20	NCO OR OTHER AGENCY COMPLAINT	P17	MULTIPLE LETTERS RECEIVED	T18	CSP DIDN'T ADVISE HIPAA VERIFIED WHEN TRANS CALL

Letters Utilized By NPAS

(Link under construction)

Flowcharts Utilized By NPAS

(Link under construction)

CLOSE AND RETURNS

The NPAS system and/or CSPs will schedule Insurance and/or Private Pay accounts to be "closed and returned" to the PAS/hospital every day including the reason for return. These accounts, unless otherwise noted, will be ready for the hospital's review or subsequent turnover to an outside agency. The hospital's master files and processes establish the criteria. As stated earlier, NPAS' goal is to return accounts that are uncollectible within 140 days of placement.

Request for accounts to be returned to the PAS/hospital can be accomplished by sending a message to NPAS via the account notes, call NPAS Client Services at (800) 422-2714 or contact the appropriate Client Support Manager. In addition, an explanation is requested needed as to why an account is to be closed back to the PAS/hospital.

Standard Closed Codes & Collection Series

NPAS Close Quick Reference

Close Code	Description	Withdrawn /Closed	PA Action
A	GN is Bankrupt	Closed	Coll series 990; BD type BK
B	Balance is Discount	Withdrawn	Coll series 596/598
C	Hospital Review (Medicaid/Medicare)	Closed	597/599
D	Close to Agency Hosp Req	Withdrawn	Primary agency *
E	GN has Medicaid	Closed	Coll Series 550/551
H	SM Bal HMO End of Cycle	Closed	Coll Series 554/ 555
Z	PA Withdrawn	Withdrawn	
1	Paid in Full	Closed	
2	Deceased, no estate	Closed	Coll Series 990; BD type ES
3	Uncollectable	Closed	Primary agency *
4	GN Skipped (skip trace unable to trace)	Closed	Primary agency *
5	Hospital Request Close	Withdrawn	Coll Series 597/599
8	Charity / Medicaid Pending	Withdrawn	Coll Series 552/553
9	Auto Close	Closed	Primary agency *
7	Small Balance	Withdrawn	

NOTE: Accounts with a balance below $10.00, paid in full, or that have a credit balance will be automatically recalled by Patient Accounting. These close codes, 1 & 7, do not prompt any action in PA.

Close Codes and Transactions Generated by PA

Based on the close code returned by NPAS, the patient accounting system will generate the following transactions:

	Close	*Code*	*Generated*	*Transaction*
	Spaces	Agency reset days transaction	C	with field code AGNY and new data of Sxxx (where xxx is the number of agency placement days to be reset

	Close	*Code*	*Generated*	*Transaction*
				from the current date.
	A	GN is Bankrupt	C	To recall account from early out to bad debt
			S;N	To show message: PER AGENCY — GN BANKRUPT
			I;Z(s)	To release and set claim submit dates on any outstanding insurances
			C	To set account's bad debt type to BK
	B	Balance is Discount	C	To recall account from early out to patient collection series 596
			I;Z(s)	To set all insurance collection series to 598; for insurances in status of M (payments posted but tracking not released) or spaces (insurance still tracking)
			S;N	To show message: PER AGENCY — BALANCE IS DISCOUNT — REVIEW
	C	Hospital Review	C	to recall account from early out to patient collection series 597
			I;Z(s)	to set all insurance series to 599; for insurances in status of M (payments posted but tracking not released) or spaces (insurance still tracking)
			S;N	to show message: PER AGENCY — CLOSED FOR HOSPITAL REVIEW
	D	Hospital Request Close to Primary Agency	C	to recall account from early out to the agency defined (in the host Collection Agency Master File) as the next placement for agency 771
			I;Z(s)	to release and set claim submit dates on any outstanding insurances
			S;N	to show message: PER HOSPITAL — MOVED TO PRIMARY
	E	GN has Medicaid	C	to recall account from early out to patient collection series 551
			I;Z(s)	to set all insurance series to 550; for insurances in status of M (payments posted but tracking not released) or

	Close	Code	Generated	Transaction
				spaces (insurance still tracking)
			S;N	to show message: PER AGENCY – GN HAS MEDICAID
	H	Managed Care End of Cycle	C	to recall account from early out to patient collection series 555
			I;Z(s)	to set all insurance series to 554; for insurances in status of M (payments posted but tracking not released) or spaces (insurance still tracking)
			S;N	to show message: PER AGENCY-MANAGED CARE-END OF CYCLE
			S;N	to show message: PER NPAS — FORWARDED TO NPAS MEDICARE
			S;N	to show message: PER NPAS — FORWARDED TO AGED ACCOUNTS UNIT
	2	Deceased; No Estate	C	to recall account from early out to bad debt
			I;Z(s)	to release and set claim submit dates on any outstanding insurances
			S;N	to show message: PER AGENCY — PT/GUAR DECEASED — NO ESTATE
			C	to set account's bad debt type to ES
	3	Uncollectible	C	to recall account from early out to the agency defined (in the host Collection Agency Master File) as the next placement for agency 771
			S;N C	If the next placement is to an agency to show message: UNCOLLECTIBLE, XFER TO PRIMARY AGENCY to set account's bad debt type to CA
			S;N C	If the next placement is to bad debt: to show message: PER AGENCY — UNCOLLECTIBLE, XFER TO BAD DEBT to set account's bad debt type to UN
			I;Z(s)	to release and set claim submit dates on any outstanding insurances

	Close	Code	Generated	Transaction
	4	GN Skipped (Skip Trace Performed; Unable to Locate)	C	to recall account from early out to the agency defined (in the host Collection Agency Master File) as the next placement for agency 771
			I;Z(s)	to release and set claim submit dates on any outstanding insurances
			S;N C	If the next placement is to an agency: (for Collection System facilities) to show message: PER AGENCY — SKIP TRACE FAILED, XFER TO PRIMARY to set account's bad debt type to CA
			S;N C	If the next placement is to bad debt: (for Collection System facilities) to show message: PER AGENCY — SKIP TRACE UNSUCCESSFUL, XFER TO BD to set account's bad debt type to UN
	5	Hospital Requested Return	C	to recall account from agency 771, the patient portion will be placed in collection series 597 and the insurance portion (if applicable) will be placed in collection series 599
			S;N	to show message: PER AGENCY — HOSPITAL REQUESTED RETURN
	8	Medicaid Pending	C	to recall account from early out to patient collection series 552
			I;Z(s)	to set all insurance collection series to 553; for insurances in status of M (payments posted but tracking not released) or spaces (insurance still tracking)
			S;N	to show message: PER AGENCY - CHARITY - MEDICAID PENDING
	9	Auto Close (System or User)	C	to recall account from early out to the agency defined (in the host Collection Agency Master File) as the next placement for agency 771

	Close	Code	Generated	Transaction
			S;N	to show message: PER AGENCY — ACCOUNT CLOSED
			I;Z(s)	to release and set claim submit dates on any outstanding insurances

EDUCATION and LEARNING

Summary Overview

The education curriculum at NPAS is a comprehensive program that includes customer service, collection and systems training. The 80+/-hour program is designed to encompass all areas of the business and consists of the following:

- Introduction to NPAS
- Insurance Terms
- Systems Introduction
- Account Handling
- Account Balance Resolution
- Customer Service
- Gung Ho
- HIPAA

All NPAS employees, management and non–management alike, go through a three-week training program that is designed to encompass all areas of the business. Management level employees also participates in additional departmental and course training.

- ***Week 1***
  Classroom education focusing on integrating operations, compliance, insurance terminology, system information, account handling and customer service techniques.

- ***Week 2***
  Observing senior CSPs, role-playing (mock account handling), and supervised handling of actual accounts, which reinforces the classroom training. Trainer observation, testing, quality monitoring, and feedback from senior floor training CSPs evaluate if learning has occurred.

- ***Week 3***
  Upon successful completion of the two-week new hire program, initial calls are made under the supervision of senior CSPs. Techniques and skills learned in training are implemented during live phone calls.

On Going & Continuous Training

- Additional training is conducted for existing CSPs as needed, based on recommendations of management in conjunction with the use of quality monitoring. The focus is to improve weaknesses in the over all quality of collections, customer service and compliance. CSPs will receive feedback and are couched by their manager/supervisor in areas that are deemed necessary.
- Every other month or as needed, CSPs attend a class where client hospital updates or procedural changes are examined and explained. This class may also include improvement of skill sets or learning new techniques.

QUALITY REVIEW

NPAS employs a systematic use of supervisory account/call monitoring to ensure the highest possible quality and consistency of collection work is executed on every account worked. As an extension of the hospital's business office, NPAS realizes the importance of confidentiality, professionalism, and service to the customer (both the patient and the hospital). A quality review is a primary component of the NPAS performance review given to all CSPs.

Quality Review Procedures

- Each CSP has 5 accounts/calls reviewed during the process. Management scores each call on an online scorecard.
- The scorecard is designed to guide management in the review to focus on customer service, collections and compliance as well as account handling.
- Once the quality review is complete, CSPs receive coaching from management. The CSP will have an opportunity to hear some of the calls that were reviewed.
- The completed review is forwarded to the Quality Department for auditing purposes.
- CSP are subject to follow up monitoring and/or disciplinary action for poor quality reviews.

Communication

CLIENT SUPPORT MANAGERS

Five Client Support Manager (CSM) positions were created in 2000 to bolster the ability of NPAS to proactively communicate with our client PAS/hospitals in a timely and consistent manner.

The CSMs are trained to handle concerns, issues or questions that arises with any PAS/hospital. Each CSM will be assigned a set group of approximately 45 hospitals. The CSMs act as a liaison between NPAS and the PAS/hospitals. The CSMs are responsible for ensuring that all communications are open and responsive. In addition to phone communications, the CSMs will employ email, fax and correspondence regarding updates to technology utilized by NPAS, new training issues, changes in policy and procedures, etc. Anything that NPAS can do to increase the efficiency and success of our client hospitals will be the primary goal of the CSM (See Contact Information section for listing of CSMs).

The CSMs will invite any appropriate personnel from the PAS/hospitals to visit NPAS for meetings and tours that will provide presentations with updates on our increasing use of technology, our expanded training facilities and training programs, the flow chart processes of our many units, and etc. These visits are intended to improve the communication with our clients while affording the client and NPAS to engender closer working relationships based on common understanding of our joint efforts. The CSM will also be available to make on-site visits to PAS/hospitals as needed.

Standard Reporting

NPAS produces monthly standard reporting that is available through Atlas.

Monthly Performance Reports

NPAS will report collection performance to each hospital by type of business (Private Pay vs. Insurance) at each month-end. Performance reports will provide recovery rates by month of placement. Placements, close and returns, and collections are included. NPAS also stands ready to assist any PAS/hospital with any other reporting needs.

National Patient Account Services — **Monthly Performance Report** — May 2004

Division: All Divisions
Client Type: Insurance

Month		Placed			Withdrawn		Payments		Recovery	Closed		Active	
		Number	Amount $	Adjustment $	Number	Amount $	This Month$	To Date $	%	Number	Amount $	Number	Amount $
	1999	Total 1617002	979,179,330	59,211,601	270907	163,559,716	10	624,231,927	82.31	1346093	134,176,182	2	184
	2000	Total 1526503	879,293,096	35,711,242	274446	169,331,998	234	553,919,064	83.92	1252050	121,827,321	7	3,424
	2001	Total 1285473	700,906,497	30,515,439	220378	140,381,283	1,480	439,462,422	82.92	1065052	90,520,235	43	27,198
Jan	02	111998	57,349,508	648,414	16749	11,065,312	8,090	37,981,007	83.23	95238	7,648,018	11	6,668
Feb	02	107466	60,379,584	1,933,332	15819	10,910,904	1,028	39,101,997	82.26	91627	8,422,197	20	11,153
Mar	02	114003	59,983,891	561,882	17622	12,341,969	433	38,879,500	82.41	96355	8,295,101	26	6,239
Apr	02	123759	66,753,551	2,922,202	18218	11,898,531	1,940	41,889,889	79.44	105499	10,869,230	42	33,700
May	02	128099	70,649,794	1,856,345	18733	13,786,558	1,790	44,125,843	80.22	109319	10,869,450	47	11,598
[illegible]	02	112029	60,302,532	1,566,314	16505	10,398,578	845	38,516,938	79.68	95484	9,782,016	40	38,686
[illegible]	02	111794	59,405,547	1,424,381	16539	11,394,759	2,217	36,267,179	77.85	95198	10,300,396	57	18,833
Aug	02	111440	57,230,272	2,267,877	17133	11,417,771	1,742	32,773,040	75.26	94248	10,728,064	59	43,521
Sep	02	101672	53,857,633	1,655,906	17034	10,156,686	2,052	31,581,312	76.57	84571	9,641,935	67	21,795
Oct	02	108833	57,949,207	1,298,836	20173	12,238,477	4,756	33,334,766	76.61	88575	10,150,774	85	26,554
Nov	02	101421	57,971,851	1,900,123	19379	15,163,889	8,480	31,283,248	76.50	81920	9,541,446	122	73,944
Dec	02	115312	57,621,503	1,484,873	21979	13,354,299	10,746	33,970,599	79.22	93190	8,850,858	143	60,874
	2002	Total 1347826	717,754,873	19,519,486	215883	143,126,933	44,118	439,715,407	79.21	1131224	115,039,484	719	359,583
Jan	03	112109	55,628,792	939,259	20200	12,807,721	10,315	32,505,920	77.59	91726	9,310,196	183	75,696
Feb	03	97514	44,721,720	-1,181,893	19535	12,422,746	31,500	24,631,943	73.57	77719	8,746,495	268	102,429
Mar	03	104343	47,620,895	-495,672	19439	12,227,595	15,083	26,501,648	73.85	84470	9,259,816	334	126,708
Apr	03	97147	44,972,543	-489,784	15914	9,773,786	20,733	26,386,054	73.93	80722	9,116,835	511	185,650
May	03	100683	44,654,676	-471,956	15597	10,334,214	33,198	25,625,321	73.65	84391	8,931,670	695	235,437
Jun	03	92470	43,163,061	-1,253,073	14696	10,941,691	64,387	24,929,038	74.47	76900	8,156,773	874	388,633
Jul	03	93031	48,375,682	-1,490,475	16336	13,685,550	67,852	25,922,559	71.65	75444	9,771,518	1251	488,529
Aug	03	86363	44,235,669	1,721,828	14654	10,836,534	110,094	22,539,582	71.12	70005	8,562,798	1644	584,928
Sep	03	92337	43,150,096	-626,415	14683	9,811,439	179,541	24,714,619	72.76	74780	8,249,579	2874	1,060,874
Oct	03	88209	37,866,247	6,472	10722	8,203,540	278,708	20,578,352	69.39	65597	7,655,752	3890	1,422,131
Nov	03	93197	45,125,184	-348,759	13664	12,588,826	461,231	22,547,309	68.56	73830	8,139,486	6503	2,198,323
Dec	03	110259	50,169,428	943,244	15298	10,425,694	846,938	27,698,777	71.39	83347	7,224,456	11644	3,877,257
	2003	Total 1159592	549,683,100	-2,757,223	190738	134,059,335	2,148,579	304,571,120	72.80	938191	103,125,374	30663	10,684,584
Jan	04	118797	61,882,233	3,434,654	17085	13,784,747	1,654,699	31,562,960	70.75	75032	6,056,898	18680	6,992,974
Feb	04	90851	48,319,053	2,102,592	16102	11,778,805	2,239,120	21,622,226	62.79	48278	3,991,994	26471	9,723,346
Mar	04	113745	59,586,104	1,027,962	15924	14,287,601	4,774,499	25,731,366	58.12	55184	2,140,500	42637	16,399,335
Apr	04	99738	53,124,853	732,476	11551	9,651,772	9,915,866	20,107,141	47.04	33839	870,495	54348	21,762,970
May	04	85472	43,049,050	540,568	6211	6,149,448	8,113,475	8,113,475	22.31	13621	337,438	65640	27,908,121
	2004	Total 500603	265,961,292	7,838,192	66873	55,651,863	26,697,658	107,137,168	52.93	225954	12,497,324	207776	82,786,745
Total Active Accts							28,892,081					239218	93,855,619

Division Matrix Report

This report allows for comparison of all facilities within a given division. It highlights key measurements that are critical in maximizing collections. These areas give the hospital an overview of opportunities for improvement. This report is being phased out and being replaced with the new Divisional Matrix Report. (See attached link for sample copies).

Sample Divisional Matrix

NPAS DIVISIONAL MATRIX

May 2004

WESTERN GROUP - CONTINENTAL DIVISION

PRIVATE PAY

Facility#	Client Name	Recovery %	3 Month Avg Placed $	Curr Month Placement vs 3 Month Avg	Avg. Bal	Avg. Age	Bad Home Phone %	Bad Address%	Outstanding Req. For Info.	Recall %	F/C 99 %	Cmplnts Inv
	COMPANY TOTAL	17.73	395,778,793	-3.42	1207	60	16.2	7.2	0.2	21.6	67.2	0.04
30668	ROSE MEDICAL CENTER	44.14	2,130,889	3.5	658 X	71 X	7.3	3.6	0.2	20.6	45.35	0.11 X
30650	HEALTHONE CENTENNIAL MEDIC	41.77	593,293	-7.7 X	420 X	63 X	8.0	6.3	0.2	6.7	55.80	
30651	HEALTHONE AIRLIFE	40.82	176,534	12.6	3426	95 X	31.0 X	10.3 X	0.5 X	19.2	100.00	
30641	PRESBYTERIAN ST LUKES MEDIC	31.33	2,877,360	-8.5 X	1154 X	71 X	11.3	4.6	0.3 X	28.1 X	65.33	
40136	EDMOND MEDICAL CENTER	31.19	682,349	-10.2 X	504 X	67 X	12.4	6.3		23.1 X	55.67	0.12 X
30642	SWEDISH MEDICAL CENTER	30.23	5,525,445	-6.3 X	1329	64 X	12.0	5.3	0.2	20.1	64.37	0.02
30667	NORTH SUBURBAN MEDICAL CEN	21.77	2,183,592	-6.4 X	874 X	68 X	16.0	6.9	0.2	10.3	71.76	0.06 X
40323	WESLEY MEDICAL CENTER	19.57	4,058,068	-1.3	1074 X	75 X	18.1 X	6.1	0.3 X	19.9	47.11	0.09 X
[illegible]241	SOUTHWESTERN MEDICAL CENTE	19.17	922,138	-32.3 X	570 X	76 X	11.9	5.0	0.1	21.6	63.32	0.18 X
[illegible]0666	AURORA REGIONAL MEDICAL CE	18.87	7,403,940	-14.0 X	1349	57	16.9 X	8.0 X	0.2 X	19.8	78.06	0.01
42357	PRESBYTERIAN REFERENCE LAB	15.52 X	34,562	-56.3 X	68 X	59	26.7 X	5.4	0.2 X	9.7	92.31	
40322	CU MEDICAL CENTER	3.98 X	2,861,493	13.5	966 X	70 X	36.4 X	7.9 X	0.1	26.9 X	59.09	0.02
	DIVISION TOTAL	22.42	29,449,663	-6.1	1005	70	17.0	6.2	0.2	20.9	64.03	0.05

-"X" INDICATES NEGATIVE TREND COMPARED TO COMPANY AVERAGE
-RECOVERY = ROLLING 12 MONTH AVERAGE EXCLUDING MOST CURRENT 6 MONTHS
-ONLY HOSPITALS ROUTINELY PLACING AT LEAST 50 ACCOUNTS/MONTH
CURR MONTH PLACEMENT VS 3 MO AVG=CURRENT MONTH AVERAGE ACCOUNT BALANCE PLACED VS PRIOR 3 MONTH AVERAGE
-OUTSTANDING REQ. FOR INFO. = PERCENTAGE OF OUTSTANDING MESSAGES SENT VS TOTAL ACTIVE INVENTORY
-BLANK = NON-APPLICABLE
-FC99%=PERCENTAGE OF ACCOUNTS PLACED WITH FINANCIAL CLASS 99 IN PRIOR 3 MONTHS
-CMPLNTS/INV=PERCENTAGE OF COMPLAINTS RECEIVED VS ACTIVE INVENTORY (BLANK INDICATES NO COMPLAINTS)
-FACILITIES CONVERTING TO PA FROM MEDITECH WILL BE LISTED ON THE REPORT TWICE UNTIL THE CONVERSION IS COMPLETE

Bill Summary Report

This report shows how many accounts were either rebilled or originally billed by NPAS in a given month.

Bill Summary Report
Date of Report-4/1/00

Bill Requests within Active Accounts
Bill Requests to Active Accounts >= 5%

Client Id	Client Name	Active Amount	Number of Active Accounts	Initial Bill	% of Initial Bill to Active Accts	Rebill with No Claim on File	Rebill More 100	% of Rebill to Active Accts	Other Bills	Total Bill Requests	% of Bill Reqts Active Accts
45637	BEAUMONT REGIONAL MEDICAL CENTER	4,580.73	20	0		1	0	5.0%	0	1	5.0%
45684	CRESTWOOD MEDICAL CENTER	1,252,365.23	4,503	6	0.1%	122	1	2.7%	1	130	2.9%
45689	CARLSBAD MEDICAL CENTER	660,839.67	1,924	7	0.4%	11	0	0.6%	0	17	0.9%
45697	LEA REGIONAL HOSPITAL	640,860.44	1,265	3	0.2%	5	0	0.4%	0	8	0.6%
45604	WOMEN & CHILDREN'S HOSPITAL	632,164.66	2,206	7	0.3%	41	0	1.9%	1	49	2.2%
45611	DETAR HOSPITAL	1,349,555.68	2,657	6	0.2%	33	0	1.2%	1	40	1.5%
45620	LONGVIEW REGIONAL MEDICAL CENTER	1,557,500.22	2,429	7	0.3%	16	0	0.7%	0	22	0.9%
45626	WOODLAND HEIGHTS MEDICAL CENTER	1,374,367.19	3,046	14	0.5%	58	1	1.9%	3	76	2.5%
45631	GULF COAST MEDICAL CENTER	479,868.26	369	1	0.3%	4	0	1.1%	0	5	1.4%
45653	COLLEGE STATION MEDICAL CENTER	1,036,388.86	1,918	9	0.5%	35	0	1.8%	0	42	2.2%
45660	ALICE REGIONAL HOSPITAL	791,839.84	1,327	5	0.4%	6	0	0.5%	0	11	0.8%
45691	DOCTOR'S HOSPITAL OF LAREDO	80,547.72	126	0		1	0	0.8%	0	1	0.8%
		9,822,925.72	21,831	65	0.3%	333	2	1.5%	6	402	1.8%
45687	MEDICAL CENTER AT TERRELL	682,714.73	1,017	1	0.1%	6	0	0.6%	0	7	0.7%
45722	EL DORADO HOSPITAL	556,720.75	1,208	8	0.7%	10	0	0.8%	0	17	1.4%
45730	NORTHWEST MEDICAL CENTER	1,653,284.96	5,969	43	0.7%	60	1	1.0%	0	103	1.7%
45734	COLUMBIA PARADISE VALLEY HOSPITAL	1,393,736.55	1,779	18	1.0%	38	1	2.2%	0	56	3.1%
45745	PHOENIX REGIONAL MEDICAL CENTER	123,020.67	214	3	1.4%	5	0	2.3%	0	8	3.7%
45781	OVERLAND PARK REGIONAL MEDICAL CENTER	75,103.05	101	0		6	0	5.9%	0	6	5.9%
45793	INDEPENDENCE REGIONAL HEALTH CENTER	14,066.19	25	0		3	0	12.0%	0	3	12.0%
45821	CLAREMORE REGIONAL HOSPITAL	496,589.78	1,081	2	0.2%	6	0	0.6%	0	8	0.7%
45836	SOUTHCREST HOSPITAL	1,609,454.68	2,126	21	1.0%	100	1	4.8%	2	124	5.8%
#		6,803,690.35	13,510	96	0.7%	234	3	1.8%	2	332	2.5%
45521	DEQUEEN REGIONAL MEDICAL CENTER	44,485.14	129	0		4	0	3.1%	0	4	3.1%
45525	MEDICAL CENTER OF SOUTH ARKANSAS	2,590,374.14	4,791	13	0.3%	40	0	0.8%	0	53	1.1%
45507	MEDICAL PARK HOSPITAL	1,197,837.51	2,415	3	0.1%	27	0	1.1%	3	33	1.4%
45519	WILLAMETTE VALLEY MEDICAL CENTER	329,208.93	1,108	8	0.7%	18	0	1.6%	0	26	2.3%
45523	DOUGLAS COMMUNITY MEDICAL CENTER	206,801.92	523	2	0.3%	10	0	1.5%	1	13	2.1%
45552	MISSION BAY HOSPITAL	215,941.18	568	5	0.9%	6	0	1.1%	0	10	1.8%
45566	TAMPA REGIONAL MEDICAL CENTER	960,195.51	1,452	1	0.1%	29	0	2.0%	1	31	2.1%
45570	BROWNWOOD REGIONAL MEDICAL CENTER	1,191,991.83	3,369	13	0.4%	45	3	1.4%	0	59	1.7%
45574	SAN ANGELO COMMUNITY MEDICAL CENTER	323,669.98	285	2	0.7%	2	0	0.7%	0	4	1.4%
		7,010,290.14	14,742	47	0.3%	181	3	1.2%	5	233	1.6%
34206	EAST RIDGE HOSPITAL	1,220,997.18	3,038	14	0.5%	30	0	1.0%	0	44	1.4%
40001	CENTENNIAL MEDICAL CENTER	5,000,108.66	11,270	42	0.4%	481	4	4.3%	1	526	4.7%
40024	RIVER PARK HOSPITAL	727,710.58	2,691	1	0.0%	25	0	0.9%	1	27	1.0%
40025	SUMMIT MEDICAL CENTER	3,376,147.82	8,793	21	0.2%	261	2	3.0%	4	288	3.3%
40031	PARKRIDGE MEDICAL CENTER	2,114,804.48	4,051	12	0.3%	24	0	0.6%	1	37	0.9%
40037	GREENVIEW REGIONAL HOSPITAL	1,647,139.81	3,052	9	0.3%	76	1	2.5%	3	89	2.9%
40059	FRANKFORT REGIONAL MEDICAL CENTER	1,036,309.84	3,036	5	0.2%	62	0	2.0%	3	70	2.3%
40070	ATHENS REGIONAL MEDICAL CENTER	536,711.31	2,434	10	0.4%	21	0	0.9%	0	31	1.3%
40097	TERRE HAUTE REGIONAL HOSPITAL	1,444,522.35	1,877	5	0.3%	3	0	0.2%	0	8	0.5%
40145	SOUTHERN HILLS MEDICAL CENTER	3,152,473.02	8,020	36	0.4%	205	1	2.6%	4	246	3.1%
40447	HENDERSONVILLE HOSPITAL	1,537,369.51	6,000	28	0.5%	197	0	3.3%	5	230	3.8%
40631	SMYRNA MEDICAL CENTER	557,863.20	2,694	14	0.5%	48	0	1.8%	1	63	2.3%
40658	GRANDVIEW MEDICAL CENTER & NORTH VALLEY	962,106.17	3,759	12	0.3%	58	0	1.5%	1	71	1.9%
41278	THE WOMEN'S HOSPITAL- INDIANAPOLIS	780,548.65	1,977	12	0.6%	40	0	2.0%	0	52	2.6%
42902	HORIZON MEDICAL CENTER	1,879,759.35	5,444	10	0.2%	118	0	2.2%	2	130	2.4%
48020	NASHVILLE MEMORIAL HOSPITAL	2,614,305.21	6,245	25	0.4%	148	1	2.4%	1	175	2.8%
		28,649,059.95	74,220	256	0.3%	1,797	9	2.4%	27	2,089	2.8%

The Outstanding Message Report

This report is e-mail monthly and it shows the total number of messages sent by NPAS that have had two consecutive messages sent over a 10 day timeframe without a response.

HCA Patient Account Services

Outstanding Messages
Greater Than 10 Days
5/14/2004

Group and Facility

Name	Group #	ID #	15-Dec-03	15-Jan-04	18-Feb-04	16-Mar-04	15-Apr-04	14-May-04	Current month $ Amt	Ave. # per Month	# of Accts. % from prior month
Triad East	90001										
The Sugical Center	90001	34366- 45664	0	0	0	0	0	0	$0	0	0.0%
Crestwood Medical Ctr	90001	45584	0	0	0	0	0	0	$0	0	0.0%
[illegible]ad Med Ctr	90001	45589	0	0	0	0	0	0	$0	0	0
[illegible] Regional Med Ctr	90001	45597	0	0	0	0	0	0	$0	0	0
Detar Hospital	90001	45611	0	0	0	0	0	0	$0	0	0.0%
Woodland Heights Med Ctr	90001	45626	0	0	0	0	0	0	$0	0	0.0%
Alice Regional Hospital	90001	45680	0	0	0	0	0	0	$0	0	0.0%
Doctor's Hospital of Laredo	90001	45691	0	0	0	0	0	0	$0	0	0.0%
Womens & Childrens Hosp-Lake Charles	90001	31822- 45604	0	0	0	0	0	0	$0	0	0.0%
Beaumont Med Ctr	90001	34314- 45637	0	0	0	0	0	0	$0	0	0.0%
Gulf Coast Med Ctr		45631	0	0	0	0	0	0	$0	0	0.0%
College Station Med Center	90001	45663-34306	0	0	0	0	0	0	$0	0	0.0%
90001 Total			**0**	**0**	**0**	**0**	**0**	**0**	**$0**	**0**	**0.0%**

FEES

NPAS is a zero based HCA department that merely allocates its' actual cost. NPAS does not make a profit. The NPAS cost allocation is charged as a percentage of collections for the calendar month. The cost for any and all services is 4.42% for insurance accounts and 4.53% for private pay accounts as of 01/01/2004.

EXHIBIT A

AGENCY MINIMUM WORK STANDARDS

Primary Work Standards

Balance Range	Min. Letters	Attempts	Combined Work Activity - Attempts/ Letters/Contacts	First Attempted Contact	Work Frequency	Notice Frequency
0 - 50	1		1	7 days		
51 – 500	2	2	4	7 days	21 days	30 days
501 – 1000	2	3	5	7 days	14 days	30 days
1001 – 5000	3	3	6	7 days	14 days	30 days
5000 – above	3	4	7	7 days	14 days	30 days

Assumptions:

1. The above work standards are applicable only to those Accounts with a good address or telephone number. These Accounts will be worked in accordance with the VENDOR's defined process for bad address/telephone number.

2. The time period for First Attempted Contact will begin on the date that the Account is received from HCA.

EXHIBIT B

HCA ACCOUNT PLACEMENT ACTIVITY

HCA ACCOUNT RECALL/ADJUSTMENT POLICY AND PROCEDURE

A. Administrative Write Off

Policy - In the event it is necessary to recall an account for an administrative write off as determined by the Facility.

Procedure - The agency representative will be responsible to ensure the account is appropriately recalled to the facility with the placement activity description "Administrative Write Off."

B. Bankruptcy, Insurance Write Off or Medicare/Medicaid Write Off

Policy - Accounts that are determined not legally collectable will be returned to the facility as a recall. These types of accounts may include but not be limited to:

1. Bankruptcy
2. Third party discounts
3. Contractuals
4. Medicare Allowances
5. Medicaid residual balances (where applicable)

Procedure - Accounts identified as not legally collectable will be recalled with the placement activity description of "Bankruptcy", "Insurance Write Off" or "Medicare/Medicaid Write Off"

C. Charity/Indigent Write Off

Policy - An account is determined to be charity by the facility or the agency based upon Federal Poverty Guidelines and HCA's Charity Policy.

Procedure - These accounts will be validated by a member of management and worked according to HCA's Charity Policy. The account will be recalled using the placement activity description "Charity/Indigent Write Off."

D. Client Request

Policy – Facility has identified accounts placed in error with the agency.

Procedure – Accounts will be recalled to the facility using the placement activity description "Client Request."

E. Deceased or Incarcerated

Policy/Procedure - If an estate is not present and all other avenues have been exhausted; these accounts will be recalled using placement activity description "Deceased" or "Incarcerated."

F. Legal Declined by Facility

Policy – Facility has declined legal suit on accounts.

Procedure – Accounts will be recalled to the facility using the placement activity description "Legal Declined by Facility"

G. Settled in Full

Policy - Accounts that have paid the settlement amount will be reported as settled in full, carrying a zero balance and indicating the dollar amount to write off.

Procedure - Settlement accounts will have a settlement flag that will zero the balance on agency system, report the write-off amount on the cancellation process and notify the credit bureau of the settlement. Accounts will be recalled back to the facility with placement activity description "Settled in Full."

H. Small Balance Write Off

Policy - Accounts that have a remaining balance of $24.99 or less.

Procedure - Set system parameters to comply with policy. Recall accounts with placement activity description "Small Balance Write Off."

HCA ACCOUNT CLOSE/RETURN POLICY AND PROCEDURE

Policy - Accounts that have not received a payment or a promise to pay within 150 days from the assign date or the date of the last payment or promise to pay, whichever is later, shall be returned to the facility at the end of 150 days. This also includes letter or no contact received from the debtor or debtor's attorney, and the account is not suit worthy. Litigation/Suit pending is the exception to this policy.

Procedure - The system parameter shall be set on each HCA facility to ensure that all accounts not in litigation and without payment or promise data at the end of 150 days will be automatically closed/returned using placement activity description "Uncollectible"

HCA ACCOUNT PAID IN FULL POLICY AND PROCEDURE

Policy - Accounts that have been paid in full, carrying a credit balance or have a remaining balance of $24.99 or less will be returned via the cancellation process as paid in full.

Procedure - Set system parameters to comply with policy. Cancel back to client with placement activity description "Paid in Full".

AGENCY PLACEMENT ACTIVITY DESCRIPTIONS FOR REPORTING

Accounts returned from the agency will be identified with one of the following Placement Activity Descriptions. The activity on the account should be reported in the designated RPA column as defined in Exhibit C, if applicable.

Placement Activity Descriptions	RPA Column Distribution
Administrative Write Off	Recalled/Adjusted
Bankruptcy	Recalled/Adjusted
Charity/Indigent Write Off	Recalled/Adjusted
Client Request	Recalled/Adjusted
Deceased	Recalled/Adjusted
Incarcerated	Recalled/Adjusted
Insurance Write Off	Recalled/Adjusted
Legal Declined by Facility	Recalled/Adjusted
Medicare/Medicaid Write Off	Recalled/Adjusted
Settled in Full	Recalled/Adjusted
Small Balance Write Off	Recalled/Adjusted
Uncollectible	Closed/ Returned
Paid in Full	Paid in Full

EXHIBIT C

AGENCY LEGAL SUIT PROCESS

The minimum balance threshold for legal suit on combined guarantor accounts is $200.

A. Determine if account is suit worthy.

1. Review agency account notes and PAS account notes.
   a. Clarify any references to disputed charges, pending third party payment resources, charity applications, and clinical care issues. Involve agency insurance department and/or PAS if additional clarification is required.
   b. Review information on file regarding patient's income and household to ensure there is not a potential for charity qualification based upon Federal Poverty Guidelines and HCA's Charity Policy.

2. Verify valid home address for potential legal service.
   a. Patient must be sued in county of primary residence.
   b. PO Box address is not acceptable. If account has mail return and/or an incomplete address, collector completes a national database address check.

3. Determine if there is a potentially liquid asset.
   a. Employment should be non-transitional with income above minimum wage range.
   b. In states that do not allow garnishment, need a verified second income or significant property value.

4. Determine if account balance is suit worthy depending on cost for suit in state of residence.

5. Review credit report for qualification.
   a. A poor credit score indicates it is unlikely a judgment will be liquid.
   b. A pattern of judgments may result in forced bankruptcy.

6. Agency collection manager makes final determination on suit worthiness.
   a. Verify the above referenced criteria are met
   b. Review the collection effort on the account to ensure the patient has been given proper opportunity to settle the account voluntarily. The work standards should be used as a guideline to

evaluate collection effort; to include number of letters sent, number of telephone attempts, number of telephone conversations and content of those conversations.

B. Obtain approval to proceed with suit.

1. Agency legal department prepares affidavit and forwards to the PAS Representative for approval.
2. The affidavit must contain detailed results of the guarantor's asset review.
3. Once the affidavit is sent to the PAS Representative, agency holds the account for 15 days to allow the PAS Representative to consider the suit.
4. If affidavit is signed and suit is approved, account is referred to attorney.
5. If suit is denied, account is closed and returned to the PAS as a cancelled account. No further collection action is allowed.
6. If the PAS Representative does not respond to the affidavit, the account is referred to attorney.

C. Refer account to attorney for suit action.

1. Attorney sends 30 day demand letter and initiates thorough asset search to confirm information provided by agency.
2. Attorney files suit.
3. Attorney requests patient for payment in lieu of judgment. If no settlement is reached, attorney pursues judgement.
4. Assuming judgement is obtained, if the patient is gainfully employed and lives in a state that allows garnishment, proceedings begin. Garnishment is not recommended if the patient's job is transitional in nature with minimum wage range income.
5. If the patient is not employed or lives in a state that does not allow garnishment, a lien is perfected on patient's property, including the patient' primary residence if permissible under applicable law.
6. Property liens are not filed on residence unless the home value exceeds $300,000.
7. In cases where local law requires "automatic liens" when a judgment is obtained, local law will override.

EXHIBIT A

AGENCY MINIMUM WORK STANDARDS

Secondary Work Standards

Balance Range	Min. letters/or phone attempts	First Attempted Contact	Work Frequency	Notice Frequency
0 – 100	Based on vendor's documented process	Based on vendor's documented process	Based on vendor's documented process	Based on vendor's documented process
101 – 500	2	30 days	30	45
501 – 1000	5	10 days	30	45
1001 – 5000	6	10 days	30	45
5000 – above	6	10 days	30	45

Assumptions:

1. The above work standards are applicable only to those Accounts with a good address or telephone number. These Accounts will be worked in accordance with the VENDOR's defined process for bad address/telephone number.

2. The time period for First Attempted Contact will begin on the date that the Account is received from HCA.

EXHIBIT B

HCA ACCOUNT PLACEMENT ACTIVITY

HCA ACCOUNT RECALL/ADJUSTMENT POLICY AND PROCEDURE

A. Administrative Write Off

Policy - In the event it is necessary to recall an account for an administrative write off as determined by the Facility.

Procedure - The agency representative will be responsible to ensure the account is appropriately recalled to the facility with the placement activity description "Administrative Write Off."

B. Bankruptcy, Insurance Write Off or Medicare/Medicaid Write Off

Policy - Accounts that are determined not legally collectable will be returned to the facility as a recall. These types of accounts may include but not be limited to:

1. Bankruptcy
2. Third party discounts
3. Contractuals
4. Medicare Allowances
5. Medicaid residual balances (where applicable)

Procedure - Accounts identified as not legally collectable will be recalled with the placement activity description of "Bankruptcy", "Insurance Write Off" or "Medicare/Medicaid Write Off"

C. Charity/Indigent Write Off

Policy - An account is determined to be charity by the facility or the agency based upon Federal Poverty Guidelines and HCA's Charity Policy.

Procedure - These accounts will be validated by a member of management and worked according to HCA's Charity Policy. The account will be recalled using the placement activity description "Charity/Indigent Write Off."

D. Client Request

Policy – Facility has identified accounts placed in error with the agency.

Procedure – Accounts will be recalled to the facility using the placement activity description "Client Request."

E. Deceased or Incarcerated

Policy/Procedure - If an estate is not present and all other avenues have been exhausted; these accounts will be recalled using placement activity description "Deceased" or "Incarcerated."

F. Settled in Full

Policy - Accounts that have paid the settlement amount will be reported as settled in full, carrying a zero balance and indicating the dollar amount to write off.

Procedure - Settlement accounts will have a settlement flag that will zero the balance on agency system, report the write-off amount on the cancellation process and notify the credit bureau of the settlement. Accounts will be recalled back to the facility with placement activity description "Settled in Full."

G. Small Balance Write Off

Policy - Accounts that have a remaining balance of $24.99 or less.

Procedure - Set system parameters to comply with policy. Recall accounts with placement activity description "Small Balance Write Off."

HCA ACCOUNT CLOSE/RETURN POLICY AND PROCEDURE

Policy - Accounts will be placed with Agency for so long as they may be reported on the patient's credit report by the credit reporting agencies.

Procedure - The system parameter shall be set on each HCA facility to ensure that all accounts without payment or promise data at the end of the period during which the account may be reported on a patient's credit report by the credit reporting agencies will be automatically closed/returned using placement activity description "Uncollectible"

HCA ACCOUNT PAID IN FULL POLICY AND PROCEDURE

Policy - Accounts that have been paid in full, carrying a credit balance or have a remaining balance of $24.99 or less will be returned via the cancellation process as paid in full.

Procedure - Set system parameters to comply with policy. Cancel back to client with placement activity description "Paid in Full".

AGENCY PLACEMENT ACTIVITY DESCRIPTIONS FOR REPORTING

Accounts returned from the agency will be identified with one of the following Placement Activity Descriptions. The activity on the account should be reported in the designated RPA column as defined in Exhibit C, if applicable.

Placement Activity Descriptions	RPA Column Distribution
Administrative Write Off	Recalled/Adjusted
Bankruptcy	Recalled/Adjusted
Charity/Indigent Write Off	Recalled/Adjusted
Client Request	Recalled/Adjusted
Deceased	Recalled/Adjusted
Incarcerated	Recalled/Adjusted
Insurance Write Off	Recalled/Adjusted
Medicare/Medicaid Write Off	Recalled/Adjusted
Settled in Full	Recalled/Adjusted
Small Balance Write Off	Recalled/Adjusted
Uncollectible	Closed/ Returned
Paid in Full	Paid in Full

HCA 1-F4

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Patients
PAGE: 1	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PP.COLL.035

SCOPE:
All PAS and Facility areas responsible for offering discounts at the time of service or after services are rendered for the sole purpose of expediting collection efforts.

PURPOSE:
To define the policy for providing discounts to patients with outstanding patient liable amounts for the purposes of liquidating receivables. All discounts will be offered in an effort to liquidate receivables and not to induce incremental volume.

POLICY:
Discounts as defined below may be provided to uninsured and insured patients receiving non-elective and elective care based on the patient liable amount as courtesy type discounts. Discounts cannot be considered for Medicare Bad Debt and should not be included in the Medicare Bad Debt Log. Discounts cannot be advertised and are to be offered only in an effort to liquidate receivables. The following outlines the associated discount types:

Uninsured Patients

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service. The discount should be offered contingent on payment of the remaining balance.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the collection process.

Insured Patients

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service provided the patient liable portion has been determined.
- **Out of Network Discounts** – Out of Network discounts may be applied provided the Payer has been notified in advance that the facility intends to waive the out-of-network penalty.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the patient liability collection process.

The Division and PAS management teams will work together to establish the allowable discount percent for their respective facilities.

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Discount Policy for Patients
PAGE: 2	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE: 06/01/2004	REFERENCE NUMBER: FSG.PP.COLL.035

PROCEDURE:

Responsible Party	Action
Registrar/Financial Counselor/Collection and Support Services Staff	Identifies that the patient/responsible party collection efforts could be shortened if a discount would be provided.
Registrar/Financial Counselor/Collection and Support Services Staff	Determines the appropriate type of discount to offer in accordance with the list of discounts previously approved by the facility, Division and PAS.
Registrar/Financial Counselor/Collection and Support Services Staff	Offers discount to patient/responsible party.
Registrar/Financial Counselor/Collection and Support Services Staff	Documents the account.

REFERENCE:

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Processing Liens
PAGE: 1	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE:	REFERENCE NUMBER: FSG.PP.COLL.036

SCOPE:
Processing liens for resolution of patient account balances by the Patient Account Service Centers (PAS).

PURPOSE:
To establish protocols for the processing liens for patients that have not paid their hospital bills.

POLICY:
Liens for patients that have not paid their hospital bills should not be applied to primary residence worth less than $300,000.00 for those that have a proven inability to pay. All collection vendors will follow HCA's guidelines when seeking to apply a lien. Collectors should utilize all relevant on-line systems available to gather correct information. All efforts should be documented in a clear, concise and consistent manner in the Collections System. Collectors should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all collectors. All guidelines set forth by management should be adhered to without exception.

PROCEDURE:

Responsible Party	Action
Collector	Identifies an account for potential lien.

Collector	Evaluate the patient/responsible party's ability to pay.
	• If patient/responsible party is not able to pay, determine the ability for the patient to qualify for Medicaid.
	  o If the patient could qualify for Medicaid, see FSG.PP.COLL.023.
	  o If the patient clearly would not qualify for Medicaid, evaluate potential charity see FSG.PP.COLL.018

Collector	• If patient/responsible party is able to pay, continue.
Collector	Place account with appropriate collection agency for continued collection follow up. Document all actions in the Collections System if applicable.

REFERENCE:
- FSG.PP.COLL.018
- FSG.PP.COLL.023

HCA

DEPARTMENT: Patient Access	POLICY DESCRIPTION: Procedure for Inhouse Review (Financial Counseling)
PAGE: 1	REPLACES POLICY DATED: 06/15/2001
APPROVED:	RETIRED:
EFFECTIVE DATE: 10/01/2003	REFERENCE NUMBER: RCOM.PP.PTAC.009

SCOPE:
Patient Access process for providing financial counseling to in-house patients.

PURPOSE:
To ensure that all patients obtain financial clearance before leaving the facility. Courtesy discharges are granted to those patients who meet all financial obligations prior to discharge.
** The facility needs resources dedicated to the Financial Counseling area. With the business office operations being relocated to an RSC, this position will handle all financial matters at the facility level.

POLICY:
Patient liability amounts will be collected prior to discharge or at discharge. Patients unable to pay will be referred to eligibility vendor and Case Management will be notified. Financial counseling and charity guideline screening will be provided to patients not eligible for financial assistance. Partial payments will be made for patients ineligible for charity.

PROCEDURE:

Responsible Party	Action
Financial Counselor	Calculate estimated patient liability based on service type and verified insurance benefits.
Financial Counselor	If the patient is able to pay, collect estimated deposit; give patient receipt and document in collection notes.
Financial Counselor	If the patient is unable to pay, collect the information necessary to determine if the patient is eligible for financial assistance.
Financial Counselor	If the patient is eligible for financial assistance, notify eligibility vendor and update the insurance plan and document activity in collection notes and notify case management department.
Financial Counselor	If the patient is not eligible for financial assistance, refer to the Discount Policy for Uninsured Charity Patients, RCOM.PP.COLL.018.
Patient Access Director	Notify case management department, if applicable.

HCA

DEPARTMENT: Patient Access	**POLICY DESCRIPTION:** Procedure for Inhouse Review (Financial Counseling)
PAGE: 2	**REPLACES POLICY DATED:** 06/15/2001
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.PTAC.009**

Patient Access Director/Financial Counselor	Upon determination, updates insurance plan and documents activity in collection notes.

REFERENCE:

- RCOM.PP.COLL.018 Discount Policy for Uninsured Charity Patients

HCA

DEPARTMENT: Patient Access	**POLICY DESCRIPTION:** Procedure for Pre-Service Financial Counseling
PAGE: 1	**REPLACES POLICY DATED:** 01/05/2001
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/15/2001	**REFERENCE NUMBER: RCOM.PP.PTAC.008**

Scope: Patient Access procedure for the handling of accounts when patient liability is identified after the insurance verification process is complete.

Purpose: To ensure all scheduled patients with an estimated liability are contacted and informed of their responsibility prior to the date of service.

Policy: Schedule patients that do not have full insurance coverage will be contacted prior to the date of service and informed of their estimated liability. The patients will also be informed of the expectation that payment of the estimated liability is due at the time they are registered for services.

Procedure

Responsible Party	**Action**
Financial Counselor	Contacts patient to inform them of their estimated liability.
Financial Counselor	Patient indicates they can pay the estimated liability in full. Documents conversation in the Meditech collection notes. Communicates instructions to Registrar indicating the amount to collect at time of registration.
Financial Counselor	Patient indicates they are unable to pay estimated balance in full. Requests deposit from patient based on hospital guidelines. Obtains financial information from patient to establish partial payments for remaining balance.
Financial Counselor	Documents deposit requirements in Meditech collection notes and indicates financial information was obtained.
Financial Counselor	Indicates they are unable to meet deposit requirements. Refer to Patient Access Director.
Patient Access Director	Determines if physician should be called to postpone procedure.
Financial Counselor	Calls physician's office to see if hospital can postpone procedure until patient can meet financial obligation.
Financial Counselor	Notifies scheduling department and patient if the procedure is postponed.

HCA

DEPARTMENT: Patient Access	**POLICY DESCRIPTION:** Procedure for Pre-Service Financial Counseling
PAGE: 2	**REPLACES POLICY DATED:** 01/05/2001
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 06/15/2001	**REFERENCE NUMBER: RCOM.PP.PTAC.008**

Financial Counselor	Refers account to Patient Access Director if physician will not postpone procedure and documents in Meditech collection notes.
Patient Access Director	Notifies appropriate administrative staff per hospital policy.
Financial Counselor	Completes documentation and completes pre-registration process in Meditech.

Reference:

HCA

DEPARTMENT: Patient Access	POLICY DESCRIPTION: Procedure to Initiate Partial Payments with Patient
PAGE: 1	REPLACES POLICY DATED: 10/01/2003
APPROVED:	RETIRED:
EFFECTIVE DATE: 07/22/2004	REFERENCE NUMBER: FSG.PP.PTAC.020

SCOPE:
To initiate partial payments with patient.

PURPOSE:
The purpose of this procedure is to establish guidelines for initiating partial payments with patient.

POLICY:
All patient partial payments made within the Patient Access or PAS areas should follow the NPAS payment arrangements outlined in the NPAS Tool Kit, payment resolution section.

PROCEDURE:

Responsible Party	Action
Financial Counselor/Collection Staff	Receive call indicating that the patient is interested in setting up partial payments to resolve the balance of the account.
Financial Counselor/Collection Staff	Determine the patient's account balance.
Financial Counselor/Collection Staff	If the account indicates Bad Debt, and is already placed with an agency, then the patient is advised to make all arrangements through the agency.
Financial Counselor/Collection Staff	If the account is not with the agency, work with patient using the NPAS Tool Kit, payment resolution section.
Financial Counselor/Collection Staff	If the patient agrees to partial payments, establish partial payments in the system and send the account to NPAS for monitoring.
Financial Counselor/Collection Staff	If the patient doesn't agree to partial payments, follow the self-pay collection policy, RCOM.PP.COLL.012.

REFERENCE:
- RCOM.PP.COLL.012 Procedure for Self Pay Collections
- NPAS Tool Kit, Payment Resolution Section

HCA

DEPARTMENT: Patient Access	POLICY DESCRIPTION: Procedure to Receive a Payment from a Walk-in Patient
PAGE: 1	REPLACES POLICY DATED: 12/01/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/15/2001	REFERENCE NUMBER: RCOM.PP.PTAC.021

SCOPE:
Payments Received at the Facility by the Patient Access area.

PURPOSE:
The purpose of this procedure is to identify the steps taken by Patient Access personnel to document the receipt of payments from walk-in patients.

POLICY:
All patients making a payment at the facility will receive a receipt. Patients making payments with a credit card will be provided a credit card receipt from the Cashier. Patients making payments with a credit card will not be given a pegboard receipt.

PROCEDURE:

Responsible Party	Action
Financial Counselor	Receive payment from walk-in patient.
Financial Counselor	If the payment is made by credit card, call the Cashier to process the credit card.
Financial Counselor	If the payment is made by cash or check, determine payment is for this facility's account.
Financial Counselor	Prepare receipt pegboard with appropriate facility receipts.
Financial Counselor	Manually write a receipt for the received payment by completing the following fields on the pegboard: Name Patient Number Transaction Date Plan Code Transaction Code Payment Amount
Financial Counselor	Sign the lower right corner of the receipt.
Financial Counselor	Give the receipt to the patient.

HCA

DEPARTMENT: Patient Access	**POLICY DESCRIPTION:** Procedure to Receive a Payment from a Walk-in Patient
PAGE: 2	**REPLACES POLICY DATED:** 12/01/2000
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 01/15/2001	**REFERENCE NUMBER: RCOM.PP.PTAC.021**

Financial Counselor	At the end of each day, balance pegboard to cash receipts received that day and forward the pegboard logs and cash to the Cashier.

REFERENCE:

- RCOM.PP.SS.002 Procedure to Receive a Payment from a Walk-In Patient

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for General Follow-up
PAGE: 1	REPLACES POLICY DATED: 08/16/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.001

SCOPE:
Follow-up activities for the HMO/PPO/CHAMPUS, Medicaid and Commercial Financial Classes.

PURPOSE:
To establish protocols for the follow-up process at the Revenue Service Centers (RSCs).

POLICY:

1. Collectors should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Collectors should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.
7. Timely collection efforts are expected on all accounts.
8. Follow-up should occur at a minimum of every 7-14 days.
9. Collectors should be assertive in pursuit of account resolution.
10. The Collection Guide should be used on a consistent basis and referenced in conjunction with each contact.
11. Contacting a patient or insured at their place of employment should be used as a last resort.
12. Accounts should be worked in the following sequence: Timed Accounts; Aged Accounts; and High Dollar Accounts.

PROCEDURE:

Responsible Party	Action
Collector	Reference file track to identify eligible accounts.
Collector	Review account history.
Collector	Review account details to prepare for payor call.

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for General Follow-up
PAGE: 2	REPLACES POLICY DATED: 08/16/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.001

Collector	If there are late charges on the account, determine if they have been billed.
Collector	If late charges have not been billed, route them to the billing department to be billed.
Collector	Check the account notes to see if the account should be held from early out placement. Accounts meeting the following dollar parameters should not be placed for early out processing: • Greater than $5,000 for HMO/PPO/CHAMPUS Accounts. • Greater than $2,000 for Medicaid Accounts. • Greater than $1,000 for Commercial Accounts. Accounts that do not exceed the dollar parameters above, assign to early out placement as follows: • HMO/PPO/CHAMPUS/COMMERCIAL should be placed with NPAS. • Medicaid accounts should be placed with MedAssist.
Collector	If account notes specify that the account should be held from placement and the account exceeds the dollar placement parameters, call the Payor. Provide the following information to the Payor: • Your Full Name • Facility Name • Purpose of Call • Patient Name and Date of Service
Collector	Obtain the following information from the Payor: • Full Name of Payor Representative • Claim Status
Collector	Respond to the payor according to the parameters that follow: • Claim Paid – reference policy RCOM.PP.COLL.011 • Claim Not on File – reference policy RCOM.PP.COLL.010 • Physician/Medical Record Request – reference policy RCOM.PP.COLL.002 • Authorization/Denial – reference policy RCOM.PP.COLL.003

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for General Follow-up
PAGE: 3	REPLACES POLICY DATED: 08/16/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.001

	• Third Party Audit Request – reference policy RCOM.PP.COLL.004 • Pending Patient/Accident Details – reference policy RCOM.PP.COLL.005 • Pending Pre-Existing Review – reference policy RCOM.PP.COLL.006 • Pending Correct Insured Information/Coordination of Benefits - reference policy RCOM.PP.COLL.007. • Requires Employer Contact or Assigned to a Self Funded Company - reference policy RCOM.PP.COLL.008. • Assigned to a Re-Pricing Company - reference policy RCOM.PP.COLL.009.
Collector	If the above responses do not resolve the issue, request to speak to the insurance representative's manager.
Collector	Determine if issue is resolved. • If not, obtain involvement from RSC management. • If resolved, determine if the claim is in process and request immediate payment or if payment has been sent.
Collector	Document thoroughly in the Collections System and step account for subsequent follow-up.
Collector	If payment has been made or claim is in process, determine if payment has been received. • If payment has not been received, reference policy RCOM.PP.COLL.011. • If payment has been received, determine if there is a discrepancy. Forward all payment discrepancies to cash posting, reference policy RCOM.PP.SS.006.
Collector	Review the account for correct insured information and liability.
Collector	Make sure that all efforts have been clearly documented in the Collections System.

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for General Follow-up
PAGE: 4	REPLACES POLICY DATED: 08/16/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.001

REFERENCE:

- Collection Guidelines

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Payment or Benefits Paid to Patient or Incorrect Provider
PAGE: 1	REPLACES POLICY DATED: 03/31/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.011

SCOPE:
Procedure for account resolution when payment or benefits are paid to the patient.

PURPOSE:
To establish protocols to be followed when payments or benefits are paid to patient.

POLICY:

1. Collectors should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Collectors should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.

PROCEDURE:

Responsible Party	Action
Collector	Determine the amount paid.
Collector	Identify check number or remittance advice date.
Collector	Determine the date & address to which payment was made. Refer to the following scenarios:
Collector	Paid to Wrong Provider • Request stop payment and re-issue to correct provider/address. • Verify when the payment will be re-sent. • Set work date for subsequent follow-up to occur in 7 days. • Document efforts in Collections System.
Collector	Paid to Correct Provider at the Wrong Address • Request that payment be stopped and re-issued. • Request to speak with claims manager if unable to correct. • Verify when payment will be re-sent. • Set work date for subsequent follow-up to occur in 7 days. • Document all efforts in the Collections System.

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Payment or Benefits Paid to Patient or Incorrect Provider
PAGE: 2	REPLACES POLICY DATED: 03/31/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.011

Collector	Sent to Correct Provider and Check was Cashed
	• Request copy of front and back of cancelled check
	• Review check
	• Verify that it was paid to the correct provider.
	  • Correct Provider – document the account and route to Cash Management for research
	  • Transfer payment to correct account
	  • Set work date for 7 day follow-up
	  • Document efforts in Collection System

Collector	Sent to Correct Provider and Check was not Cashed • Identify non-covered charges. • Identify patient liability if necessary in pro-ration screen • Set work date for subsequent follow-up to occur in 7 days. • Document efforts in Collection System

Collector	Paid to Patient
	• Document why payment paid to patient.
	• Determine if check has been cashed.
	  • Not Cashed – request stop payment and re-issue payment to provider if possible.
	  • Cashed
	  • Contact patient by phone for payment in full.
	  • Send letter to patient
	  • Release insurance liability.
	  • Document efforts in Collection System and place with NPAS.

REFERENCE:	

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Self-Pay Collections
PAGE: 1	REPLACES POLICY DATED: 03/31/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 01/22/2001	REFERENCE NUMBER: RCOM.PP.COLL.012

SCOPE:
Collection of all accounts within the Self Pay financial class at all Revenue Service Centers (RSCs).

PURPOSE:
To establish protocols for the Self Pay collection process.

POLICY:

1. Collectors should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Collectors should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.
7. Due diligence should be given to every account to clearly identify who has responsibility of the account.
8. Once an account has been identified to go to NPAS, the collector should act immediately to initiate the transfer.
9. Contacting a patient or insured at their place of employment should be used as a last resort.

PROCEDURE:

Responsible Party	Action
Billing	Account is final billed.

Collector	Determine whether or not insurance information is noted on the account.
	• Accounts without insurance or with insurance tracking released – place with NPAS
	• Accounts with insurance still tracking
	  • Determine whether or not insurance has paid the claim.
	  • Insurance paid accounts - release insurance tracking and place with NPAS.

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Procedure for Self-Pay Collections
PAGE: 2	**REPLACES POLICY DATED:** 03/31/2000
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 01/22/2001	**REFERENCE NUMBER: RCOM.PP.COLL.012**

Collector	• Insurance pending accounts – review accounts, place in applicable insurance series and step/time to appropriate collector for follow-up.
Collector	Clearly document all efforts in the Collections System.
REFERENCE:	

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Bankruptcy Accounts
PAGE: 1	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE: 03/31/2000	REFERENCE NUMBER: RCOM.PP.COLL.016

SCOPE:
Bankruptcy notices submitted to the Revenue Service Centers (RSCs).

PURPOSE:
To establish protocols for the processing of bankruptcy notices.

POLICY:

1. Collectors should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Collectors should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.

PROCEDURE:

Responsible Party	Action
Collector	Receive notice of bankruptcy.
Collector	Review accounts.
Collector	Determine if account exists on the Collection System.
Collector	If yes, place account to bad debt through bad debt placement. (BDPLAC) using type BK.
Collector	If no, review HOST, for all facilities, reviewing each unit number.
Collector	Change BD type to BK using C-Line.
Collector	Review HOST and Collections System for other open accounts.
Collector	Forward copy of the bankruptcy notice to all agencies involved with the account or other existing accounts.
Collector	Document all efforts in Collections if applicable.

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Procedure for Bankruptcy Accounts
PAGE: 2	**REPLACES POLICY DATED:**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 03/31/2000	**REFERENCE NUMBER: RCOM.PP.COLL.016**

REFERENCE:

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Estate Accounts
PAGE: 1	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE: 03/31/2000	REFERENCE NUMBER: RCOM.PP.COLL.017

SCOPE:
Estate notices submitted to the Revenue Service Centers (RSCs).

PURPOSE:
To establish protocols for the processing of estate notices.

POLICY:

1. Collectors should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Collectors should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.

PROCEDURE:

Responsible Party	Action
Collector	Receive estate notice.
Collector	Review account.
Collector	Determine whether or not the account exists on the Collections System.
Collector	If yes, place account to bad debt through bad debt placement. (BDPLAC) using type ES.
Collector	If the account does not exist on the Collections System, review HOST, for all facilities, using each unit number.
Collector	Change BD type to ES using C-Line.
Collector	Review Collections and HOST for any other accounts.
Collector	Forward copy of Estate Notice to all agencies involved with the account(s).

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Estate Accounts
PAGE: 2	REPLACES POLICY DATED:
APPROVED:	RETIRED:
EFFECTIVE DATE: 03/31/2000	REFERENCE NUMBER: RCOM.PP.COLL.017

Collector	If account is not with agency, place with agency (APLAC) and send a notice to the agency.
Collector	Document all actions in the Collections System if applicable.
REFERENCE:	

HCA

DEPARTMENT: Collections	POLICY DESCRIPTION: Procedure for Processing Promissory Notes
PAGE: 1	REPLACES POLICY DATED: 11/22/2000
APPROVED:	RETIRED:
EFFECTIVE DATE: 10/01/2003	REFERENCE NUMBER: RCOM.PP.COLL.030

SCOPE:
Promissory Notes obtained by the Facility Financial Counselor, Revenue Service Center (RSC) Collector or Customer Service Representative.

PURPOSE:
To establish protocols for the processing of promissory notes.

POLICY:

1. Financial Counselors, Collectors and Customer Service Representatives should utilize all relevant on-line systems available to gather correct information.
2. All efforts should be documented in the Collections System.
3. System documentation is expected to be clear, concise and consistent.
4. Financial Counselors, Collectors, and Customer Service Representatives should demonstrate respect and integrity in all internal and external dealings.
5. Confidentiality is considered of utmost importance and should be adhered to by all collectors.
6. All guidelines set forth by management should be adhered to without exception.

PROCEDURE:

Responsible Party	Action
Financial Counselor, RSC Collector or Customer Service Representative	Review portions of claim detailing patient responsibility.
Financial Counselor, RSC Collector or Customer Service Representative	Contact patient/guarantor for payment.
Financial Counselor, RSC Collector or Customer Service Representative	Determine whether or not the patient/guarantor is capable of paying the account in full. • Full Payment – obtain payment and document collections • Down Payment with three subsequent payments – establish a promissory note. • Payments cannot exceed a down payment plus three subsequent payments.

HCA

DEPARTMENT: Collections	**POLICY DESCRIPTION:** Procedure for Processing Promissory Notes
PAGE: 2	**REPLACES POLICY DATED:** 11/22/2000
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 10/01/2003	**REFERENCE NUMBER: RCOM.PP.COLL.030**

Financial Counselor, RSC Collector or Customer Service Representative	• Complete the promissory note, obtain the patient and guarantor signatures and date. • Provide the patient and guarantor with a copy of the promissory note. • Document collection system • Maintain original with other Business Office documents. • Place with agency to monitor. • Unable to meet the criteria above, refer to Discount Policy for Uninsured Charity Patients, (RCOM.PP.COLL.018).
REFERENCE: • Promissory Note	

Table of Contents

Response to Question #3

A. Charity Education Program (effective October 03)

B. Charity Education Supplement (effective June 04)
This document describes the changes between the October 03 and June 04 Discount Charity Policy and was used for employee education purposes. Ongoing education provided to PAS (Patient Account Services) employees are integrated with ongoing education for existing and new employees.

C. Customer Service Education Materials

3-A

HCA

Uninsured Charity Policy and Procedures Effective 10/1/03

Executive Conference Call
September 8, 2003

New Uninsured Charity Policy to be Implemented 10/1/03

HCA

- Standardized Self Pay(Uninsured) discount policy to be implemented for all hospitals (excluding Partnerships pending Board approval)
- Based on sliding income scale as % of Federal Poverty Guidelines

2

Uninsured Charity Scale

HCA

Income Level	Total Charges <$1,000	Total Charges $1,001 - $2,500	Total Charges $2,501 - $5,000	Total Charges $5,001 - $10,000	Total Charges $10,001 - $25,000	Total Charges $25,001 - $50,000	Total Charges >$50,000
0 – 200% of FPG	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

3

Uninsured Charity Implementation Packet Includes:

HCA

- PAS Implementation Plan
- Power Point Presentation
- Charity Discount Policy for Uninsured Patients
- Uninsured Charity Process Flows
- Federal Charity Guidelines
- IPLAN Master File Policy
- Insurance Dictionary Policy
- LOGID Master File Policy
- Bill Code Master File Policy
- Financial Class Master File Policy
- Financial Class Dictionary Policy
- Collection Series Master Files
- Standard Uninsured Charity Letters
- Income Attestation Forms
- Income Attestation Form Instructions
- Frequently Asked Questions Document
- Education Material – Education Website
- Clear Access Queries
- Charity Reconciliation Form

4

Key Points for Implementation

HCA

- This policy will only be offered to patients with no health insurance, or other state, or federal health payor assistance.
- Other Point of Service discounts cannot be applied in combination with the Uninsured Charity discount.
- Standard IPLANS associated with FC 15 will be used for Charity Pending and each level of Uninsured Charity Discount.
- All Uninsured Charity IPLANS will be logged and autoposted, including the Charity Pending IPLAN (charity pending will be modeled at 100% payment due), however discrepancies will not be generated.
- Charity Pending IPLAN will be assigned by registration, when the Income Attestation Form is provided to the patient.
- PAS (back office) personnel are responsible for the uninsured charity determination and posting of the discount.
- NPAS and NCO will not be posting uninsured charity discounts, however, they will provide the Income Attestation Forms when applicable.

5

Key Points for Implementation – Cont.

HCA

- All ER accounts and accounts with charges < $5,000 do not require income validation.
- Verification of Income is required for accounts with charges > $5,000. If validation documents are not received, a manager must review and approve the discount to be applied.
- The Uninsured Charity Policy applies to discharges 10/1/03 forward, unless a patient requests for a prior account to be reviewed for charity.
- Uninsured Charity Expense will be recorded to a standard set of General Ledger accounts effective 10/1/03. A charity reconciliation will be performed on a monthly basis.

6

Outstanding Issues to be Clarified by Legal and Government Services

HCA

- Accounts where a portion of the visit is non-covered
  - Medicaid Exhausted Benefits or Partial Coverage
  - Medicare Part B Only
  - Commercial (small plans or pre-existing)
  - Black Lung
  - VA

7

Standardized IPLANS, LOGIDS and Contract Models

HCA

Description	IPLAN	LOGID	Contract Model
Charity Pending	099-50	CPEN	**Attach model to calc 100% due
Charity 0 - 100%	099-51	C100	C200
Charity 101 – 200%	099-52	C200	C200
Charity 201 – 300%	099-53	C300	C300
Charity 301 – 400%	099-54	C400	C400
Charity 201 – 250%	099-55	C250	C200

8

Standardized Procedure Codes and General Ledger Account Numbers

HCA

**These procedure codes are only used when the IPLANS cannot be assigned and the discount must be manually posted

Description	Code	GL Account #
Charity 0 - 100% IP	920451	549451
Charity 101 - 200% IP	920452	549452
Charity 201-300% IP	920453	549453
Charity 301 - 400% IP	920454	549454
Charity 201-250% IP	920455	549455
Charity 0 - 100% OP	920951	549951
Charity 101 - 200% OP	920952	549952
Charity 201-300% OP	920953	549953
Charity 301 - 400% OP	920954	549954
Charity 201-250% OP	920955	549955

All charity discounts posted from 10/1/03 forward will be recorded to these GL accounts.

9

Frequently Asked Questions

HCA

- What are the acceptable documents required to support discounts for charges greater than $5,000?
  - Federal Income Tax Return or
  - Any 2 of the following:
    - State Income Tax Return
    - Employer Pay Stubs for the last 6 months
    - Copy of Bank Statements for last 3 months
    - Current Credit Report
    - State Specific Forms
- What are the acceptable documents required to support discounts for ER patients or accounts with charges < $5,000?
  - Income Attestation Form

10

Frequently Asked Questions – Cont.

HCA

- Will this corporate policy supercede our current Uninsured Charity policy and can the discount % be adjusted?
  - The corporate charity policy will supercede all PAS uninsured charity policies including specialized programs like the ER Discount Point of Service Program. The PAS can only change the discount when state law mandates another percentage.
- When can a patient apply for a uninsured charity discount?
  - At anytime during the account lifecycle. This will be accomplished by assigning the appropriate IPLANs or posting a manual discount. NPAS and NCO will be required to provide the forms, but they will not be making the determination or applying the discount.
- When we approve a charity application, should we process write offs for previous dates of service?
  - We will not automatically apply the charity discount to other accounts, however the patient/responsible party may request additional charity consideration on previous visits. The P&P outlines the steps to be taken in this scenario.

11

Frequently Asked Questions – Cont.

HCA

- When can an uninsured charity application be denied?
  - Patient/Responsible Party does not meet the charity guidelines
  - Patient/Responsible Party does not provide the Income Attestation Form within 14 days
  - Patient/Responsible Party does not provide supporting income verification documents within 7 days from the request
- Will Charity IPLANS be used concurrently with the Pending Medicaid IPLAN and can the charity discount be applied when the patient qualifies for partial Medicaid?
  - Answer is pending response from Legal and Government Operations (See Outstanding Issues)

12

Frequently Asked Questions – Cont.

HCA

- How will we handle scenarios such as deceased patients, illegal aliens, homeless patients, and patients in jail?
  - The income attestation form must be obtained at a minimum. If the proper supporting documentation cannot be obtained, then refer to the Manager to review and approve/disapprove based on the information on the form and any other information available thru collection vendors, etc.
- If a patient/responsible party qualified for an Uninsured Charity discount based upon gross income but has other resources, can the Uninsured Charity discount be denied?
  - This Uninsured Charity discount policy relates to the patient/responsible party's income, family size, and total charges of the account. Other assets are not considered.

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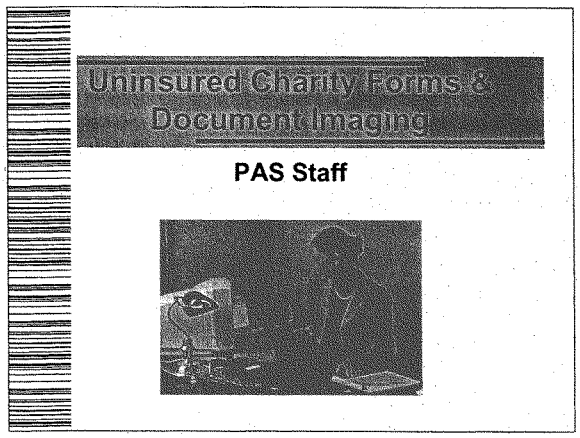
Frequently Asked Questions – Cont.

HCA

- If other assets are not considered, then why are we asking for this information on the Income Attestation Forms?
  - The additional information requested is to support Managers that are reviewing for potential Uninsured Charity discounts. With the additional asset information, the Manager may want to request follow up with the creditor to make a more informed decision.
- How should other indigent programs be handled such as county indigent plans?
  - Application to these other government programs should be made first and completely exhausted before applying the uninsured charity policy. If the patient qualifies for these other programs, then the uninsured charity policy does not apply.
  - If assistance is provided on a patient basis, these discounts should be posted as a contractual adjustment. If lump sum funds are provided that are not applied on a patient basis, these should be recorded as a contra-expense account within the charity FS code.

14



Attestation Form Review

The Charity Attestation forms and supporting documents are very important and confidential documents that may be needed during follow up processes.

These forms may be accessed by:

- Financial Counselors
- Collectors
- Research and Correspondence
- NPAS

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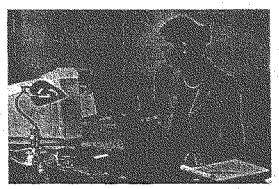
Uninsured Charity Forms & Document Imaging

PAS Staff



When forms are received at the PAS after discharge:

1. Review forms for completion and accuracy based on charity process
2. Keep all forms separate by facility
3. Complete an Uninsured Charity Documents Scanning Cover form for each patient requesting this service.
   - (Please find where these forms are located in your department)
4. Assemble all uninsured charity forms into a larger packet at the end of each day.
   - Remember to keep the forms separated by facility.
5. Complete an Uninsured Charity Batch Cover form for each batch, if applicable.
6. Send batches to the Imaging Department for scanning into the Document Imaging System.

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Document Imaging Changes for
Uninsured Charity Process Implementation

ATTENTION:
PAS Support Services Director & Document Imaging Managers

In order to meet the process, policy, and procedure implementation of the New Charity Practices at HCA, Please complete the following Steps:
*****All changes must be completed on or before 09/29/2003***

Information on the following pages will cover the necessary set up and scanning process to accommodate the upcoming implementation of the corporate wide charity policy.

Please note:

- **This document includes set up for both Current (Legacy) Document Imaging Sites and Enterprise Imaging sites**
  - **Please note the top of the page for Site Identification**
  - **A Responsible Party is identified**
  - **What to change is listed in a series of steps after Responsible Party.**

- **Scanning practices will be the same for both Current and Enterprise Sites**
  - **Please note the scanning procedures at the end of this document and provide them to the scanning staff.**

- **Batch cover forms are necessary for the Uninsured Charity Process as well. They are included, but as separate documents from this file.**
  - **The "Individual Patient Charity Documents Batch Cover" is required for each patient.**
  - **The "Charity Batch Cover Form" is optional. Please review your local practices and make a decision regarding the use of this form.**
    - **Please notify the following people of the decision:**
      - Scanning Staff
      - Patient Access Director
      - Collections Director
      - Support Services Director (if Imaging does not report to Support Services)
      - Education Director

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Document Imaging Changes for Uninsured Charity Process Implementation

Site Identification:
Current (Legacy) Document Imaging Sites
- Atlanta
- Orange Park
- Tampa
- San Antonio
- Houston
- Dallas
- Denver
- Las Vegas

Responsible Party:
Document Imaging System Administrator:

1. Add the Document Type Group: **Charity**

2. Add the Document Type: **Charity**
   - Access should be granted to:
     a. PAS Administrators
     b. Scan/Index
     c. PAS Managers/Supervisors
     d. PAS SuperUsers
     e. PAS Users
     f. NPAS Users
     g. Facilities access by facility unit number

3. Add the following Key words:
   - Fac Unit #
   - Facility
   - PT Acct #
   - Patient Name
   - Soc Sec #
   - Prepper ID
   - Date Prepped
   - Indexer ID
   - Date Indexed
   - Date Received

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Document Imaging Changes for
Uninsured Charity Process Implementation

Site Identification:
Enterprise Imaging
- Richmond
- Nashville

Responsible Party:
Corporate Document Imaging Team
- Rich Martin
- Lee Cooper

1. Modify access for the Document Type Charity to include:
   h. PAS Administrators
   i. Scan/Index
   j. PAS Managers/Supervisors
   k. PAS SuperUsers
   l. PAS Users
   m. NPAS Users
   - Facilities access by facility unit number

*****Please contact the Corporate Imaging Department with any problems or questions regarding this set up.*********

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Document Imaging Changes for
Uninsured Charity Process Implementation

Site Identification:
All PAS's

Responsible Party:
Document Imaging Prepping and Scanning Staff

1. Prep and Scan Documents received from:
   - Facilities
   - PAS Research and Correspondence Departments

Note:
Please provide the following pages to the Prep/Scan/ Index staff as a job aid.

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Document Imaging Changes for
Uninsured Charity Process Implementation

DOCUMENT PREP

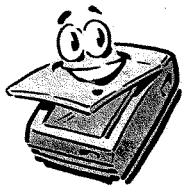
1. Separate documents/batches by Facility Unit Number
   - Do not mix batches from facilities
2. Review Charity Document Batch Control Sheet
   - Verify number of documents sent is equal to number of documents received
   - Complete fields for:
     - Date Received
     - Prepper ID

SCANNING DOCUMENTS

1. Select the Charity Document Type Charity
3. Pre-Index the batch of items by inputting the keywords:
   - Facility Unit Number
   - Facility Name (this will auto-fill after the unit number)
   - Prepper ID
   - Indexer ID

NOTE: A batch of charity packets/ documents for a multiple number of patients can be scanned together

4. Scan the batch



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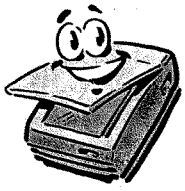
Document Imaging Changes for
Uninsured Charity Process Implementation

INDEXING DOCUMENTS

1. Select and open a Charity Batch to be indexed
2. Review the contents of the batch for quality and clarity
   - Index each charity packet to the patient level
3. Identify all pages for the first patient
4. On the first page of the next patient's' information click the New Document Icon
   - A new document will be created
   - Continue this process until all patients' information is separated into separate documents
5. After all of the documents are separated; Index the documents to the Patient Level.
6. Select the First document to index
7. Input the keywords listed from the Individual Patient Charity Documents Scanning Cover Form
8. After all keywords have been input, click Index
9. The next document will appear; continue the process until all documents are indexed.



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INDIVIDUAL PATIENT CHARITY DOCUMENTS
SCANNING COVER FORM

To be completed by:

- **Patient Access Staff**

OR

- **PAS Research and Correspondence Staff**

FACILITY (5 Digit Unit Number): _____

FACILITY NAME: _____

PATIENT ACCOUNT NUMBER _____

PATIENT NAME _____

PATIENT SSN# _____

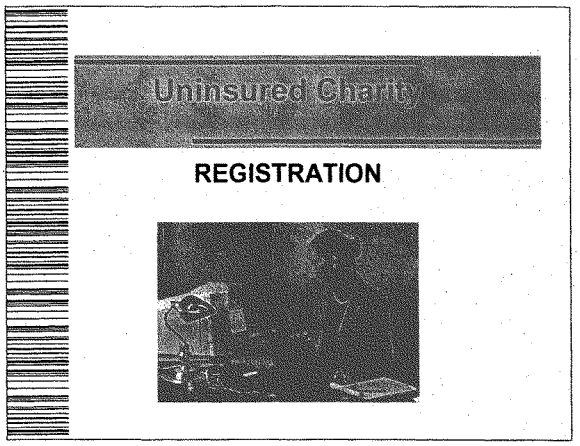
CONFIDENTIAL

Completed by PAS Imaging Staff:

DATE RECEIVED:_____

PREPPER ID: _____ **DATE:** _____

INDEXER ID: _____ **DATE:** _____



Course Overview

This Uninsured Charity course has been designed to guide Registration Personnel through the procedures necessary to provide self pay patients that could potentially qualify for uninsured charity assistance with the appropriate documentation and information.

Course Objectives

- Understand the policy and procedure for Uninsured Charity Accounts.
- Understand the different levels of the Uninsured Charity Discount.
- Understand the impact of selecting the appropriate Iplan.

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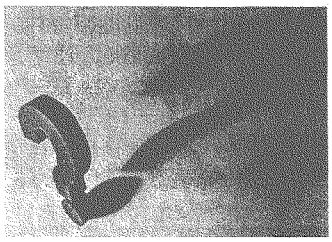
Discount Policy for Uninsured



Policy and Procedure:

We have established this policy and procedure to provide financial relief to uninsured patients receiving non-elective care thus reducing their burden of unexpected healthcare costs.

Continue to use your current processes and Iplans for all accounts that would qualify for State, County, or other Government program.

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Uninsured Charity Policy

Uninsured Charity Discounts

Uninsured Charity discounts will be provided to non-insured patients receiving non-elective care based upon the the income, family size and total charges on the account. A scale has been developed to assist you in identifying the amount of discounts allowable.

Emergency room visits and accounts with total charges less than $5000.00 will only be required to thoroughly complete the Income Attestation Short Form for uninsured charity discount consideration.

Accounts with total charges greater than $5000.00 will be required to thoroughly complete the Income Attestation Long Form and provide supporting income documentation. The preferred income documentation will be the most current year's Federal Tax Return. However, if the patient/responsible party is not able to provide this documentation then two pieces of supporting documentation from the following list will be acceptable:

- State Income Tax Return for the most current year
- Employer Pay Stubs for the past six months
- Written documentation from income sources
- Copy of all bank statements for the past three months
- Current credit report

Note: Use of the new Iplans are only for true uninsured charity accounts that do **NOT** qualify for any other State, County, or other Government programs.

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Financial Class

01	Medicare PPS
02	Medicare DPU
03	Medicaid
04	Worker's Compensation
05	Commercial
06	Champus
07	HMO
08	PPO
09	Managed Care Medicaid
10	Federal
11	State non-Medicaid
12	Local Government
13	Blue Cross/Cost
14	Other
15	Charity
99	Self Pay

Financial Class

A new financial class (15) has been identified as "Charity". The registrar/financial counselor places the patient/responsible party's account by selecting the Iplan as "**pending charity**". This Iplan stays with the account until the Attestation Form and supporting documentation (if required) is received from the patient.

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Federal Poverty Guidelines 2003

Indigent/Charity Guidelines for 2003 (48 Contiguous States and District Of Columbia)

Family Size	Federal Poverty Level	0 – 200% Poverty Level	201 – 300% Poverty Level	301 – 400% Poverty Level
1	$ 8,980	$0 – $17,960	$17,961 - $26,940	$26,940 - $35,920
2	$12,120	$0 - $24,240	$24,241 - $36,360	$36,361 - $48,480
3	$15,260	$0 - $30,520	$30,521 - $45,780	$45,781 - $61,040
4	$18,400	$0 - $36,800	$36,801 - $55,200	$55,201 - $73,600
5	$21,520	$0 - $43,040	$43,041 - $64,560	$64,561 - $86,080
6	$24,680	$0 - $49,360	$49,361 – $74,040	$74,041 - $98,720
7	$27,820	$0 - $55,640	$55,641 - $83,460	$83,461 - $111,280
8	$30,960	$0 - $61,920	$61,921 – $92,880	$92,881 - $123,840

*For family units with more than 8 members, add $3,140 for each additional member to meet the Poverty Level.

Income Guidelines

There are different IPLANS that have been established with a financial class of 15, for Charity Pending, Charity 0 – 100%, Charity 101%-200%, Charity 201%-300% and Charity 301%- 400%. Some states have specific requirements and for those states additional IPLANS will need to be established.

Registration will only be using the Charity Pending Iplan.

Self Pay Patients

Self Pay patients will fall in one of three categories:

- Self Pay for patients who can pay.
- Medicaid Eligibility Pending for those patients being evaluated for Medicaid.
- Charity Pending for patients provided the Attestation Form, instructions and letter.

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Federal Poverty Guidelines Alaska 2003

Indigent/Charity Guidelines for 2003 (Alaska)

Family Size	Federal Poverty Level	0 - 200% Poverty Level	201 - 300% Poverty Level	301 - 400% Poverty Level
1	$11,210	$0 - $22,420	$22,421 - $33,630	$33,631 - $44,840
2	$15,140	$0 - $30,280	$30,281 - $45,420	$45,421 - $60,560
3	$19,070	$0 - $38,140	$30,141 - $57,210	$57,211 - $76,280
4	$23,000	$0 - $46,000	$46,001 - $69,000	$69,001 - $92,000
5	$26,930	$0 - $53,860	$53,861 - $80,790	$80,791 - $107,720
6	$30,860	$0 - $61,720	$61,721 - $92,580	$92,581 - $123,440
7	$34,790	$0 - $69,580	$69,581 - $104,370	$104,371 - $151,160
8	$38,720	$0 - $77,440	$77,441 - $116,160	$116,161 - $154,880

Income Guidelines

The grid provided above represents the same levels of Charity Discount eligibility for Alaska.

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Income and Charge Based Discount Scale

Income Level	Total Charges <$1,000	Total Charges $1,001 – $2,500	Total Charges $2,501 – $5,000	Total Charges $5,001 – $10,000	Total Charges $10,001 – $25,000	Total Charges $25,001 – $50,000	Total Charges >$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

Income and Charge Based Discount Scale:

The Income Charge Based Discount Scale is used in conjunction with Federal Poverty Guidelines to determine the percentage of the discount based upon account total charges, family size, and amount of income. Provided below is one example of the steps involved in the determination of a discount.

Example Using the Federal Poverty Guidelines and Income and Charge Based Discount Scale:

A self pay Inpatient has presented themselves for consideration of an uninsured charity discount. The patient/responsible party earns $45,000.00 per year. The family consists of five with no other income. Total account charges for this visit are $15,000.00. The patient has also supplied his Federal Tax Return from last year.

Using the Federal Poverty Guidelines perform the following:

- Find the family size of 5
- Follow the grid across and locate the dollar range that includes $45,000.00. (201 to 300%)

Using the Income and charge based discount scale:

- Determine total charges on the account ($15000.00 for this example)
- Use the 201 to 300% category received from the information above, follow the grid across and locate the amount of the uninsured charity discount
- The patient/responsible party is eligible for a 40% Charity Discount

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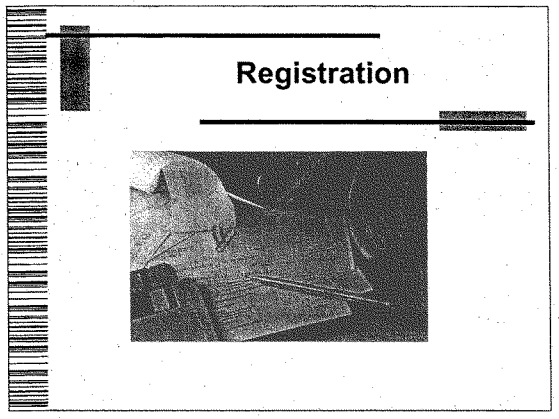

Registration Process

Because the registrar is the first point of contact for the patient/responsible party, there are several decisions that must be made to ensure the account is handled appropriately after registration. Assigning the appropriate IPLAN is key to this process. Normal financial counseling is expected to occur. Remember, the Iplan that is selected automatically assigns the designated financial class. Patients/responsible parties are **not** eligible for Uninsured Charity discounts when the visit is for .....

- Elective Services – as outlined by the facility
- Other Insurance Coverage Exists
- Patient/Responsible party is able to pay account
- Patient may qualify for Medicaid

If the patient/responsible party is unable to pay this account and potential Medicaid is not being obtained, then the patient/responsible party may qualify for an Uninsured charity discount. When this is determined, the Registrar should provide the patient with the appropriate Income Attestation Form(s), apply the Pending Charity IPLAN (099-50), and document in Meditech or Collections that the patient/responsible party received the Income Attestation documentation.

No other point of service discounts may be offered in combination with the Uninsured Charity discount.

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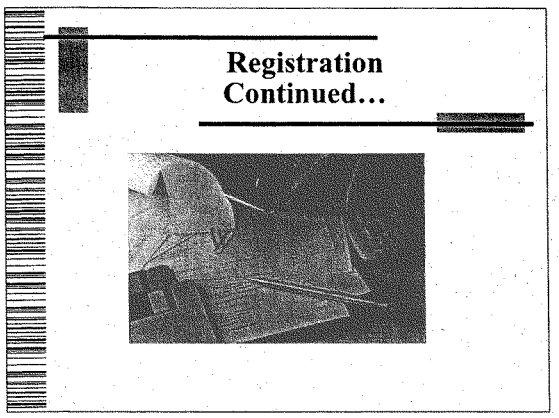

Registration Process Continued:

Determining the appropriate Income Attestation documentation to provide to the patient/responsible party is clearly defined.

- If this is an ER visit and the patient is being discharged or an Outpatient visit where charges are expected to be less than $5000.00, then the patient/responsible party should receive the Income Attestation Short Form along with the Short Form Instructions.
- If this is an Inpatient or Outpatient visit where total charges are expected to be greater than $5000.00, then the patient/responsible party should receive the Uninsured Charity Introduction Letter, Income Attestation Long Form and the Long Form Instructions.

There will be times when the patient/responsible party completes the Income Attestation Form before leaving the facility. In this case, accept the Income Attestation Form and document the receipt of the completed form in Meditech or the Collection System. Place the Income Attestation Form with the documents for scanning.

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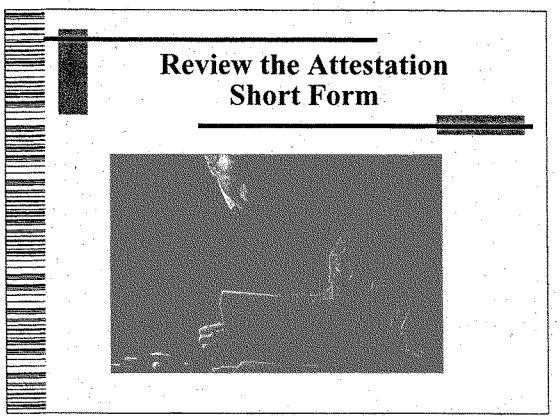

Short Form Review

A copy of the short form has been provided in a word document format and included with this presentation.

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Review the Attestation Short Form Instructions

Short Form Instructions Review

A copy of the short form instructions has been provided in a word document format and included with this presentation.

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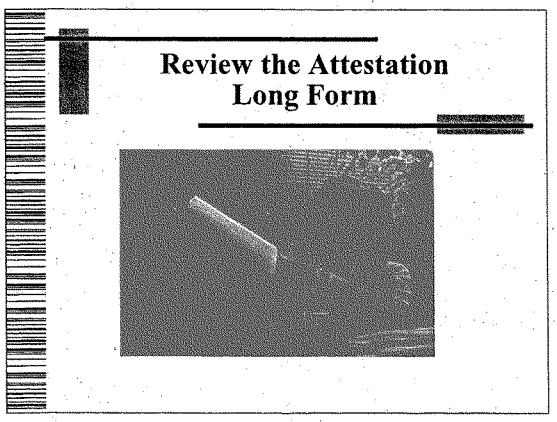

Long Form Review

A copy of the long form has been provided in a word document format and included with this presentation.

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Review the Attestation Long Form Instructions

Long Form Instructions Review

A copy of the long form instructions have been provided in a word document format and included with this presentation.

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After Discharge

Documenting in the system:

If the Income Attestation Form or Income Validation documentation is received at the facility after discharge, document the account using the collection system, attach the scanning cover sheet if appropriate and place the form with the packet for scanning.

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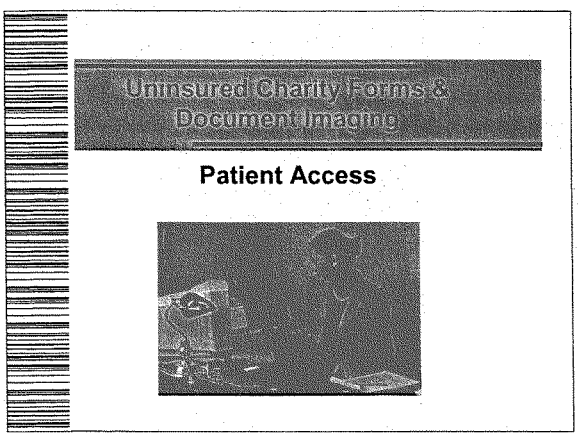

Attestation Form Review

The Charity Attestation forms and supporting documents are very important and confidential documents that may be needed during follow up processes.

These forms may be accessed by:

- Financial Counselors
- Collectors
- Research and Correspondence
- NPAS

When forms are received at the facility at the time of admission or pre-admission complete the following steps:

1. Complete an Uninsured Charity Documents Scanning Cover form for each patient requesting this service.
   - (Please find where these forms are located at your facility)
2. Assemble all uninsured charity forms into a larger packet at the end of each day.
3. Complete an Uninsured Charity Batch Cover form, if applicable. (This works similarly to the the Patient Folder Batch Cover.)
4. Send all forms to the PAS for Scanning into the Document Imaging System.

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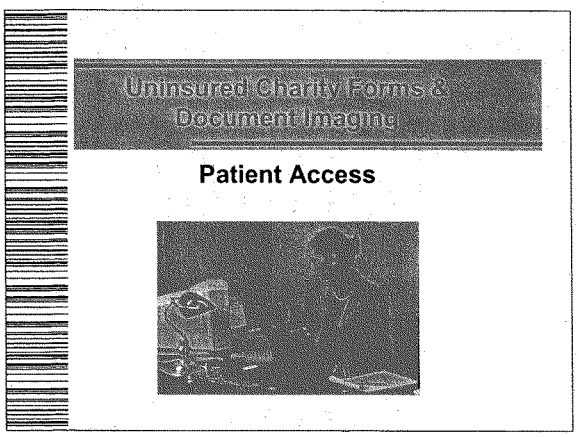

When forms are received at the facility after discharge or by a Financial Counselor:

1. If the items are received in the mail, forward the information to research and correspondence at the PAS.
2. If the items are received in person by a Financial Counselor, Complete the following:
   - Review the items with the Patient.
   - Complete the Uninsured Charity Documents Scanning Form and include the packet with others to be sent to the PAS.
     - Review the steps on the previous page.

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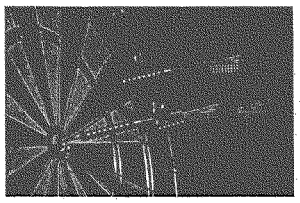
Summary



Course Objectives

- Understand the policy and procedure for Uninsured Charity Accounts.
- Understand the different levels of the Uninsured Charity Discount.
- Understand the impact of selecting the appropriate Iplan.

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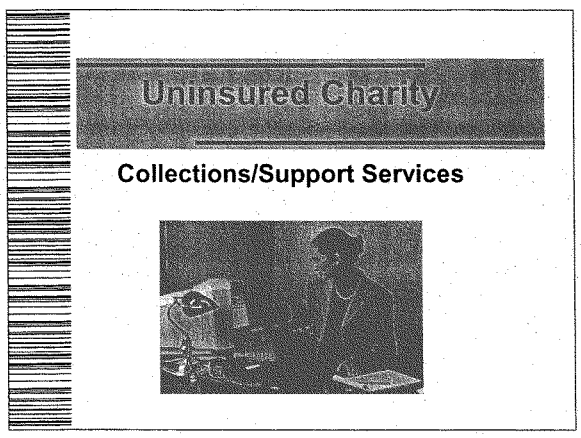

Course Overview

This Uninsured Charity course has been designed to guide Collections and Support Services Personnel through the procedures necessary to provide self pay patients that could potentially qualify for charity assistance with the appropriate documentation and to determine the patient/responsible party's uninsured charity qualification.

Course Objectives

- Understand the policy and procedure for Uninsured Charity Accounts.
- Understand the different levels of the Uninsured Charity Discount.
- Learn the impact of the selection of the appropriate Iplan.
- Understand how to work accounts from the Pending Charity and Charity Collection Series.
- Learn the additional steps for Medicaid Eligibility Denial and the relationship with the Uninsured Charity policy.
- Understand the process for handling Uninsured Charity requests for prior discharges.
- Learn what steps to follow if the account has been placed with an agency.

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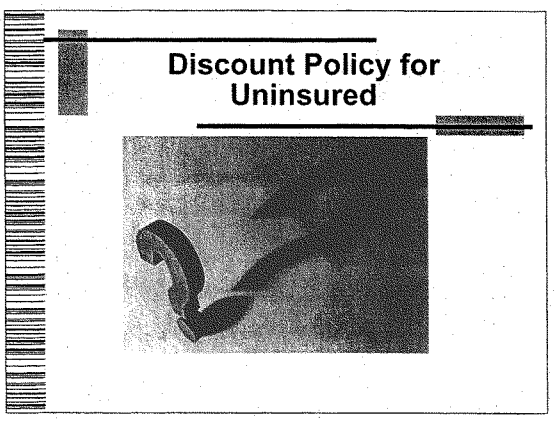

Policy and Procedure:

We have established this policy and procedure to provide financial relief to uninsured patients receiving non-elective care thus reducing their burden of unexpected healthcare costs.

Note: Continue to use your current processes and Iplans for all accounts that would qualify for State, County, or other Government program.

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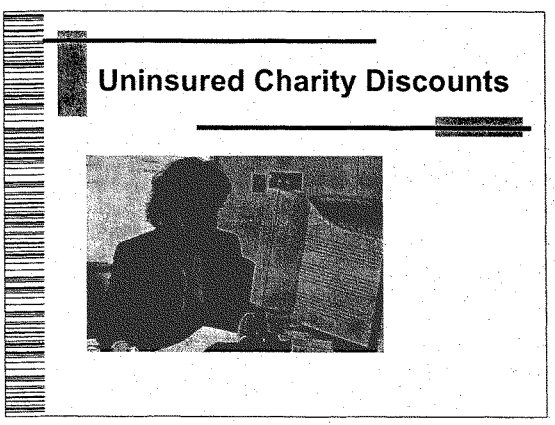

Uninsured Charity Discounts:

Uninsured Charity Discounts will be provided to non-insured patients receiving non-elective care based upon the uninsured charity grid provided in this presentation.

Emergency room visits and accounts with total charges less than $5000.00 will only be required to thoroughly complete the Income Attestation Short Form for uninsured charity discount consideration.

Accounts with total charges greater than $5000.00 will be required to have supporting documentation. The preferred documentation will be the most current year's Federal Tax Return. However, if the patient/responsible party is not able to provide this documentation then two pieces of supporting documentation from the following list will be acceptable:

- State Income Tax Return for the most current year
- Employer Pay Stubs for the past six months
- Written documentation from income sources
- Copy of all bank statements for the past three months
- Current credit report

Note: Use of the new Iplans are only for true uninsured charity accounts that do **NOT** qualify for any other State, County, or other Government programs.

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Financial Class

01	Medicare PPS
02	Medicare DPU
03	Medicaid
04	Worker's Compensation
05	Commercial
06	Champus
07	HMO
08	PPO
09	Managed Care Medicaid
10	Federal
11	State non-Medicaid
12	Local Government
13	Blue Cross/Cost
14	Other
15	Charity
99	Self Pay

Financial Class

A new financial class (15) has been identified as "Charity". The registrar/financial counselor places the patient/responsible party's account by selecting the Iplan as "pending charity". This Iplan stays with the account until the Attestation Form and supporting documentation (if required) is received from the patient.

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Family Size	Federal Poverty Level	0 - 100% Poverty Level	201 - 300% Poverty Level	301 - 400% Poverty Level
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6	$24,680	$0 - $49,360	$49,361 – $74,040	$74,041 - $98,720
7	$27,820	$0 - $55,640	$55,641 - $83,460	$83,461 - $111,280
8	$30,960	$0 - $61,920	$61,921 - $92,880	$92,881 - $123,840

*For family units with more than 8 members, add $3,140 for each additional member to meet the Poverty Level.

Income Guidelines

There are different IPLANS that have been established with a financial class of 15, for Charity Pending, Charity 0 – 100%, Charity 101%-200%, Charity 201%-300% and Charity 301%- 400%. Some states have specific requirements and for those states additional IPLANS will need to be established.

Self Pay Patients

Self Pay patients will fall in one of three categories:

- Self Pay Iplan for patients who can pay.
- Medicaid Eligibility Pending for those patients being evaluated for Medicaid.
- Charity Pending for patients provided the Attestation Form, instructions and letter.

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Federal Poverty Guidelines Alaska 2003

Indigent/Charity Guidelines for 2003 (Alaska)

Family Size	Federal Poverty Level	0 - 200% Poverty Level	201 - 300% Poverty Level	301 - 400% Poverty Level
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3	$19,070	$0 - $38,140	$30,141 - $57,210	$57,211 - $76,280
4	$23,000	$0 - $46,000	$46,001 - $69,000	$69,001 - $92,000
5	$26,930	$0 – $53,860	$53,861 – $80,790	$80,791 - $107,720
6	$30,860	$0 - $61,720	$61,721 - $92,580	$92,581 - $123,440
7	$34,790	$0 - $69,580	$69,581 - $104,370	$104,371 - $151,160
8	$38,720	$0 - $77,440	$77,441 – $116,160	$116,161 - $154,880

Income Guidelines

The grid provided above represents the same levels of Uninsured Charity Discount eligibility for Alaska.

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Income and Charge Based Discount Scale

	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges
Income Level	<$1,000	$1,001 – $2,500	$2,501 – $5,000	$5,001 – $10,000	$10,001 – $25,000	$25,001 – $50,000	>$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

Income and Charge Based Discount Scale:

The Income Charge Based Discount Scale is used in conjunction with the Federal Poverty Guidelines to determine the percentage of the discount based upon account total charges, family size, and amount of income. Provided below is one example of the steps involved in the determination of an uninsured charity discount.

Example Using the Federal Poverty Guidelines and Income and Charge Based Discount Scale:

A self pay Inpatient has presented themselves for consideration of an uninsured charity discount. The patient/responsible party earns $45,000.00 per year. The family consists of five with no other income. Total account charges for this visit are $15,000.00. The patient has also supplied his Federal Tax Return from last year.

Using the Federal Poverty Guidelines perform the following:

- Find the family size of 5
- Follow the grid across and locate the dollar range that includes $45,000.00. (201 to 300%)

Using the Income and charge based discount scale:

- Determine total charges on the account ($15000.00 for this example)
- Use the 201 to 300% category received from the information above, follow the grid across and locate the amount of the charity discount
- The patient/responsible party is eligible for a 40% Uninsured Charity Discount.

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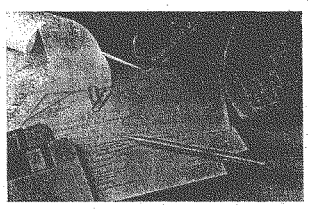
Pending Uninsured Charity



Importance of the Iplan:

Because the registrar is the first point of contact for the patient/responsible party, there are several decisions that must be made to ensure the account is handled appropriately after registration. Assigning the appropriate IPLAN is key to this process. Normal financial counseling is expected to occur. This information is provided to collections and support services personnel because an account may be considered for uninsured charity during the normal follow up on an account. Remember, the Iplan that is selected automatically assigns the designated financial class.

Patients/responsible parties are **not** eligible for Uninsured Charity discounts when the visit is for .....

- Elective Services – as outlined by the facility
- Other Insurance Coverage Exists
- Patient/Responsible party is able to pay account
- Patient may qualify for Medicaid

If the patient/responsible party is unable to pay this account and potential Medicaid is not being obtained, then the patient/responsible party may qualify for an uninsured charity discount. When this is determined, the Registrar should provide the patient will the appropriate Income Attestation Form(s), apply the Pending Charity IPLAN (099-50), and document in Meditech or Collections that the patient/responsible party received the Income Attestation documentation.

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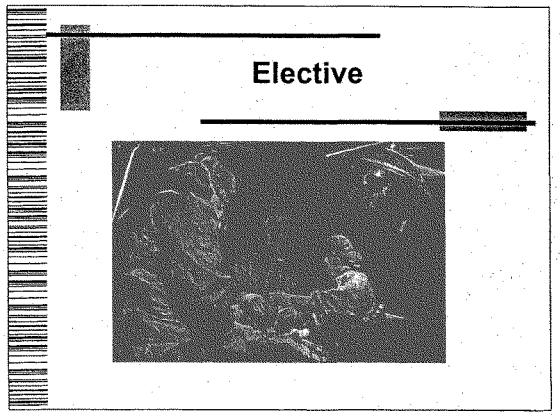

Elective Procedure Consideration:

The next step to be performed by the registrar and/or financial counselor is to determine if the visit is considered an elective procedure.

- If yes, the patient will **not** qualify for an Uninsured Charity Discount.
- If no, the patient may qualify, continue the process.

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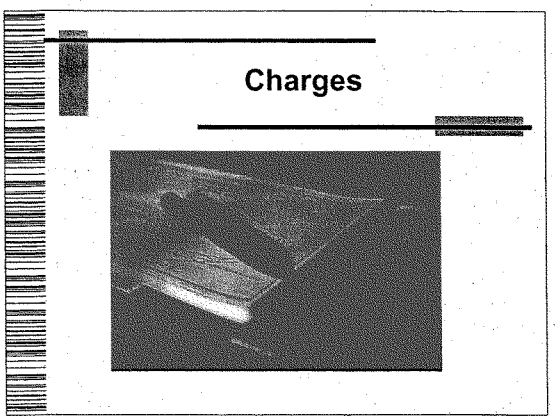

Charges

The registrar and/or financial counselor must determine if the patient or responsible party is able to pay estimated charges.

The registrar determines if the patient was previously evaluated for potential Medicaid coverage.

- If yes, apply the pending medicaid Iplan.
- If no, complete the registration and begin the financial counseling process.

Then the registrar and/or financial counselor will determine if the patient and/or responsible party is able to pay the estimated charges.

- If yes, collect the money
- If no, determine if the patient meets the Medicaid Eligibility Criteria.
  - If yes, assign the Pending Medicaid Iplan.
  - If no, continue with the process.

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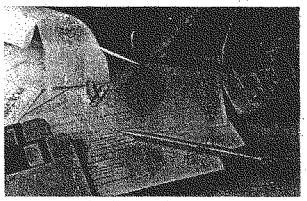
Requirements



Selection of the Appropriate Income Attestation Document:

Determining the appropriate Income Attestation documentation to provide to the patient/responsible party is clearly defined.

- If this is an ER visit and the patient is being discharged or an Outpatient visit where charges are expected to be less than $5000.00, then the patient/responsible party should receive the Income Attestation Short Form along with the Short Form Instruction.
- If this is an Inpatient or Outpatient visit where total charges are expected to be greater than $5000.00, then the patient/responsible party should receive the Uninsured Charity Introduction Letter, Income Attestation Long Form and the Long Form Instructions.

There will be times when the patient/responsible party completes the Income Attestation form before leaving the facility. In this case, accept the Income Attestation Form and document receipt in Meditech or the Collection System. Place the Income Attestation Form with the documents for scanning.

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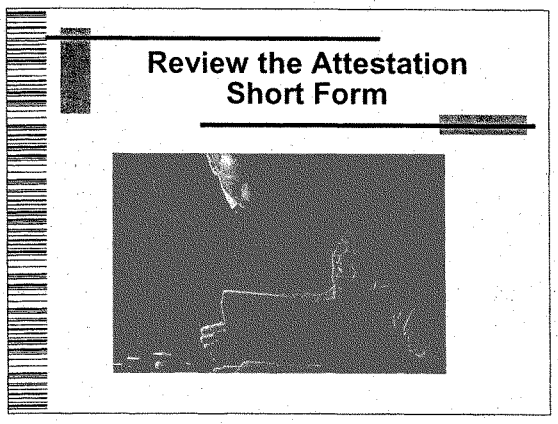

Review of Short Form:

A copy of the short form has been provided in a word document format and included with this presentation.

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Review the Attestation Short Form Instructions

Review of Short Form Instructions:

A copy of the short form instructions has been provided in a word document format and included with this presentation.

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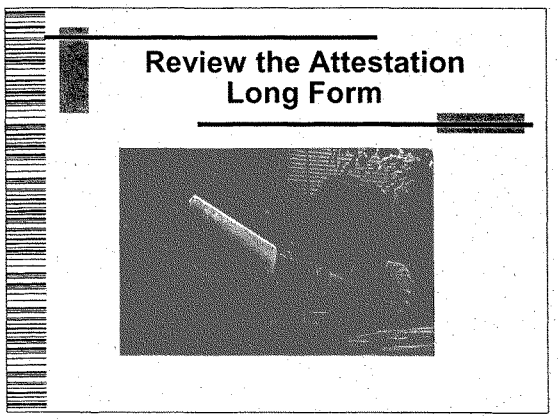

Review of Long Form:

A copy of the long form has been provided in a word document format and included with this presentation.

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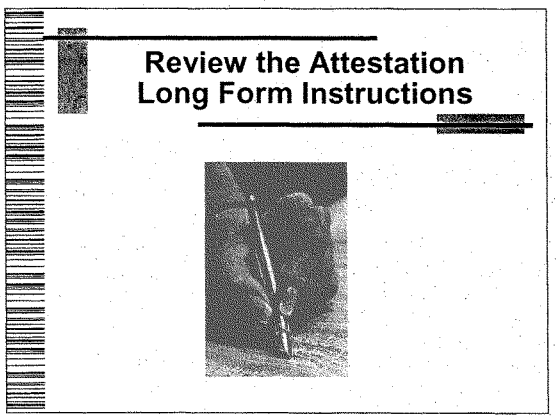

Review of Long Form Instructions:

A copy of the long form instructions has been provided in a word document format and included with this presentation.

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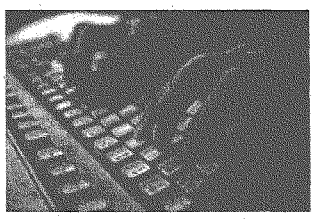
Document
Charity Attestation Form



Documenting the System:

The registrar and/or financial counselor documents in the Meditech System that the Charity Attestation Form was provided to the patient.

- If the patient/responsible party returned the form completed, then the registrar and/or financial counselor documents in the Meditech System that the form was completed.
- The registrar and/or financial counselor places the completed form with the packet of documents for scanning at the PAS.

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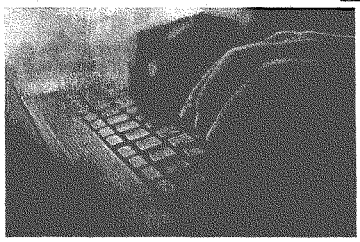
Attestation Form Received at the Hospital After Discharge



Receipt of Attestation Form at the Hospital Post Discharge:

If the Attestation Form is received at the hospital after the patient's visit, place the form with the packet for scanning.

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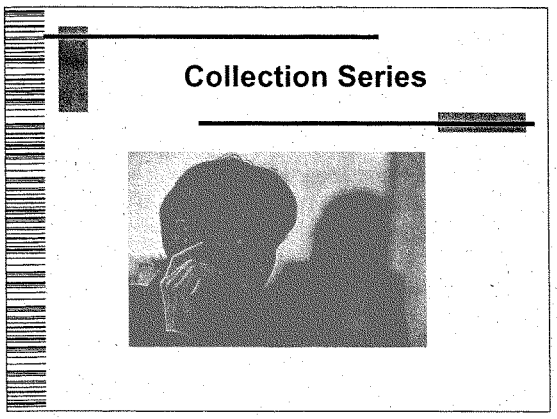

Collection Series:

When working accounts from the Charity collection series, you will be responsible for:

- Determining if all applicable documentation has been obtained and was completed thoroughly
- Evaluating whether or not the patient/responsible party meets the uninsured charity guidelines as outline in the Uninsured Charity policy.
- Update with the appropriate charity Iplan and re-prorate the account or delete the pending charity IPLAN if no discount is due.
- Requesting a manual Uninsured Charity Discount on accounts with a primary or secondary Collection Vendor or in bad debt.
- Notifying the patient/responsible party of the Uninsured Charity determination.
- Updating the Collection System or Patient Account accounts notes to reflect your evaluation and final decision.

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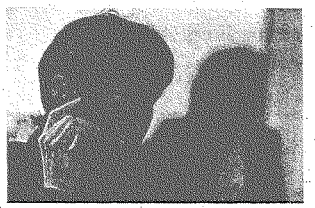
Collections Series Continued...



Collection Series Continued...

When determining that all applicable documentation has been obtained, remember that regardless of total charges on an **Emergency Room visit, no additional supporting income information is needed**. If the documentation was sent to the PAS after the patient's visit, the information will be stored in the Imaging System. If you have received the completed Income Attestation Form but still need supporting income information from the patient, determine the length of time this information has been requested. You may want to contact the patient either by phone or letter to assist in receiving the additional information. If you have previously requested this additional information and the patient/responsible party has not responded, forward the account to your Manager for review and final determination.

Evaluation of the Income Attestation Form with and without supporting documentation should be based solely on the patient's income, family size and total charges on the account.

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Income and Charge Based Discount Scale

	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges	Total Charges
Income Level	<$1,000	$1,001 – $2,500	$2,501 – $5,000	$5,001 – $10,000	$10,001 – $25,000	$25,001 – $50,000	>$50,001
0 – 200% of FPG- Charity	100%	100%	100%	100%	100%	100%	100%
201 – 300% of FPG	15%	25%	30%	35%	40%	45%	65%
301 – 400% of FPG	15%	20%	25%	30%	35%	40%	55%

Income and Charge Based Scale:

Use the Income and charge based scale to help you determine the poverty level. If the patient/responsible party does not meet the poverty guidelines then no uninsured charity discount should be applied and the Pending Charity IPLAN should be deleted.

If the patient/responsible party meets the poverty guidelines then determine, using the Uninsured Charity Policy, which Charity IPLAN to assign based upon their level of discount and reprorate account. It is important to assign the appropriate Charity IPLAN to ensure the correct discount is applied. If the account is currently at a primary or secondary Collection Vendor or in bad debt, then the Charity IPLAN will not be applied and a manual discount request should be completed.

Always notify the patient/responsible party of the final determination and thoroughly document your efforts in the Collection System or Patient Accounting.

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Uninsured Charity Correspondence

Correspondence:

Many times the patient/responsible party will not have the correct information or time to provide a completed Income Attestation Form at the point of registration or prior to discharge from the facility. Other pieces of Charity correspondence are generated from the Collection Vendor pursuing potential Uninsured Charity through their normal collection processes. Either way, the information should be sent to the PAS within seven (7) days of requesting the Income Attestation Form from the patient/responsible party. These documents will follow the same incoming correspondence procedures set up at your PAS. The documents will be imaged and available to you to complete the same steps as outlined when working from a Charity Collection Series. However, since these accounts may be in very different steps within their collection follow up process, there may be manual steps you will need to take complete.

What to watch for:

- Accounts requiring additional supporting documentation will be worked from the current Charity Collection Series.
- Accounts currently at an early out collection vendor will not require manual posting of a discount. Apply the appropriate Charity IPLAN and the discount will be auto posted.
- Accounts currently placed with an primary or secondary collection agency will not allow the addition of a Charity IPLAN and will require a manual Uninsured Charity discount posting.
- Always document the account with all actions taken.

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Uninsured Charity Forms & Document Imaging

PAS Staff

Attestation Form Review

The Charity Attestation forms and supporting documents are very important and confidential documents that may be needed during follow up processes.

These forms may be accessed by:

- Financial Counselors
- Collectors
- Research and Correspondence
- NPAS

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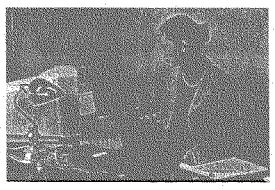
Uninsured Charity Forms & Document Imaging

PAS Staff



When forms are received at the PAS after discharge:

1. Review forms for completion and accuracy based on charity process
2. Keep all forms separate by facility
3. Complete a Charity Documents Scanning Cover form for each patient requesting this service.
   - (Please find where these forms are located in your department)
4. Assemble all charity forms into a larger packet at the end of each day.
   - Remember to keep the forms separated by facility.
5. Complete a Charity Batch Cover form for each batch, if applicable.
6. Send batches to the Imaging Department for scanning into the Document Imaging System.

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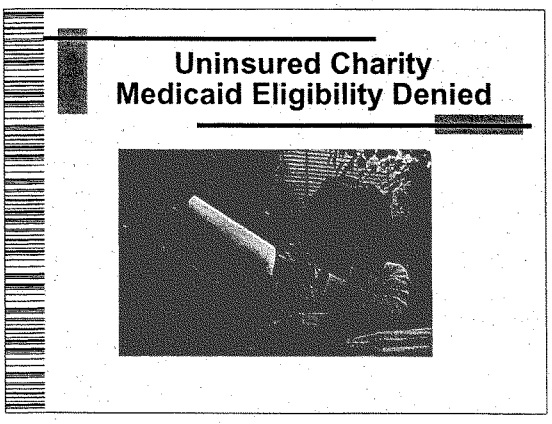

Denial of Medicaid Eligibility:

When Medicaid eligibility is denied, the Collection/Support Service staff should evaluate the potential of the account for a possible Uninsured Charity Discount. The following steps should be taken:

- Obtain the patient/responsible party's Medicaid application and any supporting documentation.
- Evaluate the documentation for a potential uninsured charity discount using the Uninsured Charity Grid and Uninsured Charity Policy.
- If Uninsured Charity guidelines are not met, determine if the account is placed with a Collection Vendor.
- If not, place account with NPAS.
- If the account is with another agency, document account in the Collection System.
- If Uninsured Charity guidelines are met, determine if the account is in open A/R, Early Out, at a primary or secondary Collection Vendor or in bad debt.

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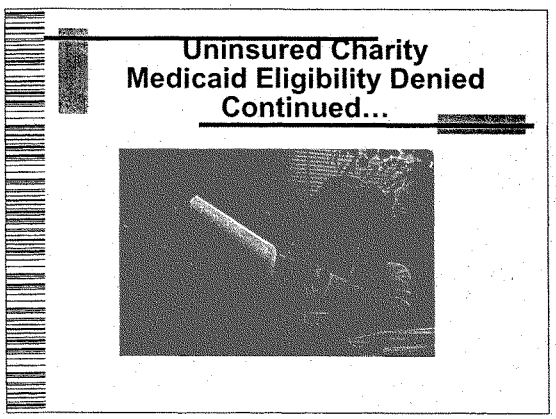

Denial of Medicaid Eligibility Continued:

- If the account is with a primary or secondary Collection Vendor or bad debt, determine whether or not additional supporting documentation is needed.
- Determine…
  - If additional documentation is needed, request information from the patient and document account in the Collection System or HOST/PA System.
  - If no additional information is needed, apply manual discount, document in either the Collection System or Host/PA System and notify the patient.
- If the account is in open A/R or with an early out Collection Vendor determine…
  - If additional documentation is needed, request the information from the patient and document account in the Collection System
  - If no additional documentation is required, apply the appropriate Charity IPLAN, re-prorate the account, notify the patient/responsible party, and document the Collection System.

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Uninsured Charity Prior Discharge Requests

Uninsured Charity Discounts for Accounts Prior to October 1, 2003:

****Accounts with discharges prior to 10/1 are to be processed according to your policy that was effective prior to 10/1, no matter when the discount is applied. All discounts that are posted after 10/1 that apply to a policy **prior to 10/1** are to use the following procedure codes.****

- **586000 – Charity pre 10/1 IP**
- **586001 – Charity pre 10/1 OP**

The only exception to this is if a patient requests that previous stay be reviewed based on a current stay, (post 10/1) qualifying for a charity discount under the new policy. Complete the following steps:

- Obtain Manager approval for Uninsured Charity discount consideration.
- Use the existing documentation received from the patient/responsible party to determine the level of the Uninsured Charity discount.
- Determine if the account(s) are currently in open A/R or with an early out Collection Vendor.
  - Apply the appropriate charity Iplan, re-prorate the account, notify the patient/responsible party and document the collection system.
- Determine if the account(s) are currently with a primary or secondary collection vendor or in bad debt.
  - Apply the appropriate manual discount, notify the patient/responsible party and document the collection system or HOST/PA system.

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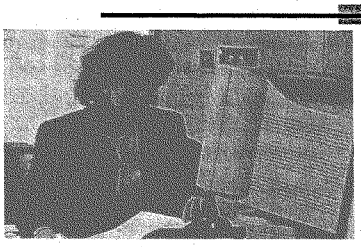
Uninsured Charity Collection Letters



English and Spanish are available

There are several new collection letters that have been developed for communication with the patient/responsible parties after the Uninsured Charity determination has been performed:

- CHFULL – This letter is to be used when a complete uninsured charity discount has been applied. (Spanish Version: CSFULL)
- CHPRTL – This letter is to be used when a partial uninsured charity discount has been applied and a remaining balance is due from the patient/responsible party. (Spanish Version: CSPRTL)
- CHDFPG – This letter is to be used when the patient/responsible party income has exceeded the Federal Poverty Charity Guidelines and no discount will be applied. (Spanish Version: CSDFPG)
- CHDIVD – This letter is to be used when the patient/responsible party income validation information is missing and no discount will be applied. (Spanish Version: CSDIVD)
- CHDINS – This letter is to be used when the patient/responsible party has obtained insurance coverage for this visit and no discount will be applied. (Spanish Version: CSDINS)
- CHDOTH – This letter is to be used when the patient/responsible party does not qualify for an Uninsured Charity discount for other reasons. (Spanish Version: CSDOTH)
- CHDIFM – This letter is to be used when the patient/responsible party does not return the Income Attestation Form and no Uninsured Charity discount will be applied. (Spanish Version: CSDIFM)
- CHDOCR – This letter is to be used when additional supporting income documentation is needed. (Spanish Version: CSDOCR)

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Vendor Process for Uninsured Charity Accounts

Collection Vendors:

The Collection Vendors will also be identifying self pay accounts for potential Uninsured Charity Discounts. However, it will be the overall responsibility of the PAS to determine the patient/responsible party's eligibility.

The Vendor will identify potential accounts and mail the applicable Income Attestation Form and Instructions to the patient/responsible party. These forms will be returned to the PAS for processing. Earlier we described the processes for receiving and working Uninsured Charity correspondence. It is important to know that the Collection Vendors will be relying on the PAS to work Uninsured Charity correspondence timely. In the case of NPAS, they will have access to the Imaging system for retrieving documentation to validate the information has been received at the PAS. However, it will still be up to the PAS to determine the Uninsured Charity eligibility, apply or remove the Charity IPLANS, reprorate and document the account.

When the Vendor sends the Income Attestation Form to the patient/responsible party, the Vendors will continue to monitor the accounts. If the PAS has not made a determination on the account within the given time period, the Vendor will contact the PAS in their usual manner. If the documentation has not been received, then the Vendors will continue normal collection follow up activity.

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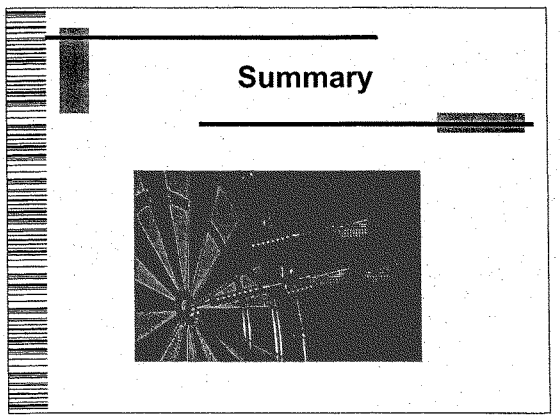

Course Objectives

- Understand the policy and procedure for Uninsured Charity Accounts.
- Understand the different levels of the Uninsured Charity Discount.
- Learn the impact of the selection of the appropriate Iplan.
- Understand how to work accounts from the Pending Charity and Charity Collection Series.
- Learn the additional steps for Medicaid Eligibility Denial and the relationship with the Uninsured Charity policy.
- Understand the process for handling Uninsured Charity requests for prior discharges.
- Learn what steps to follow if the account has been placed with an agency.

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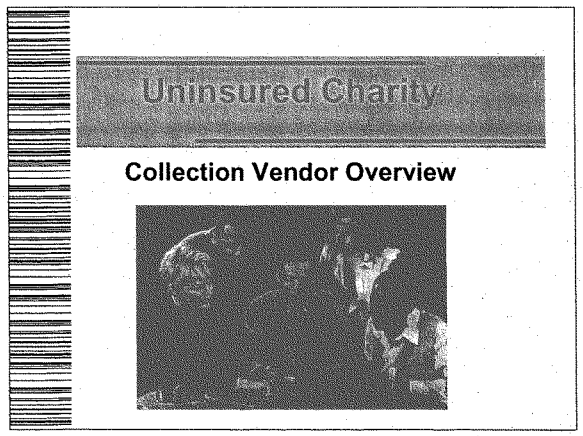

Course Overview

This Uninsured Charity course has been designed to provide Vendor Personnel a high level overview through the procedures necessary to provide self pay patients that could potentially qualify for charity assistance with the appropriate documentation.

Course Objectives

- Understand the process for the Uninsured Charity Discount guidelines.
- Understand the role for supplying patient/responsible party with documentation for uninsured charity consideration.
- Understand the role of the Vendor in the process of the Uninsured Charity Policy.

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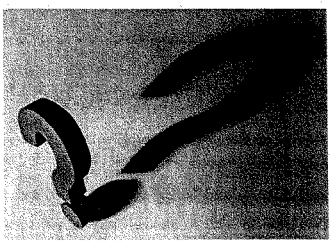
Discount Policy for Uninsured



Policy and Procedure:

We have established this policy and procedure to provide financial relief to uninsured patients receiving non-elective care thus reducing their burden of unexpected healthcare costs.

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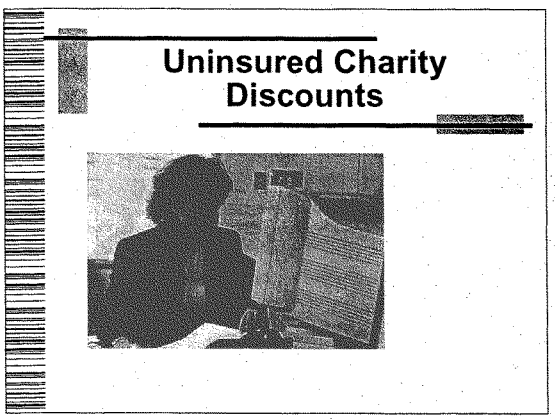

Uninsured Charity Discounts:

Uninsured Charity Discounts will be provided to non-insured patients receiving non-elective care based upon income, family size and total charges on the account.

Emergency room visits and accounts with total charges less than $5000.00 will only be required to thoroughly complete the Income Attestation Short Form for Uninsured Charity Discount consideration.

Accounts with total charges greater than $5000.00 will be required to thoroughly complete the Income Attestation Long Form and provide supporting income documentation. The preferred income documentation will be the most current year's Federal Tax Return. However, if the patient/responsible party is not able to provide this documentation then two pieces of supporting documentation from the following list will be acceptable:

- State Income Tax Return for the most current year
- Employer Pay Stubs for the past six months
- Written documentation from income sources
- Copy of all bank statements for the pas three months
- Current credit report

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Income and Charge Based Discount Scale

Indigent/Charity Guidelines for 2003 (48 Contignous States and District Of Columbia)

Family Size	Federal Poverty Level	0 – 200% Poverty Level	201 – 300% Poverty Level	301 – 400% Poverty Level
1	$ 8,980	$0 – $17,960	$17,961 - $26,940	$26,940 - $35,920
2	$12,120	$0 - $24,240	$24,241 - $36,360	$36,361 - $48,480
3	$15,260	$0 - $30,520	$30,521 – $45,780	$45,781 – $61,040
4	$18,400	$0 - $36,800	$36,801 - $55,200	$55,201 - $73,600
5	$21,520	$0 - $43,040	$43,041 - $64,560	$64,561 - $86,080
6	$24,680	$0 - $49,360	$49,361 – $74,040	$74,041 - $98,720
7	$27,820	$0 - $55,640	$55,641 - $83,460	$83,461 - $111,280
8	$30,960	$0 - $61,920	$61,921 - $92,880	$92,881 - $123,840

*For family units with more than 8 members, add $3,140 for each additional member to meet the Poverty Level.

Income and Charge Based Discount Scale :

The grid provided above represents the levels of Charity Discount eligibility for the 48 contiguous states.

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Income and Charge Based Discount Scale - Alaska

Indigent/Charity Guidelines for 2003 (Alaska)

Family Size	Federal Poverty Level	0 - 200% Poverty Level	201 - 300% Poverty Level	301 - 400% Poverty Level
1	$11,210	$0 - $22,420	$22,421 - $33,630	$33,631 - $44,840
2	$15,140	$0 - $30,280	$30,281 - $45,420	$45,421 - $60,560
3	$19,070	$0 - $38,140	$30,141 - $57,210	$57,211 - $76,280
4	$23,000	$0 - $46,000	$46,001 - $69,000	$69,001 - $92,000
5	$26,930	$0 – $53,860	$53,861 – $80,790	$80,791 - $107,720
6	$30,860	$0 - $61,720	$61,721 - $92,580	$92,581 - $123,440
7	$34,790	$0 - $69,580	$69,581 - $104,370	$104,371 - $151,160
8	$38,720	$0 - $77,440	$77,441 – $116,160	$116,161 - $154,880

Income and Charge Based Discount Scale - Alaska:

The grid provided above represents the same levels of Charity Discount eligibility for Alaska.

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Vendor Account Flow

Process for Working Accounts:

During the normal process of working accounts that have been turned over to a collection agency, a patient/responsible party's account may be identified as a potential Uninsured Charity account.

If an account has been identified as a possible uninsured charity account, the following steps should be completed by the vendor personnel:

- Determine if an Uninsured Charity Discount has been previously applied to the account.
  - If yes, pursue normal collection efforts.
  - If no, complete the following steps:
    - Determine if uninsured charity eligibility was previously denied.
      - If previously denied, pursue normal collection efforts.
      - If not, then initiate the uninsured charity request process.

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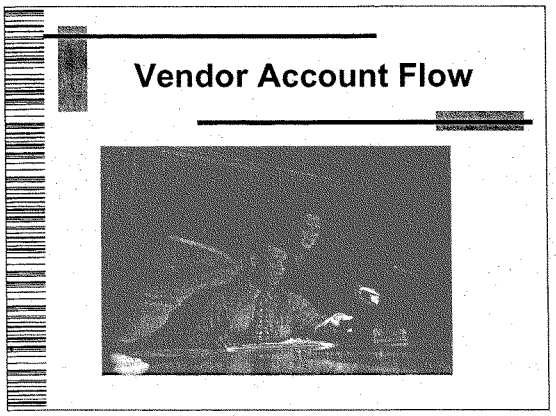

Process for Working Accounts Continued…:

- Evaluate account type and total charges to determine which Income Attestation to send to the patient/responsible party.
  - Send the Income Attestation Short Form and Instructions to the patient/responsible party with a **return address to the PAS** on Emergency Room visits or accounts with total charges less than $5000.00
  - Send the Income Attestation Long Form, Instructions and Charity Introduction Letter to the patient/responsible party with a **return address to the PAS** on accounts greater than $5000.00.
  - Document and time the account for next follow up.
  - The PAS is responsible for approving and manually posting a discount when the account comes up for follow up.
- Determine if the Charity Discount has been applied.
  - If yes, continue normal collection efforts.
  - If no, contact the PAS for status.

NOTE: If an account is eligible for a full uninsured charity discount, the account will close and return systematically when the discount is processes.

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Uninsured Charity Documentation

- Attestation Forms
- Instructions
- Long Form
  Introduction Letter

Form Review:

Located in the packet provided to you, please review the forms and their instructions to become more familiar with the content.

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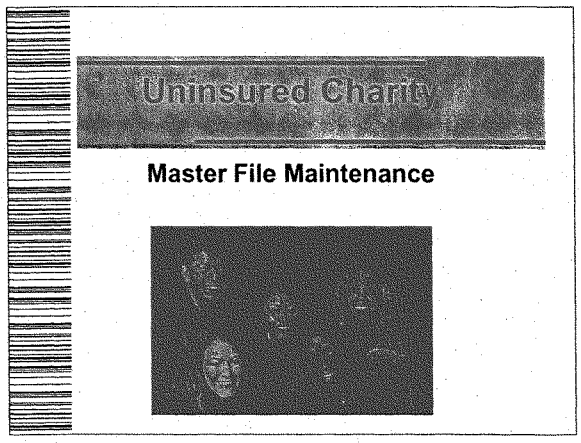

Course Overview

The Uninsured Charity course has been designed to provide a high level overview of procedures necessary to establish the Master File changes required for the implementation of the uninsured charity parameters.

Course Objective

- Provide information needed to establish and/or maintain Master Files specific to the Uninsured Charity Discount Policy for Patients.

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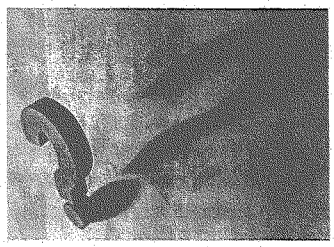
Discount Policy for Uninsured



Policy and Procedure:

We have established this new policy and procedure to provide financial relief to uninsured patients receiving non-elective care thus reducing their burden of unexpected healthcare costs.

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Iplan Dictionary and Master File

Iplan, Collection Series and Log ID Information:

Establish the new Iplans on both the Meditech and Patient Accounting Systems.

The listing for the Iplans that are necessary to establish include:

099-50 Charity Pending
099-51 Charity 0 thru 100
099-52 Charity 101 thru 200
099-53 Charity 201 thru 300
099-54 Charity 301 thru 400
099-55 Charity State Required 201 thru 250 (Georgia)

- Attach the following information to the Iplans:
  - Collection Series 108 insurance and 4 patient (pending)
  - Collection Series 109 insurance and 208 patient (charity)
  - Log ID's and Contract Models

Charity Pending	CPEN**	
Charity 0 thru 100	C100	C200
Charity101 thru 200	C200	C200
Charity201 thru 300	C300	C300
Charity301 thru 400	C400	C400

For states that require charity based on 250% (Georgia)

Charity 201 thru 250	C250	C200

Note: ** *establish the model to calculate a zero discount.*

Pro-ration amount for these IPLANS should be 100%

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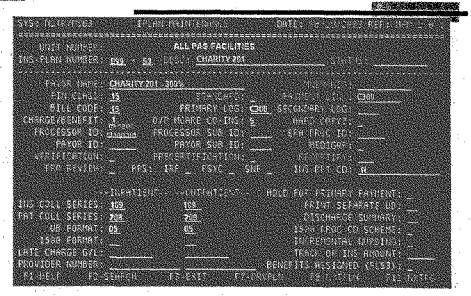
Iplan PA Master File



Example of IPLAN:

The example provided shows the Charity 201 thru 300 established the day after the Iplan has been set-up on the Meditech System.

The screen shows what the Charity 201 thru 300 Iplan looks like after completing the set up using the information contained in the packet provided to you titled "Iplan Set up Form". Press the "F9" key to update the keyed information. Continue to establish all of the new Iplans on the PA/Host system.

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Collection Series Master File – Collection System

```
CAPS    FOX      1:48p  13- 71
HCA      DATE  STA   ACTIVITY: COLLECTION SERIES        ASSUME-DATE: 08-28-03
CS R7.6 08-28-03 6297  FCS      MANUAL-REF: NFM 2-4-1    TRAIN
NOTE  3393 * F2=Modify F3=Range Screen F5=Next F6=Prev F7=Apply E9=Del F12=Add
CS 108 CHARITY PENDING ACCTS INS                          Type I Init Step Day 0
                                                          Early-Out Hold      N
                                                          Early-Out Agency
## Letter   E A Act# R.    Desk Days Stp  CS ## Description
02                                  0   3 108  2 CHARITY DISC NOT POSTED WHY?
01                                  5  12 108  2 CHARITY DISC POSTED?
```

Collection Series:

Establish the collection series by performing the following steps:

- Type "FCS" at the activity prompt and press the enter key.
- Type "108" and press the enter key.
- Type the name of the series " Uninsured Charity Pending Accts Ins" and press the enter key.
- Type "I" for insurance series and press the enter key.
- Press the enter key again. (Initial step day = 0)
- Type "N" at the early out hold indicator prompt.
- Press the enter key again at the early out agency prompt.
- Press the F12 function key to begin entering the data.
- Type "2" and press the enter key.
- Press the enter key until you reach the days column.
- Type "0" under the days column.
- Type "3" under the step column.
- Type "108" under the cs column.
- Type "2" under the ## column. (Indicates the step number)
- Type "Charity Disc Not Posted Why?" under the description prompt and press the enter key.
- Type "1" under ## column.
- Press the enter key until you reach the days column.
- Type "5" under the days column and press the enter key.
- Type "12" under the step column and press the enter key.
- Type "108" under the cs column and press the enter key.
- Type "2" under the ## column and press the enter key.
- Type "Charity Discount Posted?" and press the enter key.
- Press the "F1" function key to exit and save the series.
- Continue to establish the other series – 109 in the same manner.

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FDESK Master File

```
CAPS    FDX      SCRN  25   N
HCA     DATE   SIM   ACTIVITY: DESK CS SEQUENCING      ASSUME-DATE: 09-02-03
CS A7:6 09-02-03 0336  FDESK   MANUAL-REF. MFM 2-5-1    TRMIM

 Desk:      1

 Seq  CS   Description
 ---  ---  ----------------------------------------
  52  902  SEMI-MONTHLY ARRANGEMENT
  53  903  BI-WEEKLY ARRANGEMENT
  54  908  NOTE ARRANGEMENT
  55  931  PRESRVC MONTHLY ARRG
  56  932  PRESRVC SEMI-MONTHLY ARRG
  57  933  PRESRVC BI-WEEKLY ARRG
  58  998  BAD DEBT
  59  948  INTERIM BILL
  60  978  INDUSTRIAL
  61  988  SMALL BALANCE
  62  982  CREDIT BALANCE
  63  981  ZERO BALANCE
  64  108  CHARITY PENDING ACCTS INS
```

FDESK:

Next, each of the series must be added to every desk. The information provided below provides an example of the steps involved with achieving the addition to each desk.

- Type "FDESK" at the activity prompt and press the enter key.
- Type "1" at the desk prompt and press the enter key.
- Press the "F12" function key to add the new series to desk 1.
- Type "108" and press the enter key.
- Type "109" and press the enter key.
- Press the "F1" function key to save the new series additions.
- Press the "F1" function key again to exit.
- Continue to establish the new series on each desk.

Note: *Collection series 4 and 208 should already be established as Pending Charity and self pay respectively.*

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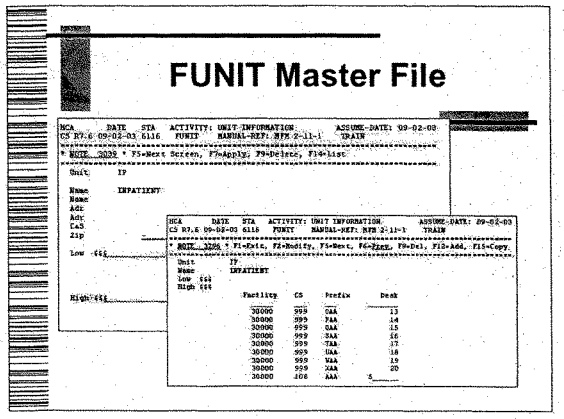

FUNIT:

The last Master File to be considered for the collection system is the FUNIT Master File. Once you have established the new collection series and assigned the priority of the series inside each of the desks, the FUNIT Master File must route the account to the correct target desk. Complete the instructions below.

- Type "FUNIT" at the activity prompt and press the enter key.
- Type "IP" at the activity prompt and press the enter key.
- Press the "F5" function key to go to the second page.
- Press the "F12" function key to add the new series.
- Type "108" and press the enter key.
- Type "AAA" and press the enter key.
- Type the desk number responsible for the follow up and press the enter key.
- Continue adding the new series to each of the lines of business. The packet contains the series that must be added.

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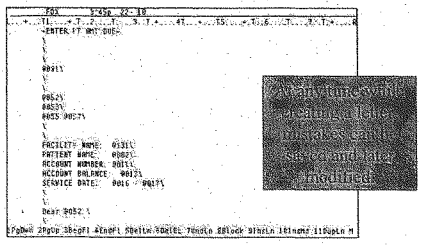
Flettr Master File – Collection System



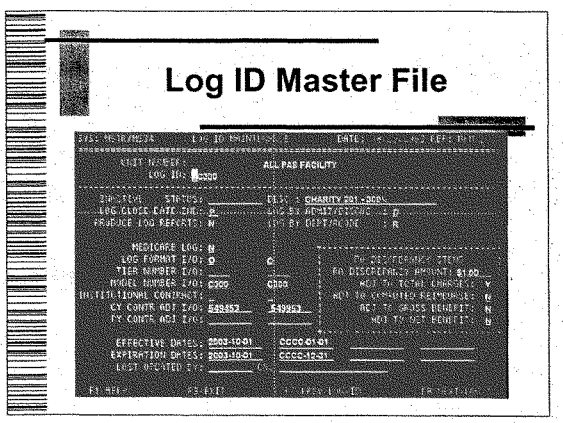
FLETTR:

There are many letters that must be established due to their usage throughout the normal process of working accounts. The instructions that follow provide you the steps necessary to build the "CHPRTL" (partial uninsured charity) letter. All of the letters are located in the packet provided to you. The steps to establish the letters follow the same process.

Once you have signed on to the collection system using your access code and password, perform the following steps:

- Type "FLETTR" at the activity prompt and press the enter key.
- Type "CHPRTL" (the name of the letter will change depending on the letter that is to be created) and press the enter key.
- Type "y" at the ok to proceed prompt and press the enter key.
- Press the tab key once to begin typing the letter contents.
- Type ~Pt Amt Due~ and press the enter key. (This is known as a free form prompt and require the requestor of the letter to type in the amount as $XX.XX format.)
- Type "\" at each line necessary to drop the letter down to the appropriate place. The system recognizes this action as the end of a line.
- Type the letter exactly as it is shown include each "\" at the end of each line.
- Press and hold down the "CTRL" key and tap the "page up" key at the same time once. A new menu will appear.
- Press the **"Q"** key to quit the letter.
- Press the **"R"** key to replace even though it is a new letter. *Pressing the "S" key to save will make the system lock and require a shut down. The letter will NOT be saved.*
- Continue to build all letters contained in the packet.

Log ID Master File



LOG ID:

The screen shown above depicts how the LOG ID Master File should look once it has been completed. All charity Iplans will be logged and auto posted except Uninsured Charity Pending which will not be set up to auto post. The reports indicator for each LOGID is to be set to "N" so that discrepancies will not be generated.

The screen shows what the Charity 201 thru 300 Iplan looks like after completing the set up using the information contained in the packet provided to you titled "Log ID Set up Form". Press the "F9" key to update the keyed information. Continue to establish all of the new Log ID's using the PA/Host system.

Clear Access scripts should be run daily to ensure the accounts are logged and auto-posted.

LogID: For Uninsured Charity logs, enter the appropriate Charity G/L account number. Set the Produce Log Indicator to Yes

NOTE: Accounts with discharges prior to 10/1 are to be processed according to your policy that was effective prior to 10/1, no matter when the discount is applied. All discounts that are posted *after* 10/1 that apply to a policy prior to 10/1 are to use the following procedure codes:

586000 Charity pre 10/1 IP

586001 Charity pre 10/1 OP

The only exception to this is if a patient requests for previous stays to be reviewed based upon a current stay (post 10/1) qualifying for a charity discount under the new policy.

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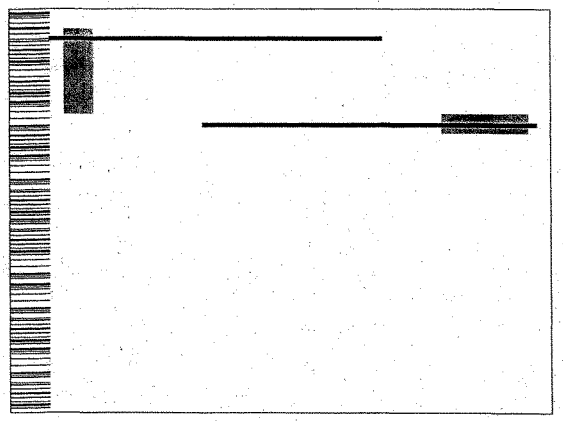

Establish an additional set of procedure codes to be used when a different discount percentage is being granted based on a state or local government regulation. The following procedure codes are to be used and linked to the same G/L account numbers as the standard procedure codes. These are only to be used if a different discount percentage is being granted than our standard policy.

The "NS" in the descriptions below stand for "non standard".

- 186451 Charity NS 0-100% IP
- 186452 Charity NS 101-200% IP
- 186453 Charity NS 201-300% IP
- 186454 Charity NS 301-400% IP
- 186455 Charity NS 201-250% IP

- 186951 Charity NS 0-100% OP
- 186952 Charity NS 101-200% OP
- 186953 Charity NS 201-300% OP
- 186954 Charity NS 301-400% OP
- 186955 Charity NS 201-250% OP

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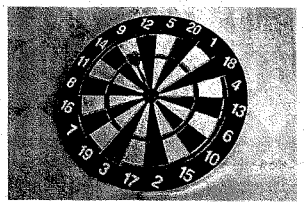
Summary



Course Objective

- Provide Master File Maintenance information needed to establish and/or maintain Master Files specific to the Uninsured Charity Discount Policy for patients.

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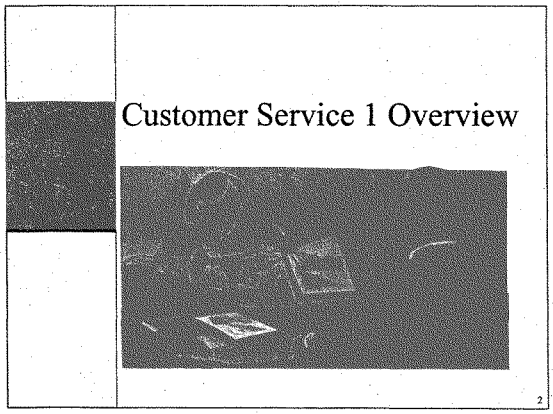
Charity Policy Comparison

Major Components	Original Policy Effective 10/1/03	New Policy Effective 6/1/04
Patient Types	Uninsured Only	Uninsured and Under Insured
Documentation required prior to Charity write off being approved	•All accounts with charges greater than $5,000 required a two page charity form to be completed along with supporting documentation (i.e. tax return, bank statements, etc.).	•Every applicant must complete a one page form. Only IP and Medicare accounts require verification of income. In addition, Medicare accounts require additional documentation according to CMS rules. •The form has been simplified to only include the data needed to determine income, employer, # of dependants and whether any other coverage exist.
Examples of extenuating circumstances for the purposes of management discretion	None were included in the original policy	Included several examples of extenuating circumstances (i.e. patient expiration, undocumented residence, homeless, etc.)



Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion 	•Not just for patients: internal AND external customers •Learn to exceed customer expectation •Improve our ability to provide great quality service •Build on values we already embrace -- charity, compassion, competence, collaboration and challenge •Learn practical skills to apply these values in dealing with others •Goal: Teach registrars to succeed.	Possible use of flipchart to list all customers. Customer service is not just for patients. We use customer service with all departments, physicians and co- workers. **Student Workbook:** **Page 1 matches Slide 1** **Page 2 – Table of Contents**

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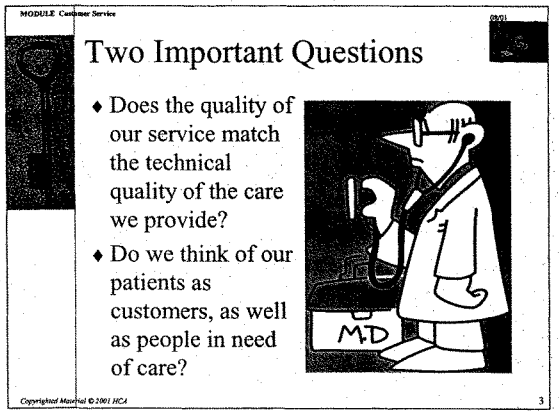
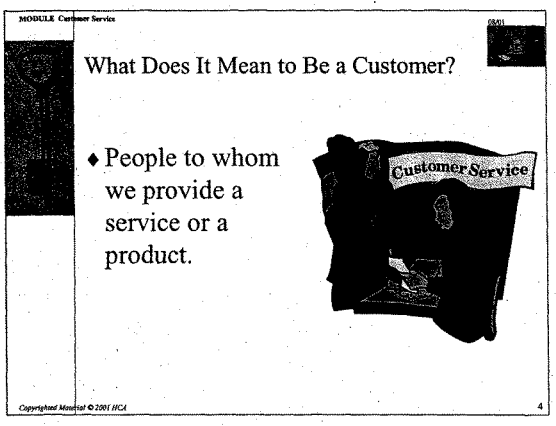


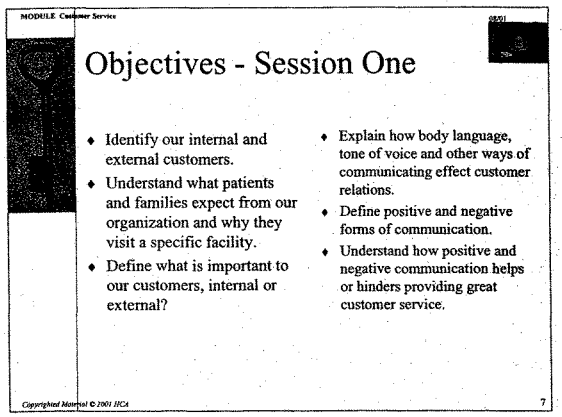
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion 	•Do we understand what customer service is? •Do we think of our customers as "just our job"? • Who are our customers? •Quality of services surrounding delivery of care is of critical importance to patients and their family members. •Judge quality of care by services received because they do do not expertise to evaluate technical aspects of care	When we survey patients, what are some of the top issues they complain about? Allow discussion: food cleanliness Timeliness **Student Workbook: Page 3 – Two Important Questions**



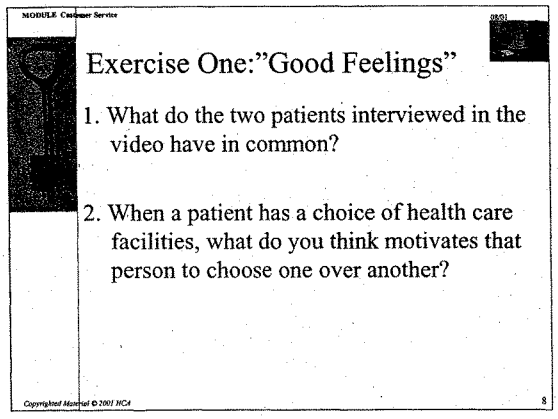
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	Customers are the people to whom we provide a service or product. They may or may not pay us in some way for the product or service. Customers are divided into two groups: External and Internal Customers. Patient Access is service oriented, and is often the first impression for all patients. (Phone and in person)	MIRROR: Try to be unfriendly while smiling-- it's almost impossible. •Samples of good and bad customer service among attendees. •Thorough understanding of implications for future service when customer service is good/bad. **Student Workbook: Page 4** **What does it mean to be a Customer**

Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion •Discuss the two types of customers •Ask students to list their internal and external customers	•Customers are people to whom we provide a service or product. •Internal - employees or departments within the organization who also have a job to do and who depend on you for your services or products. •External - **Immediate** (nursing serves patients/family members, physicians & their offices, payers, vendors, nursing homes. **Indirect** - Central Supplies provides supplies to Nursing. **Registration is almost always direct.** •Some departs serve both - Registration serves patient and Radiology	**External**: our ultimate customers are people not employed by our organizations, such as patients, family, friends, managed care, referring physicians, the community and others. They have a choice about where to take their business. Each of you provides them a service, either directly or indirectly. **Internal**: For example, if you are a supervisor, your staff are your customers; they depend on you. The reverse is true as well. Our supervisors are our customers because they depend on us to accomplish their goals. **Student Workbook: Page 4 Who are our Customers?**

Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion 	•Have class share experiences of good and bad customer service •What do you think our organization's customers say about us? •Why is it important to know who our customers are and what they want? Ex: wait times and registration confusion **•So that we better satisfy their needs** •How do people feel at your facility? How do you know?	List improvement suggestions from group. Examples to demonstrate: •eye contact •smiling •tone of voice •ignoring lost patients •assuming patient knows what to do next. **Student Workbook: Page 5** **The Best and Worst of Times**



Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion Video 	Go over what you expect the to look for in the video. The video is designed to get you thinking about the issues presented. The effectiveness of the program depends on your participation. So, speak up and share your experience with the rest of the group. YOU ARE THE EXPERTS! • Analyzing interactions staff members have with patients, visitors and coworkers •Identifying ways to improve service we provide to internal and external customers •How to put these ways into practice.	•Display positive and negative gestures and words, and give examples. •Introduce video, and instruct what to look for. **Student Workbook:** **Page 6** **Objectives – Session One** **SHOW VIDEO** •Spirit of Excellence - Introduction



Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion 	1. The two patients both had good feelings about the hospital because they were treated well. They appreciated the care and service they received. 2. What is primary reason for return patients? Preferred answer to this is reputation. We want community perception to be: Best staff •Newest equipment •Best overall care •Other: insurance, word of mouth; location	**Student Workbook:** **Exercise One:** **Page 7** **" Good Feelings"**

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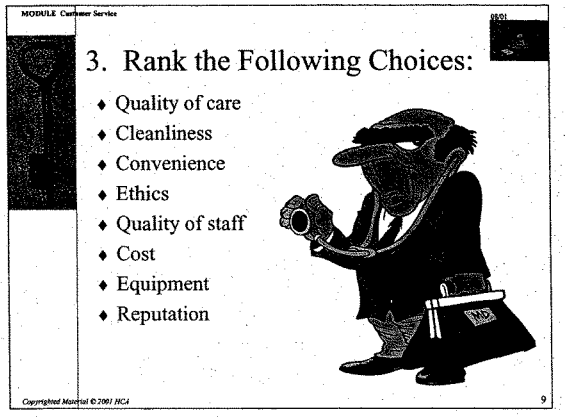
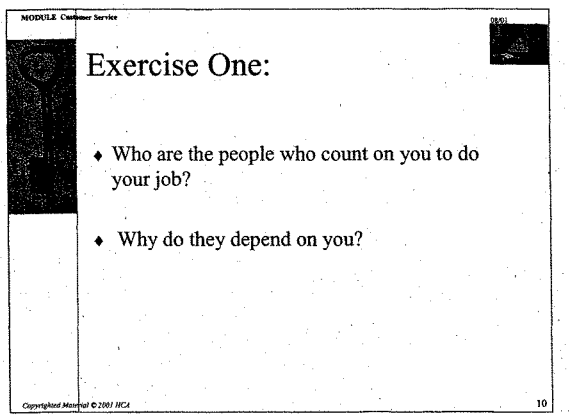
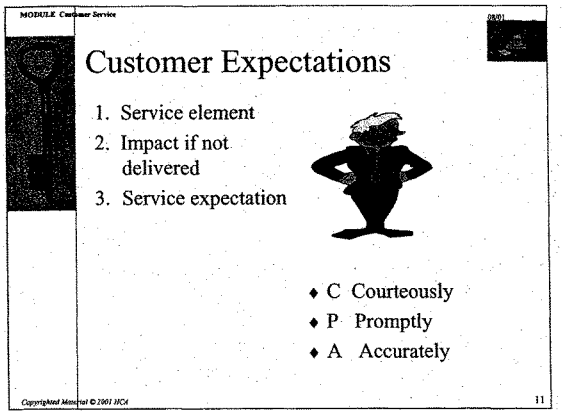


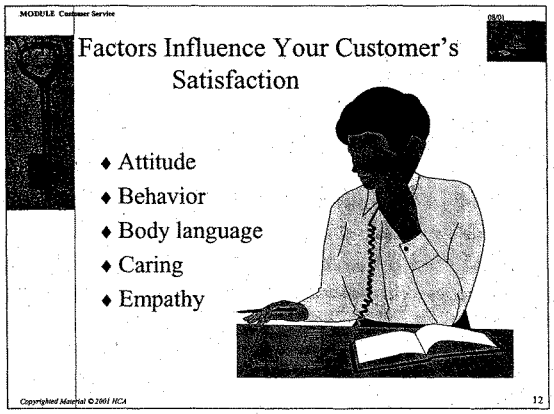
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	DISCUSSION Have the class choose which order the above rank in importance (One being the least important) Explain there are no right or wrong answers but each customer will have something that he/she feels made this a positive or negative experience.	Rank on flip chart Reputation: best staff; newest equipment, best overall care. Takes into account all of the above. Word of mouth. **Student Workbook:** **Exercise One** **Page 7** **Rank the Following Choices**



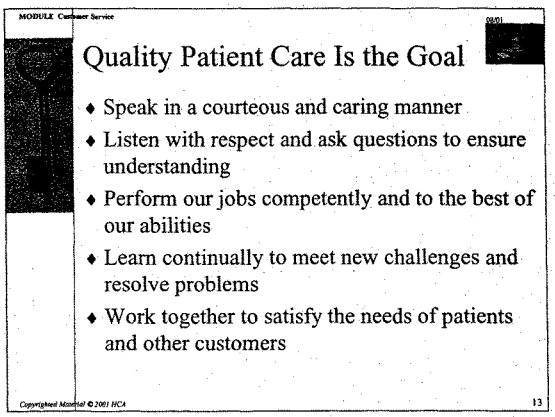
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion 	•1. List the people who count on your to do your job •2. Define the reasons they depend upon you. --Correct information --Directions --Calm answers to their questions List on flip chart • Patient •Physician •Insurance company •Patient's family •Ancillary depts.	**Student Workbook:** **Exercise One** **Page 8** **"Who counts on you"** Have the class list examples from their own jobs. Each hospital may be a little different



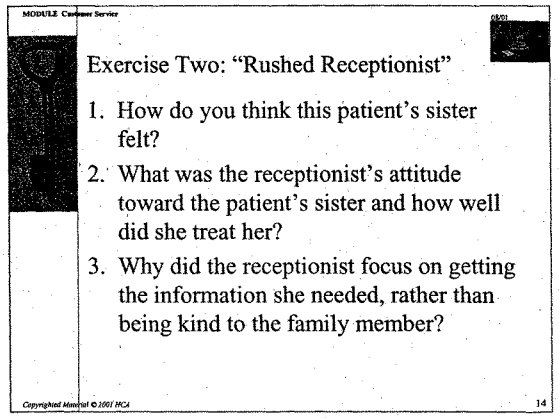
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	•Do your customers expect you to do your job in any particular way? •Courteously •Promptly •Accurate	**Student Workbook:** **Exercise One** **Page 8** **"Customer Expectations"** **All the courtesy in the world means nothing if you cannot deliver what your customer wants!** **Reverse is also true!**



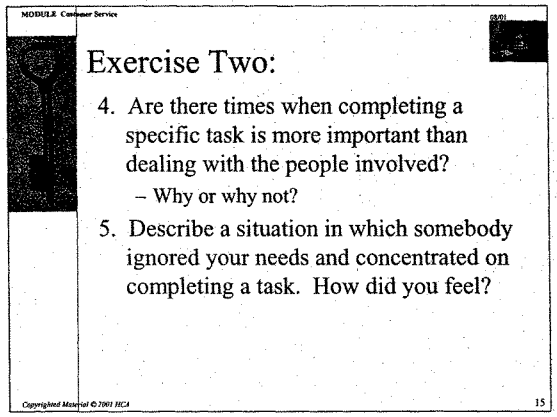
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion 	Have the class review the above and give examples of how these behaviors can influence the customer List several positive and negative examples. •What do you do that influences customer •Attitude •Behavior •Body Language •Caring/Concern •Empathy	• As one individual in the effort to care for and satisfy our patients, the way you perform your job has a profound impact on how patients, guests and families feel about our facility and can affect our organization's reputation in the community. • Providing quality service to your customers, whether they are patients or other medical staff, means that you are committed to total service. **Student Workbook:** **Page 9** **What factors influence...**



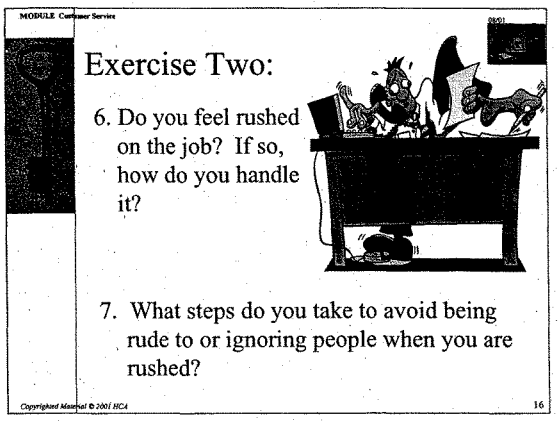
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion Video 	•The goal of all we do here is quality patient care and patient satisfaction. •What we expect as customers are what our customers-- patients, visitors, and co-workers-- expect from us •Patients and others expect that we care about them and their problems and that we will do all we can to help them through a difficult time. •How can we accomplish this goal? - Avoid initial problem; teamwork	**Student Workbook:** **Page 9** **Quality Patient Care is the Goal** **PLAY VIDEO** **Spirit of Excellence - Session One, Quality Patient Care is the Goal** Discuss how to acknowledge patient concerns without making promises you can't keep.



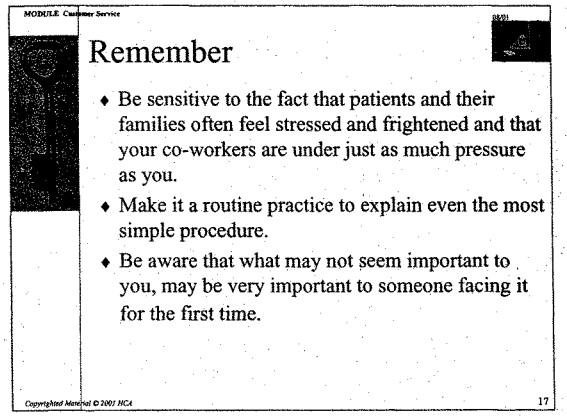
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	•1. She probably felt hurt and angry. More worried about brother's condition than filling out paperwork. •2. Receptionist did not provide comfort. She didn't seem to notice customer was upset. Focused only on required information. Perhaps she was very busy -- is than an acceptable excuse? She was insensitive and uncaring. No eye contact, no empathy. •3. Rushed and concerned about being accurate. Did she have guidance on how she should act? DISCUSS: Both concerns are valid, but there are ways to do things kindly. What was the patient's sister concerned about? What was the registrar concerned about?	Flipchart answers **Student Workbook:** **Page 10** **Exercise Two** **"Rushed Receptionist"**



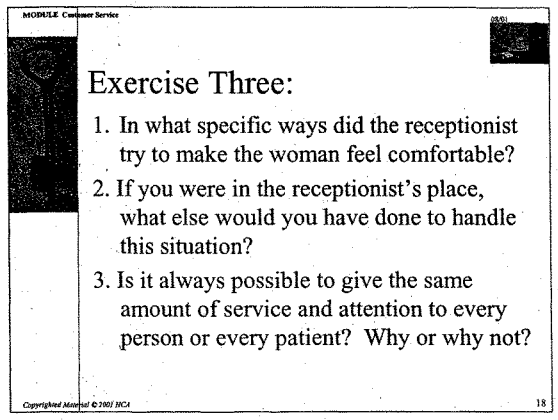
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	•4. Life or death situations are such times when getting the job done is more important - but that's about it. •5. Most say that they feel hurt and angry in such situations.	Flipchart answers This slide is not in the student book, so special discussion may be necessary. **Student Workbook:** **Page 11** **Exercise Two** **"Rushed Receptionist?"**



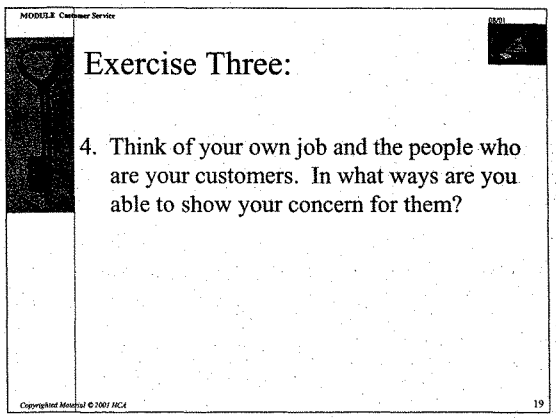
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	•6. To do lists, ask for help under pressure, inform supervisor •7. It takes conscious effort, more effective personal scheduling and time management, off the job interests.	•Flipchart answers •Scripted answers to fragile situations. •List unacceptable responses: --We are under-staffed today. --We can't get a hold of the dr. •Physiological aids: --Count --Deep breathing --Relax shoulders **Student Workbook:** **Page 11** **Exercise Two** **"Rushed Receptionist?"**



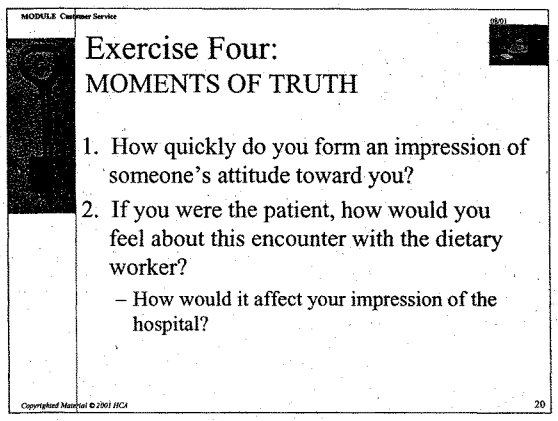
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion Video	•Commitment to our values can guide us toward improving the way we deal with situations such as these. •Acting with charity, compassion and respect involves using words and actions to make someone feel comfortable and in control. •Teamwork helps everyone who is stressed-share the load. •Don'ts: --give medical advice; share personal experiences or point fingers/blame others.	**Student Workbook: Page 12 "Remember"** Use the guidelines to help you act with commitment. **PLAY VIDEO** **Spirit of Excellence - Session One, Quality Patient Care is the Goal...The Right Way**



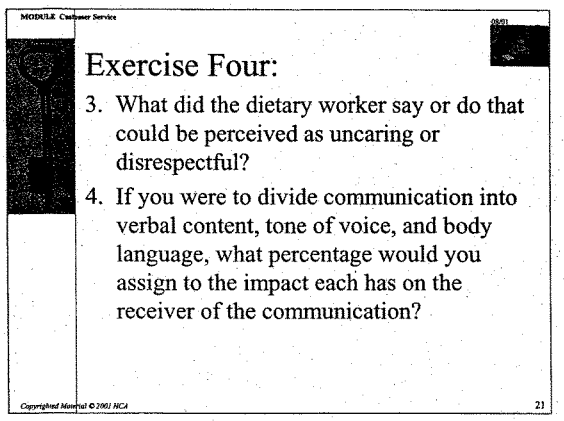
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	1. Introduced herself, made eye contact, showed sensitivity to problem and family member's concerns, shared knowledge about excellent staff and care and offered to go out of way to help. 2. There are many ways to properly handle. No right or wrong. (Group suggestions) • Not always possible -- emphasize that common courtesy does not make interactions longer. • All attempts to please are good • **Wait times more pleasant when patient kept informed.** • Understand that even long wait times seem shorter when staff is pleasant. Answer question: Does every patient WANT the same level of service?	**3.** Group will agree that it is not always possible. Encourage some healthy discussion. Some will feel strongly that it is always possible. There is no right or wrong answer. Also, emphasize that using common courtesy does not make interactions take longer. Flipchart answers **Student Workbook:** **Page 13** **Exercise Three**



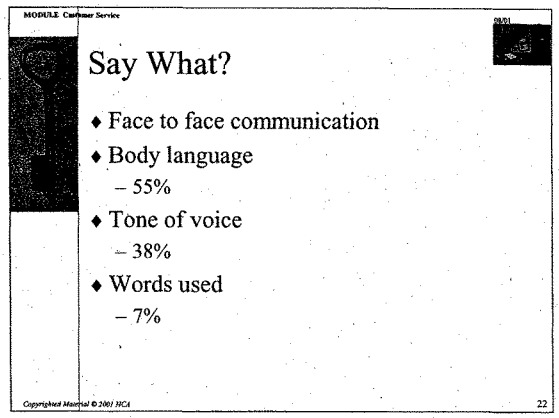
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion Video	•Treat people with respect and compassion Let them see your recognition of their presence: eye contact, head nod, etc. •Find out how they want to be treated and then treat them that way. •Imagine yourself in their places. Go out of your way to help, Is there anything else I can do for you, I have the time. Ask a few participants to share their ideas.	**Student Workbook:** **Page 13** **Exercise Three #4** **PLAY VIDEO** **Spirit of Excellence - Session One, Moments of Truth** Examples: How to phrase answers to patient questions so that they feel it is to their advantage? DISCUSS: Why is "by the rules" not always the best method?



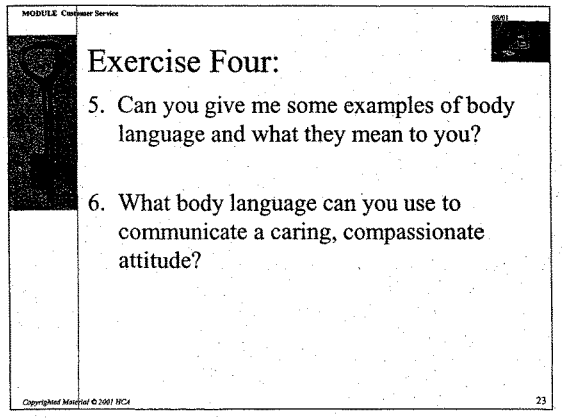
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	1. Lasting impressions are transmitted within the first five seconds of a meeting -- from tone of voice, words used, facial expression, posture. This is often called the "moment of truth". Whether that impression is good or bad, word of mouth will carry it to others. 2. Typically they'd be angry, demeaned and otherwise displeased. Think about experiences you have had as a patient or even as a customer in a store or restaurant. You probably agree that the most significant contributor to your overall impression of the facility are the interactions you had with its employees.	YOU ARE THE ORGANIZATION. Each customer who comes into contact with any aspect of an organization has an opportunity to form an impression. That contact is a MOMENT OF TRUTH. **Student Workbook: Page 14 "Moments of Truth" # 1 & 2**



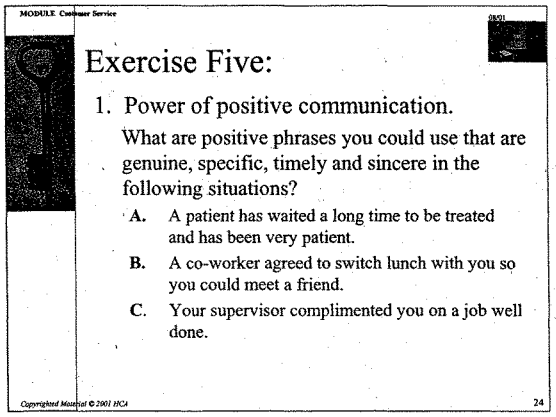
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	•3. Words not disrespectful, but what about body language. Rolled eyes, crossed arms, tone of voice indicated lack of interest or patience. **•4. Go to next slide for answer.**	**Student Workbook: Page 14 "Moments of Truth" # 3 & 4** ,,



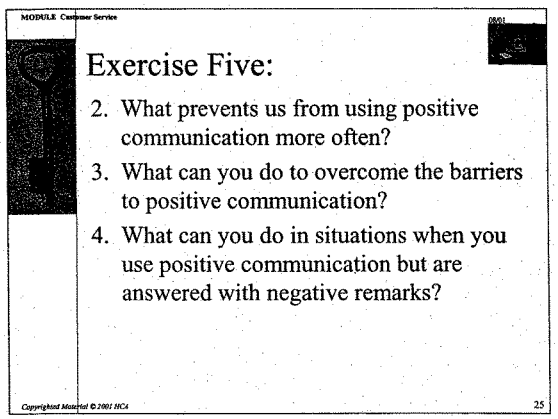
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	When communicating face to face: Body language: 55% Tone of voice: 38% Words used: 7% Someone's actions may indeed speak louder than words.	• Ask group to extend their right arms parallel to the floor. • State "Now make a circle with thumb and forefinger? Demo • "Now, bring your hand to your chin: (Note: As you say this, bring your hand to your cheek, not your chin. • Pause (Most of the group will have done what you did. • Wait 5-10 seconds - a few will realize their error and move hands to chins **Student Workbook:** **Page 15** **"Say What?"**



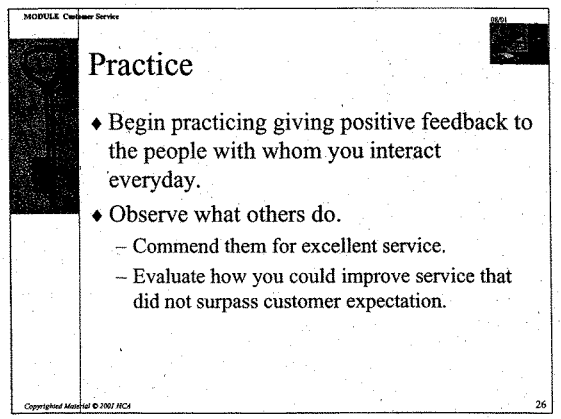
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion Video	5. Crossed arms, denoting suspicion or a closed mind; hand on chin, indicating thoughtful agreement; looking at watch, showing impatient or lack of concentration. 6. Smile, eye contact. **See things from the perspectives of others, not just patients and visitors, but from your co-workers.** This way you can be aware of how you are perceived by them and you can positively impact their impression of our facility. Remember, in the patient's eyes, you are the organization	Be careful to look for clusters of behavior rather than just one action. For example, you may make the assumption that someone is being defensive when they have their arms crossed while talking with you but this may also mean that the person is just cold (temperature) **Student Workbook: Page 15 # 5 and 6** **PLAY VIDEO**



Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture	1-a "We have been so busy this morning. Thanks for being so patient" 1 -b "I really appreciate your switching lunch hours with me today. I haven't been able to get together with my friend for a long time.	Direct the participants to form groups of three or four, and allow the groups a few minutes to complete the exercise.
Group Discussion	1-c "I really appreciate getting this material so much ahead of time. It's hard to do everything at the last minute." Positive feedback is a big part of positive communication. Stress from video: communication should be genuine, specific, timely & sincere.	Demonstrate breaking the negative chain of communication and stress that EVERYONE has the power to do this! **Student Workbook: Page 16 Exercise Five "Positive Power" #1**

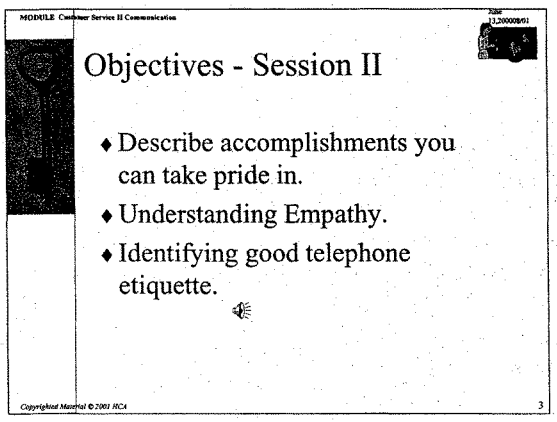


Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion Video	Emphasize this is time consuming! 2. Others use negative communication or do not reciprocate positive feedback -- negativity breed negativity. Stress and busy schedules Lack of self-worth and job satisfaction Failure to realize that patients and others want recognition from all of us, no matter what role we play. 3. Encourage discussion. 4. Don't just take it. Confront the person in a positive way -- like the aide did in the video. To break the barriers of negative communication: Use training, and role models/mentors.	All of us need positive communication from others. If you have worked hard at something, whether it is a job-related task, a dinner for family or friends, or something to help another, you deserve recognition for it. If you get no recognition, no feedback, you will quickly lose your motivation. We all want to be motivated and encouraged but we often forget that others look for us for their motivation. **Student Workbook: Page 16 Exercise Five "Positive Power" #2 - 4** **PLAY VIDEO**

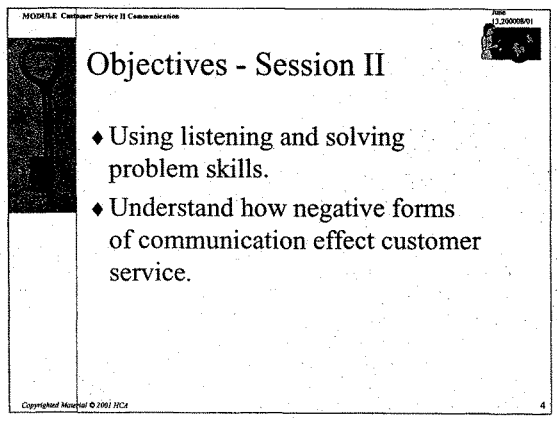


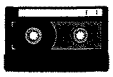
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture Group Discussion	Practice positive feedback with team members until it becomes a habit, or it will crumble under stress. Catch people doing "things RIGHT", and give positive feedback. Self-observation: How can I improve my customer service.	Construction paper merit badges for group great group demonstrations. (Key words: positive attitude, helpful, kind, politically correct, etc.) Understanding that in today's competitive climate, it is not enough to have satisfied customers - They need to be **Raving Fans**, per Kenneth Blanchard of One Minute Manager fame. **Student Workbook: Page 17 "Practice Giving Positive Feedback"**

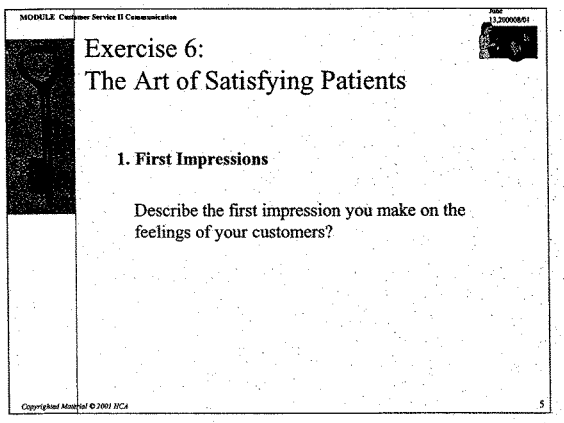
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions 	Today, we will be focusing on speaking and listening skills. At the end of session, I asked you to practice using positive communication. Well, how did it go? Please share some of your experiences. Discuss the participants' success stories and ask the group to comment on them.	
Group Discussion 	I also asked you to watch for examples of service excellence. Did any of you observe interactions in which excellent service was given to an internal or external customer? Ask the observer of the behavior to describe the interaction. Ask the questions below: • What did the staff person do during the interaction? • How will the interaction affect the customer and facility? • How would you improve the interaction, if it could be done over? • Ask other participants to comment on how they would have handles the situation	



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Video	Go over each objective in detail: • Identify accomplishments you can take pride in. Be able to receive praise and give self praise. • Speaking in a way that shows concern for others (empathy) • Communicate courteously and effectively over the telephone	**Student Workbook: Page 2 "Objectives"**



Instructional Strategy/Hook	Content	Props/Gestures
Lecture Video 	Use questioning and listening techniques to solve problems and enhance understanding of the perspectives of others Avoid negative forms of communication in interactions with patients, visitors and co-workers : --lack of communication --crooked communication --plastic communication --planned communication in greeting	Video Session II, Part I



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	•Exercise 6 asks you to evaluate the quality of your own communications. •Sometimes we do not realize the importance of the role each of us plays at our own organization. •We think because we do not directly effect their patient care that our customers do not notice us. The positive interaction with all of us plays a part in their total experience. •A combination of positive words, tone of voice and body language adds up to positive communication and quality service. •Positive communication like this creates warm atmosphere that promotes healing. Our customers appreciate warmth, courtesy, friendliness and thoughtfulness. 1. Quality of work and body language.The way you walk down the hall, ride the elevator and hold the door has a direct impact on them. 2. Encourage discussion 3. Smile, state your name, eye contact	**Student Workbook:** **Page 3** **Exercise 6** **"The Art of Satisfying the Patient" #1**

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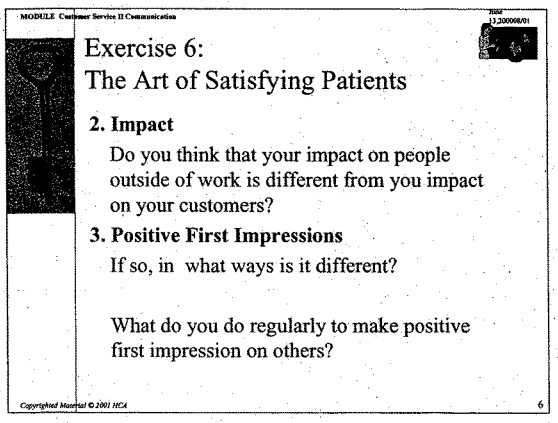
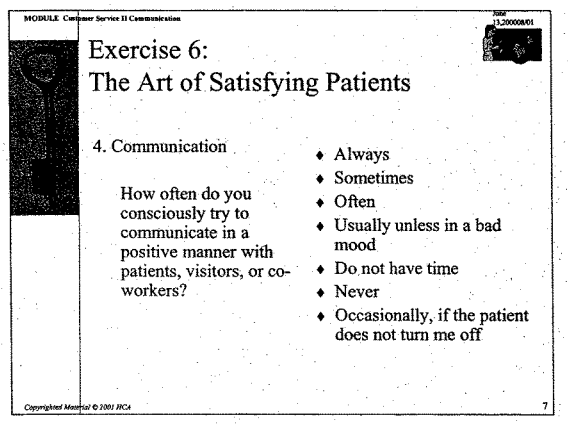
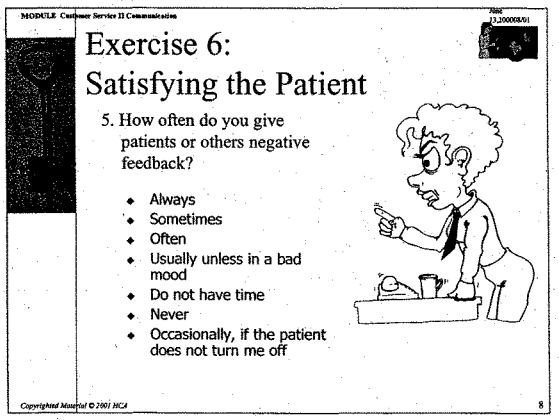


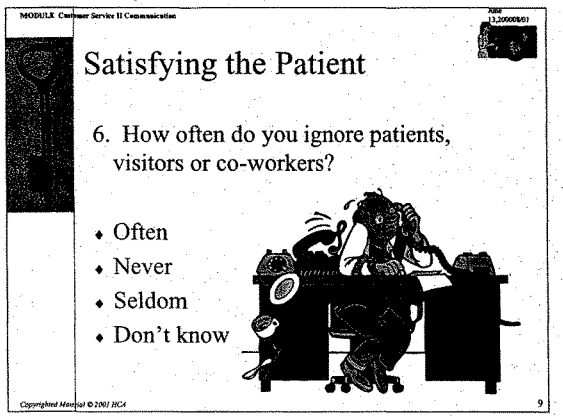
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Exercise 6 asks you to evaluate the quality of your own communications. Sometimes we do not realize the importance of the role each of us plays at our own organization. We think because we do not directly effect their patient care that our customers do not notice us. The positive interaction with all of us plays a part in their total experience. A combination of positive words, tone of voice and body language adds up to positive communication and quality service.Positive communication like this creates warm atmosphere that promotes healing. Our customers appreciate warmth, courtesy, friendliness and thoughtfulness. 1. Quality of work and body language The way you walk down the hall, ride the elevator and hold the door has a direct impact on them. 2. Encourage discussion 3. Smile, state your name, eye contact	**Student Workbook:** **Page 3** **Exercise 6** **"The Art of Satisfying the Patient" # 2 & 3**



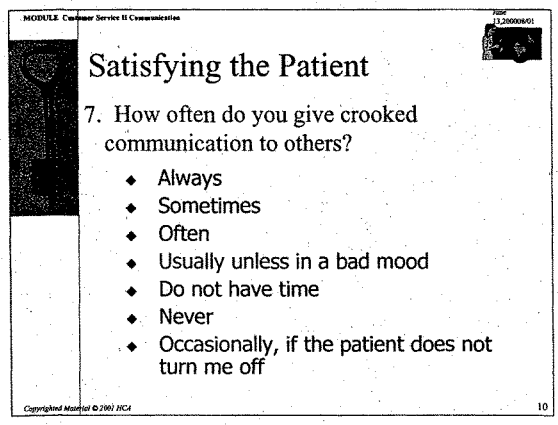
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples	Most people will say sometimes or usually - always and often are the only acceptable answers. Encourage openness.	**Student Workbook:** **Page 3** **Exercise 6** **"The Art of Satisfying the Patient" #4**
Group Discussion	Explain these questions are for self-evaluation and to begin to think about these issues. Sometime we do not realize what we say and how we say it. "I'm not feeling well" is not acceptable as reason for poor customer service	



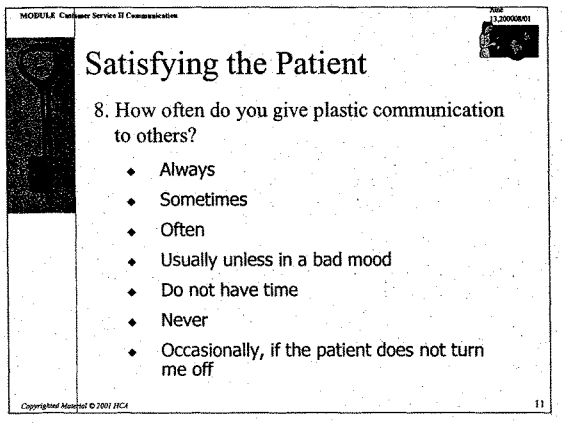
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	•Everyone is guilty of this at times. •Need for constant awareness •Think about ways to change the perception we give the customers. Give examples you have seen: Example: Patient is trying to tell you something, and we say "have a seat and we will be right with you". Others:	**Student Workbook:** **Page 4** **Exercise 6** **"The Art of Satisfying the Patient" #5**



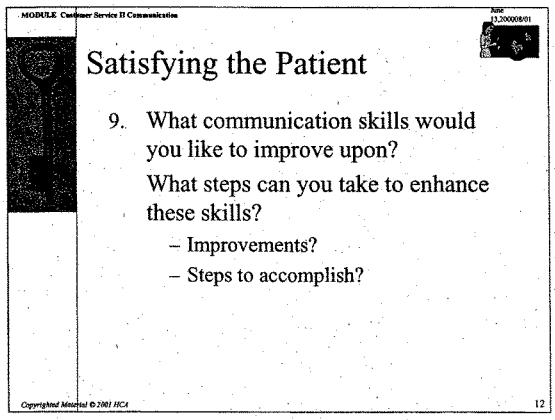
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	How often do you ignore patients, visitors or co-workers? (even un-intentionally). Common reasons: Discuss Ways to improve: Discuss	**Student Workbook:** **Page 4** **Exercise 6** **"The Art of Satisfying the Patient" #6**



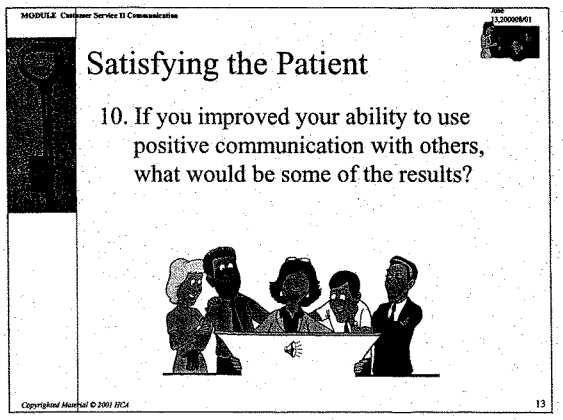
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples	Encourage openness Crooked communication is a positive comment that is followed by a negative one. For example: "Thank you so much for going grocery shopping for me. You got the wrong kind of cereal?" It could only involve a negative tone of voice: "Nice hair!" What examples can you share?	**Student Workbook:** **Page 4** **Exercise 6** **"The Art of Satisfying the Patient" #7**
Group Discussion		



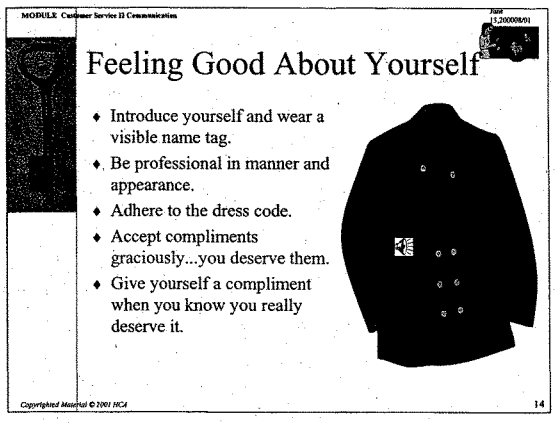
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion 	Encourage open discussion. Plastic Communication: A subtle form of negative communication which is very common. It is insincere and routine. Comments are made mechanically, as a matter of routine. An example would be "Have a Nice Day", or another over-used phrase. For example, asking a co-worker "How are you today," but not waiting for or wanting a response.	**Student Workbook:** **Page 4** **Exercise 6** **"The Art of Satisfying the Patient" #8**



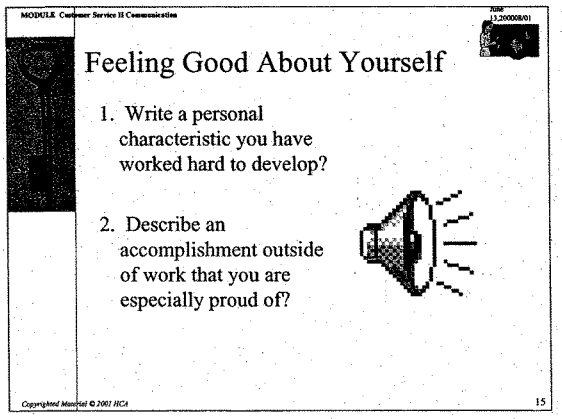
Instructional Strategy/Hook	Content	Props/Gestures
Group Discussion	Ask several participants to share their goals with the group. •Set personal goals •Practice on tape recorder •Pay attention to small details when talking with people, and anticipate their needs. •Eye contact •LISTEN •Repeat back what you think they said so they feel heard •Verifying that person heard what you told them.	**Student Workbook:** **Page 5** **Exercise 6** **"The Art of Satisfying the Patient" #9**



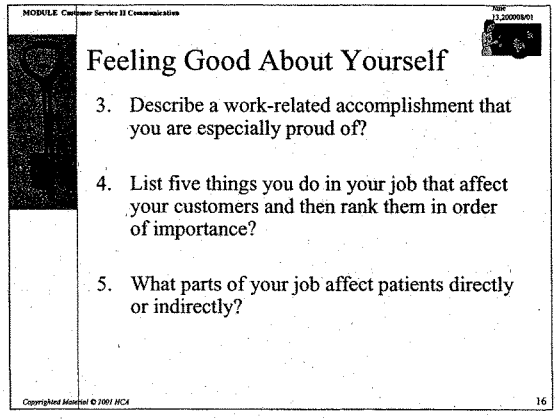
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Video	Answers may include: it feels good, your job becomes more enjoyable, & others would be more likely to use positive communication, which would create a more positive work environment. It is contagious….. It seems that most of us want to give more positive feedback to others. Let us start by learning a little more about how to do just that.	**Student Workbook:** **Page 5** **Exercise 6** **"The Art of Satisfying the Patient" #10** **Video**

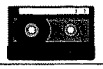


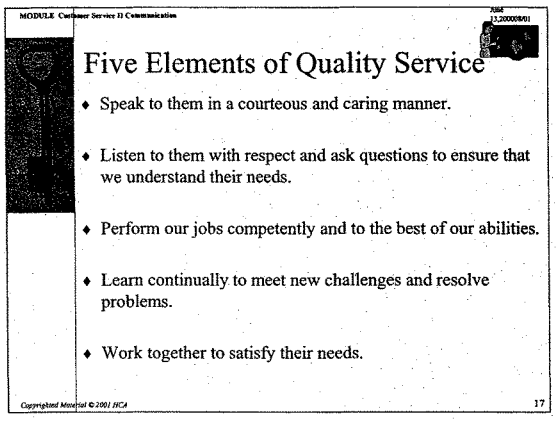
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Feeling good about yourself is important to being able to communicate in a positive, caring manner. How can we promote feeling good about ourselves? You should be proud of who you are and what you do. Show your pride in yourself. Go over the five items above plus: •Dress like you want to work •Watch gum chewing •No evening wear or sexy clothes You should be proud of your co-workers, as well. Show your support by giving them positive feedback.	**Student Workbook: Page 6 "Feeling Good About Yourself"** Magazine photos of acceptable and unacceptable clothing, hairstyles, etc.



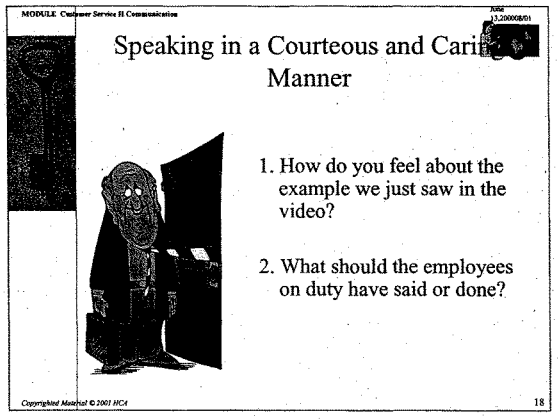
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	These questions are for self-evaluation. Encourage discussion. The way you deal with others is strongly affected by the way you feel about yourself. Feeling good about yourself is essential to mastering positive communication and providing excellent service. Feeling good about yourself is also highly contagious to the people you interact with throughout the day; it can stop that chain reaction of negative communication. Be proud of who you are and your contributions.	**Student Workbook: Page 6 "Feeling Good About Yourself" # 1 & 2**



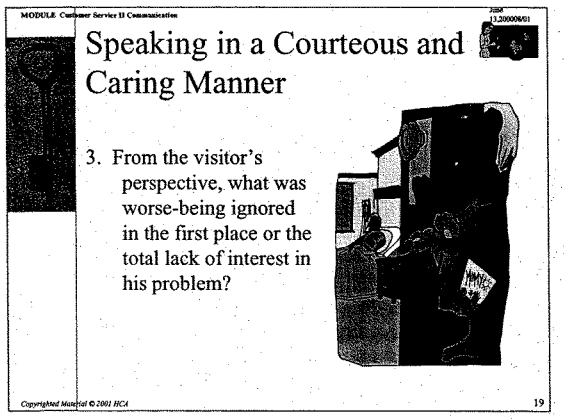
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples	Encourage open discussion • Accomplishments to be proud of may include Patient Day Rec, tracking Kronos, opening the registration area and serving early patients quickly.	**Student Workbook: Page 6 & 7 "Feeling Good About Yourself" # 3 -5**
Group Discussion	• Think of 5 things that affect your job and prioritize them, i.e., items like being organized, completing proper forms, high level of accuracy	**Video**
Video 	• Effects on patients include the daily registration and patient directing, or indirectly, choosing the right I-Plan.	



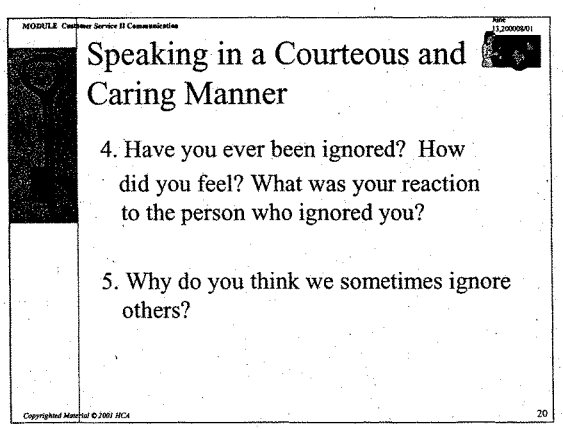
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion 	REMEMBER the Five Elements we learned in Module One. Go back over.... Review 5 elements on the slide. Reminder that customers include internal and external. Excellence means doing more than is expected. Consider empowerment issues so that employees can do their jobs more efficiently. Examples from the group--	**Student Workbook:** **Page 8** **"Five Elements of Quality Service"** **PLAY VIDEO**



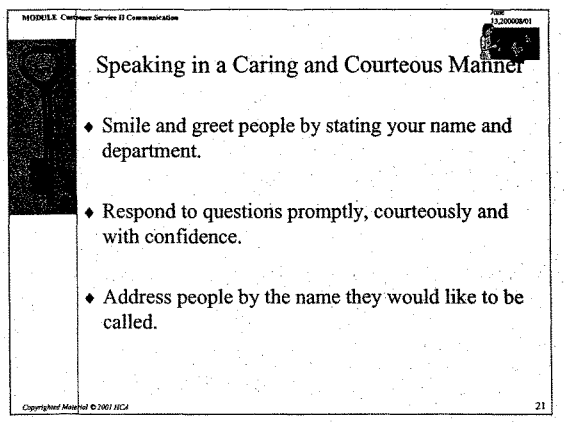
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Video	Allow discussion. 2. They should have immediately stopped their discussion and asked if they could help. Apologize, recognize, listen… 3. Lack of interest was far worse. The employees did not offer an apology for ignoring him; in fact, they were irritated that he interrupted them.	**Student Workbook: Page 9 Speaking in a Caring and Courteous Manner" # 1 & 2**



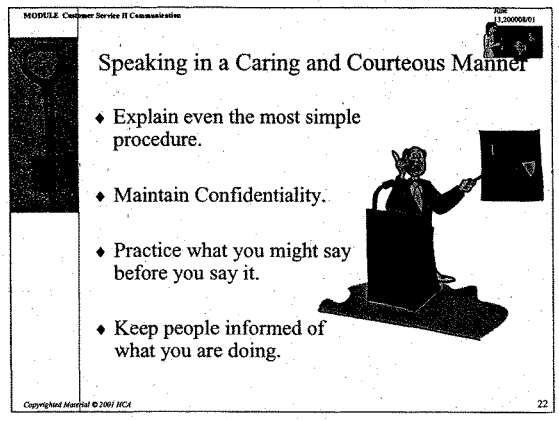
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Allow discussion. 2. They should have immediately stopped their discussion and asked if they could help. Apologize, recognize, listen… 3. Lack of interest was far worse The employees did not offer an apology for ignoring him; in fact, they were irritated that he interrupted them.	**Student Workbook: Page 9 Speaking in a Caring and Courteous Manner" # 3**



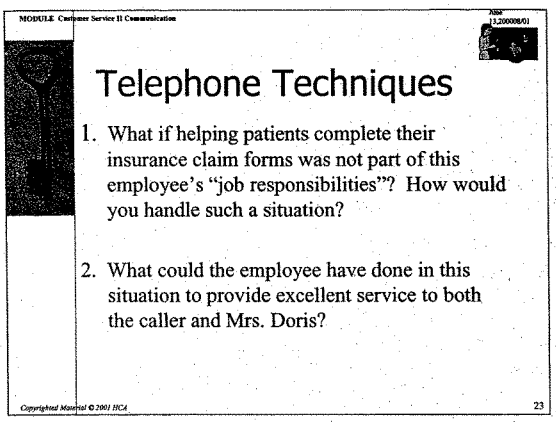
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	4. The typical reaction is hostility; it is always negative. 5. We ignore people when we get very busy and place a higher priority on completing tasks than on dealing with people. It is important to recognize our own value, but it is more important not to let ourselves get wrapped up in our own problems. Caring about someone comes naturally. When you are busy, what is hard is making sure others know that you care. What other reasons do we use for ignoring others? What can we do to remind ourselves and others when it occurs?	**Student Workbook: Page 9 Speaking in a Caring and Courteous Manner" # 4 & 5**



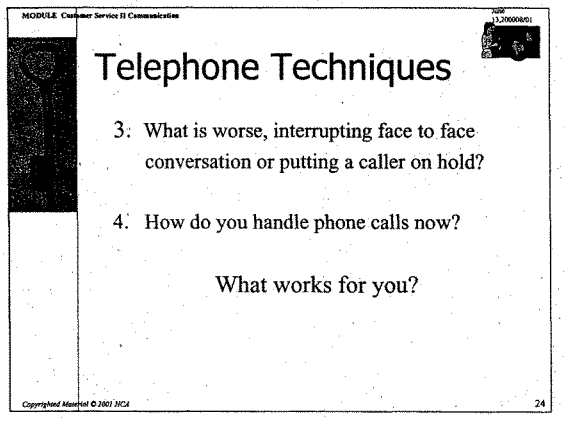
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	**Have participants read the following points on this slide and the following slide** An important element of positive communication is speaking in a courteous and caring manner. Both verbal and non verbal communication is important. It is not only words you use that convey your level of concern toward others, it is also tone of voice and body language.	Give examples of body language and what it says to the other person. (Hands on hips? Crossed arms? Etc.?) **Student Workbook: Page 10 "Speaking in a Caring and Courteous Manner"**



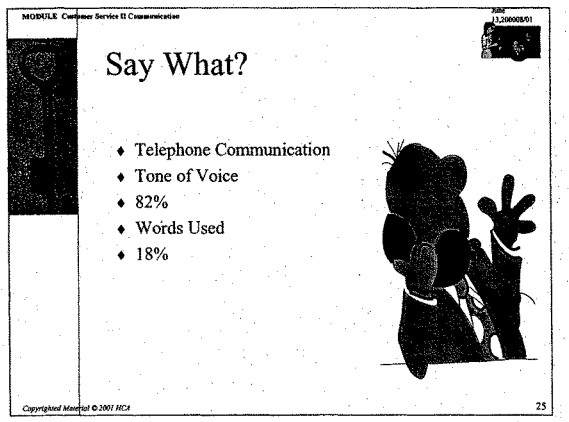
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Video	Speaking courteously is important not only when you deal with people face to face but also when talking on the telephone. Often, we must deal with both situations at the same time--you know when a phone call interrupts a meeting, for example. Stress confidentiality and ramifications. How can you handle situations like these and still treat both parties courteously? **LETS GO TO THE VIDEO**	**Student Workbook: Page 10 "Speaking in a Caring and Courteous Manner** **Video**



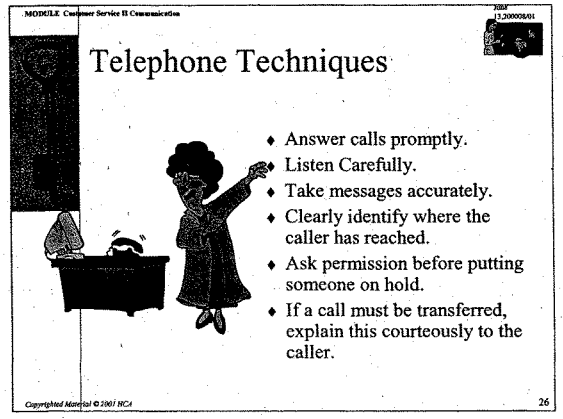
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	1. If you truly can not help, refer her to someone who can help. Make the point that it is important to know the scope of your responsibilities, as well as priorities. Your supervisor can help you with this. 2. Possible Answers: •Answer the phone, but say to the caller, " I am sorry. Can you hold a moment"? or "I am helping someone else right now, can I call you back as soon as I am done?" Maybe a co-worker can take the phone call. •Say to Mrs. Doris, "I am sorry. Please excuse me while I answer this call." •It is important to be able to read your customers, their mood and body language.	**Student Workbook: Page 11** **"Telephone Technique Questions" # 1 & 2**



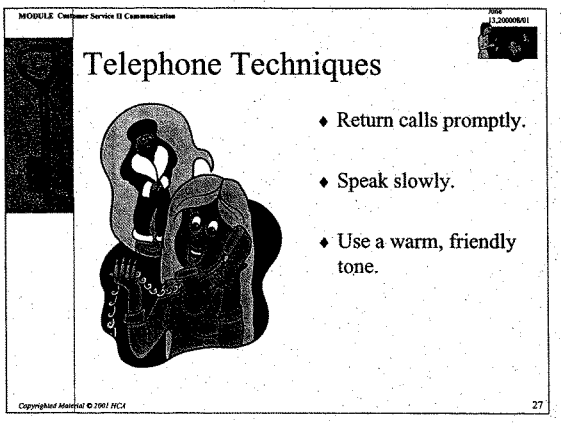
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	3. Encourage discussion regarding situations where you must make one of them wait. You must determine which is the priority and courteously explain to the other the reason for the wait or interruption. 4. Allow discussion Discuss phone policy of facility	**Student Workbook: Page 11** **"Telephone Technique Questions" # 3 & 4**



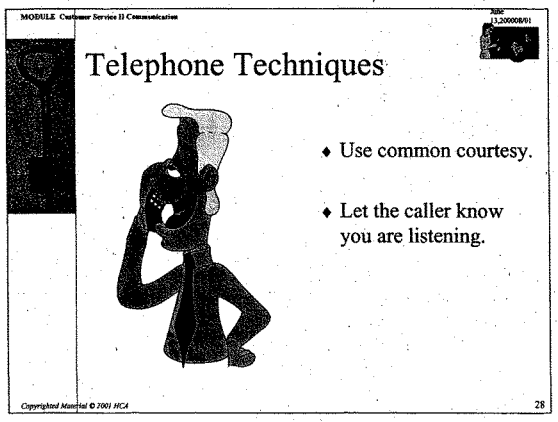
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture / Examples Group Discussion	It's important to remember that when you are on the phone, **82% of how you say something** delivers the message, and only 18% are the actual words. Give examples: Say "Can you hold, please?" in a positive and then negative manner. Others? Use the mirror trick. Watch yourself as you speak on the phone, and you will be more positive and upbeat.	**Student Workbook:** **Page 12** **"Say What"**



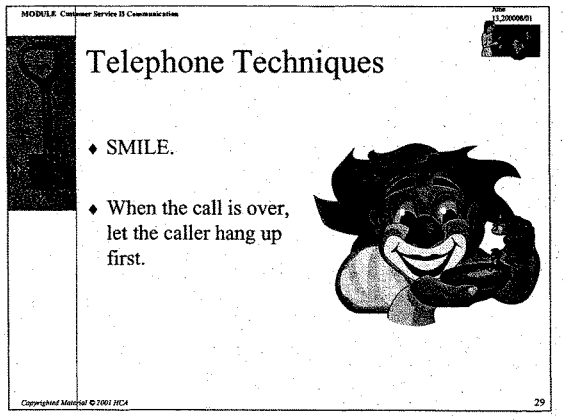
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Go over each technique: •Answer calls promptly- Experts advise that all calls should be answered by the second or third ring. Ask permission before putting someone on hold. Clearly identify: State the organization, department or unit, and add your name. Listen carefully: Listening is absolutely vital. There is no other way to effectively communicate. Take messages accurately: Repeat the message back to the caller. Find out when the call can be returned to reduce phone tag. Ask a little about the nature of the call. Transferring: Give the caller the name and the extension of the party to whom the call is being transferred, just in case the parties get disconnected. When you transfer a call, make sure someone at the other end picks up before you complete the transfer. Go one step further. Explain to the party to whom you are transferring the call, the name of the person calling and why. Therefore, the caller does not have to re-tell their situation.	**Student Workbook:** **Page 13** **Telephone Techniques**



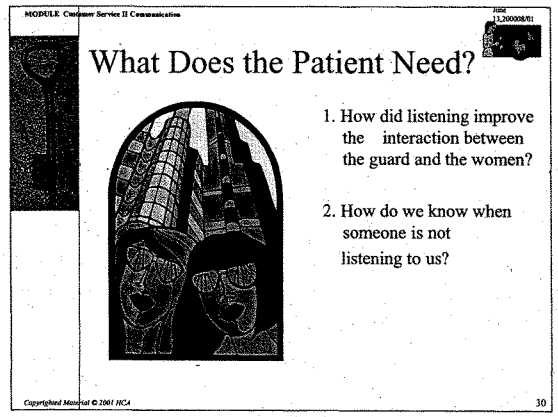
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	•Return calls promptly. •Speak slowly. Be aware of accents and compensate. Make sure you are not speaking to loudly or to softly. •Use a warm tone: Even if you have repeated the same information many times. This is the first time your caller has heard it. Let your tone of voice tell others that you sincerely want to help; it serves as your handshake over the phone.	**Student Workbook:** **Page 13** **Telephone Techniques**



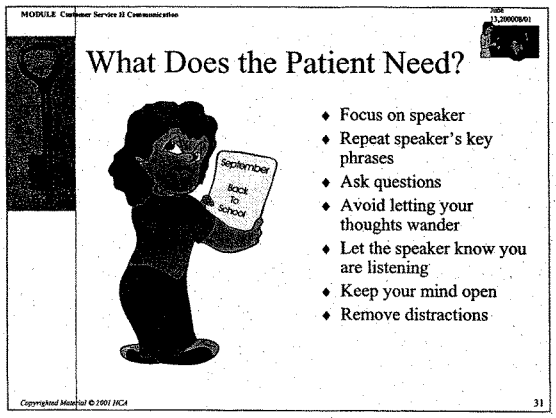
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Remember common courtesy: For example, say "Thank you for calling," or "We appreciate your call, Mrs. Jones." Listening: Use spoken acknowledgments, such as "Yes, I understand" or "Let me repeat that."	**Student Workbook:** **Page 13** **Telephone Techniques**



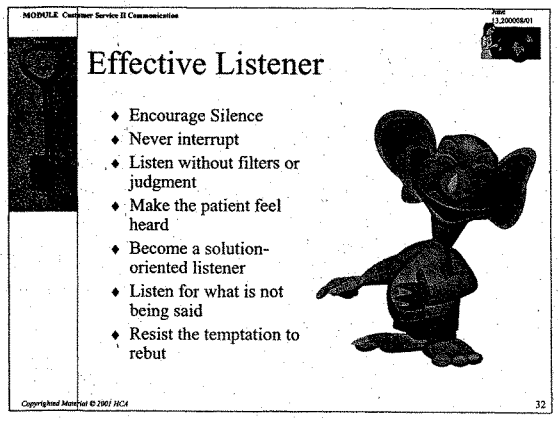
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	SMILE: Even though it can not be seen over the phone, it changes the sound of your voice and the way you speak. Let caller hang up first.	**Student Workbook:** **Page 13** **Telephone Techniques**



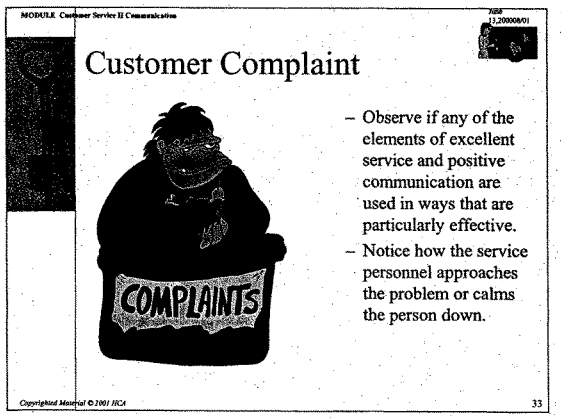
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Role Play	Most people pride themselves on being good listeners. On the other hand, we have heard that we do not really listen well. Be aware of the importance of listening. Think about the positive example for a minute. How did listening improve the interaction between the guard and the woman? 1. By listening and asking questions, the guard was able to assist the woman and show that he was interested in solving her problem. 2. They do not look at us. Their eyes wander. They do something else as they listen to us. They ask questions that imply that they did not hear what we said.	EXERCISE: Testing our Listening Skills: Get in groups of two, one person will play the "designer" and the other person will be the "artist". See handout for Rules: Allow participants five minutes to complete the exercise. In the second try, the artist may now ask questions. Discuss outcome. **Student Workbook: Page 17 "What Does the Patient Need?"**



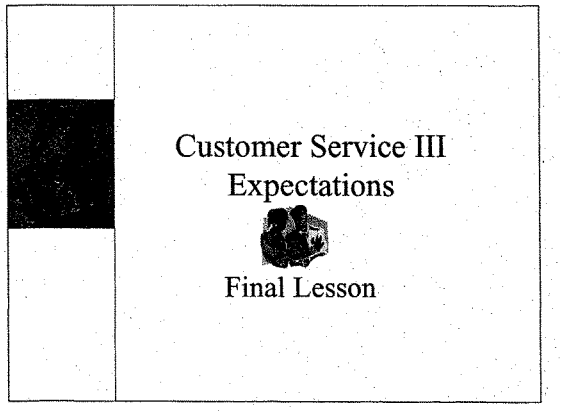
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	• Asking questions during the drawing game is the same as identifying the needs of customers. Most interactions with others may be ineffective if we do not take the time to really listen and ask questions to make sure we understand. • Permit the speaker to share feelings, expand ideas and clarify what you do not understand. • Briefly review the tips for active listening above: signals of listening such as verbal agreement, nodding, or smiling. Avoid reacting until you are certain you understand • Focus on speaker. If possible, make eye contact with the other person. • Repeat: This ensures that you understand what the speaker has said.	**Student Workbook: Page 17 "What Does the Patient Need?"**



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion Video	•Encourage silence •Never interrupt - allow people to finish their sentences. •Listen without judging •Make the patient or other customer feel heard. "Be There". •Be a solution-oriented listener •Listen for what is implied •Don't argue! Discuss examples.	**Student Workbook: Page 18 "Effective Listener"** **Video**



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Examples Group Discussion	Think of this complaint as the first you have heard. Have fresh, helpful ears. Apologize for their experience. Follow through on whatever you say you will / can do. Keep your promises Complete the module by answering questions, and continuing discussion as time allows. Wrap-up	**Student Workbook:** **Page 22** **"Customer Complaint"**



Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture / Introduction Questions 	Have you seen any changes in your environment or in the attitudes of your patients, visitors, or co-workers since the first two sessions? I also asked you to watch for a positive example of how a staff person handled a difficult situation. Did any of you observe interactions that you would like to share with the group? Ask the observer of the behavior to describe the interaction. Ask 1. What the staff person did during the interaction? 2. How will the interaction affect the customer and our organization? 3. How would you improve the interaction, if it could be done over? Ask the other participants to comment on how they would have handled the situation.	

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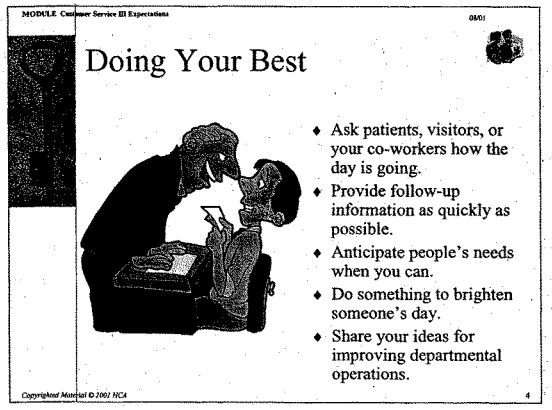
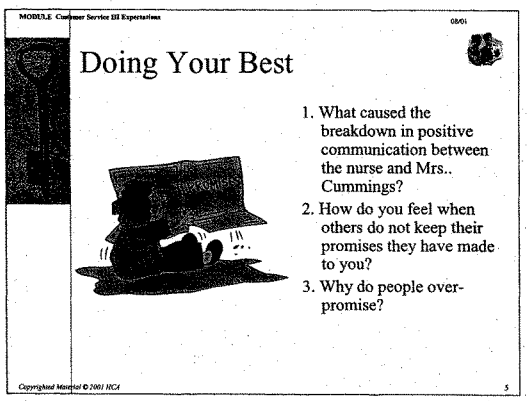
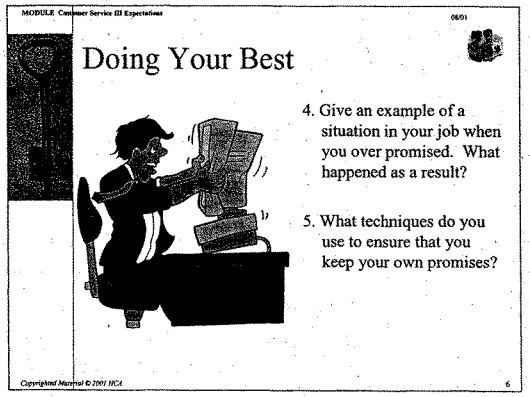
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture / Questions	Go over the three different objectives. 1. Performance expectations 2. How to be a problem-solver 3. How does team work figure into good customer service?	**Student Workbook: Page 2 "Objectives"**
Group Discussion	We will be concentrating on the last three elements of positive communication and quality service: **--performance** **--learning** **--working together.**	**Video**
Video	We will also look at some ways of dealing positively with problem situations.	



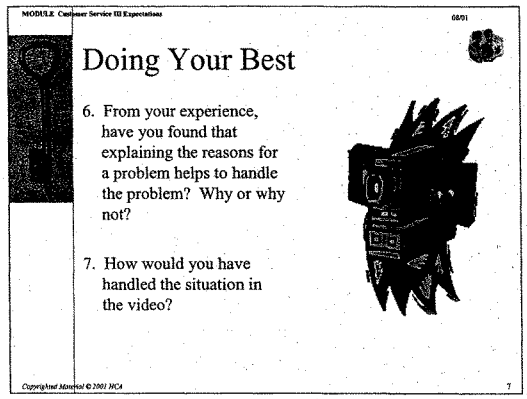
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	•Poor quality and poor service are the result of people failing to put a high value on their work. •People who have not had the experience of doing something well and taking pride in an achievement do not understand the difference between doing a good job, and doing work that just passes. •Think of the people you know who really give their all to their jobs. The most successful people perform to the best of their abilities. They **set high standards and meet them.** Take advantage of situations that lend themselves to doing your best.	**Student Workbook:** **Page 3** **"Doing Your Best"**



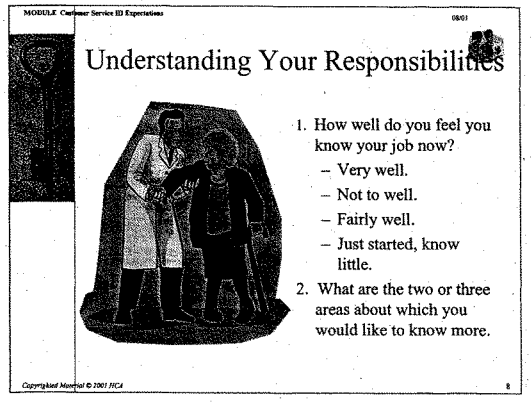
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Group Discussion	1. The key error was that the nurse made an affirmative promise by saying, We'll take care of you." She meant to be soothing, but from Mrs.. Cummings' perspective, she made a promise. The situation was a particular problem because the nurse, by herself, could not fulfill the promise. **So, what can we learn?** Do not promise what you may not be able to deliver and be aware that casual remarks can be viewed as promises, particularly when the person hearing the words is in pain or under stress. 2. Invariably, the reaction is negative. 3. The promise-maker is not aware of the commitment needed to keep the promise, or they intended to help others, but for some reason couldn't follow through. The intent was positive, but not the action.	**Student Workbook:** **Page 4** **"Questions on Doing Your Best"** **# 1 - 3**



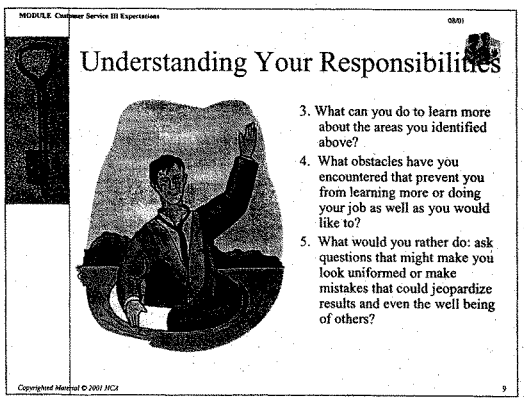
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Lecture	4. Ask for a few examples of times when you may have over-promised, and explain what happened as a result. Why is it important to be truthful about what and when you can deliver things? How important are apologies?	**Student Workbook:** **Page 4** **"Questions on Doing Your Best"** **# 4 - 5**
Group Discussion	5. Ask for a few examples of ways you ensure that you will keep your promises.	
	What are some tools / gifts that would be helpful if we can't keep our promt service promises in the patient access area? --phone card gifts --cafeteria gift certificates --other??	



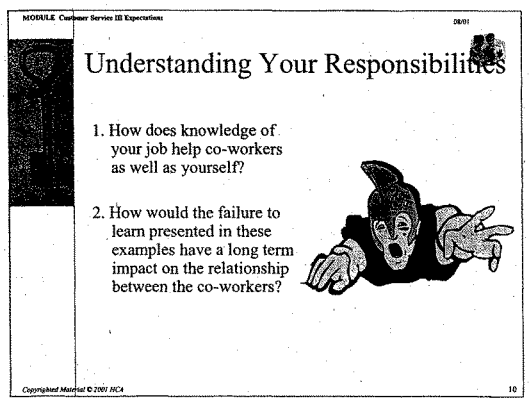
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions	6. Invariably, yes. People may not like the message, but they appreciate an explanation why something can not be done or why something must be done. Some explanations are NOT acceptable such as "we are short-staffed".	**Student Workbook:** **Page 5** **"Questions on Doing Your Best"** **# 6 - 7**
Role Play	7. You can either discuss the options for dealing with the situation or, pair up the participant and instruct them to role play!!	
Video	Delivering on our promises is how our customers evaluate our performance.	**Video**
	Unless we know our jobs well and continue to learn and improve our skills, we will be unable to perform at our best. ROLE PLAY the video situation.	



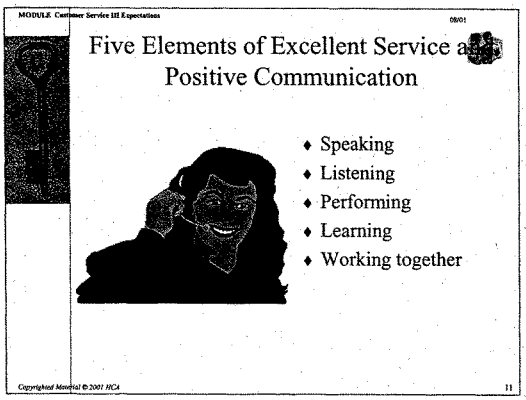
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion 	To do our best on or off the job, it is important to know what is expected of us and how to meet those expectations. **•Do you all understand the expectations of your supervisor?** **•What are the department goals?** **•How can you go about obtaining more information on areas you feel weakest?** •Failure to learn your job means someone else must work harder. How does this affect teamwork? Allow discussion. 1. The dramatization we just saw illustrates the problems that can arise from lack of knowledge. 2. What would you like to learn more about in your department? Hospital?	**Student Workbook:** **Page 6** **"Understanding Your Responsibilities"** **# 1 - 2**



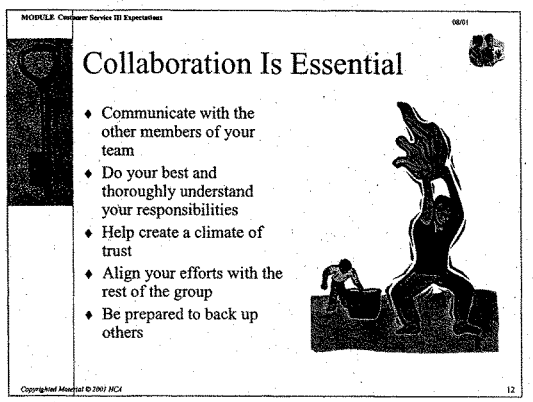
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	3. Discuss: Meetings? Classes? OJT? 4. Usually, two main barriers to learning: lack of time and fear of appearing stupid. •The problem of lack of time can be solved by realizing that learning does not have to occur in a structured, classroom environment. It can simply be asking questions, taking notes when a procedure is explained to you, and having the interest to learn. •Fear of feeling dumb is quite common. The only way to overcome this barrier is to understand that curiosity is not dumb. There are no dumb questions. 5. We know you feel overwhelmed! It is more important to ASK than to make unnecessary mistakes!!	**Student Workbook:** **Page 6** **"Understanding Your Responsibilities"** **# 3 - 5**



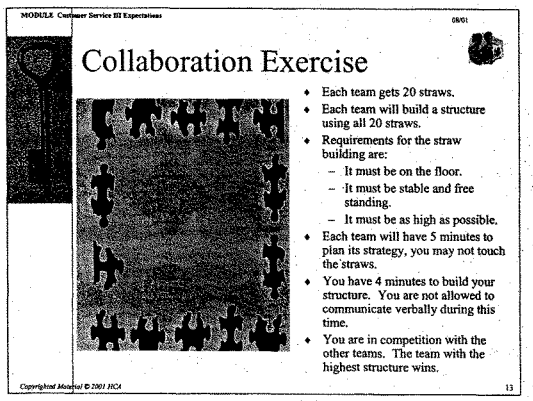
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Group Discussion Video	1. Knowing your job and doing it well improves teamwork and collaboration; the team works better and everyone's job is easier, resulting in improved service to our ultimate customer. In health care, our jobs are highly specialized, but they are part of a much bigger, very important whole--the care and comfort of patients. 2. Failure to learn often results in someone else doing the work, which will have a negative impact on teamwork and ultimately on service. It also causes burn-out for good employees. Learning your job well gives you confidence to handle any situation. Remember, you are not alone - you must operate as a team.	**Student Workbook:** **Page 7** **"Understanding Your Responsibilities"** **Part II** VIDEO



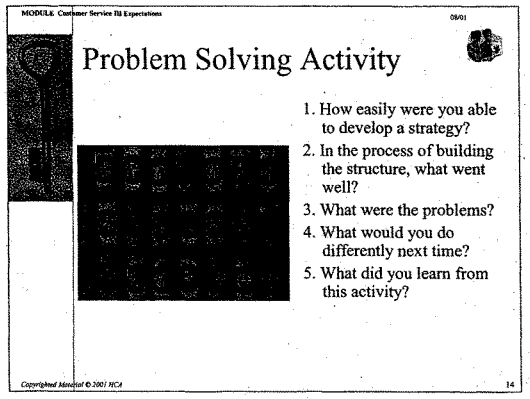
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions	Let's review the 5 elements of excellent service and positive communication: -- Speaking -- Listening -- Performing -- Learning -- Working together (collaborating and cooperating - internal and external) Work toward improvement. If you think you are doing something right, you won't change anything!	**Student Workbook:** **Page 8** **"Five Elements of Excellent..."**



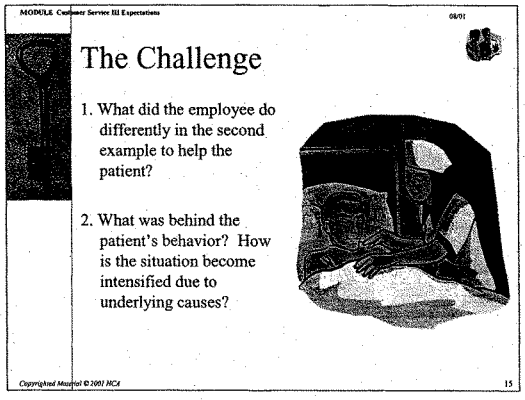
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Group Discussion	Communication is essential. You and your co-workers need to meet, talk, and engage in open give and take, so that differences are aired. That is the only way to achieve understanding of the best approach to solve the problem. •Teams need talent. The more of it you bring to the group, the more you can contribute and the more others will believe in you. So, keep learning. •True collaboration requires that people have faith in one another. The only way you can build that kind of faith is by the way you act. Do you keep your word?Do you honor your commitments? Are you consistent? Do you play fair? Can others count on you? •Commit yourself to the team's common goals and show support for the leader. But, also be able to take a stand when you feel it is important to achieving the group's common goals.	**Student Workbook:** **Page 9** **"Collaboration is Essential"**



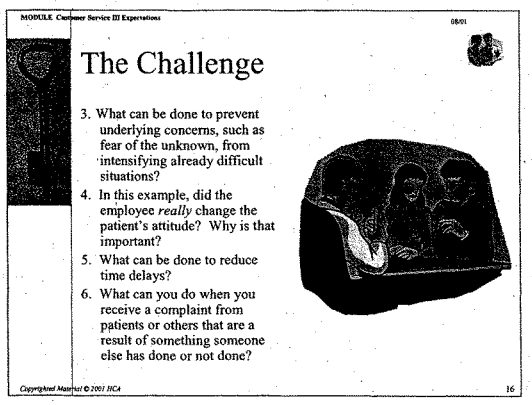
Instructional Strategy/Hook	Content	Props/Gestures
Game	Collaboration among health care workers is essential to providing quality care and service expectations.. PROBLEM-SOLVING GAME: Break into 4-5 teams.. Each team gets 20 straws. See Rules Above. Each team has 5-7 members. Ask the groups to start their strategy session reminding them they can not touch their straws. Time the strategy session for 5 minutes.. Then call "Start Building". Each team takes possession of their straws. Remind them that they are not allowed to talk (you will have to enforce this) and that they will have 4 minutes to complete their straw building.	•Materials Needed: box of straws, a timer, a ruler to measure structures, and a prize for winner. •Time the session. At the end of the session, ask the teams to stop and step away from their structures. Determine which one is highest and declare a winning team. **Student Workbook:** **Page 10** **"Collaboration Exercise"**



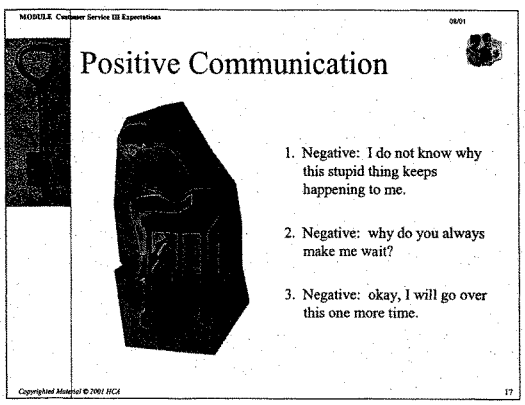
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Group Discussion	1. Discuss how they determined their team strategy.	**Video**
	2. Discuss what went well as they built the structure?	
	3. Discuss what problems they encountered, and how they solved them.	
	4. Discuss what changes they would make for another attempt.	
Video	5. Discuss what the team members learned in this activity.	



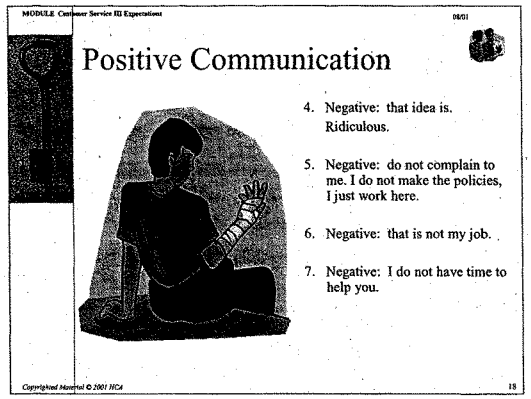
Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Group Discussion	Complaints give us the opportunity to resolve problems and better satisfy the needs of our customers. Although the word "complaint" does not sound positive, complaints do suggest solutions if we listen carefully, with an open mind and respond positively and promptly.. Is the patient fearful about what is about to happen? Is there concern about the outcome? Does the patient completely understand the procedure? You need to focus on the patient's needs and identify the nature of the problem and how to solve it. Personal power, friendliness, sense of humor, and diplomacy are much more influential in a difficult situation than "position power" or "rules" could ever be. DISCUSS WHAT THE VIDEO SAID	**Student Workbook:** **Page 11** **"The Challenge"** **# 1 & 2**



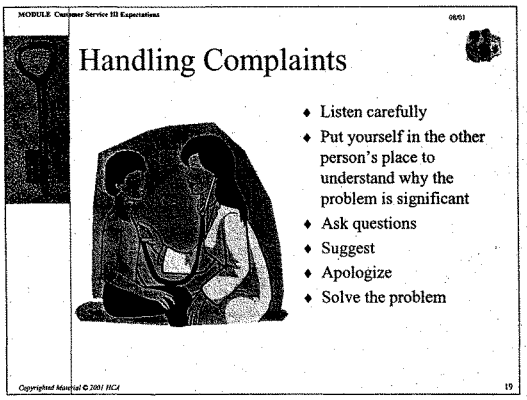
Instructional Strategy/Hook	Content	Props/Gestures
Group Discussion	Many of the situations we deal with are intensified due to underlying causes, such as fear, anxiety and discomfort. It is important to identify and respond to the emotional content of your customer's compliant, as well as to the actual verbal content. Ask yourself "What am I really hearing? 3. Provide written explanation of procedures.. Provide phone number for any questions. Introduce yourself upon arrival and ask if they have any questions. 4. The patient was still annoyed that he had to wait so long but he was also willing to stay 5. Tell them up front how long to expect for tests, etc. & Pre-registration 6. Solve the problem and do not place blame on your co-worker.	**Student Workbook:** **Page 11** **"The Challenge"** **# 3 - 6**



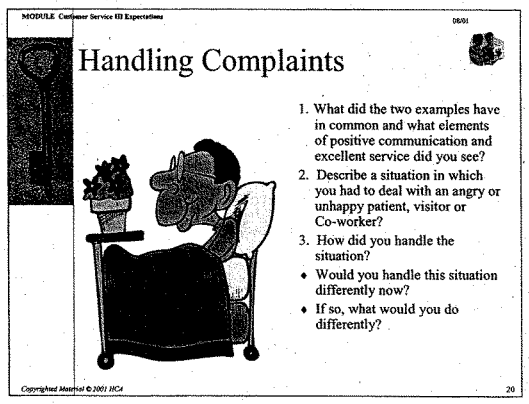
Instructional Strategy/Hook	Content	Props/Gestures
Team Activity	Almost any idea or feeling can be expressed in either a negative or positive way. Practice turning negative comments into positive ones. Pair up students and let then work on the examples for a few minutes. Then return with their responses. 1. How can I solve this problem that keeps recurring? 2. It is important to me that you be on time. 3. Let me explain this better. Why don't you take notes?	**Student Workbook:** **Page 12** **"Positive Communication"** **# 1 - 3**



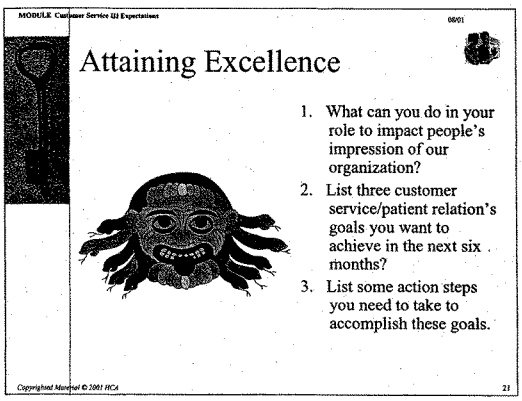
Instructional Strategy/Hook	**Content**	**Props/Gestures**
Team Activity	4. I do not agree with that idea? 5. I will be sure to pass your concern on to someone in authority here. 6. Here is what I can do for you. To solve the rest of your problem you need to see (name) in the (department) 7. I can not help right now, but let me see if I can find someone that can.	**Student Workbook:** **Page 12** **"Positive Communication"** **# 4 - 7**
Video		**Video**



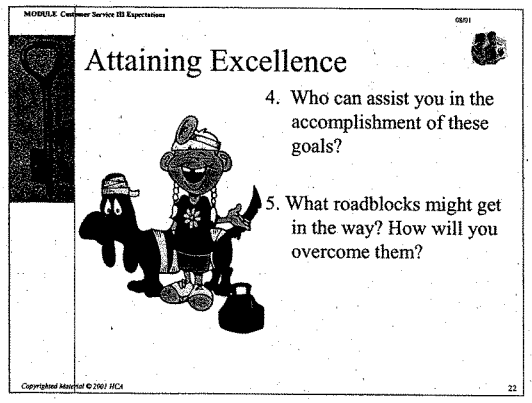
Instructional Strategy/Hook	Content	Props/Gestures
Lecture Group Discussion	Realize the complaint is a request for help and not a reflection on you personally. Focus on the customer to show a courteous and helpful attitude. You have the power to handle problem situations in a positive way. Try to anticipate the problem and start out with a smile and a positive comment. Identify and respond to the emotional content of the complaint, as well as the practical one. Ask yourself, "What is this person really saying?' What might seem insignificant to you may be very important to the other person. You may be dealing with many of the same problems all day long, but it is the first time your customer has experienced it. Handling complaints is a skill you can develop.	**Student Workbook:** **Page 13** **"Six Steps..."**



Instructional Strategy/Hook	Content	Props/Gestures
Group Discussion Role Play	**Discuss answers to each question.** In each case, The employees remained in control of the situation, did not get baited into negative communication. They demonstrated a willingness to help by the words spoken, tone of voice and actions. They each listened to determine the nature of the problem, explained what they were going to do to resolve it, and spoke in a courteous way. Handling difficult situations is an important skill. When complaints are handled effectively, our patients and other customers will return satisfied, and you will experience a great deal of satisfaction in developing and improving this skill.	**Student Workbook: Page 19 "Handling Complaints"** **ROLE PLAY:** Break into groups of 4-5. Use problem situations you described in the last exercise. ADD THREE DIFFERENT ROLE PLAY SITUATIONS. Have them show you the wrong way and the correct way.



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Group Discussion	Attaining excellence means putting what you have learned to good work. One way to do that is to set goals for yourself and to develop a plan of action to carry them out. It is helpful to share your goals with others who will support your achievements and celebrate with you when you are successful. When you reach your present goals, be sure to set new ones for yourself. Achieving excellence is a never-ending process. We can always learn, and we can always do better. All you need to succeed is commitment and dedication to doing your best. I encourage you to share your goals with someone and review them monthly to ensure your own personal success.	**Student Workbook:** **Page 15** **"Attaining Excellence"** **# 1 - 3**



Instructional Strategy/Hook	Content	Props/Gestures
Lecture / Questions Wrap-up	Continue to think about your personal goals. Who can help you attain these goals? What roadblocks might stand in your way? How will you overcome them? What is the first thing you will do, and when will it be accomplished? Congratulations on your new road to personal improvement as it will affect not only your career, but your life.	**Student Workbook:** **Page 15** **"Attaining Excellence"** **# 4 – 5** **WRAP UP** **STUDENT WORKBOOK** **Page 16 - What Customers Want Most** **Page 17 – The Customer Approach**

Customer Service – "The Guest" Instructor
Lesson Plan Summary Sheet

Materials Needed:

Flipchart, markers, play money, prizes, candy, video "The Guest" , LCD, TV/VCR, laptop with instructor file

Instructional Strategy	Topic	Time
Group Discussion	Grandparents as your guest Opener	3 min
Lecture	Introduction	2 min
	Learning Objectives	
Brainstorm	Who's the Customer	3 min
Workshop	Customer Expectations	5 min
Group Discussion	Share Expectations	2 min
Lecture	Introduce Video	1 min
Video	The Guest	14 min
Group Discussion	5 Key Points	3 min
Workshop	Applying Ideas to Your Job	15 min
Group Discussion	Review Ideas from Workshop	8-10 min
Workshop (Individual)	How will you implement?	5 min
Lecture	Summarize and Close	1 min
Total Time		**60 min**

Instructional strategy/hook	Script	Props, materials
 3 min 1 min	Let's pretend that the people that you see here on the screen are your grandparents and they just finished visiting with you and are now bragging about their visit to one of your siblings. • What did you do to get ready for their visit that made them so happy? • How did you greet them when they arrived? • How did you treat them while they were staying at your house? Great ideas - good feedback! This is very similar to the way that you should treat every customer at work. Let's look at the next slide to review what we will focus on in today's session.	Flipchart markers **Set the Scene**: •As the students arrive, treat them poorly -room too cold, pick up their own handouts, crowded seating, blinds shut, dark room, etc. •Use as an example of what NOT to do, and discuss how the students felt when this happened.

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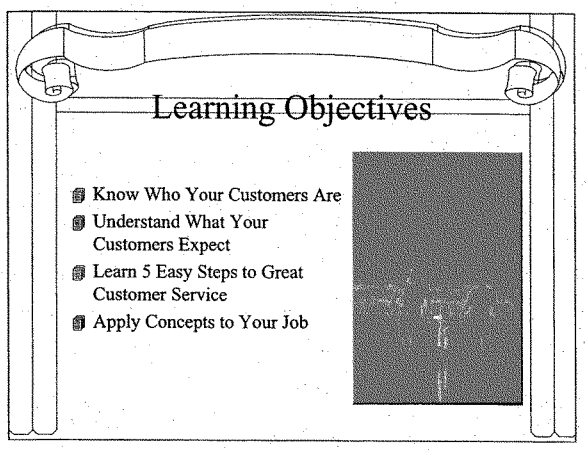

Instructional strategy/hook	Script	Props, materials
2 min	By the end of this session you will… • Know who your customers are both internal and external • Understand what they expect from your for good service • learn 5 easy steps on providing unbelievable customer service • Learn ways to actually apply these new ideas in your everyday job	Use pointer Show 5 fingers

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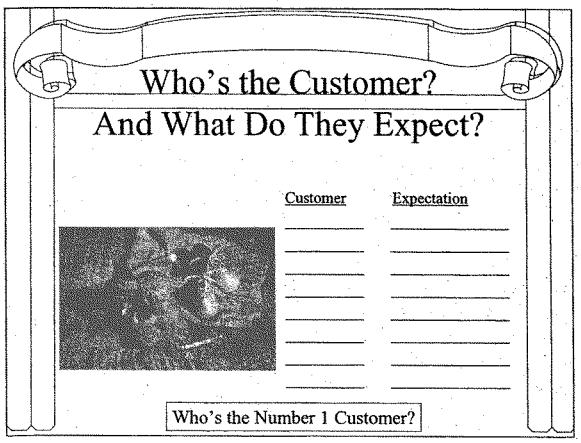

Instructional strategy/hook	Script	Props, materials
3 min	OK, who are your customers? Let's list them on this flipchart - brainstorm. Anyone else a customer?	Flipchart markers candy prizes
5 min	What I'd like you to do now is highlight the top 5 customers that you have in your job - specific to you. And write them in your workbook on page 2. Then next to each of the 5 customers that you selected write in what you think that that specific group of customer expects or wants from you when they meet you or work with you. You have up to 5 minutes to complete this task - write the answers in your handout so that you will be ready to share with the class.	
	Who wants to share their ideas? Who's the number ONE Customer??	

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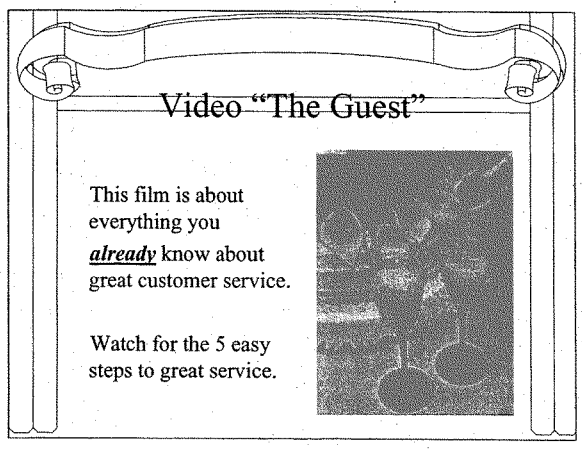

Instructional strategy/hook	Script	Props, materials
2 min	OK, now I'd like to show you a super video that demonstrates the 5 easy steps to great customer service. The video is titled "The Guest" and I'm sure that you will get some good ideas from watching this. Pay special attention to the 5 Key steps for achieving great customer service.	TV/VCR Video "The Guest"
14 min		

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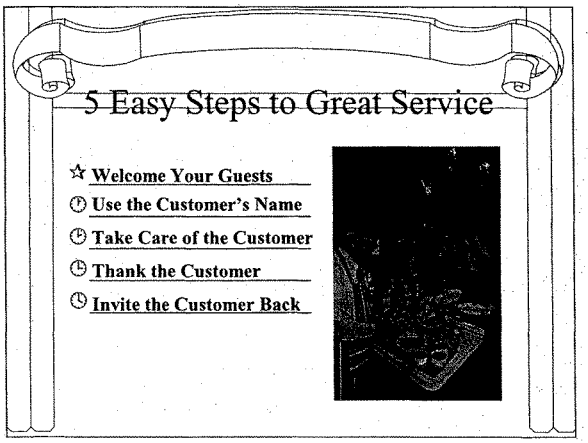

Instructional strategy/hook	Script	Props, materials
3 min	Let's review what the 5 key points were for providing Great Customer Service. Who can name them?	Candy Prizes

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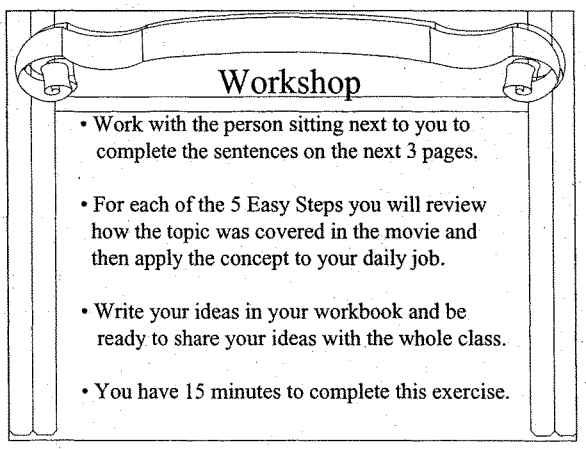

Instructional strategy/hook	Script	Props, materials
15 min	Read the workshop instructions from the slide and ask them to work on this for the next 15 minutes.	Student workbook

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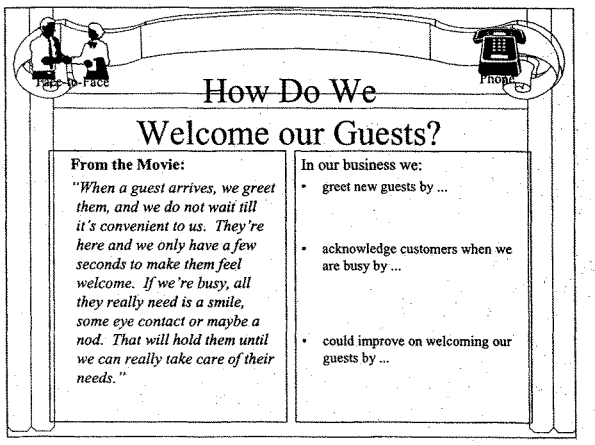

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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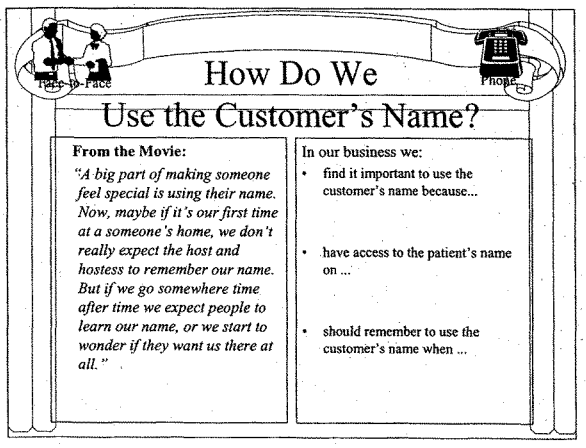

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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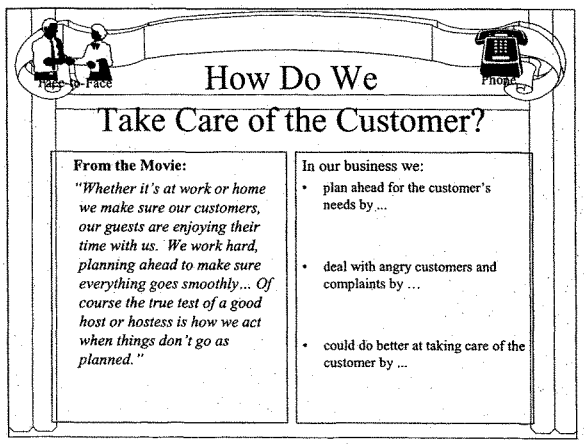

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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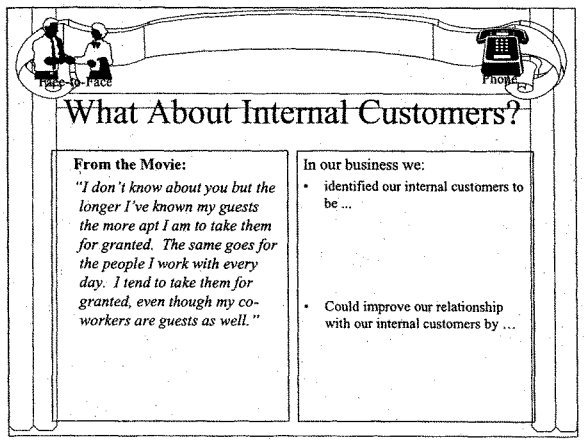

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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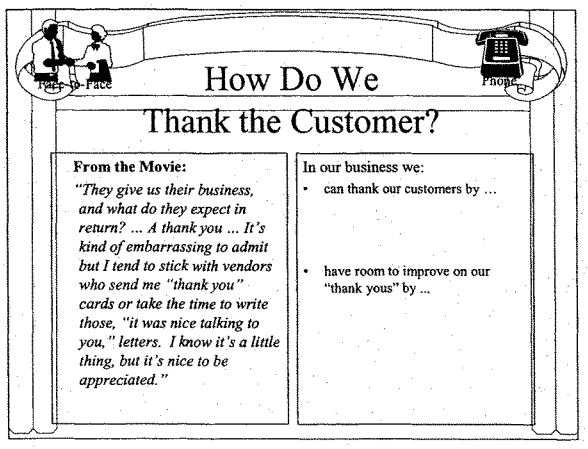

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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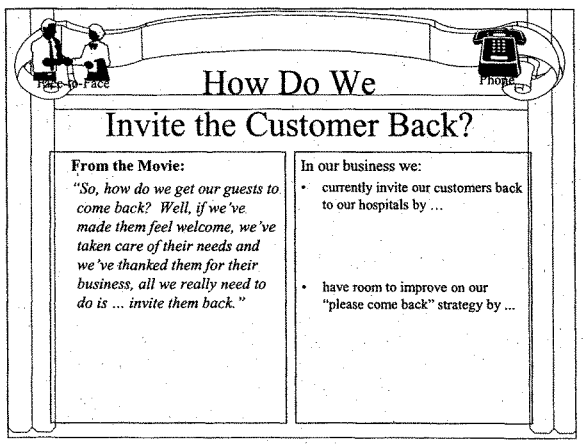

Instructional strategy/hook	Script	Props, materials
 2 min	Ask the class to share their ideas with the whole class.	Candy Prizes

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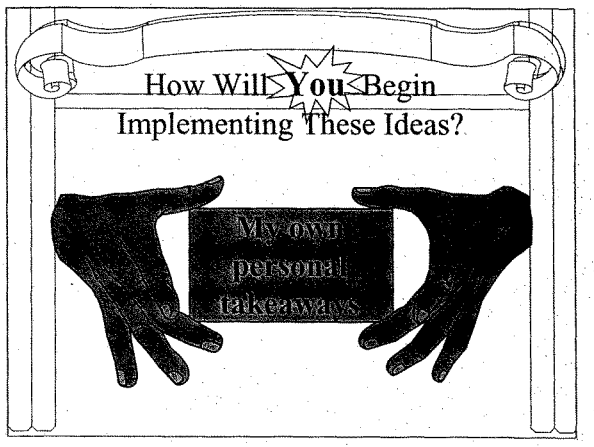

Instructional strategy/hook	Script	Props, materials
 5 min	What I'd like you to do now is identify those ideas that you heard in this session that you can start implementing today! This time work by yourself and personalize this for your own job. You have 5 minutes.	Student workbook

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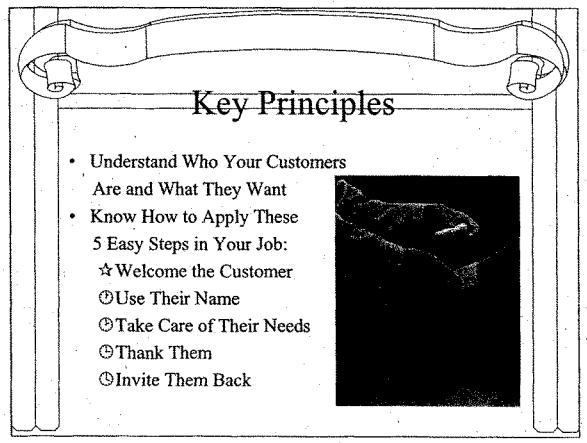

Instructional strategy/hook	Script	Props, materials
	OK, so let's review what we learned today. Thank you for coming and I hope that you found this session thought provoking and valuable to you in your job. Please come back now, Ya Hear?	

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ONE RINGY-DINGY - QUALITY TELEPHONE SKILLS
INSTRUCTOR SUMMARY
(Approximate Presentation Time: 60-75 min.)

1. Introduce the topic of customer service as it relates to telephone skills and the irate caller. Begin with the students taking the pre-test. Tell them the answers will become clear after more discussion. 6 min.

2. Slide 2 speaks to the accountability of every phone user, and the chances for customer service victories. Show the video, "The End of the Line" 20 min.

3. Slides 3 and 4 present the ideas of how each employee can make a difference in the customer service arena, and how wearing a smile will cause your voice to respond positively. Do hand mirror exercise. 10 min.

4. Slide 5 is a Model-netics model that helps introduce and express the dangers of stereotyping when dealing with the public in customer service. 3 min.

5. Slide 6 separates the customer's anger from their problem, and slide 7 helps identify those anger signs. Workshop 6 min.

6. Slide 8 is a model (Psychic Radar) that discusses the ability to react to someone no matter what their emotional signals. 3 min.

7. Slides 9,10 and 11 sort out how to handle the callers emotions and their actual problem. 6 min.

8. Slide 12 is a model (Perceptual K/H) that shows how we need to learn what to look for. It shows that we can't be expected to know it without that assistance and that the eye sees what the mind tells it to see. 3 min.

9. Slides 13 – 15 discuss specific and detailed irate customer situations and how to best handle them. 8 min.

10. Slide 16 is the reference slide, and allows time for questions and comments. Discuss the pre-test answers and hand out the post-test. Discuss post-test answers. Give out laminated takeaway cards. 10 min.

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture/Intro Test	Working with customers over the phone is a situation encountered by thousands daily - and that certainly includes working with angry customers! How do you work with someone who is SURE he paid his bill last month? Or someone who says she has never had services at your facility? Or how about the one who gets downright nasty? It is one of the most demanding jobs any one can possibly have, and yet it is also one with the highest potential for customer satisfaction. It's the customer who will not let us fix their problem, but just goes somewhere else for services, that we need to worry about. What you are experiencing then is a potential victory - a success in the making, so let's talk about how to do it with ease. We will have some fun, see a movie, and talk about experiences we have had.	Pretest Handout test and talk about answers. (See separate sheets_:

PHONE SKILLS PRE-TEST

1. T/F When an angry customer calls, all he or she cares about is the resolution of the problem in his or her way.

2. T/F Angry customers are angry at you, personally, when they call.

3. T/F When people show unreasonable emotion over a problem, the best thing to do is ignore it and solve the problem as soon as possible.

4. T/F Getting a person to talk and really explain a problem will help the person let off steam.

5. T/F Retaining an angry customer as a satisfied customer, is impossible.

PHONE SKILLS PRE-TEST

1. T/F When an angry customer calls, all he or she cares about is the resolution of the problem in his or her way.

False. The caller wants someone to listen and to provide alternatives as solutions.

2. T/F Angry customers are angry at you, personally, when they call.

False. Many angry customers are having a bad day or week and don't realize they are frustrated with all the events.

3. T/F When people show unreasonable emotion over a problem, the best thing to do is ignore it and solve the problem as soon as possible.

False. Dealing with the feelings is equally important as resolving problems.

4. T/F Getting a person to talk and really explain a problem will help the person let off steam.

True. Using open-ended questions is an excellent technique to help calm the caller.

5. T/F Retaining an angry customer as a satisfied customer, is impossible.

False. Studies show a quick and empathetic response to a problem will help you to retain angry customers as satisfied customers.

THE END OF THE LINE

"The Buck Stops Here"

2

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture Video Group Discussion	What US President is famous for saying this? (Answer: Harry Truman) The End of the Line means the same thing, and that means US! It's up to us to take care of problems as they occur and to establish positive productive phone relationships with all of our internal and external customers. Who are your internal customer? External? We will watch a short video now, and I want you to come away with at least 2 ideas that you will use immediately. Think of a particularly difficult phone situation you have had in the past, and see if you would have handled it differently, after watching this video. How many of you would rank yourselves as having good to great phone skills? Keep that in mind, and let's watch the Video, called The End of the Line.	Show video: "The End of the Line" Think of a particularly difficult phone situation you have had in the past, and see if you would have handled it differently, after watching this video. Discuss at end of video.

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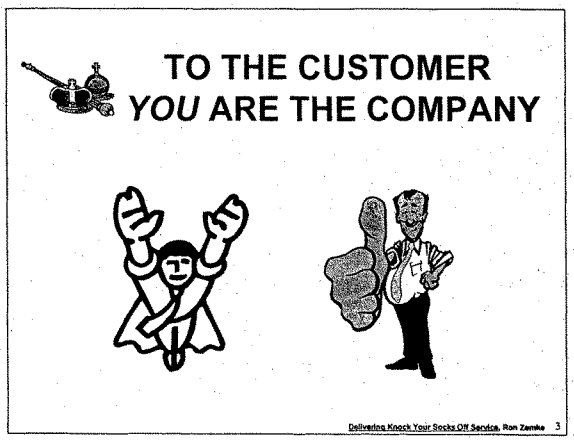

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	In the Knock Your Socks Off Customer Service series, they say that customers expect you to make the organization work for them. They expect you to understand the big picture, and be able to answer their question, solve their problems, and refer them to the right people for the right things. Because what our customers want and need changes so much, so must our company....and following that thought through....so must YOU! If you feel like you are just a clerk, you will be treated like that, AND you won't be able to help the customer. But if you feel ownership, helping becomes much easier. What are the little things that make your customers happy?	

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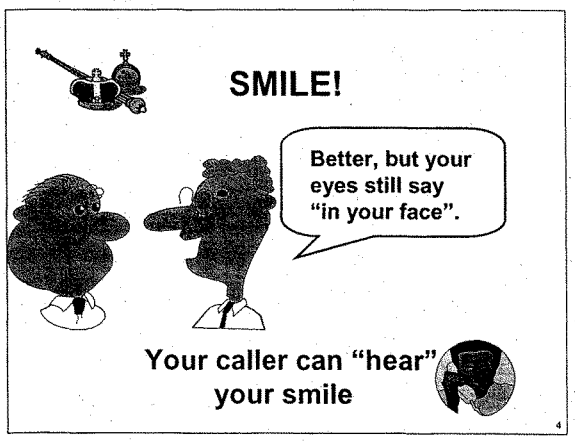

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture Team Activity 	OK, you may not FEEL like smiling at the times you most need to, but if you do it anyway, eventually your brain will catch up, and you will feel more like smiling. Fake it 'til you make it! Events don't cause feelings -- we have full choice as to how we will feel. Choose your attitude, and make their day--2 very basic customer service philosophies, practiced successfully by nationally known companies. To stay positive remember that your feelings are separate from the work you need to do: •Take 3 deep breaths (not sighs) •Take a 30 sec memory vacation •Think about a positive customer service role model--- and then become one!	Ask the group to pair up, and try being negative while smiling. Ask them to share the results briefly. SUGGESTION: Place a hand mirror directly in front of you while you are on the phone with your patients / payors. **Consider purchasing hand mirrors for each participant as a take-away.**

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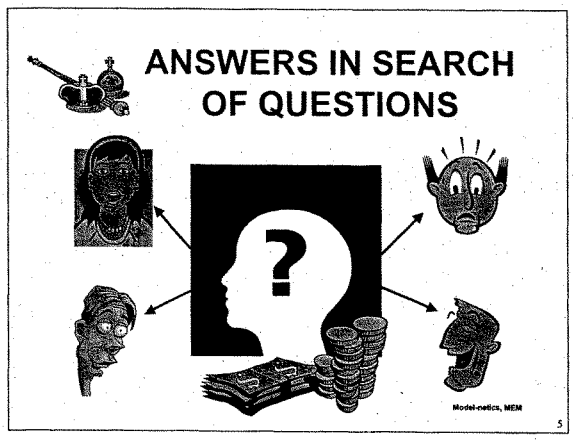

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	This model means that we see the answers to a problem within the limits of our knowledge. In other words, this: •limits the kind of problem we see as being important, and •it influences our analysis of the cause of the problem, so our course of action can be wrong. This model warns us to be very careful. We may miss something as being a real problem, and we may not solve something correctly because of our personal filters. It's like a dr who prescribes aspirin for every complaint because that's all he knows. This poses 2 potential dangers: 1. Not having enough information to make a decision 2. Making the wrong conclusions-stereo typing callers- no ins., so must be MCD or opinions about accents.	Example: •Stereotyping people by accents, insurance type, or lack of ins. (Recall the scene from "Pretty Woman" when she first enters the exclusive shop on Rodeo Drive, and contrast with the 2nd visit.)

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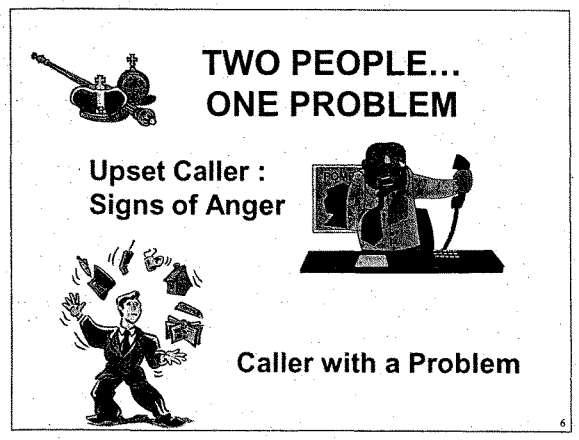

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	There is really only 1 person on the other end of the phone, but what they need is to be treated like 2 people when they are upset. There are plenty of calls or walk-ins that you handle daily, who are not upset, and only need a question answered. We can all do that efficiently and kindly, but what about the ones who are dissatisfied and mad? *(Give example: "Excuse me, can you please help me with this bill?" vs "Where is Billing?! I have asked 3 people and have had the grand tour of the hospital because nobody here knows what they are doing!")* You can't begin to really solve their root problem until you deal with their emotions, and we will talk about that in just a minute	

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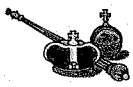

SIGNS OF ANGER

- Higher-pitched speech
- Louder volume
- Long pauses
- Sighs
- Swearing
- Condescending tone
- Demands
- Threats to take business elsewhere
- Short, terse answers

7

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture Role Play	What are our first clues that the person you are talking to (especially on the phone when you can't see their face) is angry or upset? (List on slide)	Instructor prompts 9 people with "May I help you with this billing question?" Each of the 9 responds using the angry response list on the slide, by asking where the billing is.

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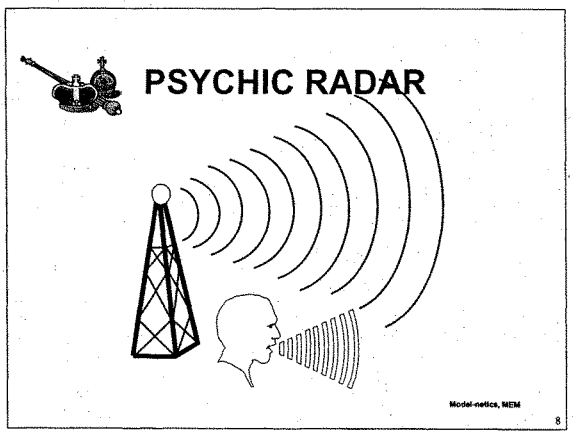

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	Psychic radar is the ability some people have to interpret attitudes, feelings and reactions in a face to face communication setting. People who have this radar also quickly pickup the anger signals on the phone. The radar analogy shows that these people are continually doing real-time adjustments to what they see and hear. This causes them to modify their own behavior as a response. Psychic radar requires reaction- if you want to stop communicating, don't react. This is a good example of why we need to give the listening feedback to our callers. It encourages the communication needed to solve the problem.	

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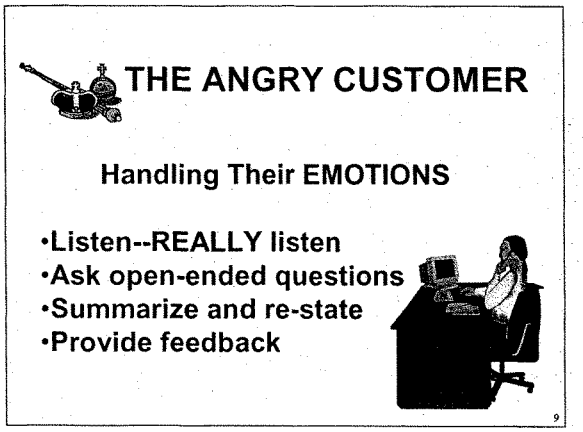

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	Let's talk now about how to deal with the angry monster lurking in that nice patient or payor! **LISTEN:** Really BE THERE, and make listening sounds to prove it. Apologize for their being upset, but: • *DON'T* tell them you know how they feel! Why? •*DON'T* make excuses of any kind. They don't care why it happened, but they do want it fixed. **ASK OPEN-ENDED QUESTIONS** to encourage them to blow off steam. These are questions that need more than a yes/no response. **SUMMARIZE AND RE-STATE:** Example: "I'm hearing you say that you have talked to 3 other people and you are still getting a bill for an account you show paid. Is that correct?" **PROVIDE FEEDBACK:** I understand how that would make you feel angry."	

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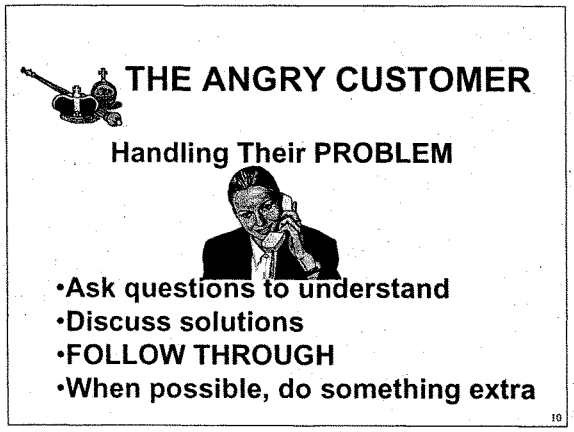

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	Now, the caller can hear you when you solve the actual problem - you have defused them, so they can be rational. **ASK QUESTIONS TO UNDERSTAND:** Closed-ended questions now, to get the facts. "What is the account number?" "What date do you show that you sent in the payment?" **DISCUSS SOLUTIONS:"** I can look this up while you wait, or I can call you back in about 10 min. Which would you prefer?" **FOLLOW THROUGH:** This is the MOST important step - they have already been disappointed by somebody else. Even if you don't have the answer in that 10 min., call them and TELL them that. **DO SOMETHING EXTRA:** This is facility-specific. Some hospitals will send coupons for the cafeteria, or gift shop, for confusion about a bill--You can SAY something extra like "My name is xxx. In the future, don't hesitate to call me directly and I will help."	

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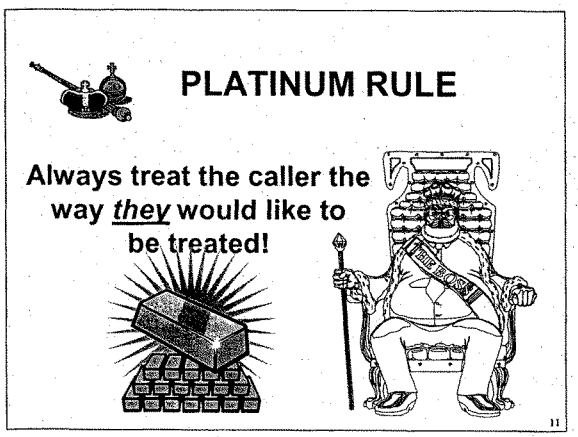

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture Role Play 	Why is the Platinum Rule better than the Golden Rule? Only the customer knows how they want to be treated. It's like your mother or your spouse saying to you "Just come with me to this function. I know you will like it!" That's because THEY like it, and can't imagine anyone who can't.	Role Plays: (2 player for each role) 1)"I've had it!! I keep getting bills that say I owe money. I have 2 insurances!!- How can I possibly owe you money?! Class critiques. 2) I talked to someone last week who said they would call back about my billing problem, and NOBODY ever called!! Class critiques.

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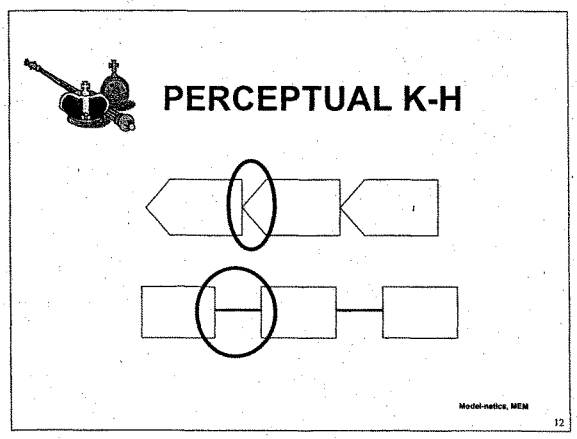
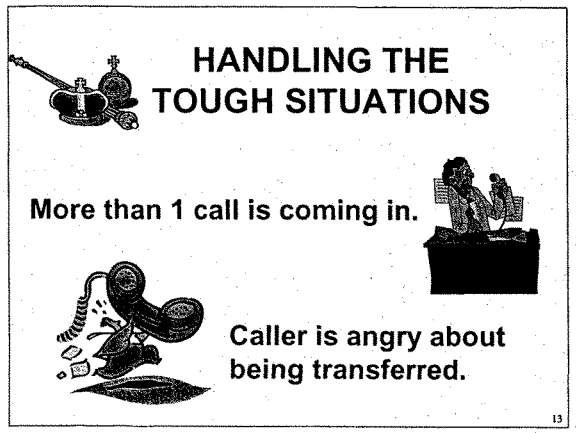


Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	Here is a visual perception model that demonstrates 2 concepts: It shows how our brain deals with new information. 1. You are only as good as you know how to be - emphasizing the importance of training. 2. The eye sees what the mind tells it to see. Learning is impacted by what we are prepared tosee. Let's illustrate this: Look at the first set of shapes. What is it? After guesses, show that it is a series of Ks. Now that they know that, they will easily pick out that the second series of shapes are Hs. The eye sees what the mind tells it to see- What does this have to do with phone skills? Once you become more experienced, you will learn the tell-tale signs of dissatisfaction more quickly, and so you will get better and better at becoming an outstanding customer svc rep.	



Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	Let's look at some stress triggers. Things that happen all day long. If you are clear how to handle them, they may cause less stress. If you have **more than 1 call** coming in at a time, tell the 1st caller that you have another call. ASK if you can place them on hold for a moment - and LISTEN to their response. If can't hold, get a callback number. Pick up 2nd call and ask them to hold. Go back to the 1st caller. The length of time someone is holding seems like an eternity. Be aware, and reconnect quickly, if only to see if they want to continue to hold. **Angry about transfer or hold**: Give a brief, blameless apology. "I'm really sorry for the inconvenience. I know your time is valuable. Now that you have my full attention, how may I help you?"	

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MORE TOUGH ONES

What if the caller:

..hangs up.

... is crying.

...speaks another language.

14

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	If the caller is so upset they **hang up** on you, tell your manager. If you have the information, offer to call back. Give a blameless apology sincerely, and ask how you can help now. If the caller is **crying**, slow your pace, and lower your voice. Restate your willingness to help. Say, "It's ok, take your time." If still can't speak, offer to call back in 30 min. If caller speaks **another language** refer to your departmental policy for transferring a non-English speaking person to someone who is fluent in foreign languages. AT&T offers a service for the interpretation of hundreds of languages that you may want to investigate They may speak more loudly-Be aware of your volume.	

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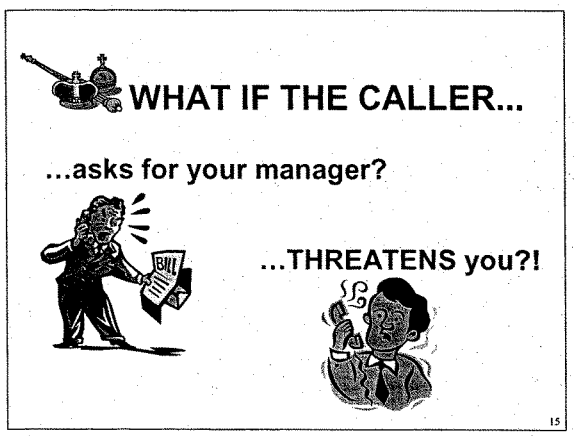

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture	If the caller asks to **speak to your mgr**, try to take responsibility to make sure it isn't something you can handle. If they insist, ask if they can hold while you transfer.Be sure to stay on the line until the mgr answers, and if they don't reconnect with your caller and keep them informed. Do they want the mgr's voice mail box? Etc. If the mgr answers, introduce the call and give details so the caller doesn't have to repeat.	Give Post Test.
Test	If the caller is **abusive**, follow your department guidelines. You might begin with a simple "Excuse me." If the language continues, tell the caller "Your language is keeping me from solving your problem. Depending on dept policy, terminate the call if it continues further.	

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REFERENCES

The End of the Line, American Media, Inc.

Delivering Knock Your Socks Off Service, Kristin Anderson and Ron Zemke

Keep Them Calling, Superior Service on the Telephone, Sherry L. Barrett

Model-netics, Main Event Management, Inc.

16

Instructional Strategy/Hook	Contents	Props/Gestures
Lecture/Questions	Here are the sources used to develop this presentation. What questions do you have?	

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PHONE SKILLS POST-TEST

1. When an angry customer calls, what two people want attention?
   A.
   B.

2. How can you strengthen the relationship with the angry customer?

3. When a situation produces an angry customer, what two things were broken?
   A.
   B.

4. Describe listening skills that will help calm the caller.
   A.
   B.

5. Why should you summarize your understanding of the situation for the caller?

6. When should you apologize to the customer?

7. What are the 4 steps in dealing with an angry customer's problem?
   A.
   B.
   C.
   D.

8. What are the 3 steps in dealing with an angry customer's feelings?
   A.
   B.
   C.

PHONE SKILLS POST-TEST
Instructor

1. When an angry customer calls, what two people want attention?
   A. A person whose feelings need attention
   B. A person who has a problem.

2. How can you strengthen the relationship with the angry customer?
   By listening, asking open-ended questions, and solving the problem.

3. When a situation produces an angry customer, what two things were broken?
   A. Relationship
   B. Product or service

4. Describe listening skills that will help calm the caller.
   A. Ask open-ended questions so the caller can let off steam.
   B. Summarize the situation back to the caller.

5. Why should you summarize your understanding of the situation for the caller?
   Summarizing confirms understanding by both parties that each one understands the situation, and also communicates to the caller that you have taken the time to carefully listen to the problem.

6. When should you apologize to the customer?
   Apologize when you have wronged the customer and inconvenienced him/her.

7. What are the 4 steps in dealing with an angry customer's problem?
   A. Suggest alternatives
   B. Agree on a solution
   C. Follow through on the agreed-upon solution
   D. Do something extra

8. What are the 3 steps in dealing with an angry customer's feelings?
   A. Ask questions
   B. Give feedback
   C. Summarize the problem

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Phone: 314-733-8000
www.ascensionhealth.org

July 22, 2004

The Honorable James C. Greenwood
Chairman
Subcommittee on Oversight and Investigations
Room 2322 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Greenwood:

Thank you for your follow up request for information of July 14, 2004. Enclosed please find Ascension Health's responses to each question. Please do not hesitate to call if there are any clarifications needed.

I look forward to continuing to work with the Subcommittee Members to assure that uninsured patients are treated with fairness and compassion. Ascension Health's mission emphasizes care for the most vulnerable, and I believe that our policy for billing and collections for the uninsured reflect this deeply held value.

Sincerely,

Anthony R. Tersigni, Ed.D., FACHE
President and Chief Executive Officer

cc: Anthony Cooke
Edith Holleman

Jul-14-04 05:33pm From-House Energy & Commerce Cate Ford 202-226-2447 T-232 P.002/003 F-994

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U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

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July 14, 2004

Anthony R. Tersigni, Ed.D., FACHE
Chief Operating Officer and Interim CEO
Ascension Health
4600 Edmundson Road
St. Louis, MO 63134

Dear Mr. Tersigni:

Thank you for appearing and testifying at the June 24, 2004 Subcommittee on Oversight & Investigations hearing entitled: "A Review of Hospital Billing and Collection Practices."

Pursuant to the Chair's order of June 24, 2004, the record of the Subcommittee's hearing remains open to permit Members to submit questions to witnesses in writing. Attached you will find additional questions for the record from the Subcommittee. Please respond to these questions in writing no later than the close of business on July 22, 2004, in order to facilitate the printing of the hearing record.

If you have any questions, please contact Anthony M. Cooke, Majority Counsel for Oversight and Investigations, at (202) 226-2424.

Sincerely,

James C. Greenwood
Chairman
Subcommittee on Oversight
and Investigations

cc: The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

Attachment

Jul-14-04 05:33pm From-House Energy & Commerce Cmte Ford 202-226-2447 T-232 P.003/003 F-894

QUESTIONS FOR THE RECORD
TO ASCENSION HEALTH
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
"A Review Of Hospital Billing And Collection Practices"
JUNE 24, 2004

1. Please produce for the record a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.

2. If your system has implemented any changes recently to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the planned date of implementation of each such change.

3. Please produce for the record all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients.

4. How are patients made aware of your charity policy and how is the substance of that policy made available to patients, e.g., brochures, postings in the hospital or on the system website?

5. For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of poverty?
   a. Are there plans to change the discount percentage rates as charges rise?

6. The AHA states that in 2002 the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care ... for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?

7. Did the HHS / OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self-pay patients? What specific further guidance is needed?

8. Have you ever reviewed and investigated complaints from patients against any of your collection agencies?

9. Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse all other means of paying undiscounted charge master rates (except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 1

Please produce for the record a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.

Enclosed is a copy of our Ascension Health Policy # 16 for Billing and Collection for the Uninsured (Ascension Health Policy). This Policy establishes minimum standards with which all Ascension Health hospitals must comply. Our hospitals are permitted to provide, and in many cases have provided, more generous assistance than established in this Policy.

Also enclosed is Ascension Health Policy # 9 Care of Persons Who Are Poor and Community Benefit and the accompanying Procedure, Care of the Poor / Community Benefit Planning and Reporting (Procedure). This policy and related procedure address charity care and community benefits for Ascension Health and mirror the Ascension Health Policy Billing and Collection for the Uninsured.

Enclosed are copies of local hospital policies and procedures. Policies and procedures from each of the hospitals in the Data Reporting Group were provided to the Subcommittee in our submission on October 23, 2003. All hospitals reviewed the Ascension Health Policy and compared it to their current policy and procedures. Some of our hospitals changed their policies and procedures to comply with the Ascension Health Policy. However, many hospitals did not need to change their local policies and procedures to comply with the Ascension Health Policy because they were already meeting or exceeding the requirements of our Policy.

Attachments:

- Ascension Health Policy # 16 Billing and Collection for the Uninsured
- Ascension Health Policy # 9 Care of Persons Who Are Poor and Community Benefit
- Ascension Health Procedure Care of the Poor / Community Benefit Goal Planning and Reporting
- Local Hospital Policies and Procedures

SYSTEM POLICY#: 16	**SUBJECT: Billing and Collection for the Uninsured**
BOARD APPROVAL DATE:	**12/10/03**
EFFECTIVE DATE:	**07/01/04**
REVISION DATE:	

Chief Operating Officer and
Interim CEO, Ascension Health

POLICY

It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital or medical center and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does

not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
    f. Financial counselors are available to all Patients.
    g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
    a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
    b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
    a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments,

utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, <u>and</u> a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal

Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

POLICY#: 9 **SUBJECT: Care of Persons Who Are Poor and Community Benefit**

BOARD APPROVAL DATE: 9/6/00
EFFECTIVE DATE: 9/6/00

REVISION DATE: 3/12/03

Executive Vice President/COO

POLICY

It is the policy of Ascension Health that each Health Ministry, guided by the Mission ,Vision, Values, and Philosophy of the System, will plan for care of persons who are poor and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. Ascension Health desires to strengthen its commitment to this principle through a unified system of accountability.

2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their strategic and financial planning.

3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.

4. Annually Ascension Health will produce an aggregate report highlighting the best practices and innovative programs in the System.

APPLICABILITY TO CO-SPONSORED ENTITIES

It is expected that all co-sponsored integrated delivery networks (IDNs) with which Ascension Health member organizations are affiliated will adopt a policy that is consistent with and supportive of this Ascension Health policy. The IDNs also will be expected to comply with Ascension Health reporting requirements regarding care of persons who are poor and community benefits.

SYSTEM PROCEDURES

Guidelines and Procedures for planning and reporting on Care of Persons Who are Poor and Community Benefit can be found in the Ascension Health Procedures binder. **[Note: System Procedure is in the process of being drafted.]**

PROCEDURE #A-1 **SUBJECT:** **Care of the Poor / Community Benefit Goal Planning & Reporting**

EFFECTIVE DATE: 7/01/04

Chief Operating Officer

REFERENCE TO SYSTEM POLICIES:

Policy No. 9	Care of Persons Who are Poor and Community Benefit
Policy No. 16	Billing and Collection for the Uninsured

Subject

This procedure sets forth the requirement that each Health Ministry have an effective Care of the Poor Policy, and establishes a process to develop annual Care of Persons Who are Poor / Community Benefit goals and to report progress towards those goals. All activities related to Care of the Poor will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship. Each hospital must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

Rationale

Care of Persons Who are Poor / Community Benefit planning and goals are incorporated into the existing Integrated Strategic and Financial Planning process. Progress towards established goals will be reported upon annually. This procedure provides guidelines to assist Health Ministries:

a. establish care of persons who are poor / community benefit goals within the framework of the Integrated Strategic and Financial Planning process and report progress towards those goals.
b. report costs for Categories I through V associated with allowable care of persons who are poor / community benefit programs and services.

Procedure

Charity Care (Minimum Standards)

1. At a minimum, patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.

2. At a minimum, patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in number 1 (above) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.

3. Eligibility for charity care may be determined at any point in the revenue cycle.

4. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

Financial Assistance (Also see Policy #16 – Billing and Collection for the Uninsured)

Each Health Ministry should have a methodology to determine qualifying incomes and/or assets available to satisfy the patient's obligation to the hospital.

1. All eligible patients and the families are advised of the hospital's applicable policies, including the charity care policy and the availability of need-based financial assistance in easily understood terms, as well as in language commonly used by patients in the community.

2. The financial assistance policy must address a patient's eligible income and assets.

3. The policy may allow the determination to be made on a case-by-case basis, but in this circumstance, a review panel must be formed to ensure a patient has the right to appeal a decision.

4. Requiring a patient to apply for public financial assistance programs is permissible.

For further guidance, reference Sections 4 and 6 of Policy #16 – Billing and Collection for the Uninsured.

Other Requirements and Exceptions (Also see Policy #16 – Billing and Collection for the Uninsured)

1. Health Ministries may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance programs to qualify for charity.

2. Other programs that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured. This is encouraged and will continue.

3. A nominal charge may be charged to patients qualifying for charity. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons who are poor since it respects their dignity as well as their sense of responsibility.

Planning

1. As part of the annual Integrated Strategic and Financial Planning process, establish substantial, measurable and meaningful Care of Persons Who are Poor / Community Benefit goals. These goals should include:

   a. An Ascension Health access goal, where applicable
   b. Three (3) to five (5) local Care of Persons Who are Poor / Community Benefit goals developed in response to a local community needs assessment

2. Goal Setting.

   a. A goal may span more than one year and, therefore, may be included in several years' plans. However, once the program/service/activity is functional and part of the on-going operations, a new goal(s) will be established.

   b. A Health Ministry may choose to include as a goal the continuation of a service that is at risk due to its operating at a loss, if this represents a clear decision for the sake of the mission impact of that service. In such a case, the goal will include ways to sustain the service. Once stabilized, it opens the opportunity for establishing a new goal.

3. The CEO and Local Board determine which of these goals will be attached to the local executive incentive.

4. The Integrated Strategic and Financial Plan budget for Care of Persons Who are Poor / Community Benefit should include budget dollars for **Categories I through V** (defined in the *Reporting* section) for the upcoming fiscal year as well as projected budget dollars for **each** Category. **The projected budget dollars should, at a minimum, contribute on an on-going basis to the system's targeted benchmark that will be established in FY06 and updated in each subsequent fiscal year.**

Reporting

1. Dollar values should be reported on an annual basis for each of the following five categories:

   a. Category I – Charity Care (free care or reduced fee/sliding scale care for persons who qualify for financial assistance).

   b. Category II – Unreimbursed cost of care provided to patients enrolled in public programs.

   c. Category III – Community benefit programs and services targeted to persons who are poor

   d. Category IV – Community benefit programs and services targeted to the general community

   e. Category V – Bad debt costs attributable to Charity Care.

2. Guidelines for Category I. The following should serve as guidelines for reporting Category I – Charity Care. (Also see Policy on Billing and Collections for the Uninsured)

   a. Charity care dollars should be an estimate of the cost to provide services to patients who qualify for charity care.
   b. Charity care should include the cost of services provided to charity care patients in all settings (acute and non-acute settings such as ambulatory surgery centers, etc.)

3. Guidelines for Category II. The following should serve as guidelines for reporting Category II – Unreimbursed cost of care provided to patients enrolled in public programs.

   a. Medicare losses/shortfalls should not be reported. This is consistent with standards set by the CHA community benefit network and used by other Catholic systems.
   b. Losses/shortfalls from all Medicaid sources, including Medicaid managed care products, should be included.
   c. Medicaid disproportionate share (DSH) payments should be considered Medicaid payment/income.
   d. Prior year settlements from Medicaid programs (including Medicaid DSH) should be considered as an offset to the cost of care provided and, accordingly, increase or decrease the shortfall reported.

4. Guidelines for Category III Programs and Services. The following should serve as guidelines for identifying appropriate programs, services, and/or wellness activities/events to be included in Category III – Community benefit programs and services targeted to the poor. (See Exhibit A for examples of included/allowable Category III and Category IV programs/services/ activities.)

a. The program/service/activity/event must respond to the needs of special populations; for example, the frail elderly, poor persons with disabilities, the chronically mentally ill, persons with AIDS, or those who find it hard to meet basic needs due to on-going poverty.
b. The program/service/activity/event should be quantifiable in terms of dollars and should not be included in Category I or II.
c. The program/service/activity/event should generate a low or negative margin.
d. The program/service/activity/event may be financed by philanthropic contributions, volunteer efforts, and endowment, grants, shortfalls, etc.
e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue is primarily motivated by a mission commitment versus a marketing interest.
f. The program/service/activity/event would no longer be available, or would be insufficiently available in the community, or would be the responsibility of the government if not provided by the healthcare organization.

5. Guidelines for Category IV Programs and Services. The following should serve as guidelines for identifying appropriate programs, services and/or wellness activities/events to be included in Category IV – Community benefit programs and services targeted to the general community. (See Exhibit A for examples of included/allowable Category III and Category IV programs/services/ activities.)

   a. The program/service/activity/event should be quantifiable in terms of dollars.
   b. The program/service/activity/event should generate a low or negative margin.
   c. The program/service/activity/event may be financed by philanthropic contributions, volunteer efforts, and endowment, grants, shortfalls, unrestricted donations and/or board designated donations, etc.
   d. The program/service/activity/event provides a response to a unique or particular health problem in the community or is directed to promoting the wellness of the population in a holistic manner.
   e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue generally represents a mission commitment versus a business decision.

   For health ministries whose broader community is predominately those persons who are poor and vulnerable, program/services/activities/events targeted towards the broader community should be recorded in Category III.

6. Reporting Costs for Categories III and IV Programs and Services. The following should serve as guidelines for reporting costs for programs, services, activities or events appropriate to be included in Category III – Community benefit programs and services targeted to the poor and Category IV – Community benefit programs and services targeted to the general community.

   a. Report cost less any reimbursement received.

b. All unrestricted donations and/or board designated donations for Category III or IV programs/services/activities/events should be reported as a community benefit.
c. Medical Education programs should be reported as a community benefit.
   i. Medicare Graduate Medical Education (GME) payments should offset costs.
   ii. Medicare Indirect Medical Education (IME) payments should not be offset against the direct cost of medical education programs.
d. Volunteering may be reported.
   i. Include employee reported volunteer time for hospital supported activities such as:
      - Employee time volunteered to assist in health screenings performed after hours
      - Replacement cost for employees performing management approved volunteer activities
      - Staff volunteer time (with supervisor approval) spent conducting organizational sponsored events
      - Board representation on management approved organizations

7. Guidelines for Category V. The following should serve as guidelines for reporting Category V – Cost of Bad Debt attributable to Charity Care.

   Bad debt cost of services can be calculated for certain bad debt write-offs. This acknowledges that there are charity care patients that may not be identified initially as eligible for charity care. Two possible formulae for determining the cost of bad debt for services provided to charity care patients include:

   a. *Cost of bad debt excluding the portion related to coinsurance and deductibles.* Patients who have a coinsurance payment or deductible are assumed to have insurance.

   b. *Identify the zip code average income that constitutes "poor" and count all bad debts from those zip codes, excluding the portion related to coinsurance and deductibles.* It is recognized that while this methodology may count patients with the ability to pay who reside in these zip codes, the methodology also excludes patients from other zip codes that may not be able to pay.

8. Beginning with the Care of Persons Who are Poor / Community Benefit report due for FY05 and beyond, provide a narrative for each Care of Persons Who are Poor / Community Benefit goal identified in the Integrated Strategic and Financial Plan and describe progress towards achievement for each goal, including to the extent possible baseline measures of success being established, outcomes achieved, program impact, etc.

9. Care of Persons Who are Poor / Community Benefit goals are part of the Integrated Strategic and Financial Plan. Therefore, reporting for Goals is due consistent with the Integrated Strategic and Financial Plan timeline.

AL, Birmingham
St. Vincent's Hospital

ST. VINCENT'S HOSPITAL BIRMINGHAM, ALABAMA HOSPITAL POLICY	SUBJECT	NUMBER
	CHARITY CARE/ FINANCIAL ASSISTANCE	8530-403

ORIGINATING DEPARTMENT	EFFECTIVE DATE	SUPERSEDES POLICY NO.	DATED
BUSINESS OFFICE	5/1/04	8530-028	3/27/94

Approval: _____
Jerry C. Smith
Director, Business Services and HIM

POLICY

Consistent with St Vincent's Hospital's Charity Care Policy #8530-020 the Business Office will offer patients an opportunity to apply for financial assistance with their hospital bills. No Patient will be refused admission to St Vincent's based on their ability to pay for the services provided.

PROCEDURE

A. During the initial financial review or in the process of collecting an account balance, patients who need financial assistance with their hospital bill(s) are identified. At that time, St Vincent's Financial Assistance program is fully explained by the Financial Counselor, Senior Financial Counselor or the Supervisor of Customer Service and Collections.

B. A Financial Assessment application (Attachment 1) will be completed upon interview of a patient or an application may be completed over the telephone. All unusual expenses, income or circumstances will be fully explained on the work summary. The patient will be responsible for submitting proof of income, including the most recent IRS 1040 form, W-2 forms, copies of Social Security check(s) and/or any other requested proof of income.

Review Date: 4/15/04

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C. Charity: When the Financial Assessment application is completed, the application, proof of income, and the patient account(s) will be reviewed and a recommendation for assistance will be based on the comparison of the patient's household income to the Federal Poverty Income Guidelines and on the patient's demonstrated ability to pay. Also, any outstanding medical bills the patient may have accumulated will be taken into consideration. Patients, whose income is within the Federal Poverty Guidelines or within twice the guidelines, will be given a full allowance on their account(s) balance.

D. Financial Assistance: Patients, whose income is more than twice but less than 3 times the Federal Poverty Guidelines will be allowed a discount based on the family unit size and income amount. (Attachment 2) Patients with income over 3 times the Federal Poverty Guidelines will receive a discount based on the best payor rate.

E. Based on the assessment, an analysis and a recommendation will be documented on each account the patient may have on the hospital billing system.

F. The allowance transactions bill be recorded on the computer source document, assigned a batch number and approved by the Supervisor of Customer Service and Collections.

G. The Financial Assessment application, proof of income, and all other documentation will be scanned to the patient's account(s) as documented type "Charity".

H. The Supervisor of Customer Service and Collections will compile a report of all patients, who receive a $45,000 or more in charity allowances. Supervisor will present the report to St Vincent's Board of Directors for approval on a bimonthly basis during the fiscal year.

I. If a patient applies for financial assistance in the succeeding calendar year, a Financial Assessment application will be processed as outlined above each and every time.

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Financial Assessment

ST. VINCENT'S HOSPITAL

AL, Birmingham
St. Vincent's Hospital

PATIENT INFORMATION DATE:

Name		Social Security No.	Marital Status	Sex	Birth Date
Address			Zip Code	Home Phone Number	
County	Attending Physician		Referring Physician		
Employer	Employer Contact		Phone Number	Previous Patient Yes No	
Employer's Address			Zip Code		
Spouse's Employer	Address		Zip Code		
Name of Church	Mother's Maiden Name		Father's Name		

GUARANTOR INFORMATION (if other than patient or spouse):

Name		Social Security No.	Phone Number
Address			Zip Code
Employer	Employer's Address		Phone Number

DEPENDENTS (excluding patient)

Name	Age	Relationship	Social Security Number	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

INSURANCE INFORMATION

Insurance #1	Policyholder's Name	Contract Number
	State (other than Alabama)	Group Name and Number
Insurance #2	Name (as listed on card)	Contract Number
	Group and Group Number	Contract Number

Form 8530-595

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AL, Birmingham
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Other Income Per Month		Personal Assets		Monthly Living Expenses	
Social Security		Cash on Hand		Mortgage	
S.S.I.		Savings Account		Rent	
V.A. Pension		Checking Account		Electric	
Pension		CD's		Gas	
Unemployment		Securities		Telephone	
Worker's Comp.		Life Insurance		Water	
Interest Income		Property		Food	
Dividend Income		Other		Furniture	
Child Support				Car Payment	
Alimony				Clothing	
Rent				Boat Payment	
Other				Day Care	
Food Stamps				Child Support	
Total		Total		Total	

Financial Settlement		Vehicle Information		(Make)	(Year)
Insurance		Car			
Inheritance		Truck			
Other		Boat			
		Other			
Total					

Other Monthly Expenses:

Type	Monthly Payments	Balance
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Total:		

Property Information
Description

Location

Use

In addition to the information requested above, I have provided the following as evidence of my income: (1) My last three bank statements; (2) IRS Form 1040 with Schedules and W-2 Wage Statements. If I am unable to provide this information, St. Vincent's has my permission to request same from my employer.

To the best of my knowledge, I hereby certify that the above information is true and correct, and that this is a complete record of my assets and liabilities. St. Vincent's Hospital has my permission to investigate my credit history.

Date:

Signature of Patient or Guarantor

Signature of Interviewer

Form 8530-194
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2004 Financial Assistance payment scale per SVH Charity Policy

AL, Birmingham
St. Vincent's Hospital

Size of Family unit	Annual Salary	Charity adjustment	Patient Payment amount
1	$18,620 - $20,481	100%	0%
	$20,482 - $22,343	80%	20% of total billed or Best payor rate, whichever is less.
	$22,344 - $24,205	60%	40% of total billed or Best payor rate, whichever is less.
	$24,206 - $26,067	40%	60% of total billed or Best payor rate, whichever is less.
	$26,068 - $27,929	20%	80% of total billed or Best payor rate, whichever is less.
	$27,930 or greater	0%	Best payor rate for services
2	$24,980 - $27,477	100%	0%
	$27,478 - $29,975	80%	20% of total billed or Best payor rate, whichever is less.
	$29,976 - $32,473	60%	40% of total billed or Best payor rate, whichever is less.
	$32,474 - $34,971	40%	60% of total billed or Best payor rate, whichever is less.
	$34,972 - $37,469	20%	80% of total billed or Best payor rate, whichever is less.
	$37,470 or greater	0%	Best payor rate for services
3	$31,340 - $34,473	100%	0%
	$34,474 - $37,607	80%	20% of total billed or Best payor rate, whichever is less.
	$37,608 - $40,741	60%	40% of total billed or Best payor rate, whichever is less.
	$40,742 - $43,876	40%	60% of total billed or Best payor rate, whichever is less.
	$43,876 - $47,009	20%	80% of total billed or Best payor rate, whichever is less.
	$47,010 or greater	0%	Best payor rate for services
4	$37,700 - $41,469	100%	0%
	$41,470 - $45,239	80%	20% of total billed or Best payor rate, whichever is less.
	$45,240 - $49,009	60%	40% of total billed or Best payor rate, whichever is less.
	$49,010 - $52,779	40%	60% of total billed or Best payor rate, whichever is less.
	$52,780 - $56,549	20%	80% of total billed or Best payor rate, whichever is less.
	$56,550 or greater	0%	Best payor rate for services
5	$44,060 - $48,466	100%	0%
	$48,466 - $52,871	80%	20% of total billed or Best payor rate, whichever is less.
	$52,872 - $57,277	60%	40% of total billed or Best payor rate, whichever is less.
	$57,278 - $61,683	40%	60% of total billed or Best payor rate, whichever is less.
	$61,684 - $66,089	20%	80% of total billed or Best payor rate, whichever is less.
	$66,090 or greater	0%	Best payor rate for services
6	$50,420 - $55,461	100%	0%
	$55,462 - $60,503	80%	20% of total billed or Best payor rate, whichever is less.
	$60,504 - $65,545	60%	40% of total billed or Best payor rate, whichever is less.
	$65,546 - $70,587	40%	60% of total billed or Best payor rate, whichever is less.
	$70,588 - $75,629	20%	80% of total billed or Best payor rate, whichever is less.
	$75,630 or greater	0%	Best payor rate for services

Effective 3/1/04

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2004 Financial Assistance payment scale per SVH Charity Policy

AL, Birmingham
St. Vincent's Hospital

7	$56,780 - $62,457	100%	0%
	$62,458 - $68,135	80%	20% of total billed or Best payor rate, whichever is less.
	$68,136 - $73,813	60%	40% of total billed or Best payor rate, whichever is less.
	$73,814 - $79,491	40%	60% of total billed or Best payor rate, whichever is less.
	$79,492 - $85,169	20%	80% of total billed or Best payor rate, whichever is less.
	$85,170 or greater	0%	Best payor rate for services
8	$85,170 - $63,139	100%	0%
	$63,140- $69,453	80%	20% of total billed or Best payor rate, whichever is less.
	$69,454 - $75,767	60%	40% of total billed or Best payor rate, whichever is less.
	$75,768 - $82,081	40%	60% of total billed or Best payor rate, whichever is less.
	$82,082 - $88,395	20%	80% of total billed or Best payor rate, whichever is less.
	$88,396 or greater	0%	Best payor rate for services

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AL, Mobile
Providence Hospital

Page 1 of 1	Code Number: 50155
PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS Providence Hospital 6801 Airport Blvd. Mobile, AL 36608	Section: Business Office Subject: Collection Practices

Donna Bragg 6-30-04 Vincent Fonvit 6-30-04
Department Director Date Line Officer Date

Policy: The Providence Hospital Business Office will strive to ensure socially just billing and collection practices are followed for our patients.

Procedure:

1. Liens on personal residences are permitted only in the following circumstances:
   a. The patient does not qualify for charity or financial assistance, and the patient is not complying with payment arrangements that have been agreed to by the hospital and the patient.
   b. The lien will not result in a foreclosure on a personal residence.
   c. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from hospital management.
2. Garnishments are only permitted if:
   a. The patient does not qualify for charity or financial assistance and a court determines that the patient's wages are sufficient for garnishment.
   b. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from hospital management.
3. We will not persue an involuntary bankruptcy proceeding against a patient as a result of our collection efforts on uninsured patients.
4. No collection agency, collection attorney, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person to be issued.
5. Interest charges on outstanding balances may only be assessed if:
   a. The patient does not qualify for charity or financial assistance and the patient is not complying with payment arrangements.
   b. No add on to hospital discount.
6. Management is accountable to ensure that all collection policies follow the federal Fair Debt and Collection Practices Act.

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AL, Mobile
Providence Hospital

Page 1 of 3	Code Number: 501.06
PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS Providence Hospital 6801 Airport Blvd. Mobile, AL 36608	Section: Business Office Subject: Bad Debt Approval

Department Director 6-30-04 Date Line Officer 6-30-04 Date

Policy:

An amount deemed uncollectible must be approved prior to write-off.

Procedure:

Bad Debt

1. **A Patient Accounts Representative will review each potential charge-off as Bad Debt for:**

   A. Proper Insurance Billing
      i. Were all insurances filed?
      ii. Have the carriers paid their part in full?
      iii. Has the carrier requested additional information?
   B. Notification to patient and/or guarantor of insurance rejections by the Billing Department
   C. Collections calls and follow-up
   D. Collection letters
   E. Returned bank note/Miracorp Finance

2. **At such time the Patient Accounts Representative has exhausted all possible collection efforts and determined that the account in uncollectible or that the account should be referred to a commercial collection agency, he/she will prepare the account for Bad Debt. The accounts will be forwarded for approval with the following documents.**

   A. $3,000.00 and above
      1. A written summary of all pertinent billing and collection activity (typed if $75,000.00 and over), with the appropriate "Bad Debt Approval" stamp indicating the correct Bad Debt financial class to be used.
      2. A copy of the admission sheet.
      3. Account history

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B. $1,000.00 - $3,000.00
   1. A written summary of all pertinent billing and collection activity, with the appropriate "Bad Debt Approval" stamp indicating the correct Bad Debt financial class to be used.
   2. A copy of the admission sheet.
   3. Account history.

C. Inpatients accounts with balances less than $1,000.00 will be reviewed from the patient account history card.

D. All accounts with balances $1,000.00 and should have a credit inquiry.

E. All correspondence, financial statements, etc. are available in IMS.

3. The approval for Bad Debt write-off is as follows:

A. All accounts from $14.01 to $500.00 are approved by the Patient Accounts Representative.

B. All accounts from $500.00 to $1,000.00 are approved by the Patient Accounts Representative and the Patient Accounts Supervisor.

C. All accounts from $1,000.00 to $3,000.00 are approved by the Patient Accounts Representative, Patient Accounts Supervisor, and the Patient Accounts Manager.

D. All accounts from $3,000.00 to $50,000.00 are approved by the Patient Accounts Representative, Patient Accounts Supervisor, Patient Accounts Manager and the Vice President of Finance.

E. All accounts from $50,000.00 to $75,000.00 are approved by Patient Accounts Representative, Patient Accounts Supervisor, Patient Accounts Manager, Vice President of Finance, and the President.

F. All accounts greater than $75,000.00 are approved by the Patient Accounts Representative, Patient Accounts Supervisor, Patient Accounts Manager, Vice President of Finance, President, and Board of Directors.

4. Any file placed with a collection agency or collection attorney will require additional approval for garnishment or suit requests. A request must be submitted from the

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AL, Mobile
~~Providence Hospital~~

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Bad Debt Approval

Providence Hospital
6801 Airport Blvd.
Mobile, AL 36608

agency/attorney and must go through the same approval process outlined in number 3.

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AL, Mobile
Providence Hospital

Code Number: 501.07A

Providence Hospital
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Mobile, AL 36608

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Charity Guidelines

Donna Bragg 6-10-04
Department Director Date

Vincent Fonvx 6-10-04
Line Officer Date

Policy: CHARITY GUIDELINES 2004

Procedure:

FAMILY SIZE	MINIMUM	MAXIMUM	DIFFERENCE
1	$18,620	$23,275	$ 4,655
2	$24,980	$31,225	$ 6,245
3	$31,340	$39,175	$ 7,835
4	$37,700	$47,125	$ 9,425
5	$44,060	$55,075	$11,015
6	$50,420	$63,025	$12,605
7	$56,780	$70,975	$14,195

For each additional family member add $3,180

If the annual family income is equal to or less than the minimum, the patient should receive 100% charity.

If the annual family income is equal to or greater than the maximum, then no charity is applied.

If the annual family income is between the minimum and maximum ranges, the charity discount should be calculated as shown below:

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AL, Mobile
Providence Hospital

Code Number: 501.07A

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Charity Guidelines

Providence Hospital
6801 Airport Blvd.
Mobile, AL 36608

1. Subtract the minimum from the annual income.

2. Divide the sum by the difference between the minimum and the maximum.

3. The result is the percentage of the bill the patient should pay. If this amount is less than 10%, consider 100% charity.

*Patient Responsibility Cap

Regardless of priority of visit, if patient responsibility is less than $20,000.00, then patient responsibility cap is 75% of charges.

If total charges are greater than $20,000.00, then patient responsibility cap is 5% - 10% of income per year for five years. Sliding scale is based on the fact that monthly payment cannot exceed ability to pay.

*Exclusion:

1. If employer offers health insurance and patient did not obtain.
2. The patient is uncooperative (will receive agency letter, possible non-exclusive)

Financial Statement:

Eligible expenses are listed on the patient's financial statement, without exception.

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AL, Mobile
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Page 1 of 1	Code Number: 501.0 B
PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS Providence Hospital 6801 Airport Blvd. Mobile, AL 36608	Section: Business Office Subject: Appeals Process for Charity Care Denials

Department Director 6-30-04 Date Line Officer 6-30-04 Date

Policy: The Business Office will review any request for charity care in accordance with policy 501.07. The patient or guarantor may submit an appeal of a charity care denial.

Procedure: The Patient Accounts Representative will notify the patient/guarantor of the denial for charity assistance.

1) The Patient Accounts Representative will provide an explanation for the denial to the patient/guarantor.

2) If a patient feels additional critical information, not included on the original financial statement, would allow for reconsideration of the charity assistance, they may appeal, in writing.

3) The appeal must include the additional information and the reason it was not on the original financial statement.

4) The appeal will be forwarded to the Patient Accounts Supervisor for review. If the additional information or extenuating circumstances have the potential to reverse the denial, a summary will be prepared & submitted to the Patient Accounts Manager.

5) The appeal will be forwarded to the Sr. Vice President of Finance and the Vice President of Mission Services for review and consideration of a panel review, as deemed necessary. If the appeal does not overturn the original decision, a reason for the denial should be provided to the patient/guarantor.

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AL, Mobile
~~Providence Hospital~~

Page 1 of 1	Code Number: 502.19
PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS Providence Hospital 6801 Airport Blvd. Mobile, AL 36608	Section: Business Office Subject: Referrals to Agencies

Donna Burgy 1-8-04 — Department Director, Date
Vincent Ferm 1-8-04 — Line Officer, Date

Policy:

The Patients Accounts Representatives will at all times be aware of available community service agencies available to the patients.

Procedure:

1. The Patients Accounts Representatives will keep an updated list of available agencies to give to patients requiring or requesting assistance. (See sample attached)

2. Any patient requesting assistance from any agency not on the list will be referred to the Social Work Service Department of MedAssist.

3. The Patient Accounts Representatives will stay in contact with agencies to insure receipt of changed information.

4. The Patient Accounts Representatives will maintain an up-to-date file of agencies, adding and deleting when necessary.

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AL, Mobile
Providence Hospital

Page 1 of 2	Code Number: 501.57
Providence Hospital 6801 Airport Blvd. Mobile, AL 36608 PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS	Section: Business Office Subject: Discounts

Donna Bowsy 6-10-04 Vincent Tom 6-10-04
Department Director Date Line Officer Date

Policy:

All patient balances are due and payable in full at the time service is rendered. A discount may be offered to assist with prompt remittance.

Procedure:

The Patient Accounts Department is responsible to collect all outstanding patient balances. Every effort should be made to collect patient balances in full. Preferred payment methods are cash, and/or credit cards. Alternate methods are bank financing or monthly payments as outlined in policy and procedure numbered 501.82.

A Patient Accounts Representative may offer an incentive discount, if necessary, to obtain payment in full within ten (10) days from contact of patient. The discount may not exceed 40% of total charges on private pay accounts and may not exceed 30% of the patient balance due after insurance has paid. Any account with a balance that is less than $100.00 is not eligible for a discount.

Amount of Discount	Approval Discount
$00 to $500.00	Patient Accounts Representative
$501.00 to $1,000.00	Patient Accounts Supervisor
$1,001.00 to $19,999.00	Patient Accounts Manager
$20,00.00 and above	Patient Accounts Manager and Senior Vice-President of Finance

After a verbal agreement regarding payment and discount are made, an agreement/disclaimer will be mailed to the patient on any account balance greater than $500.00. See Exhibit I. The agreement/disclaimer must be returned with patient and/or guarantor signature before discount may be applied to account.

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AL, Mobile
~~Providence Hospital~~

Page 2 of 2	Code Number: 501.37
PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS Providence Hospital 6801 Airport Blvd. Mobile, AL 36608	Section: Business Office Subject: Discounts

Discounts to commercial insurance companies (on accounts 45 days or less) should not exceed 5% for balances under $4,999.99, 10% for $5,000.00 to $29,999.00, and 15% for balances over $30,000.00. Payment must be received with ten (10) working days and in lieu of audit. Discounts should not be offered or agreed to if an account is more than seventy-five (75) days old or benefit is not greater than 70%. Special circumstances may dictate further review by the Patient Accounts Manager.

All discounts should be written under Prompt Payment Discount transaction number (530093).

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AL, Mobile
Providence Hospital

Code Number: 501.07

Providence Hospital
6801 Airport Blvd.
Mobile, AL 36608

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Charity Care

Donna Bourgeois 6-10-04 Vincent Fornia 6-10-04
Department Director Date Line Officer Date

Policy:

In a manner consistent with the philosophy and mission of the Daughters of Charity and Sisters of St. Joseph, Providence Hospital shall provide all available health care services to the sick and injured. All people have the right to enjoy adequate health care. This inherent right shall not be abridged on the basis of race, religion, sex or national origin. Respect for the dignity of the individual will be maintained at all times.

Definitions:

- The Poor – Those persons so classified by the organization rendering the service.
- Bad Debt – Bad Debt accounts are those accounts determined to be delinquent after all collection procedures have been concluded without payment or response from the guarantor, the accounts are transferred to a collection agency or attorney for further collection procedures.
- Examples of Bad Debt Accounts –
  (1) Non-poor uninsured not paying bill
  (2) Non-poor insured not paying copay or deductible
  (3) Debtors with the ability to pay, but are unwilling to do so
- Charity Care – A patient is classified as a charity patient in accordance with certain established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In addition to providing charity care, the Hospital provides other services for the general community. The cost for providing these services is included in operating expenses.

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AL, Mobile
Providence Hospital

Page 1 of 1	Code Number: 501.53A
Providence Hospital 6801 Airport Blvd. Mobile, AL 36608 PROVIDENCE HOSPITAL POLICY & PROCEDURE MANUALS	**Section: Business Office** **Subject: Discounts-Prompt Pay**

Donna Bonagy 6-30-04 Vincent Ferrer 6-30-04
Department Director Date Line Officer Date

Policy:

An important collection tool is the offering of prompt pay discounts to patients for their balance due. The Patient Accounts Representative has the authority to offer prompt pay discounts in accordance with procedure.

Procedure:

1. Patient Accounts Representatives can offer prompt pay discounts up to 30% on patient balances after insurance. The Patient Accounts Manager must approve any higher discount requests.

2. Patient Account Representatives can offer up to 40% discount on straight private pay accounts. The Patient Accounts Manager must approve any higher discount requests.

3. Any account with a balance that is less than $100.00 is not eligible for a discount.

4. Once it has been determined what the patient balance is, a discount may be offered within a 45-day period. The Patient Accounts Manager must approve any exception.

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AL, Mobile
Providence Hospital

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Charity Care

Providence Hospital
6801 Airport Blvd.
Mobile, AL 36608

- Examples of Charity Patients -

(1) Low-income uninsured not expected to pay all or part of the bill
(2) Uninsured able to pay only a portion via an income-related fee schedule
(3) Medicaid or state-local patients, who exceed coverage limits (i.e., inpatient days)
(4) Low-income insured not paying copay or deductible
(5) Medicaid payments below costs
(6) State local government program payments below cost
(7) Patients willing to pay who are without the resources to do so
(8) Deceased patients
(9) Medicare patients that meet charity guidelines and assets (convertible to cash & unnecessary for daily living) do not exceed account balance.

Procedure:

1. The Patient Accounts Representative will provide a financial statement to any patient/guarantor who requests one, or anyone the Patients Accounts Representative feels may be a candidate for charity. At times it may be necessary to take this information over the telephone, with the condition that the patient will mail all supporting documentation within two weeks if the personal credit history does not match the financial statement. The Patient Accounts Representative will review each potential charity account to insure it meets one or more of the following criteria:
   A. Patient expired, no estate, no family.
   B. Patient/guarantor meets low-income guide criteria as by hospital policy.
   C. Patient/guarantor not eligible for financial aid from community resources (see attached listing).
   D. Payment of bill would create an extreme hardship on family or patient if account balance is greater than $5,000.

2. Accounts may be prepared for charity upon recommendation from Social Work Services or Administration.

3. Balances due from patients who are eligible for Medicaid will quality for charity without further review (i.e., non-covered days, outpatient visits exceed limits, non-covered service)

4. Income is defined as total cash receipts before taxes from all sources. These include money, wages, and salaries before deductions, receipts from self-employment

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Providence Hospital
6801 Airport Blvd.
Mobile, AL 36608

PROVIDENCE HOSPITAL

POLICY & PROCEDURE MANUALS

Section: Business Office
Subject: Charity Care

(includes farm income after deduction for expenses), payments from public assistance, social security, unemployment, workers' compensation, strike benefits, child support, military allotments and any other sources of income.

5. Each account deemed eligible for charity will be processed and will be forwarded for approval with the following documents:
   A. A written summary of pertinent patient financial medical and family data stamped for charity approval.
   B. A copy of the admission sheet.
   C. Account History Card (i.e., TransUnion credit file if greater than $1,000.00, if not Medicaid)

6. Once the account has been approved for charity write-off based on patient's income levels, any remaining balance should be reviewed under Section I (D).
   A. The Patient Representative should determine from the financial statement and discussions with the patient the maximum monthly payments for which the patient can contract.
   B. At no time should the amount remaining as due from the patient, after charity write-off, fall under 5% of the annual income over five years.
   C. The amount remaining, as due from the patient, should then be set up as monthly payments (reference Policy 501.82).

7. The approval for charity is as follows:

   A. All accounts from $25.00 to $1,000.00 are approved by the Patient Accounts Supervisor.
   B. All accounts from $1,000.00 to $3,000.00 are approved by the Patient Accounts Supervisor and Patient Accounts Manager.
   C. All accounts from $3,000.00 to $50,000.00 are approved by the Patient Accounts Supervisor, Patient Accounts Manager and the Senior Vice President of Finance.
   D. All accounts from $50,000.00 to $75,000.00 are approved by the Patient Accounts Supervisor, Patient Accounts Manager, Senior Vice President of Finance, and President.
   E. All accounts greater than $75,000.00 are approved by the Patient Accounts Supervisor, Patient Accounts Manager, Senior Vice President of Finance, President, and Board of Directors. (summary must be typed)

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CT, Bridgeport
St. Vincent's Health Services, Inc.

DRAFT

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Charity Care	Classification: 700-1
Effective Date:	February 3, 1992 January 1, 1998	Category: Financial
Revision Date:	August 22, 1994 April 16, 1996 March 9, 1998 May 20, 2002	
Reference Material:	Ascension Policy #16	Administrative Approval:

DRAFT

Policy: St. Vincent's Medical Center has established the provision of health care to all members of the Community as an integral part of its Mission. In an effort to ensure that care is available to all segments of the community, St. Vincent's Medical Center has established a Charity Care Policy which will absolve a portion of the bills which are beyond the patient's ability to pay. While no person is turned away for their inability to pay, it is expected that each patient will contribute to the cost of their health care in a manner befitting their individual financial circumstances.

Purpose: To provide guidelines for decision making regarding the provision of health care based on the patients ability to pay for care. These will be developed and updated periodically for all Services at the Medical Center.

Special Instructions, Information, Implementation Procedures:

At the time of their initial interview, the above patients are to be informed that the Medical Center does have a policy entitling them to a possible reduction in their liability for services rendered by the Medical Center. The Medical Center will determine income standards based on fixed percentages of those prescribed within the Federal Register as the "Federal Poverty Guidelines".

All recurring patients who are eligible for a discount will receive a Discount Identification Card. The card will show patient name, unit record number, financial class and a date of issue. Discount Identification Cards will be reviewed at least annually.

Eligibility Requirements

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DRAFT

Policy 700-1

Patients may apply for discounted or free care by filling out an "Application for Charity Discount".

Charity Care shall be granted provided:

1. The applicant's income renders him/her eligible based on the income levels in relationship to the family size according to the Federal Poverty Guidelines.

2. After all applicable third party benefits have paid for their portion of the cost of the service.

3. Patient's income is above the DSS income standard, but insufficient to pay for medical bills.

4. If the amount requested for Charity Care is greater than $5,000, the applicant shall agree to the placement of a lien on any real property he/she owns in order to qualify. No patient will ever be forced into selling the real property to satisfy the lien. In addition, the applicant shall agree to establish payment arrangements on that portion of the bill that is equal to the amount of excess income as determined by the asset grid.
   WE NEVER PLACE LEINS ON CHARITY CARE PATIENTS. (*)

5. The applicant cooperates by providing and verifying all information necessary to establish their eligibility. Applicants who fail to cooperate shall not be granted Charity Care and will be expected to pay their bill in full.

Income/Asset Parameters

1. Earned and unearned income shall be applied against medical needs when determining eligibility. (Earned income is income from employment; unearned income is income from other sources).

2. The income of all family members shall be applied against medical needs.

3. Income shall not be counted unless it is actually available to the applicant.

4. Earned income shall be counted for a four-week period preceding the ~~date of service~~ FINANCIAL ASSISTANCE APPLICATION DATE; unearned income shall be determined based on the interview.

5. The Asset Grid shall be applied once the total of the outstanding bills owed exceeds $5,000 or greater. ~~A lien shall be placed on any real property.~~

6. The Medical Center will compare the patient's total family income to the income limits established for Charity Care.

7. Patients found to have income equal to or below State and City Welfare standards shall be referred to that agency by following the application process for said program.

8. Patients will be screened for suitableness for Special Programs, such as Healthy Start, or Husky B before

#4 WILL BE DELETED
(*) WE HAVE PLACED LEINS FOR SELF PAY COLLECTIONS PRIOR TO 1999. CURRENTLY 12 LEINS OUTSTANDING.

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being considered for Charity Care.

Reviewed: March 28, 1994, June 10, 1996, January 24, 2000, March 3, 2004
/bjk

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CT, Bridgeport
St. Vincent's Health Services, Inc.

St. Vincent's - Bridgeport, CT
Admin - Patients with No Medical Insurance
Item #12

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Patients With No Medical Insurance	Classification: 700-12 700-13 now combined
Effective Date: Revision Date:	May 18, 1977 May 26, 1987 October 30, 1989 October 29, 1990 March 16, 1992 December 18, 1995 August 9, 1999 December 11, 2000	Category: Fiscal
Reference Material:	Patient Access Services and Patient Financial Services Manuals Admission Policy (600-1) Urgent Admission Policy (600-18) Charity Care Policy (700-1)	Administrative Approval:

Policy: Outpatients and Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their entire bill.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implementation Procedures:

I. Elective Patients

A. The physicians' offices shall schedule patients in accordance with St. Vincent's Medical Center policies and procedures. (600-1 and 600-18)

B. When a physician schedules a self pay patient, the arrival date is to be held in a pending status until the Patient Access Services Financial Counselor is able to establish a financial source.

C. Prior to the pending arrival date, the Financial Counselor will do the following in accordance with hospital procedures to establish a payment plan:
- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Charity Care Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital charges resulting from the treatment if a payment plan is established by the Medical Center.

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D. Once a financial source is determined the pending date will be finalized and detailed information provided to the physician's office.

E. If a financial source cannot be determined, the physician's office will be notified of this and the patient will be held in pending status until a financial source has been determined.

F. In the event a financial source cannot be established, the decision to treat the patient will be made by Senior Management of the Medical Center.

II. Urgent or Emergent Patients

A. Emergent or urgent services will never be refused to a patient due to the inability to pay the Medical Center.

B. The Financial Counselor will interview the patient or appropriate family member on the next business day in accordance with hospital procedures to establish a payment plan:

- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Charity Care Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital charges resulting from the treatment if a payment plan is established by the Medical Center.

C. If a financial source cannot be established, the Director of Patient Access Services will refer the account over to the Collections section of the Patient Finance Department and will notify Senior Management of the situation.

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

/bjk

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St. Vincent's, Bridgeport, CT
Item #12
Admin - Patients with no Medical Insurance

CT, Bridgeport
St. Vincent's Health Services, Inc.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Patients With No Medical Insurance	Classification: 700-12 700-13 now combined
Effective Date: Revision Date:	May 18, 1977 May 26, 1987 October 30, 1989 October 29, 1990 March 16, 1992 December 18, 1995 August 9, 1999 December 11, 2000	Category: Fiscal
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Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

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St. Vincent's Bridgeport, CT
Admit - Ambulatory Patients
With No Medical Insurance
Nurx #12

CT, Bridgeport
St. Vincent's Health Services, Inc.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Ambulatory Patients With No Medical Insurance	Classification: 700-12
Effective Date:	May 18, 1977	Category: Fiscal
Revision Date:	May 26, 1987 October 30, 1989 October 29, 1990 March 16, 1992 December 18, 1995 August 9, 1999	
Reference Material:	Business Office	Administrative Approval:

Policy: Ambulatory Patients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their entire bill.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implemention Procedures:

During the interview process, some patients may indicate that they have no third party coverge for their health services. The patient (or the responsible party) will be asked to certify in writing that he/she intends to pay all hospital charges resulting from the treatment.

No urgent or emergency services will ever be refused to a patient because of inability to pay. Patients may qualify for "Charity Care" through a means test which determines their ability to pay and the charge is reduced accordingly or entirely abated based upon their ability to pay. (See Policy 700-1).

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

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St. Vincent's, Bridgeport, CT
Item #12
Admin: Ambulatory Patients with No Medicare Insurance

CT, Bridgeport
St. Vincent's Health Services, Inc.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Ambulatory Patients With No Medical Insurance	Classification: 700-12
Effective Date:	May 18, 1977	Category: Fiscal
Revision Date:	May 26, 1987 October 30, 1989 October 29, 1990 March 16, 1992 December 18, 1995 August 9, 1999	
Reference Material:	Business Office	Administrative Approval:

Policy: Ambulatory Patients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their entire bill.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implemention Procedures:

During the interview process, some patients may indicate that they have no third party coverge for their health services. The patient (or the responsible party) will be asked to certify in writing that he/she intends to pay all hospital charges resulting from the treatment.

No urgent or emergency services will ever be refused to a patient because of inability to pay. Patients may qualify for "Charity Care" through a means test which determines their ability to pay and the charge is reduced accordingly or entirely abated based upon their ability to pay. (See Policy 700-1).

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

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Attorney-Client
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St. Vincent's, Bridgeport CT
Item #12
Admin - Inpatients without Hospitalization

CT, Bridgeport
St. Vincent's Health Services, Inc.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Inpatients with No Hospitalization Insurance	Classification: 700-13
Effective Date:	May 18, 1977	Category: Fiscal
Revision Date:	May 26, 1987 November 8, 1994 May 26, 1998	
Reference Material:	Business Office	Administrative Approval:

Policy: Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their entire bill.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implementation Procedures:

During the Admission process, some patients may indicate that they have no third party coverage for their health services. The patient (or the responsible party) will be asked to certify in writing that he/she intends to pay all hospital charges resulting from the treatment. No urgent or necessary admissions will ever be refused to a patient because of inability to pay.

Early in the hospital stay of a patient without third party coverage, a representative of the Patient Financial Services Department will visit the patient at a medically appropriate time to discuss payment of the bill. The representative will discuss the patient's financial situation and attempt to locate some source of third party payment for the hospital bill. If no such source is available, the representative will arrange a realistic payment plan consistent with the patient's social and financial situation, prior to discharge. See policy 700-14. In addition, the Patient Financial Services Representative will review the patient's financial resources in view of our Charity Care Policy. See Policy 700-1.

Reviewed: May 1979, March 1981, April 23, 1984, November 27, 1989, October 29, 1990
March 16, 1992, August 12, 1996

/bjk

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St. Vincent's - Bridgeport CT
Item #12
Admin - Inpatients without Hospitalization

CT, Bridgeport
St. Vincent's Health Services, Inc.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Inpatients Without Hospitalization Insurance	Classification: 700-13
Effective Date:	May 18, 1977	Category: Fiscal
Revision Date:	May 26, 1987 November 8, 1994 May 26, 1998 March 6, 2000	
Reference Material:	Business Office	Administrative Approval: William J. Riordan

Policy: Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their entire bill.

Purpose: To maintain the financial integrity of the Medical Center.

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Reviewed: May 1979, March 1981, April 23, 1984, November 27, 1989, October 29, 1990
March 16, 1992, August 12, 1996

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Attorney-Client
Privileged Information

DC, Washington
Providence Hospital

Policy: **Charity Care**

Effective Date: **June 1st, 2001**

_____
Departmental Approval

Definition: Consistent with its mission to care for the needy, the hospital provides a specific amount of services without charge or at reduced rates depending on the patient's ability to pay. The amount of free care will be determined by the resources available at the time and the patient's ability to pay. Charity care is separate and different from Bad Debt and their budgets are maintained separately as well in the General Ledger for the purposes of recording and identifying amounts attributable to charity and to monitor charity care in regards to budgetary constrains.

Procedure:

1. **Retrospective Determinations: Urgent & Emergency Admissions.**
   A. **Application**: A completed "Application for Eligibility Determination for Charity Care" initiates the process. Applications are directed to the Resource Counselor for evaluation. Any statement or indication made by or for the patient will be taken as a request for charity care evaluation. Applications may be submitted at any time, including after an account has been transferred to Bad Debt. (Note: This program is intended for those patients with enough resources to justify the process. Patients with no income or assets can be granted Charity Care administratively by the Department Director or the Collections Manager).
   B. **Criteria**: Determinations are based on income and family size. Only those portions of the bill that are the responsibility of the patient may be considered. Applicants must also seek alternative sources of funding whenever possible (Medicaid, Crime Victim's Compensation, Cancer Aide, etc., for which the patient could be eligible. Verification of income, assets, family size, other medical expenses and Medicaid eligibility denial (approval), complete the application.
   C. **Determination**:
   1. **Determine Gross Annual Income**: Income include earnings from all sources: wages, interest, dividends, pensions, social security, welfare, unemployment compensation, etc.. If after-tax income is used, divide by one minus the tax rate

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to arrive at before-tax income. If weekly or biweekly income is used, income must be annualized. Income in kind must also be counted, i.e., if patient lives rent-free, count the fair market value of his/her lodging as income, if board-free, the fair market value of the meals must be counted. Copies of the most recent year's Federal or State Income Tax Return and/or current paycheck stubs must be submitted to verify income. It is expected that the patient will make every effort to substantiate an income that is less than the verifications show: if income is seasonal, if periods of higher earnings alternate with periods of lower earnings or unemployment or if income is expected to change in the near future, every effort will be made to adjust for the differences so as to arrive at an accurate annualized projection. In the absence of reliable verification, i.e., letters or other proof of termination or job changes, etc. (Telephone verifications may be considered but not where the extent of verifications would be burdensome), gross annual income will be calculated from the documents supplied.

2. **Add the value of assets and resources.** Assets in excess of $3,000 will be counted as income. Bank statements must be submitted to verify checking and savings account balances. Interest and/or dividend income claimed on a tax return should be queried as indicative of financial holdings. Personal residences are excluded, unless the patient is deceased and there is no surviving spouse or disabled children.

3. **Subtract medical payment.** Only the amount actually being paid is allowed, not the amount owed, and only those expenses for which the patient is legally responsible may be included. The total of medical bills may be used to determine how long payments are likely to continue. One payment on an account is not enough to substantiate a pattern of payments or a payment plan. All payments may be used to reduce income, but only regular payments may be annualized. Prior payments to Providence on other accounts may be credited but not annualized, since the balance of all accounts will be affected if charity is approved (See procedure to compute the discount). This step completes the adjustments for gross annual income.

4. **Determine family size.** The number of dependants are those which were reported on the most recent Federal or State Tax returns, plus verifiable additions, i.e., birth notices for newborns, etc.. Birth certificates are also acceptable. A patient's word is acceptable if family size has decreased.

5. **Compute the discount.** Locate the applicable percentage of patient's responsibility on the Charity Allowance Scale (Exhibit B), according to the previous verifications of family size and income. This is the percentage of the charges the patient must pay. The charity allowance is equal to one minus the applicable percentage. If payments have already been made, they may be accounted for in one of two ways: 1) used to reduce annual income. If this

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method is chosen, the discount is applied to balance remaining. 2) not used to reduce annual income. If this method is chosen, the discount is applied to the total of the charges, with the payments subtracted from the discounted amount. Care should be taken to select the most favorable method.

D. **Approval Levels**. The level of authorization is as follows: 1) the Collection Manager may approve write-offs to $5,000, and 2) the Department Director approves write-offs in excess of $5,000. The amount of the charity allowance is submitted for approval on a pink "Charity Write-off" sheet, utilizing adjustment code 007. The note message screen on the affected accounts is updated to reflect the determination and a print-out of the notes along with the application, all supporting documents, the work sheet, the write-off sheet and a copy of the bill are submitted together for approval.

E. **Conclusion**. The pink write-off sheet is forwarded by the approving manager to Posting for adjustment of the account, the application is returned to the resource counselor, along with the approval form signed by the manager and finally is filed.

The patient is notified of the approval (or rejection) by letter (Exhibit C), a copy of which is kept with the application. Applications should be processed within 10 days of receipt. Conditional Eligibility may be granted (Exhibit D) where applications are incomplete. If the necessary information or verification are not received within 30 days after the granting of conditional eligibility, the application may be denied. The patient may reapply at any time.

2. Prospective Determinations. Elective Admissions

A. For self-pay patients of hospital staff physicians seeking elective admission who express difficulty making the pre-admission deposit required under the Pre-admission Deposit Policy, and in accordance with paragraph D under section "Self-pay Patients", a charity application may be accepted. All of the foregoing procedures apply, with the exception that the completed application be submitted for approval prior to admission and before any charges have been accrued, unless already paid for. The levels of authorization outlined above will be based on an estimate of charges prepared by the Resource Counselor as called for in the Pre-admission Deposit Policy (Section III, Paragraph A).

B. At the same time, an application for medical assistance must also be submitted to the appropriate government agency. The assistance of the Resource Counselor may be offered and the necessary forms and a list of the documents that will be needed to complete the application may be provided. The application must be submitted by the prospective patient and/or family at the proper location, the necessary face-to-face interview must be conducted and a letter or some other verification returned to the Resource Counselor, to attest that the application has

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been completed to the case worker's satisfaction. Receipt of the case worker's name and number will facilitate the verification procedure.

C. In addition, a recommendation or some other statement from the physician will also be required, justifying the patient's charitable status and setting forth the physician's intention to treat the patient for free or at a reduced rate.

D. The applicable discount, if approved, is then applied to the estimate of charges already prepared by the Resource Counselor (see above and Pre-admission Deposit Policy, Section III, Paragraph A). This then becomes the new amount on which the pre-admission deposit is calculated, which the patient must pay as required by the Pre-admission Deposit Policy.

E. After discharge, the charity allowance, based on the discount already approved, is submitted on a pink "Charity Write-off" form, using adjustment code 007. The note message screen is updated and a print out of the notes along with the application, all supporting documents, the work sheet and a copy of the bill are submitted as a package with the write-off sheet for review. The write-off sheet goes to Posting as above, while the application comes back to the Resource Counselor along with the manager's signature for filing. The pre-paid deposit is treated according to Method B, as in the sub-section that describes the computation of the discount above.

F. The same procedure will be followed for patients seeking outpatient services and who are requesting charity care.

3. **Miscellaneous Charity Write-offs: Catholic clergy, nuns, and closed Bad Debt accounts.**

A. **Catholic Clergy and Nuns.** After all sources have been exhausted, including insurance coverage payments and other funding sources, application may be made for free care. Since the stipend or salary for religious is below Federal poverty guidelines, these amounts will be considered charity if applicable. They should be written-off as indicated in part 1, sections C&D.

B. **Charity from Bad Debt.** Once the collection agency has pursued an account for collection and closed it, an analysis will be performed to determine if the patient is eligible for charity care. This would include accounts which have been closed by the law firm for the following reasons:

A. Judgement obtained, no assets or wages to attach.
B. Unemployed, no assets.
C. Homeless.
D. Indigent.

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From time to time the hospital may be notified of cases in collection which qualify for charity based upon income and family size of the debtor. The hospital at its discretion may decide to grant charity care status retrospectively on a case by case evaluation by the Department Director.

The amount of the charity allowance will be submitted on a pink "Charity Write-off" form, using Bad Debt adjustment code 008. The account should be noted with the reason for the write-off.

4. **Related Sites. Fort Lincoln Family Medicine Center, Providence Health Services, OB/GYN Center, Carroll Manor and Rehabilitation Center.**

A. Once a determination has been made on an application, a separate notification sheet will be forwarded to the sites mentioned above. The Resource Counselor will note individual patient approval or denial. If approved, the discount percentage will be stated in the sheet. If a patient is approved for less than 100% discount, the patient must make arrangements to pay the balance as stated. If the patient has no charges and service is pending, he/she should call to set up "Self-pay" payment arrangements for the amount of the anticipated care.

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Original Date:	October, 1998	**References:**	
Present Date:	June, 2003		
Review Date:	June, 2005	**Supercedes:**	BSVHS: 3.14 SVHS: FP007
Applicable: SVHS & Affiliated Companies ✓ SVMC ✓ SCLM			
Approval:			

POLICY

In accordance with the philosophy, mission and core values of St. Vincent's Health System (SVHS), health care is provided to the poor and those who lack financial resources to obtain health care. This policy applies only to SVHS services. The evaluation of the need to receive medical care will be based primarily upon clinical assessment. However, consideration of financial status may be necessary under certain circumstances. In cases where a possible urgent or emergent medical condition exists, the financial evaluation should occur only after appropriate medical evaluation and care have been rendered. In cases of non-urgent and non-emergent services, a financial evaluation should occur prior to rendering care. After clinical and/or financial evaluation, individuals may be referred to appropriate alternative programs or services. Approval by the applicable Chief Medical Officer or Chief Operating Officer/Administrator is required for unfunded, non-urgent/non-emergent services.

Confidentiality of information and the dignity of the individual will be maintained for all who seek and/or are provided assistance.

PURPOSE

To establish the criteria for determining if a patient is eligible to receive free or discounted services.

DEFINITIONS

Charity Care: That portion of a patient's bill for which the patient is not responsible due to inability to pay as determined by the charity care criteria outlined in this policy.

Charity Chart of Approval: Identifies and delineates the approval limits for charity care allowances.

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Emergent Condition: Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, including a pregnant woman or fetus, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, that there is inadequate time to effect safe transfer to another hospital prior to delivery, that a transfer may pose a threat to the health and safety of the patient or fetus, or that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Financial Counselor: An employee empowered to accept and evaluate an Application for Charity Care and compute qualified charity care allowances.

Medically Necessary: Services provided by a physician or other provider to identify or treat an illness, injury, or condition and which in the opinion of a physician or other provider are:

1. Consistent with the symptom(s) or diagnosis and treatment of the condition, disease, ailment, or injury.
2. Not primarily for the convenience of the patient, the patient's family, the physician or other provider.
3. The most appropriate level of services which can safely be provided to the patient.

Urgent Condition: Condition, based on physician evaluation, if left untreated could develop into a life threatening condition.

PROCEDURES

1. Identification/Screening

   1. Referrals for charity care determination are primarily initiated or identified by Financial Counselors, Patient Accounting personnel, Social Work personnel, or Collection Agency personnel. Referrals may also be initiated or identified by other Health System employees, physicians, or community members.

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B. All patients potentially eligible for charity status will be screened by the Financial Counselor/Collection representatives for assistance through federal, state, county, and other social service programs. Financial Counselors/Collection representatives will work collaboratively with other health care members to explore alternative financial resources for the patients. Any forms completed in the field (e.g., FMC, Primary Care) will be forwarded to Patient Accounting for filing.

C. Medicaid patients, upon exhaustion of benefits, will automatically qualify for charity care allowance as long as they remain eligible for Medicaid. A Medicaid patient's cost share under the Medically Needy provisions of the Medicaid program will be eligible for charity care consideration.

D. Patients will be denied charity based on non-compliance with other assistance programs (e.g., Medicaid eligible individuals who have failed to keep required appointments with their case worker).

II. Charity Care Eligibility Criteria

A. The amount considered for charity care includes the patient responsible balance offset by discretionary assets. Discretionary assets include the fair market value of savings, investments and non-homestead property in excess of the greater of $10,000, fifty percent (50%) of such assets or fifty percent (50%) of annual family income.

B. If there is any indication that the financial status of a patient has changed, we have the right to update the information, regardless of the date of the last application.

C. Refunds of amounts previously paid by the patient are strictly prohibited.

D. The charity-care eligible portion of the patient responsible balance (after discretionary asset offset) will principally be determined by family size and income (see Attachment A).

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E. General categories and classification of charity care are presented in the table below:

Category	Charity Care	
	AHCA	Non-AHCA
Basic AHCA Charity Care Total Family income <200% of Federal Poverty Level (FPL)	Balance due from patient (after discretionary asset offset)	
Catastrophic AHCA Charity Care Total family income >200% of FPL, but <400% FPL and balance due from patient (after asset offset)> 25% of total family income	Balance due from patient (after discretionary asset offset) minus 75% of total family income in excess of 200% of FPL	
Non-AHCA Charity Care Total family income>200% of FPL and balance due from patient (after asset offset)<25% of total family income		Balance due from patient (after discretionary asset offset) minus 75% of total family income in excess of 200% of FPL

F. Regardless of income, the patient could be ineligible for charity care allowance if:

1. Medical care can be arranged at another institution at no cost or reduced cost and the patient refuses to cooperate with transfer to that facility.
2. Insurance coverage is available through the employer but coverage is refused and family income is less the 200% of the federal poverty level (FPL).
3. The service is not deemed medically necessary.

G. In accordance with Medicare regulations, Medicare deductibles and co-insurance are excluded from charity care classification. Such amounts as determined under this charity care policy will be classified as bad debt and subjected to bad debt write off without collection follow up.

III. Documentation

A. To provide a consistent format to document charity care determination, an Application for Charity Care (Attachment B-1 and C) must be completed and signed by the applicant/guarantor and witnessed.

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B. The applicant is responsible for furnishing documentation used to determine eligibility for charity care. Appropriate documentation includes one or more of the following:

1. W-2 withholding forms
2. Paycheck stubs
3. Income tax returns
4. Profit and Loss Statement from a self-employed business
5. Forms approving or denying unemployment or workers' compensation
6. Written verification of wages from employer
7. Written verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the past twelve (12) months.
8. A Medicaid remittance voucher reflecting exhausted Medicaid benefits for the applicable Medicaid fiscal year.
9. Homeless persons will be evaluated under special consideration and approved by the Director.

C. An Application for Financial Assistance may be accepted without supporting documents only upon approval of the appropriate management personnel as provided for in the Charity Care Chart of Approval specified in Item IV, (Approvals) of this policy. Waiver of supporting documentation is at the total discretion of the Health System.

IV. Approvals

A. Based on the information provided on the Application for Financial Assistance, a Financial Counselor or Patient Accounting Representative will complete the Charity Care Allowance Worksheet (Attachment B-2).

B. Approval for charity care allowance will be so determined as follows:

Charity Care Chart of Approval*	
Position	**Approval level**
Collection Supervisor	Up to $10,000
Patient Accounting Manager	$10,000 to $50,000
Director, Patient Accounting	$50,000 to $100,000
Executive Vice President or Senior Vice President, Finance	Over $100,000

* Lower approvals may be adopted by the outlying facilities.

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IV. C. Extenuating circumstances may support an increase in the charity care allowance as documented in the Charity Care Allowance Worksheet (B-2). Such circumstances may include significant other financial obligations or expected future medical needs. All exceptions must be approved by the Chief Operating Officer/Administrator, Executive Vice President and CFO, or Senior Vice President of Finance.

D. Designated staff may determine eligibility. Each facility will determine authority to key off accounts.

Attachments:

A - Poverty Guidelines
B-1 - St. Vincent's Health System/Collection Representative/Patient Accounting
B-2 - Charity Care Allowance Worksheet
C - Application for Financial Assistance

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FL, Jacksonville
St. Vincent's Health System

Attachment A

2003 Poverty Guidelines for the 48 Contiguous States and District of Columbia

Size of Family Unit		200%	400%
1	$8,980.00	$17,960.00	$35,920.00
2	$12,120.00	$24,240.00	$48,480.00
3	$15,260.00	$30,520.00	$61,040.00
4	$18,400.00	$36,800.00	$73,600.00
5	$21,540.00	$43,080.00	$86,160.00
6	$24,680.00	$49,360.00	$98,720.00
7	$27,820.00	$55,640.00	$111,280.00
8	$30,960.00	$61,920.00	$123,840.00
For each additional person add $3,140.			

SOURCE: Federal Register, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458

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Department: FL, Pensacola
Sacred Heart Health System
Date Revised:
Date Reviewed:

Departmental Policy

TITLE: CHARITY/CARE MEDICAID BENEFITS EXHAUSTED	POLICY #: FISCAL SERVICES 195

POLICY:

Sacred Heart Hospital will contribute toward improving the health status of individuals by providing patient centered economical health services with a special concern for the sick and the poor.

PROCEDURES:

Identification of Charity and Medicaid Exhausted Patients

Patients should be identified as potential charity accounts prior to billing. In-Patient Account Representatives will identify and obtain documentation necessary to determine eligibility for charity while the patient is in the hospital and prior to patient discharge. Outpatient Registration areas should also identify potential charity accounts and notify the appropriate billing area. There may be circumstances however, that necessitate the identification of charity patients following discharge. Business Office billing personnel, Patient Account Representatives or the Collection Agencies will identify potentially eligible patients while they are processing patient accounts.

Accounts may be reviewed for charity care when the patient appears to be medically indigent or where payment might create an extreme financial hardship on the patient or patient's family. Additionally, other accounts which may be reviewed for charity are where the patient has expired, left no estate, and has no family that can be located. Current Health Care Cost Containment Board Charity Guidelines will be followed in making the determination for eligibility for charity.

Additionally, patients who have exhausted their Medicaid benefits for the current fiscal year may be written off to charity based on the Medicaid remittance which indicates that the patient has exhausted their Medicaid benefits.

Documentation for Charity and Medicaid Exhausted Patients

Accounts to be considered for charity must be processed as follows:

1. A completed and signed Application For Uncompensated Care must be obtained from the patient, guarantor or next of kin, with the exception of Medicaid Exhausted patients.

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Departmental Policy

TITLE: CHARITY/CARE MEDICAID BENEFITS EXHAUSTED PAGE 2	POLICY #: FISCAL SERVICES 195

2. Documentation to substantiate income shall be obtained on Charity write offs over $10,000. In rare cases alternate documentation can be used. Usual documentation shall be limited to the following:

   a. W-2 withholding forms
   b. Pay stubs
   c. Income tax returns
   d. Written verification of wage from employer
   e. Written verification from HRS which can attest to patient's income status for the last 12 months.
   f. Medicaid remittance advice which reflects that a patient's Medicaid benefits for the fiscal year have been exhausted.
   g. Application for Uncompensated Care statement signed by the patient or patient guarantor and witnessed by a hospital representative on account(s) with a balance of $10,000.00 and above.

Note: Outpatient accounts with balances of $9,999.99 or less and inpatient accounts with balances of $9,999.99 or less only require the Application For Uncompensated Care Form in order to substantiate income.

Eligibility for Charity

After all possible sources of medical assistance programs including Medicaid have been eliminated, the account will be reviewed for charity. Current Federal Poverty Guidelines will be used in making a determination of eligibility. No patient may be approved for charity care whose family income for the 12 months preceding the determination exceeds 150% of the current Federal Poverty Guidelines unless the total charge due from the patient exceeds 25% of annual family income. However, no accounts can be approved where family income exceeds 4 times the Federal Poverty Level for a family of four. (See attached Charity Guideline Worksheet)

Approval for Charity

All charity accounts meeting the charity requirements as specified above will be prepared for approval as follows:

1. Complete CHRT2 note criteria which states patient's account has been reviewed and is eligible for assistance.

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Departmental Policy

TITLE: CHARITY/CARE MEDICAID BENEFITS EXHAUSTED PAGE 3	POLICY #: FISCAL SERVICES 195

2. Documentation to substantiate income on account(s) with a balance of $10,000.00 or greater, signed by patient, to include income comparison to Federal Poverty Guidelines.

3. Face sheet. (Inpatient accounts only)

4. Copy of billing summary stamped with charity stamp.

5. Charity Guideline Worksheet.

6. A copy of the Medifax inquiry showing that the patient is not enrolled in the Florida Medicaid program. (Inpatient accounts only)

7. A copy of the credit report inquiry according to Policy and Procedure 260. (Inpatient accounts only)

8. Proof of County residency can be proved by providing a copy of the signed Face Sheet listing patient's address, etc. If Face Sheet is not signed, other proof of residency is required.

9. Death certificate, if applicable, or death summary if patient expired in-house, (Must also have Application For Uncompensated Care Form completed by patient/guarantor or next of kin).

The Patient Accounts Manager will set up and run a monthly report for carrier 0040 and will:

1. Verify eligibility for charity for period.

2. Re-classify those not currently eligible or those incorrectly classified as charity.

3. Submit report and documentation for approval according to approval authorizations.

4. Authorization levels:

0 - $9,999	Inpatient Account Representatives
$9,999 - above	Patient Accounts Manager
$49,000 - above	Director, Business Office

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Date Revised: _____
Date Reviewed: _____

Departmental Policy

TITLE: CHARITY/CARE MEDICAID BENEFITS EXHAUSTED PAGE 4	POLICY #: FISCAL SERVICES 195

Accounts approved for Charity will be changed to carrier 0040 Charity - SHH. Patients who have been approved as charity will be eligible until next recertification which will occur at the end of the fiscal year. A file of eligible patient's documentation will be maintained for the eligibility period.

All Medicaid Exhausted accounts should be prepared for approval as follows:

1. Face sheet for inpatient accounts and a screen print of the account for outpatient accounts.
2. Copy of billing summary stamped with "Medicaid Exhausted" stamp for inpatient accounts and a copy of a monthly summary for outpatient accounts (copy attached).
3. Copy of Medicaid remittance advice reflecting the Medicaid benefits exhausted denial.
4. Authorization levels:

0 and above	Patient Accounts Manager All Billing Supervisors

MEDICARE HARDSHIP

It is a violation of Medicare Law to routinely wave collection of Medicare co-payments and unpaid deductible amounts. In rare cases, when the patient is considered to have financial hardship, the hospital can "forgive" the amounts owed. Charity care guidelines should be used. Patients who do not comply with documentation should be billed for 120 days and then be sent to the collection agency.

Procedure:

1. When a patient contacts the Billing Department and the Insurance Claims Specialist considers the patient to have financial hardship, the patient will be advised that their account will be reviewed.
2. A note will be placed in the system and the appropriate Insurance Claims Specialist will review the documentation.

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Department: _____
Date Revised: _____
Date Reviewed: _____

Departmental Policy

TITLE: CHARITY/CARE MEDICAID BENEFITS EXHAUSTED PAGE 5	POLICY #: FISCAL SERVICES 195

3. If the Insurance Claims Specialist deems the patient to have financial hardship, the Insurance Claims Specialist will contact the patient and explain the Financial Hardship Exemption form.

4. Once signed by the patient, the appropriate Insurance Claims Specialist will forward to the Inpatient Billing Supervisor for review.

5. All Medicare Hardship accounts will be approved by the Inpatient Billing Supervisor.

Accounting

Following approval, Charity documentation will be maintained alphabetically in the office of the Patient Accounts Manager. Medicare hardship documentation will be maintained by the Inpatient Billing Supervisor.

Periodic audits will be performed by the Director of the Business Office, to ensure compliance with Policy and Procedure.

Michele Nelson — Written by — Date: 3-6-00

Dan Stoy — Director, Business Office — Date: 3/6/00

H. Michael Myers — Vice President, Finance — Date: 3-6-00

Original 03/06/90
Revised 3/3/00

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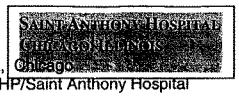

IL, Chicago
CHP/Saint Anthony Hospital

SPONSOR:	**PATIENT FINANCIAL SERVICES**	**POLICY NO: ADM 203**	**Page 1 of 4**
SUBJECT:	**CHARITY CARE**	**Date of Origin: 8-24-99**	
		Revised: 7-05-00	
		Reviewed: 4-20-02	
		Revised: 8-20-03	

I. POLICY STATEMENT

Faithful in its service to the poor, Catholic Health Partners (Hospital) provides financial assistance to patients who are unable to pay their financial obligations associated with services they receive from the Hospital. The review and determination to provide financial assistance supports the Hospital's strategic goals and objectives and the mission of the sponsors. The dignity of the individual remains paramount throughout the entire process.

Financial obligations for unpaid health services provided to patients who are unable to pay should be identified and recorded as charity care. This is distinct from financial obligations for unpaid health services provided to patients who are able to pay which should be identified and recorded as bad debt.

Catholic Health Partners may also support, sponsor or co-sponsor certain other charitable health-related programs in the public community.

II. DEPARTMENTS AFFECTED

Admitting/Registration/Scheduling, Various Clinics, Patient Financial Services, Pastoral Care and Social Work.

III. GUIDELINES

1. Only claims in financial class "S" or "E" should be included in the Financial Assessment review.
2. If the patient is pregnant, disabled, a child or a mother with children and has not yet applied for Public Aid, he/she must do that prior to completing the Charity application.
3. Charity is not appropriate for patients that have been denied Public Aid due to non-compliance.
4. Charity will be given to all undomiciled patients at the time of discharge and all denied MANGS upon receipt of denial.
5. The financial assessment should include all outstanding self-pay accounts.
6. All working persons in the household must provide the following information:
   A. A copy of the previous year's W2, 1040 and any other applicable tax forms that were filed.
   B. Copies of the last three (3) most recent paycheck stubs from the employer. (Occasionally the patient will state that he/she or spouse is paid cash and does not receive a check from the employer. In this instance, we would need a letter from the employer on letterhead stating hours worked per week, how often paid, and how much paid.)
   C. Copies of Social Security check if they are receiving a check or award letter.

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SPONSOR:	PATIENT FINANCIAL SERVICES	POLICY NO: ADM 203	Page 2 of 4
SUBJECT:	CHARITY CARE	Date of Origin: 8-24-99 Revised: 7-05-00 Reviewed: 4-20-02 Revised: 8-20-03	

III. GUIDELINES (continued)

7. All unemployed persons in the home must provide the following:

   A. A copy of the previous year's W2, 1040 and any other applicable tax forms that were filed.
   B. Copies of unemployment checks or the award letter.
   C. Room and Board letter from person paying for the household expenses.

8. When information is received from the patient, the Representative completes the Financial Assistance Application Form using the Federal Poverty Guidelines. The Representative will make a determination on the percentage discount the guarantor is eligible for.

9. The charity application and all supporting documentation will be maintained in the department for one (1) year.

10. Failure to comply with the payment arrangement terms of any remaining balances after the charity adjustment is applied will result in the claim being immediately referred to an outside collection agency. The discount will still be applicable.

11. If a patient refuses to complete the application or provide any of the necessary documentation, the charity process cannot be completed and charity will be denied. The patient is then responsible for payment of the entire debt.

13. Charity Care may be available to patients incurring emergency, urgent or elective medically necessary procedures and admissions. Patients scheduled for elective, non-medically necessary procedures are expected to pay and shall not be screened for charity.

14. Patients' qualifications for charity care will be determined through an application and screening process.

15. Patients are to be screened for other payor sources prior to consideration for charity care. Patients failing to cooperate with such screening will result in a denial to be considered a candidate for charity care.

16. Customer Service Representatives will be responsible for the screening process.

17. Hospital Charity Care is based on the Federal Poverty Guidelines with a sliding scale adjustment as follows:

    Up to 100% over Poverty Standard receive 100% discount
    Up to 150% over Poverty Standard receive a discount equal to 25% of cost
    Up to 200% over Poverty Standard receive a discount equal to 50% of cost
    Up to 250% over Poverty Standard receive a discount equal to cost
    Up to 300% over Poverty Standard receive a discount of cost plus 50%

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III. GUIDELINES (continued)

18. Approved levels for charity care are based on dollar amount of charity care being requested as follows:

Financial Counselor and/or Collectors	up to $ 2,500
Credit and Collection Manager	$ 2,501 to $ 9,999
Director, Patient Financial Services	$10,000 to $25,000
Chief Financial Officer	$25,000 to $50,000
Chief Executive Officer	over $50,000

PROCEDURE

The following procedures will be conducted in a professional and compassionate manner:

1. Hospital Charity Care is based on the Federal Poverty Income Guidelines (Exhibit I-A and I-B) with a sliding scale adjustment as follows:

   Up to 100% over Poverty Standard receive 100% discount
   Up to 150% over Poverty Standard receive a discount equal to 25% of cost
   Up to 200% over Poverty Standard receive a discount equal to 50% of cost
   Up to 250% over Poverty Standard receive a discount equal to cost
   Up to 300% over Poverty Standard receive a discount of cost plus 50%

2. The Application for Hospital Financial Assistance must be completed and signed by the patient and/or guarantor (Exhibit II).

3. Family income, including, but not limited to, wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment benefits, child support, alimony, dividends and interest must be documented.

4. Acceptable documentation is defined as one or more of the following and must be provided prior to adjudication of the application:

   - Prior year's income tax return
   - Prior year's W-2 form
   - Pay stubs or employer statement documenting earned wages for the three (3) months prior to the application for assistance.

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PROCEDURE (continued)

5. Applicants, whose current financial position is not adequately reflected by prior income reports, may submit statements and/or appropriate documentation of their current/future financial position.

   Example: An individual on temporary disability may submit a physician's report documenting his inability to work for a given period of time.

6. Applications received without sufficient and/or appropriate income documentation will be pended for ten (10) days, after which the application will be denied.

7. Decisions are reported to the applicant utilizing the applicable form letter (Exhibit III and IV). Patients will also receive a copy of the hospitals appeal policy. Decisions are made within 15 days of receipt of necessary information.

8. Patients approved for only a partial deduction must still comply with Hospital payment terms for the remaining balance.

9. Information is posted in the admitting and registration areas, including the emergency room, regarding financial assistance and charity care policies.

EFFECTIVE DATE:

Name (Printed)	Title	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

IL, Chicago
CHP/Saint Anthony Hospital

EXHIBIT I-A

2003 POVERTY INCOME GUIDELINES
EFFECTIVE FEBRUARY 7, 2003

Catholic Health Partners will give a reasonable amount of its services without charge to eligible persons who cannot afford to pay for care.

To be eligible to receive uncompensated care, your family income must be at or below the following levels:

2003 POVERTY INCOME GUIDELINES

SIZE OF FAMILY	INCOME GUIDELINE
1	$ 8,980
2	12,120
3	15,260
4	18,400
5	21,540
6	24,680
7	27,820
8	30,960

For family units with more than eight (8) members, add $3,140 for each additional member.

If you feel you may be eligible for uncompensated services, you may request a financial assistance form at the Admitting or Business Offices. Catholic Health Partners will issue a written determination of your eligibility.

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EXHIBIT I-B

Catholic Health Partners
Chicago, Illinois

IL, Chicago
CHP/Saint Anthony Hospital

Based on 2003 Federal Poverty Guidelines
Effective February 7, 2003

Discount	100%	80%	60%	40%	20%
			INCOME		
FAMILY UNIT SIZE 1	10,776	12,572	14,368	16,164	17,960
2	14,544	16,968	19,392	21,816	24,240
3	18,312	21,364	24,416	27,468	30,520
4	22,080	25,760	29,440	33,120	36,800
5	25,848	30,156	34,464	38,772	43,080
6	29,616	34,552	39,488	44,424	49,360
7	33,384	38,948	44,512	50,076	55,640
8	37,152	43,344	49,536	55,728	61,920

For family units with more than eight (8) members, add:

3,768	4,396	5,024	5,652	6,280

for each additional member to compute discount.

Up to 20% over Poverty Standard receive 100% discount
Up to 40% over Poverty Standard receive 80% discount
Up to 60% over Poverty Standard receive 60% discount
Up to 80% over Poverty Standard receive 40% discount
Up to 100% over Poverty Standard receive 20% discount

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FINANCIAL SUPPORT PROGRAM

Signed: Marc Chircop 12/02/01 *Last board Approval*: 9/27/01

I. POLICY STATEMENT:

It is the policy of St. Mary's Health Care Services as a member of Mission Health System, Inc. and Ascension Health, sponsored by the Daughters of Charity and the Sisters of St. Joseph, to provide financial support to those who seek health care services and have limited or no financial resources. This commitment is integral to our health care ministry.

A process is available for granting financial support to those patients requiring inpatient or outpatient services including those patients associated with employed physician services. Financial support is granted according to criteria set forth in this policy in a manner consistent with federal and state laws that govern the provision of charity care services by tax-exempt organizations.

Any patient expressing a need or identified by a Partner or physician as having a need shall be considered for financial support. Financial support decisions will be based on the Community Services Administrations (CSA) Poverty Income Guidelines (PIG) as published annually in the Federal Register and will not be denied on the basis of gender, race, religion, or national origin. This method of providing financial support will be consistent and will apply to all services with the exception of cosmetic procedures, infertility treatment, and services covered by health insurance in another network.

All persons are treated with utmost dignity and respect throughout this process.

It is the intent of St. Mary's Health Care Services to comply with the Ascension Health Policy #9 entitled, Care of Persons Who are Poor, Community Benefit and Advocacy and follow the principles stated therein and the Mission Health System policy on Financial Support Program.

II. PURPOSE:

To establish a procedure relating to the provision of financial support to those needy individuals who seek health care services from the entities associated with St. Mary's Health Care Services.

III. DEPARTMENTS PRIMARILY AFFECTED:

Any department that serves our patients is affected by this policy. This includes but is not limited to: Administration, Behavioral Services, Continuing Care Centers, Emergency Services, Employee Assistance Program, Clinical Services - Nursing, Pharmacy, Respiratory Therapy, Laboratory, Clinics - Family Practice, OB/GYN and Pediatrics, Home Health and DME, Mobile Outreach Clinic, Regina, Rehab Institute, Senior Services, Social Services, and Spiritual Care.

IV. DEFINITIONS:

A. Financially Indigent - An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on St. Mary's Health Care Services' eligibility criteria. Other financial assets and liabilities of the person may be considered when determining ability to pay.

B. Medically Indigent - A person whose medical or hospital bills, after payment by third-party payors, exceed a specified percentage of the patient's annual gross income, determined in accordance with St. Mary's Health Care Services' eligibility criteria, and the person is financially unable to pay the remaining bill. Other financial assets and liabilities of the person may be considered when determining ability to pay.

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C. Bountiful Assets - In evaluating eligibility, bountiful assets would be considered a second home in addition to principal residence, luxury automobiles as opposed to the average car, cash, stocks, and/or bonds into the several thousands of dollars.

D. Ordinary and Routine Assets - In evaluating eligibility, ordinary and routine assets would be defined as principal place of residence, mortgaged or not, average automobiles or trucks, without regard to age, relatively small dollar amounts of cash.

V. PROCEDURES:

A. General

1. Any person who seeks care in St. Mary's Health Care Services should be provided written information regarding the financial support program and how to apply for such support as a part of the admission process. In addition, a written notice shall be conspicuously posted in the general waiting areas, the business office and in such other locations as St. Mary's deems likely to give notice of the program to the general public. See Exhibit I: Financial Support Notice Posting.

2. Financial support requests can be initiated by the patient or other responsible party.

3. A budgeted amount for financial support will be included in each entity's annual operating budget. A plan is developed on an annual basis and approved by the St. Mary's Health Care Services Board of Directors as part of the budgeting process. After Board approval, the plan is submitted to Ascension Health's Senior Vice President of Mission.

B. Application Guidelines:

1. The department where the patient with potential needs is identified will provide an application for financial support. The department can obtain the applications from the Patient Financial Services Department if necessary.

2. Persons requesting financial support will be required to complete and sign a Financial Support Application. See Exhibit II: Financial Support Application Transmittal Letter and Exhibit III: Financial Support Application. The applicant is requested to provide financial information sufficient to determine qualifications are met.

3. The applicant is expected to provide proof of gross household income. This may be in the form of the last three pay stubs, last year's tax return, or other records documenting the year to date income.

4. If there is a large medical debt, documentation of this must be provided to enable an allowance decision under the medical indigence criteria.

5. If approved for an allowance, the applicant will be required to provide a completed Financial Support Application with proof of income at least annually.

C. Evaluation and Authorization Guidelines

1. All evaluations are to be done in as uniform and consistent a manner as possible. Data used in making a determination concerning eligibility for financial support shall be verified to the extent practical in relation to the amount involved and the significance of an element of information in the overall determination.

2. Applicants who fail the financial indigence may still qualify for medical indigence. To be perceived as being medically indigent, there must be a significant medical debt after all third party resources have been expended.

3. An Authorization Matrix is utilized by St. Mary's that specifies the levels of support and the authorization necessary for approval. See Exhibit IV: Authorization Matrix.

4. The Senior Administrator with responsibility over Patient Financial Services will be consulted for guidance when necessary to adjudicate a complex or difficult application.

5. Revisions to the CSA Poverty Income Guidelines will become effective automatically on the first of the month following annual publication in the Federal Register. The St. Mary's Patient Financial Services Director upon receiving the annual revisions will distribute them to all St. Mary's Health Care Services who utilize them.

6. Appeals of a denial of financial support may be considered if material changes in a patient's circumstances are documented and such documentation is provided and verified by St. Mary's Health Care Services.

D. Eligibility

1. Based on gross income and family size, applicants will be eligible for support as follows:

   If gross income is:

   a) Equal to or less that CSA PIG Base + 30%; 100% allowance;

   b) Greater than CSA PIG Base + 30%, but less than or equal to CSA PIG + 48%; 80% allowance;

   c) Greater than CSA PIG Base +48%, but less than or equal to CSA PIG + 66%; 60% allowance;

   d) Greater than CSA PIG Base + 66%, but less than or equal to CSA PIG + 83%; 40% allowance;

   e) Greater than CSA PIG + 83%, but less than or equal to CSA PIG + 100%; 20% allowance;

   f) Greater than CSA PIG Base + 100%, Zero allowance.

2. Assets will be considered in evaluating eligibility. Refer to the Section IV. C. and D. for explanation of bountiful versus ordinary assets.

3. Ordinary and routing assets will not be grounds for discounting or denying an allowance for which an applicant qualifies under the income criteria.

4. Bountiful assets may be a reason for discounting or denying an allowance.

5. An allowance is only applicable after all insurance has been collected, and/or other potential third party resources have been explored and eliminated.

6. Failure of an applicant to cooperate with claims filing, or collecting from a potential third party resource will be grounds for denying an allowance.

7. Applicants who fail the income eligibility requirements may still qualify for an allowance if they are perceived as being medically indigent. Refer to Section IV. B.

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8. Non-covered services for a Medicaid recipient will be considered as automatic criteria for support.

E. Reporting

The patient or responsible party requesting support is notified of the decision of the entity to provide financial support.

F. Record Retention

Documentation on financial support is maintained for a period of seven years following the end of the year in which the financial support was given or such longer period as may be required for Medicare or other programs that utilize the financial support information in completing required forms and reports.

References:

1. Annual Update. Federal Register. Department of Health and Human Services. HHS Poverty Guidelines. February 16, 2001.
2. Care of Persons Who are Poor, Community Benefit and Advocacy. Policy #9. Ascension Health. December 18, 2000.
3. Exempt Hospitals Compliance with Treasury Regulation " 1.501(c)(3)-1(c). Office of Chief Counsel. #200110030. Internal Revenue Service. Department of the Treasury. Washington, D.C. February 5, 2001.
4. Financial Support Program Policy and Procedure. Mission Health System, Inc. July 2001.
5. Omnibus Budget Reconciliation Act (OBRA) of 1981. Section 673 (2).
6. Valuation and Financial Statement Presentation of Charity Services and Bad Debts by Institutional Health- care Providers. Principles and Practices Board Statement #15. Revised Guidelines. Healthcare Financial Management Association. April 11, 2001.

Please see Policy Manual for attachments which are referred to in policy.

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IN, Evansville
Mission Health System, Inc.
St. Mary's Medical Center

FINANCIAL ASSISTANCE POLICY
INCOME CRITERIA TABLE

	FAMILY SIZE	BASE P.I.G.	BASE + 30%	BASE + 48%	BASE + 66%	BASE + 83%	BASE + 100%
	1	8,980	11,674	13,290	14,907	16,433	17,960
GROSS	2	12,120	15,756	17,938	20,119	22,180	24,240
	3	15,260	19,838	22,585	25,332	27,926	30,520
ANNUAL	4	18,400	23,920	27,232	30,544	33,672	36,800
	5	21,540	28,002	31,879	35,756	39,418	43,080
INCOME	6	24,680	32,084	36,526	40,969	45,164	49,360
	7	27,820	36,166	41,174	46,181	50,911	55,640
	8	30,820	40,066	45,614	51,161	56,401	61,640
	9	33,960	44,148	50,261	56,374	62,147	67,920
	10	37,100	48,230	54,908	61,586	67,893	74,200
	% ALLOW-ANCE		100%	80%	60%	40%	20%

	FAMILY SIZE	BASE P.I.G.	BASE + 30%	BASE + 48%	BASE + 66%	BASE + 83%	BASE + 100%
	1	748	973	1,108	1,242	1,369	1,497
GROSS	2	1,010	1,313	1,495	1,677	1,848	2,020
	3	1,272	1,653	1,882	2,111	2,327	2,543
MONTHLY	4	1,533	1,993	2,269	2,545	2,806	3,067
	5	1,795	2,334	2,657	2,980	3,285	3,590
INCOME	6	2,057	2,674	3,044	3,414	3,764	4,113
	7	2,318	3,014	3,431	3,848	4,243	4,637
	8	2,568	3,339	3,801	4,263	4,700	5,137
	9	2,830	3,679	4,188	4,698	5,179	5,660
	10	3,092	4,019	4,576	5,132	5,658	6,183

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IN, Evansville
Mission Health System, Inc.
St. Mary's Medical Center

	FAMILY SIZE	BASE P.I.G.	BASE + 30%	BASE + 48%	BASE + 66%	BASE + 83%	BASE + 100%
	1	173	225	256	287	316	345
GROSS	2	233	303	345	387	427	466
	3	293	382	434	487	537	587
WEEKLY	4	354	460	524	587	648	708
	5	414	539	613	688	758	828
INCOME	6	475	617	702	788	869	949
	7	535	696	792	888	979	1,070
	8	593	771	877	984	1,085	1,185
	9	653	849	967	1,084	1,195	1,306
	10	713	928	1,056	1,184	1,306	1,427

SOURCE: Poverty Guidelines updated yearly in the Federal Register by the U.S. Department of Health and Human Services under the authority of section 673(2) of the OBRA Act of 1981.
Federal Register Publication Date: February 7, 2003
Financial Assistance Plan Effective: April 7, 2003

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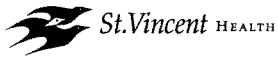

Uninsured & Underinsured Patient Management Program

Effective: July 1, 2004

Our Call to Action

Together we promise:

- ***Healthcare that works.***
- Healthcare that is safe.
- ***Healthcare that leaves no one behind.***

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St. Vincent Health Mission Statement

St.Vincent Health is a nonprofit, spiritually-centered health care system sponsored by Ascension Health. We are dedicated to the mission of improving the lives and health status of residents of Indiana through the provision of a continuum of holistic and high-quality healthcare services.

St.Vincent Health is compelled to make a positive and healing difference for those serviced by living the mission, vision and Core Values of Ascension Health while supporting the respective cultures and values of Network participants who share compatible but different core values

St.Vincent Health supports this mission by providing its participants with an improved access and ability to strengthen the quality of care and service coordination across the continuum in a values-focused environment with special concern for the sick and the poor.

St.Vincent Health will provide integrated healthcare services that prevent disease, promote wellness, and care for the sick and suffering. This will be carried out in a manner that is cost-effective and consistent with the Ethical and Religious Directives for Catholic Health Care Services approved by the National Conference of Catholic Bishops.

Our Call to Action

Together we promise:

Healthcare that works.

Healthcare that is safe.

Healthcare that leaves no one behind.

Core Values

The core values of St.Vincent Health are those of Ascension Health, namely:

Service of the Poor – generosity of spirit for persons most in need
Reverence – respect and compassion for the dignity and diversity of life
Integrity – inspiring trust through personal leadership
Wisdom – integrating excellence and stewardship
Creativity – courageous innovation
Dedication – affirming the hope and joy of our ministry

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Policy Statement

In accordance with our mission statement and Core Value of Service to the Poor and Ascension Health's (AH) Policy #9, it is the policy of St. Vincent Health (SVH) to establish and maintain a program whereby patients requiring emergency or urgent care with no insurance (uninsured) and with limited insurance (underinsured) are provided an opportunity to apply and be considered for financial assistance for their total charges or unpaid portion of their bill. SVH will create and maintain a process for effectively evaluating a patient's need for financial assistance without regard to race, color, religion, sex, age, national origin, citizenship or disability.

As stated in Policy #9, there are three types of patients as part of the uninsured population. These three patient types are as follows:

1. **Charity Care (CC):** Those who qualify as indigent under the HHS Poverty Guidelines;
2. **Financial Assistance Program (FAP):** Those who do not qualify as indigent, but have a demonstrated inability to pay for services; and
3. **Means to Pay:** Those with a demonstrated ability to pay for services (AH Policy #16)..

Using AH Policy #9 as a basis, the Uninsured and Underinsured Patient Management Program at SVH will constitute the following consideration:

A. Eligibility for governmental and local assistance programs:
   - Medicaid,
   - Medicaid/Medicare Disability, and
   - Federal, State and local grants or other healthcare assistance programs.

B. Charity care consideration based on household or family unit income level;

C. A sliding scale for those with incomes between 200% and 300% of the HHS Poverty Guidelines;

D. A discount for services for uninsured patients with income greater than 300% of the HHS Poverty Guidelines (AH Policy #16); and

E. Repayment terms for the unpaid, uninsured or underinsured portion of the bill.

Notification to the patient of this program will be conducted through signage in key waiting areas and access points, through patient statements/letters and telephone communication through all revenue cycle contact points.

Financial assistance will be provided by assessing the patient's household or family unit for their ability to pay. The income basis used for determining ability to pay will be the Federal HHS Poverty Guidelines as published annually at the following website:

http://aspe.hhs.gov/poverty/04poverty.shtml, (where 04= current year)

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The basis of this program is the truthful and accurate provision and submission of financial information from the patient and/or responsible party(ies). Patients and/or responsible party(ies) that intentionally misrepresent their household financial information will be automatically disqualified from any consideration whatsoever with regard to this program. Intentional misrepresentation determination is the sole right of SVH.

SVH reserves the right and authority to update, change or discontinue this program without any form of prior notification.

Accounting for the Uninsured & Underinsured Patient Management Program (UUPMP)

The financial impact of this program will be monitored and accounted for using a minimum of three specific transaction codes for the application of discounts and or adjustments to the account. These transaction codes are as follows:

Description	G/L Account
• Charity Care-Category I	Charity Care
• FAP Adjust-Category I	Charity Care
• Uninsured Discount	Administrative Adjustment

Screening Patients for Federal, State and Local Program Eligibility, Charity Care and Financial Assistance

An uninsured patient and/or the responsible party will be screened for financial assistance in the following manner:

1. Eligibility for Medicaid, Medicaid disability, Social Security disability and other Federal, State, HCI or local healthcare programs and/or grants.
2. Charity Care adjustment for those patients with documented income levels less than or equal to 200% of the HHS Poverty Guidelines (see chart on page 8).
3. Uninsured or Underinsured Patient Management Program as detailed in this document.

The criteria used for "A" above will be the established guidelines and policies provided by the governmental offices. Patients who appear to meet the criteria for any of these Federal, State or local programs **must apply for the programs and fulfill the application requirements for such programs and be denied coverage before being considered for "B" and/or "C" above**. If the patient fails to provide the Federal, State and/or local agency the information necessary to complete their application for assistance, they cannot be considered for "B" or "C" above. However, they will qualify for "D" above.

In some situations, insured patients may be eligible for the programs outlined in A, B and C above for the patient's liability portion of their bill and may be screened and assisted upon request.

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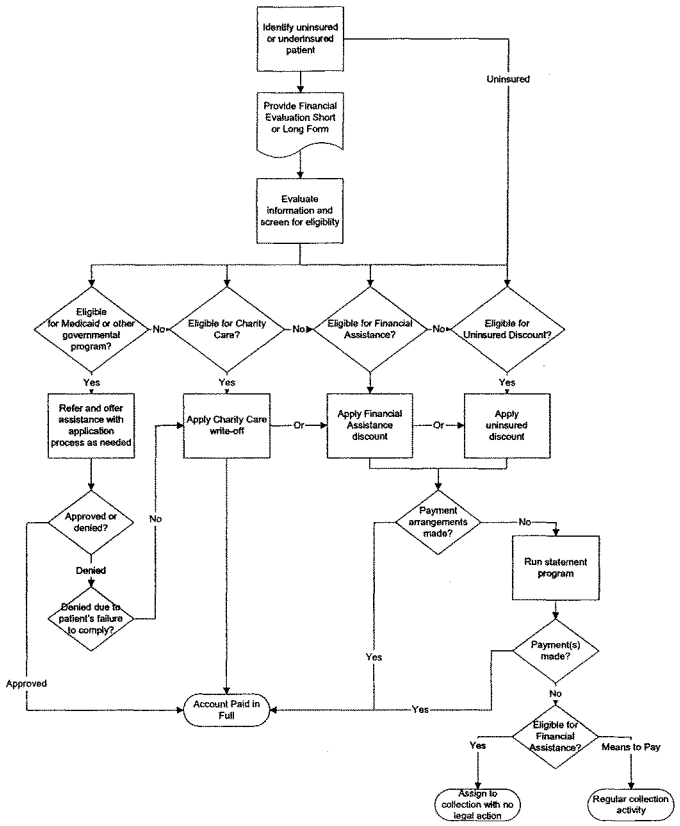
UUPMP Process Flow



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Medicaid Eligibility

If the patient appears to meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs, associates from the SVH ministry Financial Assistance Office (FAO) or their designee will:

- Inpatient - contact the patient and assist with the application process and ensure compliance with program requirements.
- Outpatient – contact the patient in person or by telephone and refer the patient to the appropriate program and provide a telephone number for assistance whenever possible.

If an inpatient case is denied coverage and we believe the denial of coverage was inappropriate, we will assist the patient in filing an appeal. If an outpatient is denied coverage and we believe the denial of coverage was inappropriate, at our discretion, we will assist the patient in filing an appeal.

Account balances for patients who receive services prior to the effective date of their Medicaid coverage will be written off as Charity Care. Account balances for services for a Medicaid recipient whose coverage ceases, is exhausted or receives services that are determined to be "non-covered services" by Medicaid will be written off as Charity Care.

Charity Care Eligibility

If the patient appears to meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs the patient must complete the application process and receive a denial before being eligible for Charity Care consideration.

If the patient's income level is less than 200% of the HHS Poverty Guidelines and does not meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs, they can be considered for Charity Care assistance. Charity care write-offs or adjustments may vary by type of service provided (see page 8).2

Patients who qualify for assistance will receive an identification card that will indicate their write-off or discount level within the SVH network of providers. Patients must reapply for Charity Care annually or whenever their financial situation changes significantly.

Account balances for patients who receive services prior to the effective date of Medicaid coverage will be written off as Charity Care. Balances for services for a Medicaid recipient whose coverage ceases or is exhausted will be written off as Charity Care.

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Financial Assistance Program (FAP)

Patients who meet the criteria of income between 200% and less than or equal to 300% of the HHS Poverty Guidelines will be eligible for a discount from total charges. They will also have a cap on their total liability for 12 months at 10% of their gross annual (calculated or anticipated) income (excluding co-payment amounts). Income is based on the total available or anticipated gross income for the household, regardless of the relationship between household members (see page 8).

Patients who qualify for assistance will receive an identification card that will indicate their discount level within the SVH network of providers. Patients must reapply for the FAP every six (6) months or whenever their financial situation changes significantly. Timing of reapplication may be adjusted or will be dependent on the individual's financial situation.

Discounts for FAP approved services are considered part of SVH's Charity Care program as Category I and are adjusted as partial Charity Care.

Means to Pay

Uninsured patients with income determination greater than 300% of the HHS Poverty Guidelines will be eligible for a discount from total charges of 20% at the time of final billing (see page 8). This discount from total charges will be considered an Administrative Adjustment and should be applied to the account with a specific transaction code to ensure ongoing reporting.

Insured patients with income determination greater than 300% are not eligible for a discount for their patient liability or non-covered services.

Appeal Process for Patients

If a patient wishes to appeal a determination with regard to Charity Care, Financial Assistance or Means to Pay, their written request and reason for an appeal should be directed to the Vice President – Finance responsible for the Revenue Cycle at St. Vincent Health or his/her designee with all pertinent forms and documentation. The Vice President of Finance or his/her designee will review the case and supporting documentation, discuss any and all pertinent issues with the patient, the responsible party and the locally sponsored ministry. A final decision with regard to the appeal will be issued in writing within 30 days of receipt of the written appeal.

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HHS Poverty and St. Vincent Income Guidelines

St. Vincent Health
2004 HHS Poverty Guidelines Calculation Table

Hospital Based Inpatient & Outpatient Services							
Household Size	Charity Care		Financial Assistance Program				Uninsured with Means to Pay
	100%	200%	225%	250%	275%	300%	>300%
1	[illegible]	[illegible]	$ 20,948	$ 23,275	$ 25,603	$ 27,930	
2	[illegible]	[illegible]	$ 28,103	$ 31,225	$ 34,348	$ 37,470	
3	[illegible]	[illegible]	$ 35,258	$ 39,175	$ 43,093	$ 47,010	
4	[illegible]	[illegible]	$ 42,413	$ 47,125	$ 51,838	$ 56,550	
5	[illegible]	[illegible]	$ 49,568	$ 55,075	$ 60,583	$ 66,090	
6	[illegible]	[illegible]	$ 56,723	$ 63,025	$ 69,328	$ 75,630	
7	[illegible]	[illegible]	$ 63,878	$ 70,975	$ 78,073	$ 85,170	
8**	[illegible]	[illegible]	$ 71,033	$ 78,925	$ 86,818	$ 94,710	
Classification	CC1	CC2	FAP3	FAP4	FAP5	FAP6	
Discount	100%	100%	**90%**	**80%**	**70%**	**60%**	**20%**
Discount Application	*1) Financial Assistance for the uninsured and Means to Pay discount is based on total charges.*						
	2) Insured discount is based on patient liability or balance due.						
Other Services Minimum Co-pay Amount (Patient Liability)							
Emergency Room	$0	$50	$75	$100	$125	$150	20% Discount
Employed or Participating Physician Office Visit	$15	$15	$25	$50	$75	$100	Full Charges

* - http://aspe.hhs.gov/poverty/04poverty.shtml, where 04= current year
** - For each additional person, add $3,180
*** - Maximum owed by any patient for 12 month period is 10% of gross household income for FAP hospital based Inpatient and Outpatient services. There is no maximum for Other Services.

Evaluation of Applications

This program is primarily income based. However, extraordinary assets will be valued and added to the household or family unit's total income. Extraordinary assets are defined as those items over and above the basic needs of housing and transportation required for self-sufficiency. Examples of an extraordinary asset are: motorcycle (in addition to automobile), boat, four-wheeler, second home or additional land that is not used as part of a business or to provide income.

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Repayment of Patient Liability

SVH is not a financing institution and payment is due at time of service. In exchange for consideration and application of the FAP and Means to Pay program, patients are expected to pay their portion of discounted services at time of service or shortly thereafter.

In extenuating circumstances it may not be possible for patients to repay SVH providers within the locally sponsored ministry's designated timeframe. Therefore, provisions will be made with various lending institutions to provide monthly payment arrangements for patients who qualify for the FAP or Means to Pay, and are unable to pay in full within a reasonable timeframe. Patients will be referred to these financial institutions to make arrangement for payment (see page 16).

Collection of Unpaid Balances

When a patient and/or responsible party fail to pay their portion of the amount due, the account will be referred to a collection agency for collection. The amount of dollars due will be the amount of the debt as calculated under this program plus a collection fee, if applicable, and as set forth in the Consent for Treatment and Authorization for Payment document signed upon admission. If non-payment occurs, the healthcare provider **will not revert to full charges** as the amount of the debt.

Legal action for payment of unpaid balances will not be initiated against patients and/or the responsible party(ies) who qualify and are approved for FAP. However, the debt may be reported to the credit reporting agencies as an unpaid debt and will remain on the debtor's credit report until such time as the debt is paid in full.

Legal action will be initiated against those patients and/or responsible party(ies) who default on payment to SVH and have the Means to Pay (income greater than 300% of the HHS Poverty Guidelines). This legal action may include lawsuit, judgment, interest applied to the balance due as allowed by Indiana statute, property or estate lien(s) and garnishment of wages. Body attachments and foreclosure will not be used as a means to collect a debt regardless of the patient's income category.

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Appendix

Definitions:

Assets – Personal property and items of value owned by the patient and/or responsible party.

Elective Care – Care provided in non-urgent, non emergency situations. Healthcare services that benefits the patient and are not the result of a life threatening or health altering condition. Cosmetic or plastic surgery is considered elective care.

Emergency – A life threatening condition that requires immediate care from a licensed physician and nurses under the direction of a licensed physician.

Family Unit – Family unit consists of parent(s) with minor children residing at the current address listed on the registration form or adult child supporting a parent(s) within a single household.

Household Income – The total amount earned by all household members residing at one residential location. If there are multiple family units living in the household, then the family unit itself is to be counted for income and the other family units are excluded from total income calculations.

Income- Any and all dollars that assist the patient in self-sufficiency. Income can be the result of wages, investment income, rental income and other sources of cash for daily living expenses.

Support – If an applicant receives partial or full financial support from another individual within residence, then that individual's income is to be included in total gross income. If an applicant receives partial or full financial support from another individual outside the residence, then only the support amount is to be included in total gross income.

Uninsured – A patient and/or responsible party who does not have third party coverage or access to third party coverage through:

- their employer,
- spouse's employer,
- mother or father's employer, and/or
- significant other's employer

for healthcare services through no fault of their own and/or lack of availability through their employer.

Underinsured – A patient and/or responsible party who has third party coverage for healthcare services yet may have an extraordinary amount due that they cannot pay due to household or family unit income.

Urgent Care – Care that is not determined to be an emergency situation, but does require some level of attention to avoid further harm or deterioration of health in the near future.

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11/20

Financial Evaluation Long Form Cover Letter

June 9, 2004

RE: Patient –
Account Number –
Balance Due - $

Dear

In response to your recent request for financial assistance with your outstanding bill, the following documents are required:

- ☐ Completed Financial Evaluation Form (enclosed);
- ☐ A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s);
- ☐ A copy of your most recent three (3) paycheck stubs;
- ☐ A copy of your most recent three (3) bank statements for each account;
- ☐ A list of your outstanding medical debts and monthly pharmacy costs; and
- ☐ The name and telephone number for your Medicaid caseworker, if applicable.

Please return all documentation within the next ten (10) days to:

Should you have additional questions please contact me directly at (XXX) XXX-XXXX.

Sincerely,

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St. Vincent Health

Financial Evaluation Long Form

MR Number & Account Number to be completed by hospital personnel:	MR Number:	Hospital:	Account Number:

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's Name:	Social Security Number:	Date of Birth/Marital Status:
Address:	Telephone Number: Home ( ) Work: ( )	
City/State/Zip:	Employer (Patient/Spouse/Responsible Party):	

List ALL household member names	Date of Birth	Soc Sec Number	Relationship to patient	Monthly Income
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$

Monthly Income		Monthly Expenses	
Responsible Party's Gross Income (before taxes)	$	Rent/Mortgage/Homeowner's Insurance	$
Other Household Gross Income (before taxes)	$	Utilities (Electric/Water/Gas)	$
Investment Income (Annuities/Stocks/Dividends)	$	Telephone	$
Child Support/Alimony Received	$	Child Support/Alimony Paid	$
Rental Property Income	$	Food (excluding cigarettes & alcoholic beverages)	$
Pension/Retirement/Unemployment	$	Car Payment (loan + insurance)	$
Other:	$	Medical & Pharmacy Bills	$
Total Monthly Income (before taxes)	$	Total Monthly Expenses	$

Assets		Liabilities	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account Balance	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's/Retirement Funds	$	Auto Loan Balance	$
Value Auto/Boat/Motorcycle	$	Total Medical Bills (attach list)	$
Other:	$	Real Estate Taxes	$
Total Value of Assets	$	Total Liabilities	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through St. Vincent Health. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by St. Vincent Health to obtain such assistance and will assign to St. Vincent Health, and upon receipt will pay to St. Vincent Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Vincent Health will result in the denial of this application. I also authorize St. Vincent Health to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party) _____ Date _____

C:\Data\Uninsured\Financial Evaluation Form.doc

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St. Vincent Health
Indianapolis, Indiana

IN, Indianapolis
St. Vincent Health
Uninsured & Underinsured
Patient Management Program

St. Vincent Health

Financial Evaluation Short Form
Account Balances Less than $300

MR Number & Account Number to be completed by hospital personnel	MR NUMBER:	ACCOUNT NUMBER:
		Insure Completed Evaluation Form to:

June 9, 2004

RE: Patient –
Account Number –
Balance Due - $

Dear

Please complete the information below and return this form to the address above.

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's Name:	Social Security Number:
Address:	Telephone Number: Home ( ) Work ( )
City/State:	

List All Household Member Names	Date of Birth	Soc Sec Number	Relationship to patient	Monthly Income
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$
			Total Monthly Income	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through St. Vincent Health. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by St. Vincent Health to obtain such assistance and will assign to St. Vincent Health, and upon receipt will pay to St. Vincent Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Vincent Health will result in the denial of this application. I also authorize St. Vincent Health to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party) _____ Date _____

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St. Vincent Health
Indianapolis, Indiana

IN, Indianapolis
St. Vincent Health
Uninsured & Underinsured
Patient Management Program

St.Vincent Health

Financial Evaluation Worksheet for Both Long and Short Forms

For Hospital Use Only

MR Number:	Account Number:	Hospital:
Patient Name:		Responsible Party Name:

Financial Evaluation

DOCUMENTATION PROVIDED	Select only one item below MEDICAID REFERRAL ?:	Select only one item below EXPIRATION DATE
○ Financial Evaluation Short Form Note: Patient will not receive a UUPMP ID card for Short Form approval. Supporting Documents Attached Select as many as are applicable: ☐ Financial Evaluation Long Form ☐ Federal Tax Forms with appropriate attachments ☐ Self-Employed Patients or Responsible Party Worksheet ☐ 3 Paycheck stubs ☐ 3 Bank Statements ☐ List of medical debts ☐ Name & telephone number of Medicaid caseworker ☐ Other:_____	○ Screened, not Medicaid eligible. ○ Medicaid eligible, referral inside, Medicaid eligibility and/or application denied. MEDICAID APPROVAL PENDING? ○ Medicaid eligible, referral inside and application submitted, Medicaid approval pending. Note: A UUPMP ID card will not be issued while Medicaid approval is pending. You must update the database to one of the first two Medicaid Referral selections above in order for an ID card to be issued. APPLICATION APPROVAL Approved for discount as follows: ○ CC1 (≤100%) ○ CC2 (>100% and ≤200%) ○ 80% FAP3 ○ 60% FAP4 ○ 70% FAP5 ○ 80% FAP6 Note: Patients who complete the Financial Evaluation Short Form will not receive a UUPMP ID card upon approval.	○ 6 month authorization ○ 12 month authorization APPLICATION DENIED ○ Failure to apply, comply with data requirements and/or follow through with Medicaid application ○ Insufficient information or data provided ○ Income level determined to be "Means to Pay" (income > 300%) ○ Applicant provided inaccurate or false data ○ Other:_____

Comments:

Account Representative Signature:	Print Name:
Telephone & extension #	Date:

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SAMPLE

January 1, 2004

Mr. John Doe
1234 East Street
Indianapolis, IN 46062

RE: Financial Assistance Application

Dear Mr. Doe:

Your application for Financial Assistance has been reviewed and approved. The initial period of coverage expires 06/30/2004.

The identification cards provided below along with a photo ID (i.e. driver's license) will allow you or a household member listed on the card to receive services from St. Vincent Health affiliates at a discounted rate. You will be responsible for full payment for the following amounts:

Hospital Inpatient and Outpatient Acute Care	XX% of total services (up to 10% of your annual income)
Hospital Emergency Room Visit	$XX.00
Hospital Employed Physician Office Visit	$XX.00
Participating Physician Office Visit	$XX.00
Primary Care Clinic Visit	$XX.00

Should you have additional questions or should your financial situation change significantly from what you originally reported, please contact (317) XXX-XXXX.

Sincerely,

Financial Assistance Program

Name	SSN
Doe, John	123-45-8888
Doe, Jane	123-45-8888
Doe, Johnny	123-45-8888
Doe, Janie	123-45-8888

**********PATIENT LIABILITY**********

Hosp Acute%	ER	ExpOrOffice	PrimCareClinic
10%	$75	$25	$15
Expiration		Member ID#	Plan Code
06/30/2004		123456	U010

Financial Assistance Program

Name	SSN
Doe, John	123-45-8888
Doe, Jane	123-45-8888
Doe, Johnny	123-45-8888
Doe, Janie	123-45-8888

**********PATIENT LIABILITY**********

Hosp Acute%	ER	ExpOrOffice	PrimCareClinic
10%	$75	$25	$15
Expiration		Member ID#	Plan Code
06/30/2004		123456	U010

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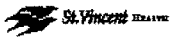
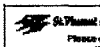


SAMPLE

(Back Printing)



Financial Assistance Program

Please direct all inquiries to:
(317) XXX-XXXX
St. Vincent Health
P.O. Box XXXX
Indianapolis, IN 46280

Not all physician practices participate in this program. You will need to contact the physician's office where services were provided.

THIS IS NOT AN INSURANCE CARD

Financial Assistance Program

Please direct all inquiries to:
(317) XXX-XXXX
St. Vincent Health
P.O. Box XXXX
Indianapolis, IN 46280

Not all physician practices participate in this program. You will need to contact the physician's office where services were provided.

THIS IS NOT AN INSURANCE CARD

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17h0

Proof of Income for
Self-Employed Patients/Responsible Party

Dear _____:

It is our understanding that you have requested financial assistance for your healthcare services and are unable to produce the normal routine documentation due to your self-employed status. Please provide the following information for the next eight (8) weeks:

Week	Business Income	Business Expenses	Your "Take Home" Pay
1	$.	$.	$.
2	$.	$.	$.
3	$.	$.	$.
4	$.	$.	$.
5	$.	$.	$.
6	$.	$.	$.
7	$.	$.	$.
8	$.	$.	$.
Total	$.	$.	$.

Return this information immediately after completion of the eight week period to:

{Insert Hospital name, address and department here}

Sincerely,

St. Vincent Health

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Financing Programs for Accounts Receivables

Objective: Reduce the amount of patient responsibility accounts receivable by offering financing options for our customers. The programs offered must be viewed as a positive by our patients and lead to an increase in customer satisfaction. Charge Card payments are promoted for payment in full. This financing in conjunction with a prompt pay discount is easy to implement and costs only the charge card administrative fee.

Concept: Patients will be encouraged to pay their accounts in full by selecting personal financing from a variety of options. The intent of the overall program is to remove obstacles for payment in full. The following options have been identified:

Option 1: A negotiated prompt pay discount for payment in full within the first statement cycle.

Option 2: Fifth Third Bank (5th/3rd) Loan program is a full recourse program that will buy any account with a balance over $ 1000. The interest charged on these accounts is based upon the variable rate at the time of the loan. St. Vincent shares in the spread earned on these accounts.

The check is paid directly to St. Vincent for the full amount of the receivable. Should the account go delinquent, St. Vincent will buy back the loan of the current balance, plus interest. The current default rate is approx. 15%. (This is based on defaults to date and probably is higher if we do not include active accounts) The account is set back up in the system, transferred to Bad Debt and forwarded to Hardamon & Associates to pursue legally. The program is very easy to implement and involves the following steps:

1. Completing the contract over the phone with the patient.
2. Mailing the contract to the patient.
3. Upon receipt of the signed contract, notifying Fifth Third.
4. Fifth Third remits account balance in full to St. Vincent.

Option 3: Personal Finance Company loan program is a no recourse program that will buy certain accounts subject to credit approval. The minimum eligible balance for this program is $250. Personal Finance charges no interest to the patients who are approved for this program if they can pay the account off within 12 months. They reimburse St. Vincent 96% of the accounts that establish a six month payment plan and 92% of the accounts that establish a 12 month payment plan.

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Those patients who need to pay off the balance over a longer term have an interest rate structure based upon the length of term. This rate normally is higher than the rate charged by Fifth Third and is therefore not a very good option for our customers. St. Vincent is currently experiencing a 90% approval rate for this program. The program is easy to implement and involves the following steps:

1) An application is taken over the phone with the patient.
2) The application is faxed to PFC.
3) PFC returns application either approved or rejected within 15 minutes.
4) A contract is filled out by the St. Vincent associate and mailed to the patient.
5) The patient returns the signed contract to the St. Vincent associate.
6) The contract is picked up by PFC and a check issued to St. Vincent.

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St. Agnes Hospital
Data Request # 12-1
Term Agreement Policy

MD, Baltimore
St. Agnes HealthCare, Inc.

St. Agnes HealthCare System Policy and Procedure Manual	Page: 1 of 1	SYS FI 16
Subject: TERM AGREEMENTS	Effective Date: 10/93	
	Reviewed: 5/01 Revised: 5/98, 5/99	

Approvals:

Final - President/CEO _____ Date _____

Concurrences: _____

(Policy becomes operational 30 days after CEO signs.)

POLICY STATEMENT

Extended payment schedules for self responsible balances owed St. Agnes HealthCare are granted based upon established criteria for eligibility and approval levels.

SCOPE

This policy applies to all entities of the St. Agnes HealthCare system.

PROCEDURE/RESPONSIBILITY

In order to be granted an extended payment schedule, the patient must provide proof of an inability to pay the obligation within the regular billing cycle. For account balances under $1,000.00, verbal justification may be acceptable. For balances over $1,000.00, written financial disclosure is required. This disclosure includes proof of assets and liabilities. The number of acceptable monthly payments and minimum payment amounts by account balance are indicated on the Term Agreement: Extended Payment Schedule. Initial payment is required to initiate the agreement.

Exceptions:

Terms extending beyond minimum payment requirements require management approval as follows:

Under $7,500:	Patient Accounts Manager
Over $7,500:	Corporate Director of Patient Financial Services

Missed Payments:

Patients who fail to maintain current payments on accounts with extended term agreement schedules and fail to respond to the next immediate collection attempt may be considered bad debt upon the first broken promise. Otherwise, two missed payments will result in the account being written off to bad debts.

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St. Agnes Hospital
Data Request #12-4
Charity Allowance Policy

St. Agnes HealthCare System Policy and Procedure Manual	Page: 1 of 2
Subject: CHARITY ALLOWANCE	**Effective Date:** 10/93
	Reviewed: 5/02 **Revised:** 5/98, 7/99

MD, Baltimore
St. Agnes HealthCare, Inc.

Approvals:
Final - President/CEO _____ Date _____

Concurrences: CMO, VP Seton Medical Group
(Policy becomes operational 30 days after CEO signs.)

POLICY STATEMENT

It is the mission of St. Agnes HealthCare to provide healthcare services to the poor within the available resources of St. Agnes HealthCare. This policy establishes criteria for evaluating the eligibility of patients for reductions in their bills based upon lack of financial resources and other criteria that may be established.

SCOPE

This policy applies to all entities of the St. Agnes HealthCare system.

PROCEDURE/RESPONSIBILITIES

In order to be eligible for a charity allowance, patients must meet each of the following criteria:

Other Sources of Payment: Before a St. Agnes charity allowance will be considered, all other possible external sources of payment must be exhausted. These include health insurance, Medicare, Medical Assistance, workers compensation, automobile insurance and other state, federal and private programs which may be available for this purpose.

Application: Anyone wishing to be considered for a charity allowance must complete an application form and provide, as necessary, supporting documentation required to verify financial resources. If an application or documentation is incomplete, an attempt may be made to confirm the patient's financial status and charity eligibility through a credit bureau report. In such cases, any charity decision must be approved by the divisional patient accounts manager and the corporate director of patient accounting, or the Seton Medical Group director of finance.

Dependent Eligibility: When an individual is determined to be eligible, all dependents of that individual whose income and assets were considered in the original application are deemed to be eligible.

Medical Assistance Eligible Persons: In addition to those persons qualifying through the normal application process, patients who are currently eligible for Medical Assistance will qualify for charity allowance for balances after Medicaid payment.

Exceptions to the Policy:

It is recognized that some patients may experience an unusual medical, financial, or humanitarian burden but, based upon the criteria set forth in this policy, fail to qualify for charity care. In such cases, it is within the discretionary authority of St. Agnes HealthCare to waive the charity eligibility requirements and apply charity care as it deems appropriate.

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What is Covered/Eligibility Period

All types of elective and emergent healthcare provided at St. Agnes HealthCare may be considered for a charity allowance, except for elective cosmetic surgery which is not typically covered under commercial insurance.

Once approved, a charity allowance is valid for six months or until there is a change in the financial resources of the applicant, whichever occurs first.

Financial Resources:

The patient's ability to pay for all or part of their care is determined by evaluating the patient's assets, income from all sources, and prior medical bills.

Assets:

Liquid assets. as defined as cash, checking accounts, savings accounts, stocks, and bonds, as a source of payment are considered first using the following table:

ASSETS	REQUIRED PAYMENT
$0-$2,500	$0
$2,500-$5,000	25% of Total Liquid Assets
$5,000-$10,000	40% of Total Liquid Assets
$10,000-$20,000	45% of Total Liquid Assets
$20,000-$100,000	50% of Total Liquid Assets
Greater than $100,000	To be determined on an individual basis

Based upon the above table, the patient is required to pay a portion of the bill from existing liquid assets.

The remaining balance is considered for a charity allowance based upon the patient's current income, number of dependents and outstanding medical bill.

Authorization Levels:

Charity allowances in accordance with the policy require the following approvals:

~~ACCOUNT BALANCE~~	~~APPROVAL AUTHORITY~~
Up to $499.99	Collection Representative/Financial Interview/Collection Supervisor
$500-$4,999.99	Patient Accounts Manager
$5,000-$9,999.99	Patient Accounts Manager Corporate Director of Patient Accounting
$10,000 and greater	Patients Accounts Manager Corporate Director of Patient Accounting Vice President of Finance

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St. Agnes HealthCare
Charity Care Income Matrix
2002

MD, Baltimore
St. Agnes HealthCare, Inc.

Income	Family Size							
	1	2	3	4	5	6	7	8+
Under $8,860	100	100	100	100	100	100	100	100
8,860 - 9,629	95	100	100	100	100	100	100	100
9,630 - 10,399	90	100	100	100	100	100	100	100
10,400 - 11,169	85	100	100	100	100	100	100	100
11,170 - 11,939	80	100	100	100	100	100	100	100
11,940 - 12,709	75	95	100	100	100	100	100	100
12,710 - 13,479	70	90	100	100	100	100	100	100
13,480 - 14,249	65	85	100	100	100	100	100	100
14,250 - 15,019	60	80	100	100	100	100	100	100
15,020 - 15,789	55	75	95	100	100	100	100	100
15,790 - 16,559	50	70	90	100	100	100	100	100
16,560 - 17,329	45	65	85	100	100	100	100	100
17,330 - 18,099	40	60	80	100	100	100	100	100
18,100 - 18,869	35	55	75	95	100	100	100	100
18,870 - 19,639	30	50	70	90	100	100	100	100
19,640 - 20,409	25	45	65	85	100	100	100	100
20,410 - 21,179	20	40	60	80	100	100	100	100
21,180 - 21,949	15	35	55	75	95	100	100	100
21,950 - 22,719	10	30	50	70	90	100	100	100
22,720 - 23,489	5	25	45	65	85	100	100	100
[illegible]90 - 24,259	PIF	20	40	60	80	100	100	100
[illegible]60 - 25,029		15	35	55	75	95	100	100
[illegible]030 - 25,799		10	30	50	70	90	100	100
25,800 - 26,569		5	25	45	65	85	100	100
26,570 - 27,339		PIF	20	40	60	80	100	100
27,340 - 28,109			15	35	55	75	95	100
28,110 - 28,879			10	30	50	70	90	100
28,880 - 29,649			5	25	45	65	85	100
29,650 - 30,419			PIF	20	40	60	80	100
30,420 - 31,189				15	35	55	75	95
31,190 - 31,959				10	30	50	70	90
31,960 - 32,729				5	25	45	65	85
32,730 - 33,499				PIF	20	40	60	80
33,500 - 34,269					15	35	55	75
34,270 - 35,039					10	30	50	70
35,040 - 35,809					5	25	45	65
35,810 - 36,579					PIF	20	40	60
36,580 - 37,349						15	35	55
37,350 - 38,119						10	30	50
38,120 - 38,889						5	25	45
38,890 - 39,659						PIF	20	40
39,660 - 40,429							15	35
40,430 - 41,199							10	30
41,200 - 41,969							5	25
41,970 - 42,739							PIF	20
[illegible]0 - 43,509								15
[illegible]10 - 44,279								10
44,280 - 45,049								5
45,050 - 45,819								PIF

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MI, Detroit
St. John Health

St. John Health

Financial Assistance Program

Effective Date 7/01/2004

Attorney-Client
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MI, Detroit
St. John Health

ST. JOHN HEALTH

MISSION

ST. JOHN HEALTH, as a Catholic health ministry**,** is committed to providing spiritually centered, holistic care which sustains and improves the health of individuals in the communities we serve, with special attention to the poor and vulnerable.

VISION

As a spiritually-based community of health care providers, **ST JOHN HEALTH** will be recognized for our teamwork and excellence in healing service.

TO HEAL, TO SERVE, TOGETHER

VALUES

***We are called to*:**

SERVICE OF THE POOR:
Generosity of spirit, especially for persons most in need.

REVERENCE:
Respect and compassion for the dignity and diversity of life.

INTEGRITY:
Inspiring trust through personal leadership.

WISDOM:
Integrating excellence and stewardship.

CREATIVITY:
Courageous innovation.

DEDICATION:
Affirming the hope and joy of our ministry.

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Received: 5/ 3/2004 22:14; ->PATIENT ACCOUNTING; #512; Page 2
FROM :MEDICAL SERVICES-SJHS 3134170555 2004; Detroit 13:02 #489 P.02/03

St. John Health

POLICY#: 9 **SUBJECT: Care of Persons Who Are Poor and Community Benefit**

BOARD APPROVAL DATE: 9/6/00

EFFECTIVE DATE: 9/6/00
REVISION DATE: 3/12/03

Executive Vice President/COO

POLICY

It is the policy of Ascension Health that each Health Ministry, guided by the Mission ,Vision, Values, and Philosophy of the System, will plan for care of persons who are poor and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. Ascension Health desires to strengthen its commitment to this principle through a unified system of accountability.

2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their strategic and financial planning.

3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.

4. Annually Ascension Health will produce an aggregate report highlighting the best practices and innovative programs in the System.

APPLICABILITY TO CO-SPONSORED ENTITIES

It is expected that all co-sponsored integrated delivery networks (IDNs) with which Ascension Health member organizations are affiliated will adopt a policy that is consistent with and supportive of this Ascension Health policy. The IDNs also will be expected to comply with Ascension Health reporting requirements regarding care of persons who are poor and community benefits.

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Received: 5/ 3/2004 22:15; ->PATIENT ACCOUNTING; #512; Page 3
FROM :MEDICAL SERVICES-SJHS 3134170555 2004/05/03 13:02 #489 P.03/03

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SYSTEM PROCEDURES

Guidelines and Procedures for planning and reporting on Care of Persons Who are Poor and Community Benefit can be found in the Ascension Health Procedures binder. **[Note: System Procedure is in the process of being drafted.]**

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MI, Detroit
St. John Health

PROCEDURE #___ **SUBJECT:** **Care of the Poor / Community Benefit Goal Planning & Reporting**

EFFECTIVE DATE: _____

_____
Executive Vice President/COO

REFERENCE TO SYSTEM POLICIES:

Policy No. 9	Care of Persons Who are Poor and Community Benefit and
Policy No. 16	Billing and Collection for the Uninsured

Subject

This procedure sets forth the requirement that each Health Ministry have an effective Care of the Poor Policy, and establishes a process to develop annual Care of Persons Who are Poor / Community Benefit goals and to report progress towards those goals. All activities related to Care of the Poor will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship. Each hospital must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

Rationale

Care of Persons Who are Poor / Community Benefit planning and goals are incorporated into the existing Integrated Strategic and Financial Planning process. Progress towards established goals will be reported upon annually. This procedure provides guidelines to assist Health Ministries:

a. establish care of persons who are poor / community benefit goals within the framework of the Integrated Strategic and Financial Planning process and report progress towards those goals.
b. report costs for Categories I through V associated with allowable care of persons who are poor / community benefit programs and services.

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Procedure

Charity Care (Minimum Standards)

1. At a minimum, patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.

2. At a minimum, patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in number 1 (above) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.

3. Eligibility for charity care may be determined at any point in the revenue cycle.

4. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

Financial Assistance (Also see Policy #16 – Billing and Collection for the Uninsured)

Each Health Ministry should have a methodology to determine qualifying incomes and/or assets available to satisfy the patient's obligation to the hospital.

1. All eligible patients and the families are advised of the hospital's applicable policies, including the charity care policy and the availability of need-based financial assistance in easily understood terms, as well as in language commonly used by patients in the community.

2. The financial assistance policy must address a patient's eligible income and assets.

3. The policy may allow the determination to be made on a case-by-case basis, but in this circumstance, a review panel must be formed to ensure a patient has the right to appeal a decision.

4. Requiring a patient to apply for public financial assistance programs is permissible.

For further guidance, reference Sections 4 and 6 of Policy #16 – Billing and Collection for the Uninsured.

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Other Requirements and Exceptions (Also see Policy #16 – Billing and Collection for the Uninsured)

1. Health Ministries may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance programs to qualify for charity.

2. Other programs that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured. This is encouraged and will continue.

3. A nominal charge may be charged to patients qualifying for charity. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons who are poor since it respects their dignity as well as their sense of responsibility.

Planning

1. As part of the annual Integrated Strategic and Financial Planning process, establish substantial, measurable and meaningful Care of Persons Who are Poor / Community Benefit goals. These goals should include:

   a. An Ascension Health access goal, where applicable
   b. Three (3) to five (5) local Care of Persons Who are Poor / Community Benefit goals developed in response to a local community needs assessment

2. Goal Setting.

   a. A goal may span more than one year and, therefore, may be included in several years' plans. However, once the program/service/activity is functional and part of the on-going operations, a new goal(s) will be established.

   b. A Health Ministry may choose to include as a goal the continuation of a service that is at risk due to its operating at a loss, if this represents a clear decision for the sake of the mission impact of that service. In such a case, the goal will include ways to sustain the service. Once stabilized, it opens the opportunity for establishing a new goal.

3. The CEO and Local Board determine which of these goals will be attached to the local executive incentive.

4. The Integrated Strategic and Financial Plan budget for Care of Persons Who are Poor / Community Benefit should include budget dollars for Category I, Category II, Category III and Category IV (defined in the *Reporting* section) for the upcoming fiscal year as well as projected budget dollars for Categories I, III, and IV that reflect an increase over the prior year.

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Reporting

1. Dollar values should be reported on an annual basis for each of the following five categories:

   a. Category I – Charity Care (free care or reduced fee/sliding scale care for persons who qualify for financial assistance).

   b. Category II – Unreimbursed cost of care provided to patients enrolled in public programs.

   c. Category III – Community benefit programs and services targeted to persons who are poor

   d. Category IV – Community benefit programs and services targeted to the general community

   e. Category V – Bad debt costs attributable to Charity Care.

2. Guidelines for Category I. The following should serve as guidelines for reporting Category I – Charity Care. (Also see Policy on Billing and Collections for the Uninsured)

   a. Charity care dollars should be an estimate of the cost to provide services to patients who qualify for charity care.
   b. Charity care should include the cost of services provided to charity care patients in all settings (acute and non-acute settings such as ambulatory surgery centers, etc.)

3. Guidelines for Category II. The following should serve as guidelines for reporting Category II – Unreimbursed cost of care provided to patients enrolled in public programs.

   a. Medicare losses/shortfalls should not be reported. This is consistent with standards set by the CHA community benefit network and used by other Catholic systems.
   b. Losses/shortfalls from all Medicaid sources, including Medicaid managed care products, should be included.
   c. Medicaid disproportionate share (DSH) payments should be considered Medicaid payment/income.
   d. Prior year settlements from Medicaid programs (including Medicaid DSH) should be considered as an offset to the cost of care provided and, accordingly, increase or decrease the shortfall reported.

4. Guidelines for Category III Programs and Services. The following should serve as guidelines for identifying appropriate programs, services, and/or wellness activities/events to be included in Category III – Community benefit programs and services targeted to the poor. (See Exhibit A for examples of included/allowable Category III and Category IV programs/services/ activities.)

   a. The program/service/activity/event must respond to the needs of special populations; for example, the frail elderly, poor persons with disabilities, the chronically mentally ill,

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persons with AIDS, or those who find it hard to meet basic needs due to on-going poverty.

b. The program/service/activity/event should be quantifiable in terms of dollars and should not be included in Category I or II.
c. The program/service/activity/event should generate a low or negative margin.
d. The program/service/activity/event may be financed by philanthropic contributions, volunteer efforts, and endowment, grants, shortfalls, etc.
e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue is primarily motivated by a mission commitment versus a marketing interest.
f. The program/service/activity/event would no longer be available, or would be insufficiently available in the community, or would be the responsibility of the government if not provided by the healthcare organization.

5. Guidelines for Category IV Programs and Services. The following should serve as guidelines for identifying appropriate programs, services and/or wellness activities/events to be included in Category IV – Community benefit programs and services targeted to the general community. (See Exhibit A for examples of included/allowable Category III and Category IV programs/services/ activities.)

   a. The program/service/activity/event should be quantifiable in terms of dollars.
   b. The program/service/activity/event should generate a low or negative margin.
   c. The program/service/activity/event may be financed by philanthropic contributions, volunteer efforts, and endowment, grants, shortfalls, unrestricted donations and/or board designated donations, etc.
   d. The program/service/activity/event provides a response to a unique or particular health problem in the community or is directed to promoting the wellness of the population in a holistic manner.
   e. The program/service/activity/event would probably be discontinued or not offered if the decision were made on a purely financial basis. The decision to continue generally represents a mission commitment versus a business decision.

   For health ministries whose broader community is predominately those persons who are poor and vulnerable, program/services/activities/events targeted towards the broader community should be recorded in Category III.

6. Reporting Costs for Categories III and IV Programs and Services. The following should serve as guidelines for reporting costs for programs, services, activities or events appropriate to be included in Category III – Community benefit programs and services targeted to the poor and Category IV – Community benefit programs and services targeted to the general community.

   a. Report cost less any reimbursement received.
   b. All unrestricted donations and/or board designated donations for Category III or IV programs/services/activities/events should be reported as a community benefit.

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c. Medical Education programs should be reported as a community benefit.
   i. Medicare Graduate Medical Education (GME) payments should offset costs.
   ii. Medicare Indirect Medical Education (IME) payments should not be offset against the direct cost of medical education programs.
d. Volunteering may be reported.
   i. Include employee reported volunteer time for hospital supported activities such as:
      - Employee time volunteered to assist in health screenings performed after hours
      - Replacement cost for employees performing management approved volunteer activities
      - Staff volunteer time (with supervisor approval) spent conducting organizational sponsored events
      - Board representation on management approved organizations

7. Guidelines for Category V. The following should serve as guidelines for reporting Category V – Cost of Bad Debt attributable to Charity Care.

   Bad debt cost of services can be calculated for certain bad debt write-offs. This acknowledges that there are charity care patients that may not be identified initially as eligible for charity care. Two possible formulae for determining the cost of bad debt for services provided to charity care patients include:

   a. *Cost of bad debt excluding the portion related to coinsurance and deductibles.* Patients who have a coinsurance payment or deductible are assumed to have insurance.

   b. *Identify the zip code average income that constitutes "poor" and count all bad debts from those zip codes, excluding the portion related to coinsurance and deductibles.* It is recognized that while this methodology may count patients with the ability to pay who reside in these zip codes, the methodology also excludes patients from other zip codes that may not be able to pay.

8. Beginning with the Care of Persons Who are Poor / Community Benefit report due for FY05 and beyond, provide a narrative for each Care of Persons Who are Poor / Community Benefit goal identified in the Integrated Strategic and Financial Plan and describe progress towards achievement for each goal, including to the extent possible baseline measures of success being established, outcomes achieved, program impact, etc.

9. Care of Persons Who are Poor / Community Benefit goals are part of the Integrated Strategic and Financial Plan. Therefore, reporting for Goals is due consistent with the Integrated Strategic and Financial Plan timeline.

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MI, Detroit
St. John Health

SYSTEM POLICY#: 16	**SUBJECT: Billing and Collection for the Uninsured**
BOARD APPROVAL DATE:	**12/10/03**
EFFECTIVE DATE:	**07/01/04**
REVISION DATE:	

Chief Operating Officer and
Interim CEO, Ascension Health

POLICY

It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital or medical center and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does

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not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
   a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
   b. Patients receive prompt access to charge information for any item or service provided.
   c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
   d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
   e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
   f. Financial counselors are available to all Patients.
   g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
   h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
   a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
   b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
   c. Eligibility for charity care may be determined at any point in the revenue cycle.
   d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
   a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
   b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments,

utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, and a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal

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Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

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Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

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7/1/04
Ascension Health

Policy #9: Care of Persons Who Are Poor and Community Benefits
Policy #16: Billing and Collection for the Uninsured

St. John Health Addendum to System Policy # 16

Page #1:

Definitions: All references to "Hospital" in text is defined as "Health Ministry/Operating Unit."

Principles #2: Elective procedure is defined as "non-medically necessary" procedure.

Page #2:

Principles #4f: Financial Counseling is available to all patients, as opposed to having a financial counselor.

Principles #4h: A $25.00 copay will be applied to all Emergency Room visits approved for Charity discount.

Principal #5a: Local Wage Index:
Providence/Oakland = 1.0703; SJH/Riverview = 1.0846; others = 1.0101

Principle #5b: SJH policy is based on 200% of FPL. VODI (Voices of Detroit Initiative) recipients are awarded 250% of the FPL.

Principle #6b: SJH assessment of patient's ability to pay is based on the State of Michigan Medicaid financial determination worksheets.

Page #3

Principle #7: SJH is waiting for final determination for this area from Ascension Health before incorporating into our policy. SJH identifies uninsured patients as those with the "presumed " ability to pay.

Principle #8aiii: Executive management is defined as the Patient Financial Service Director.

Principal #8bii: Executive management is defined as the Patient Financial Service Director.

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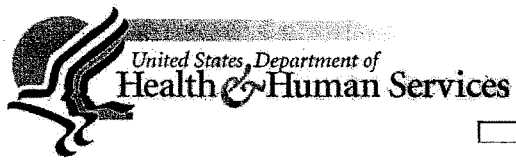

THE 2004 HHS POVERTY GUIDELINES

One Version of the [U.S.] Federal Poverty Measure

[*Federal Register* Notice with 2004 Guidelines - Full Text]
[Prior Poverty Guidelines and *Federal Register* References Since 1982]
[Information Contacts/References - Poverty Guidelines & Thresholds - History of U.S. Poverty Lines]
[Is There a Single Definition of "Income" That is Used with the Poverty Guidelines?]
[Computations for the 2004 Poverty Guidelines]

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1980 and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. (The full text of the *Federal Register* notice with the 2004 poverty guidelines is available here.)

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

A more extensive discussion of poverty thresholds and poverty guidelines is available on the Institute for Research on Poverty's Web site.

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2004 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,310	$11,630	$10,700
2	12,490	15,610	14,360
3	15,670	19,590	18,020
4	18,850	23,570	21,680
5	22,030	27,550	25,340
6	25,210	31,530	29,000
7	28,390	35,510	32,660
8	31,570	39,490	36,320
For each additional person, add	3,180	3,980	3,660

SOURCE: *Federal Register*, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility.

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in February 2004 are designated the 2004 poverty guidelines. However, the 2004 HHS poverty guidelines only reflect price changes through calendar year 2003; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2003. (The 2003 thresholds are expected to be issued in final form in September or October 2004; a preliminary version of the 2003 thresholds is now available from the Census Bureau.)

The computations for the 2004 poverty guidelines are available.

The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority

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of 42 U.S.C. 9902(2)."

Go to the page of Information Contacts and References on the Poverty Guidelines, the Poverty Thresholds, and the Development and History of U.S. Poverty Lines.

Return to the main Poverty Guidelines, Research, and Measurement page.

Last Revised: May 3, 2004

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St. John Health

St. John Health
Partial Charity Care Consideration
Eligibility Guidelines

2004 POVERTY INCOME GUIDELINES –SLIDING DISCOUNT SCALE

Yearly	/ Monthly Income	Family Size 1	2	3	4	5	6	7	8
$ 9,310 <	$776 <	100%	=	=	=	=	=	=	100%
$ 9,310	$776	100%	=	=	=	=	=	=	100%
$12,490	$777 - $1041	90%	100%	=	=	=	=	=	100%
$15,670	$1042 - $1306	80%	90%	100%	=	=	=	=	100%
$18,850	$1307 - $1571	70%	80%	90%	100%	=	=	=	100%
$22,030	$1572 - $1836	60%	70%	80%	90%	100%	=	=	100%
$25,210	$1837 - $2102	50%	60%	70%	80%	90%	100%	=	100%
$28,390	$2103 - $2366	40%	50%	60%	70%	80%	90%	100%	100%
$31,570	$2367 - $2631	30%	40%	50%	60%	70%	80%	90%	100%

(for each additional person add: $3,180)

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GENESYS REGIONAL MEDICAL CENTER

POLICY AND PROCEDURE MI, Flint
Genesys Health System

Subject: **Credit Policy** **Page 1 of 1**

Point-of-Service Collections

Effective: **08/04/03**

Reviewed/Revised: **08/15/03**

Objective: To increase collections at time of service, ensuring timely collection of patient portion and reduce bad debt.

Policy:

- The hospital will collect patient balances at time of service, based on verified insurance benefits.

- The hospital expects to have financial arrangements established for all self-pay, uninsured accounts, non-covered services, insurance co-pays and/or deductibles prior to scheduling elective services. Elective services are those services that are planned, scheduled encounters considered non-emergent in nature. A deposit of 20% of the estimated amount is expected prior to or at the time of service. Requests from physicians and/or their offices to schedule elective services, where financial arrangements have not been made based on the established GRMC guidelines, are to be deferred until the patient/guarantor can obtain the means to pay for it in advance. Cash, personal check, or credit cards are preferred means for payment.

- Self-pay, uninsured patients, who are pre-approved for state or county aid may be scheduled for elective services.

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- Scheduled procedures for patients who have not fulfilled their financial obligation will be cancelled.

- Any and all exceptions to this policy require the approval of the hospitals' COO or CFO.

- Urgent/emergent medical conditions are excluded from this policy which are defined as follows: A condition, including severe pain, psychiatric disturbances, and/or symptoms of substance abuse, in which the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious dysfunction or any bodily organ or part; or, with respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child; and a condition in which there is potential for further deterioration if not treated in the foreseeable future. The attending/ordering physician make the determination if the procedure is considered urgent/emergent/elective.

C:\mydocs\upfrontcollectionpolicy.wpd

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MI, Flint
Genesys Health System

- Best Practie Report
- Policy / Procedure
- Letters to Patient
- Application

CHARITY CARE

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MI, Flint
Genesys Health System

Charity Care Policy

Corporate #: 000013 Revision #: 0
(Last Reviewed: 02/22/2002)

Policy Applies to Entity(s):
GRMC

Policy Applies to Departments(s):
Administration

Policy Statement:
Motivated by a deep concern for human dignity, compliance with the Mission of Ascension Health and our social obligation to the community; Genesys Regional Medical Center seeks to fulfill its responsibility to provide quality health care services, without regard to an individual's race, creed, sex, etc., as mandated in the anti-discrimination laws of the United States and without consideration for their ability to pay for such services.

It will be the policy of Genesys Regional Medical Center to provide health care services to the population of our service area at no charge or a reduced charge to qualifying individuals or families as prescribed in the Procedures/Conditions of Entitlement for Charity Care Allowance.

A further consideration of this policy recognizes that in order to maintain a high level of quality care and keep abreast of technology advances, Genesys Regional Medical Center must maintain financial viability, and although we believe caring for the needy and indigent is our religious and societal obligation, it is an obligation that should not fall exclusively or disproportionately on Catholic hospitals.

Incorporated into and a part of this policy is the following "Procedures/Conditions of Entitlement for Charity Care Allowance" consideration.

Purpose of Policy:
Genesys Regional Medical Center, as a provider of high quality direct and indirect health care services, and in keeping with the Mission of Ascension Health, recognizes that it has a religious, moral, and social obligation to provide "charity care" and to establish a procedure for the identification and determination of patients and programs that should legitimately qualify for inclusion in the Genesys Regional Medical Center Charity Care Program.

Policy Detail:
Procedure/Conditions of Entitlement for Charity Care Allowance

These procedures and conditions are being documented so as to acknowledge our charity care obligation as a non-profit health care entity, acknowledge our obligation to serve all patients regardless of payor, to establish mechanisms to quantify our contribution of charity care to our community and the general public, to make known our procedures and guidelines and document that they were consistently applied, and to meet any disclosure requirements.

1. Determination of Annual Charity Care
   - It will be the responsibility of the Social Accountability Group to recommend to administration, and subsequently the Board of Trustees, the upcoming fiscal year's allocation or budget for charity care.
   - The Charity Care Allowance amount shall be an aggregate of direct and indirect medical services. This amount shall at least be equal to an amount established by governmental regulations.
   - The Finance Department shall develop a system to monitor the actual amounts of charity care charged against the budget. To the extent necessary, it will recommend adjustments to the budget and suggest changes to the Social Accountability Group to accomplish compliance with applicable laws and regulations.

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- The Finance Department will be responsible for maintaining any supporting schedules deemed necessary and any required disclosures as mandated by law, the FASB or AICPA.

2. Charity Care Qualifying Inclusions
   - It is the policy of Genesys Regional Medical Center to provide medical services to all persons. Also, Genesys Regional Medical Center has a legal requirement to provide emergency and trauma services before determining the source of payment. Thus, generally, all services related to direct medical care qualify for inclusion under the Charity Care Policy.
   - Allowable charity care amounts are those services/amounts that have not been paid by any other source (including local, State, and Federal programs). All potential sources of payment will be investigated prior to Charity Care consideration.
   - Basic distinction between bad debts and charity services in a health care setting can be determined by differentiating between the unwillingness of the patient to pay and the demonstrated inability of the patient to pay.
   - Other amounts considered Charity Care include, but are not limited to, the following:
     1. Excess of the hospital's cost in providing health care to Medicaid patients and other programs that are not covered by any other type of reimbursement.
     2. Medical Center costs in providing (directly or indirectly) health care or other health care related services designed to improve the overall health of the medically underserved and others in the community.

3. Process for Charity Care Approval/Denial
   Purpose: To provide a guide and process for distinguishing bad debts from charity care.

   Distinguishing bad debt expense from charity care requires judgment. Charity care results from and organization's policy to provide health care services free of charge to individuals who meet certain financial criteria. Although it is not necessary for us to make this determination upon admission or prior to treatment of the individual, as some point we must determine that the individual meets pre-established criteria for charity care.

   A. Individuals seeking consideration for charity care should be directed to call or visit the Patient Accounting Credit/ Cashier's Office at the West Flint Campus or the Patient Accounting Department located on the fourth floor of Genesys Regional Medical Center, West Flint Campus, (810) 762-4031.

   OR

   Individuals who have received a bill can contact the Patient Accounting Collection Department located on the fourth floor of Genesys Regional Medical Center, West Flint Campus, (810) 762-4031.

   B. All potential charity care recipients will be required to fill out an "Application for Charity Care Consideration" form.
   1. The patient/guarantor must supply a copy of a recent paycheck stub, if employed, or other compensation benefits check stub.
   2. The patient must supply a copy of his/her previous year's income tax return.
   3. An approved "Application" will be valid for six (6) months.
   4. A patient denied charity care consideration may submit a new application whenever additional medical services are required or whenever his/her financial condition significantly changes, impairing their ability to pay past, present, or future medical services.
   5. An approved application for charity care allowance will not automatically cancel prior debts owed to Genesys Regional Medical Center. If the patient has already been turned over to a collection agency due to previous Genesys Regional Medical Center medical services, these past due amounts will remain with the agency.

Regulation Number, Link, or Document:

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BORGESS HEALTH ALLIANCE

MI, Kalamazoo
Borgess Health Alliance, Inc.

POLICY AND PROCEDURE

ORIGINATOR: Director, Patient Financial Services	**POLICY DESCRIPTION**: Billing and Collection for the Uninsured	
DATE APPROVED: 7/15/04	**POLICY NUMBER**: BHA.702	**REPLACES**: NEW
ORIGINAL ISSUE DATE:	**EFFECTIVE DATE**: 7/15/04	**REPLACES**: N/A
DATE RETIRED: N/A	**PAGE**: 1 of 5	**REPLACES**: N/A

RELATED POLICIES:

None.

SCOPE:

Borgess Health Alliance, Inc. and its wholly-owned subsidiary corporations.

PURPOSE:

To set forth the policy and procedure for providing charity care and discounts to eligible patients.

POLICY:
It is the policy of Borgess Health Alliance (BHA) to ensure a socially just practice for billing for all patients receiving care. Many of our patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care with Borgess Health Alliance.

DEFINITIONS
For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at each Borgess Health Alliance hospital or medical center and person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Borgess Health Alliance policy BHA.701 and herein. (See Borgess Health Alliance Policy BHA.701),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay such as total income and number of family members. Special consideration may be given to patients that have income above 400% of the poverty guidelines but have very large medical bills.
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

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BORGESS HEALTH ALLIANCE

MI, Kalamazoo
Borgess Health Alliance, Inc.

POLICY AND PROCEDURE

ORIGINATOR: Director, Patient Financial Services	**POLICY DESCRIPTION**: Billing and Collection for the Uninsured	
DATE APPROVED: 7/15/04	**POLICY NUMBER**: BHA.702	**REPLACES**: NEW
ORIGINAL ISSUE DATE:	**EFFECTIVE DATE**: 7/15/04	**REPLACES**: N/A
DATE RETIRED: N/A	**PAGE**: 2 of 5	**REPLACES**: N/A

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavior health, and to non-elective procedures. This policy does not apply to payment arrangements for elective procedures as defined by each hospital.

3. International patient guidelines will be defined under a separate policy.

4. Each hospital must ensure that:
   a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
   b. Patients receive prompt access to charge information for any item or service provided.
   c. Patients and their families are advised of the hospital's applicable polices, including charity care and the availability of need-based financial assistance in easily understood terms.
   d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
   e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility within our community.
   f. Financial counselors are available to assist all Patients.
   g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
   h. Hospital programs that include nominal payments by Patients designed to encourage Patient to participate in their care are permissible.

5. Charity Care
   a. Patients with income less than or equal to 200% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off of the charges for services that have been provided to them.
   b. Patients with incomes above 200% of the FPL will be considered for Financial Assistance as defined below.
   c. Eligibility for charity care may be determined at any point in the revenue cycle.

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BORGESS HEALTH ALLIANCE

MI, Kalamazoo
Borgess Health Alliance, Inc.

POLICY AND PROCEDURE

ORIGINATOR: Director, Patient Financial Services	**POLICY DESCRIPTION**: Billing and Collection for the Uninsured	
DATE APPROVED: 7/15/04	**POLICY NUMBER**: BHA.702	**REPLACES**: NEW
ORIGINAL ISSUE DATE:	**EFFECTIVE DATE**: 7/15/04	**REPLACES**: N/A
DATE RETIRED: N/A	**PAGE**: 3 of 5	**REPLACES**: N/A

6. Financial Assistance
   a. Patients with income greater than 200% of the Federal Poverty Level ("FPL") up to 300% of the FPL, will be eligible for consideration of a 30% discount of their charges for hospital services based on a substantive assessment of their ability to pay. Patients with income greater than 300% up to 400% of the FPL will be eligible for a 25% discount of their charges for hospital services based on a substantive assessment of their ability to pay.
   b. Patients and families may appeal decisions of the hospital regarding eligibility for charity care or Financial Assistance by contacting the Vice President of Finance or his/her designee will all pertinent forms and documentation. The Vice President of Finance or his/her designee will review the case and supporting documentation, discuss any and all pertinent issues with the patient, the responsible party and the locally sponsored ministry. A decision with regard to the appeal will be issue in writing within 30 days of receipt of the written appeal.
   c. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishment of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this policy, and a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements

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POLICY AND PROCEDURE

ORIGINATOR: Director, Patient Financial Services	**POLICY DESCRIPTION**: Billing and Collection for the Uninsured	
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DATE RETIRED: N/A	**PAGE**: 4 of 5	**REPLACES**: N/A

f. Management is accountable to ensure that all collection policies follow the federal Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice the collection agency of Borgess Health Alliance's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

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BORGESS HEALTH ALLIANCE

MI, Kalamazoo
Borgess Health Alliance, Inc.

POLICY AND PROCEDURE

ORIGINATOR: Director, Patient Financial Services	**POLICY DESCRIPTION**: Billing and Collection for the Uninsured	
DATE APPROVED: 7/15/04	**POLICY NUMBER**: BHA.702	**REPLACES**: NEW
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DATE RETIRED: N/A	**PAGE**: 5 of 5	**REPLACES**: N/A

Addendum to Collection Agency Services Agreement

Borgess Health Alliance and _____ [Collection Agency], for mutual consideration hereby acknowledge, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. Borgess Health Alliance has adopted a new ("Policy") intended to further ensure socially just billing and collection practices for Borgess Health Alliance uninsured patients.
2. A copy of the Policy has been provided to [the Collection Agency].
3. Subject to Paragraph 4 of this Addendum, [the Collections Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured Borgess Health Alliance patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured Borgess Health Alliance patients or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to the Borgess Health Alliance; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured Borgess Health Alliance patient or person financially responsible referred to [the Collection Agency] for the purposes of collecting amounts owed to Borgess Health Alliance.

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from Borgess Health Alliance.

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MI, Kalamazoo
Borgess Health Alliance, Inc.

Borgess Health Alliance
2004 HHS Poverty Guidelines Calculation Table

Hospital Based Inpatient & Outpatient Services					
Household Size	**Charity Care**		**Financial Assistance Program**		**Uninsured with Means to Pay**
	100%*	200%	300%	400%	>400%
1	$9,310	$18,620	$27,930	37,240	
2	$12,490	$24,980	$37,470	49,960	
3	$15,670	$31,340	$47,010	62,680	
4	$18,850	$37,700	$56,550	75,400	
5	$22,030	$44,060	$66,090	88,120	
6	$25,210	$50,420	$75,630	100,840	
7	$28,390	$56,780	$85,170	113,560	
8**	$31,570	$63,140	$94,710	126,280	
Discount	100%	100%	30%	25%	Individual consideration

Discount Application *1) Financial Assistance for the uninsured and Means to Pay discount based on total charges*
2) Insured discount is based on patient liability or balance due.

*-http://aspe.hhs.gov/poverty/04poverty.shtml, where 04=current year
**- For each additional persons, add $3,180

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MI, Saginaw
St. Mary's Medical Center

Saint Mary's Policy/Procedure Manual

Policy Number: 108530-0003
Policy Owner: Patient Accounting
Original Date: 1998-02-25
Revision Date: 2004-04-01

Active

Charity Care and Financial Assistance

Keywords:

Charity, Financial Assistance

Scope (applicable to):

All Departments

Short Description:

Policy and procedure concerning charity care and financial assistance.

Policy Statement:

It is the policy of Saint Mary's to provide assistance to patients who do not have the financial resources available to pay for necessary medical service rendered. Various individuals may identify potential charity care recipients. Any patient that may be a candidate should be referred to a financial counselor. This policy reflects Ascension Health core values and principles, including: our commitment to and reverence for human dignity and the common good; our special concern for and solidarity with poor and vulnerable persons; and our commitment to distributive justice and stewardship. In addition, this policy supports the initiatives to provide Health Care that Works and Health Care that Leaves No One Behind.

Saint Mary's billing and collection practices include:

A. Treating patients and their families with dignity, respect and compassion
B. Providing notice to patients of the availability of charity care and financial assistance
C. Providing prompt access to charge information
D. Advising patients and their families applicable policies, including charity care policies, and the availability of need-based financial assistance
E. Providing access to financial counselors
F. Requiring that the patient work with the financial counselor and apply for Medicaid or other public assistance programs to qualify for charity
G. Offering payment terms or payment options that consider the patient's financial status
H. Pursuing outstanding balances on patient accounts fairly and consistently, in a manner that reflects the values and commitments of a Catholic sponsored facility. These practices **exclude:**

1. Liens on personal residences except where:

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a. Patient does not qualify for charity or financial assistance
b. Patient is not complying with payment arrangements
c. The lien will not cause foreclosure on a personal residence
d. Collection agencies must have hospital approval

2. Garnishments except where:

a. Patient does not qualify for charity or financial assistance, and
b. A court determines financial income is sufficient
c. Collection agencies must have hospital approval

3. The collection of a bill that will cause patient to have to file for personal bankruptcy
4. Bench warrants/body attachments

Policy Summary:

1. Patient eligibility will be based on the following information:

A. Any patient that may be eligible for public assistance (Medicaid) must make application for such. A documented response from public assistance must be on file prior to final determination of charity care funds.

B. All inpatient and outpatient accounts exceeding $500 are eligible for charity. A Financial Assistance Application must be completed by the patient/guarantor.

C. The application includes:

1. Income from all sources, listing gross income for the most recent three-month period.

2. Resources from savings and checking accounts, certificates of deposit, stocks, bonds, real estate, etc.

3. Assets including home, cars, boats, and any other vehicles.

4. Monthly expenses and number of dependents.

5. A copy of the two most recent federal income tax returns.

D. All third-party resources and non-hospital financial aid programs, including public assistance available through Medicaid. (Note: Public Assistance must be exhausted before charity benefits can be requested.)

E. Deductible and coinsurance amounts are eligible for charity benefits if

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financial circumstances warrant.

F. Elective services such as cosmetic surgeries are excluded from the Charity Care Program.

2. Program Administration: The Charity Care Program will be administered according to the following guidelines:

   A. The application information, along with the federal income tax forms, will be reviewed and verified by Patient Accounting personnel for hospital accounts or designated associates for the physician practices accounts.

   B. After reviewing income and expenses, Patient Accounting personnel for hospital accounts or designated associates for the physician practices accounts will determine if the patient/guarantor qualifies for charity care or financial assistance based on the Income and Assets Guideline Worksheet.

      1. If the patient/guarantor qualifies for 100% charity care, he/she will be notified and the account will be written off per procedures.

      2. If the patient/guarantor qualifies for a reduction in liability, he/she will be notified and payment arrangements made for the non-write off amount.

      3. If the patient/guarantor does not qualify for charity care or financial assistance, payment arrangements in accordance with Ascension Health Uninsured directives will be discussed with the patient/guarantor. Saint Mary's will offer to discount services to a level equivalent to the current Blue Cross/Blue Shield of Michigan payment schedule.

   C. Falsification of application or refusal to cooperate with the application process will result in denial of charity benefits.

   D. Saint Mary's reserves the right to change benefit determination if financial circumstances have changed.

3. The Charity Income Guidelines are based upon one to two times federal poverty level index. This index and Saint Mary's Charity Income Guidelines are updated annually. If the annual family income is equal to or less than the minimum, the patient is eligible for 100% charity. If the annual family income is equal to or greater than the maximum, then no charity is applied and the patient is responsible for a discounted amount equal to the current Blue Cross/Blue Shield of Michigan payment levels. If the annual income falls between the minimum and maximum limits, the charity discount is calculated utilizing the Income and Assets Guideline Worksheet for Charity Care Determination.

4. The authorization limits for charity write off amounts are as follows:
   - Patient Accounting Collector – $500 to $1,000
   - Patient Accounting Billing Analysts – $1,000 to $2,000
   - Patient Accounting Manager – $2,001 to $15,000
   - Patient Accounting Director – $15,001 to $50,000
   - Vice President of Finance – $50,001 to $99,999

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- President and Board of Directors – $100,000 or greater

Policy Definitions:

There are no definitions currently associated with this policy

Policy Reviewers:

This policy requires no additional review other than approving parties

Policy Attachments:

- Income and Assets Guideline Worksheet For Charity Care Determination
- Charity Income Guidelines
- Financial Assistance Application

Approvals:

Executive Council - (03/2004)	*President/CEO*
Board of Directors - (03/2004)	*Chairperson*

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St. Joseph Health System
Tawas City, Michigan

SUBJECT: Patient Financial Discount Program		WRITTEN BY: Patient Financial Services	
DISTRIBUTION: System Wide		EFFECTIVE: July 1, 2004	PAGE 1 of 3
APPROVED BY: CFO Signature on file	DATE: 07/01/04	REVIEWED:	
		REVISED:	

Core Value: Service of the Poor, generosity of spirit, especially for persons most in need.

To provide high quality direct and indirect healthcare services, in keeping with the Mission of Ascension Health and St. Joseph Health System (SJHS), that recognizes its religious, moral and social obligation to provide financial assistance without regard to an individual's race, color, creed, national origin, sex, age, marital status, handicap, sexual preference as mandated in the anti-discrimination laws of the United States

Policy Statement:

Motivated by a deep concern for human dignity and in harmony with St. Joseph Health System's (SJHS) mission and social obligation to the community, the health system has developed a program to assist our patients with their medical expenses. SJHS seeks to fulfill its responsibility to provide quality health care services to the population of our service area, at discounted payment rate, to qualifying individuals or families as prescribed in the Procedures/Conditions of the Patient Financial Discount Program.

A further consideration of this policy recognizes that in order to maintain a high level of quality care and to keep abreast of advances in technology, SJHS must maintain financial viability, as well as adhering to all billing and collection practices. Although it is our religious and societal obligation, it is an obligation that should not fall exclusively or disproportionately on Catholic institutions.

Procedure:

Incorporated into and a part of this policy is the following "Procedures/Conditions of **Patient Financial Discount** " consideration:

Procedures/Conditions of the Patient Financial Discount Program.

These procedures and conditions are documented to acknowledge our financial assistance program obligation as a non-profit health care entity. We acknowledge our obligation to serve all patients regardless of payer, to establish mechanisms to quantify our contribution of uncompensated care to our community and the general public. Therefore, we make known our procedures and guidelines and document that they were consistently applied, to meet any disclosure requirements.

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MI, Tawas City
St. Joseph Health System

I. Determination of Financial Discounts

1. It will be the responsibility of the Finance Department to establish and recommend to Administration and subsequently the Board of Trustees the annual allocation for discounts provided to the uninsured and/or under-insured patients with the ability to pay through the Annual Budget Process.
2. It shall be the responsibility of the Finance Department to develop and implement a system to monitor, and recommend adjustments or changes to the Board of Trustees to accomplish the program's compliance with applicable laws and regulations as well as SJHS mission/values.

II. Financial Discounts Qualifying Inclusions

1. It is the policy of the Health System to provide a 20% discount if paid in full within 45 days of the date of service. The discounts will apply on all medical services to all persons without regard for their ability to pay for services not covered by insurance or local, state and federal programs. (Co-pay and deductibles are excluded). Also, the Health System has a legal requirement to provide emergency and trauma services without regard to the source of payment. Generally all services related to direct medical care qualify for inclusion under the Financial Discount Policy.
2. All services related to direct medical care when:
   a. The services are not covered by insurance.
   b. If payment is not received in full within 45 days, the discount will be reduced to 10% regardless of payment date.
   c. Eligibility for financial discounts is not based on income. It is to recognize fair payment practices to the un-insured or under-insured.

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MI, Tawas City
St. Joseph Health System

St. Joseph Health System
Tawas City, Michigan

SUBJECT: Financial Assistance Program		WRITTEN BY: Fiscal Services	
DISTRIBUTION: System Wide		EFFECTIVE: February 1993	PAGE 1 of 3
APPROVED BY: CFO Signature on file	DATE: 07/01/04	REVIEWED: 02/02	
		REVISED: 04/94, 04/96, 04/98, 02/02,05/03, 7/04	

Core Value: Service of the Poor, generosity of spirit, especially for persons most in need.

To provide high quality direct and indirect healthcare services, in keeping with the Mission of Ascension Health and St. Joseph Health System (SJHS), that recognizes its religious, moral and social obligation to provide financial assistance without regard to an individual's race, color, creed, national origin, sex, age, marital status, handicap, sexual preference as mandated in the anti-discrimination laws of the United States

Policy Statement:

Motivated by a deep concern for human dignity and in harmony with St. Joseph Health System's (SJHS) mission and social obligation to the community, the health system has developed a program to assist our patients with their medical expenses. SJHS seeks to fulfill its responsibility to provide quality health care services to the poor and vulnerable population of our service area, at no charge or a reduced charge, to qualifying individuals or families as prescribed in the Procedures/Conditions of Entitlement for Financial Assistance.

A further consideration of this policy recognizes that in order to maintain a high level of quality care and to keep abreast of advances in technology, SJHS must maintain financial viability, as well as caring for the needy and indigent Although it is our religious and societal obligation, it is an obligation that should not fall exclusively or disproportionately on Catholic institutions.

Procedure:

Incorporated into and a part of this policy is the following "Procedures/Conditions of Entitlement for Financial Assistance" consideration:

Procedure/Conditions of Entitlement for Financial Assistance

These procedures and conditions are documented to acknowledge our financial assistance program obligation as a non-profit health care entity. We acknowledge our obligation to serve all patients regardless of payer, to establish mechanisms to quantify our contribution of uncompensated care to our community and the general public. Therefore, we make known our procedures and guidelines and document that they were consistently applied, to meet any disclosure requirements.

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3/11

I. Determination of Financial Assistance

1. It will be the responsibility of the Finance Department to establish and recommend to Administration and subsequently the Board of Trustees the annual allocation for financial assistance for the uninsured unable to pay and a discount for the uninsured patients with the ability to pay through the Annual Budget Process.
2. It shall be the responsibility of the Finance Department to develop and implement a system to monitor, and recommend adjustments or changes to the Board of Trustees to accomplish the program's compliance with applicable laws and regulations as well as SJHS mission/values.

II. Financial Assistance Qualifying Inclusions

1. It is the policy of the Health System to provide medical services to all persons without regard for their ability to pay. Also, the Health System has a legal requirement to provide emergency and trauma services without regard to the source of payment. Generally all services related to direct medical care qualify for inclusion under the Financial Assistance Policy.
2. All services related to direct medical care when:
   - **a.** The services are not covered by insurance or local, state and federal programs; and,
   - **b.** At a minimum, patients with income less than or equal to 100% of the Federal Poverty Level (FPL), will be eligible for 100% financial assistance write off for charges for non-elective services.
   - **c.** At a minimum, patients with incomes above 100% FPL but not exceeding 200% of the FPL, will receive a discount on the non-elective services provide to them on a sliding scale. The percentage of aid is based on income, family size, and assets.
   - **d.** Eligibility for financial assistance may be determined at any point in the revenue cycle, which is considered from the registration process to when the bill is paid.
   - **e.** Some exclusion may apply as they relate to Durable Medical equipment that can be purchased at a local pharmacy/drug stores.

III. Process for Financial Assistance Approval/Denial

1. All potential recipients will be required to complete an application for Financial Assistance at any time during the revenue cycle.
2. Potential participants will be required to apply for Medicaid as well as any other appropriate social program available from state, county or local governmental agencies. Eligibility under any of the aforementioned may affect the total amount of financial assistance afforded to the applicant.
3. Applicants denied for Medicaid coverage because they did not follow through with the documentation requirements for their Medicaid application, will not be approved for financial assistance under St. Joseph Health Systems Financial Assistance Program but will be eligible for a discount for the uninsured with the ability to pay policy.
4. An approved application for Financial Assistance will not cancel prior debts owed to the Health System prior to July 1, 2004. If the patient's account has been processed through the normal billing procedures and turned over to a collection agency/attorney prior to July 1, 2004, the accounts will remain with the agency/attorney regardless of whether the patient qualifies for Financial Assistance.
5. The patient/guarantor must provide a copy of his/her most recent income tax return, the most current paycheck stub or other verifiable evidence of compensation, and current bank statements.
6. Income and Asset Limitations: Qualification for Financial Assistance will be contingent upon the total household income of the patient/guarantor being at or below poverty guidelines as established by the federal government. In addition, the applicant's total household assets will be taken into consideration in determining the level of uncompensated care allowed. Applicants whose household income exceed 100% of the poverty guidelines will be eligible for Financial Assistance up to 200% based on the sliding scale listed in Table A.

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4/11

MI, Tawas City
St. Joseph Health System

Table A
2004 HHS Poverty Guidelines

	Guidelines	Guidelines +25%	Guidelines +50%	Guidelines +100%
Allowance	100%	75%	50%	25%
Family Size	Income Less Than	Income From - To	Income From - To	Income From - To
1	9,310	9,311 - 11,638	11,638 - 13,965	13,966 - 18,620
2	12,490	12,491 - 15,613	15,614 - 18,735	18,736 - 24,980
3	15,670	15,671 - 19,588	19,589 - 23,505	23,506 - 31,340
4	18,850	18,851 - 23,563	23,564 - 28,275	28,276 - 37,700
5	22,030	22,031 - 27,538	27,539 - 33,045	33,046 - 44,060
6	25,210	25,211 - 31,513	31,514 - 37,815	37,816 - 50,420
7	28,390	28,391 - 35,488	35,489 - 42,585	42,586 - 56,780
8	31,570	31,571 - 39,463	39,464 - 47,355	47,356 - 63,140

For each additional person add 3,180

Based income levels (as indicated under the 100% discount column) are the most current poverty guidelines established by Dept of HHS (Effective January 15, 2004) http://aspe.hhs.gov/poverty/04computations.htm.

7. The patient registration director will recommend approval or denial to the V.P of Finance. A written response must be sent to the patient within 15 days after the decision is made.
8. Patients denied Financial Assistance consideration may request a hearing with the Financial Assistance Appeal Committee, which is made up by the VP (Sister) of Mission Integrations, CFO, Business Office Manager and Financial counselor. .

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5/11

Changes in Financial Assistance Program-

Required review by all Patient Financial associates and clinic managers, receptionists and coder/billers

Effective July 1, 2004

MI, Tawas City
St. Joseph Health System

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6/11

Revised Financial Assistant Program

- Old policy

* Core Value- no change
* Policy Statement-no change
* Procedure-no change
* Determination of Financial Assist
  - Change wording
* Financial Assist Qualifying Inclusions
  - 11.2.b changed
  - 11.2.c changed
  - 11.2.d
  - Added 11.2.e
  - 11.3, 4,5,6

- New Policy

* Core Value- no change
* Policy statement- no change
* Procedure- no change
* Determination of Financial Assist
  - Now reads"for the uninsured unable to pay and a discount for the uninsured patients with the ability to pay.
* Financial Assist Qualifying Inclusions
  - 11.2.b -- added income level @100% FPL on non-elective services
  - 11.2.c --added sliding scale fee for income over 100% FPL not to exceed 200% on non-elective services
  - 11.2.d --added eligibility at any point in revenue cycle
  - Added 11.2.e– was 2.c but deleted exclusion for PT and Home Care.

Financial Assistance -continued

- 111- Process for Financial Assist Approval/Denial
  - 111.1 changed wording
  - 111.3 added other language
  - 111.4 added date qualification
  - 111.6 changed wording & Table A
  - 111.7 change
  - 111.8 additional information added.

- Financial Assist Qualifying Inclusions
  - 11.3,4,5,6 –eliminated
- 111- Process for Financial Assist Approval/Denial
  - 111.1 –eliminated required to completed application within 30 days
  - 111.3—patients who do not qualify for Medicaid or do not complete application is still eligible for other financial discounts
  - 111.4– stated that accounts in Bad Debts prior to July 1, 2004 will not be considered for financial assistance, implying that all new applications with accounts in Bad Debt after July 1, 2004 will be withdrawn from agency and written off.
  - 111.6 added 200% sliding scale information and updated Table A
  - 111.7 –deleted 3 month eligibility requirement
  - 111.8 –added Financial Assistance Appeal Committee and members

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8/11

St. Joseph Health System
Financial Discount Program-
Required review by all SJHS Associates
Effective July 1, 2004
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9/11

Policy

- To recognize fair payment practices for the uninsured and under-insured.
- Eligibility is not based on income.
- Discounts will only apply to service dates from July 1, 2004 forward.
- Discounts apply to uninsured and under-insured
  - For all services not covered by insurance- (does not apply to co-insurance and deductibles)

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Discounts-continued

- 20% discount to be taken if paid in full within 45 days of the date of service
- On or after 46 days, only 10% will be applied regardless of payment date.

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NY, Binghamton
Our Lady of Lourdes Memorial Hospital

OUR LADY OF LOURDES MEMORIAL HOSPITAL
Binghamton, New York
ADMINISTRATIVE MANUAL

DRAFT

SUBJECT: ***Patient Financial Assistance Program (PFAP)***	***ORIGIN DATE: March 1990***
REVIEWED: July 2002	***REVISED: June 2004***
REGULATORY REFERENCES:	***CROSS REFERENCE: Business Office Policy: Patient Financial Assistance Program; Lourdes Code of Conduct and Service Excellence Agreement***

POLICY:

It is the policy of Our Lady of Lourdes Memorial Hospital, Inc. to offer charge discounts to all eligible patients/guarantors whose medical expenses are not covered by a private and/or government insurance payer. All Lourdes employees will treat eligible patients with dignity and respect according to the Lourdes Code of Conduct and Service Excellence Agreement.

This policy is specifically designed to address the billing and collection practices for uninsured/underinsured patients who receive medically necessary hospital, Lourdes Physician Network, and/or Lourdes at Home services. This policy excludes any services provided at Lourdes by private businesses or professional groups (i.e., Radiology, Pathology, Anesthesiology, etc.)

Patients who cannot pay their balance after insurance company settlements could be eligible for discounts based on income and resource level according to the following:

Eligibility Requirements:

1. Charity program (Up to 200% of Federal Poverty Level)

a. At a minimum, patients with incomes less than or equal to 200% of Federal Poverty Level and with resources of no more than 200% of the Medicaid guidelines for resources, will be eligible for 100% charity care write-off of the medically necessary charges.

b. Patient/Guarantor has been determined ineligible for any State or Federal Health Insurance program (i.e. Medicaid, Family Health Plus, CDPHP, etc.).

c. Patient/Guarantor does not have IRA/Retirement Saving program in excess of $250,000.00.

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NY, Binghamton
Our Lady of Lourdes Memorial Hospital

d. Patient/Guarantor submits a signed Patient Financial Assistance Program application and proof of income to the Financial Counselor for review and determination.

2. Financial Assistance (Greater than 200% up to 300% of Federal Poverty Level)

a. At a minimum, patients with incomes greater than 200% and up to 300% of Federal Poverty Level and whose resources do not exceed 300% of the Medicaid resource level, will be eligible for a 50% financial assistance discount.

b. Patient/Guarantor has been determined ineligible for any State or Federal Health insurance program (i.e. Medicaid, Family Health Plus, CDPHP, etc.).

c. Patient/Guarantor does not have IRA/Retirement Saving program in excess of $250,000.00.

d. Patient/Guarantor submits a signed Patient Financial Assistance Program application and proof of income to the Financial Counselor for review and determination.

3. Uninsured Patients with the Ability to Pay (Greater than 300% of Federal Poverty Level)

a. Patients must not be eligible for health insurance coverage by a private insurance company and/or government health plan.

b. Patient will be eligible for 20% discount off charges.

c. Patient will be eligible for additional 20% discount if the balance is paid within 15 days from bill date.

d. If the patient does not pay the account within 15 days but in less than 31 days the patient will be eligible for an additional 10% discount.

PROCEDURE:

Programs A and B:

1. If the patient indicates during the Registration or Pre-Registration process that he/she does not have insurance and/or cannot pay the remaining co-payments, deductible, and/or non-covered services, the patient account should be documented and the patient referred to a Financial Counselor, or a Patient Financial Assistance Program application should be presented to the patient.

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2. The application must be signed and proof of income must be submitted before eligibility can be determined for programs A and B. Proof of income may include a copy of the most recent paycheck stub with year-to-date totals, a letter from the employer, an unemployment letter, social security benefits, pensions, etc. The Patient Financial Counselor will verify the above documentation and forward it to the Central Financial Counselor's office.

3. If it is determined by the Financial Counselor that the applicant may be eligible for any other program, then the applicant will be informed that eligibility determination must be received by Lourdes before the patient is approved for these programs.

4. If the patient has insurance which covers a portion of the charges, and if he/she is eligible for Program A and/or B, the discount will apply to the remaining balance on the account.

5. Patients/ guarantors will be required to complete the application process every 12 months from the original approval date, **or sooner if their financial circumstances change**.

Program C:

1. During the Registration/Pre-registration process, if the account is documented with a 0000 Financial Class, it will be discounted by 20% during the final billing process.

2. Program guidelines will be communicated during the Registration/Pre-registration process to determine whether patient referral to the Financial Counselor is appropriate.

3. The Patient Financial Services Department will generate a final Billing statement to the patient no more than 5 days from discharge date, indicating the appropriate discount levels available.

4. Once payment is received within the required time limits, the additional discount will be applied to the account accordingly.

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NY, Binghamton
Our Lady of Lourdes Memorial Hospital

Collection Practices

1. Patients/guarantors who are eligible for programs A or B will not be subject to liens and/or wage garnishments for any eligible remaining balances.

2. For patients/guarantors who are eligible for program C, if remaining balance is not paid during the in-house collection cycle, the account will be referred to a collection agency for further collection activity. The 20% discount will be retracted at time of collection agency placement and the patient will be required to pay the full balance of the account.

AUTHORIZATIONS:

John D. O'Neil	President/CEO Title	Date
Brian Regan	Sr. V.P./CFO Title	Date
Sr. Marilyn Perkins	V.P. Mission Integration Title	Date
Tony Cruthis	Dir., Patient Accounts Title	Date

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NY, Binghamton
Our Lady of Lourdes Memorial
Hospital

OUR LADY OF LOURDES MEMORIAL HOSPITAL
Binghamton, New York
ADMINISTRATIVE MANUAL

SUBJECT: Patient Financial Assistance Program (PFAP) (Indigent Patients)

ORIGIN DATE: March 1990

REVIEWED: July 2002
REGULATORY REFERENCES:

REVISED: July 2002
CROSS REFERENCE:
Business Office Policy: Patient Financial Assistance Program

POLICY:
Patients and/or guarantors are responsible for payment of charges rendered by Lourdes Health System. When payment of charges constitutes a barrier to services, Lourdes offers a Patient Financial Assistance Program to patients who qualify because their income and resources fall within the Federal Poverty Guidelines, or in a range acceptable to the hospital because of financial need. This program is available to the extent hospital resources allow.

PROCEDURES:

1. If patient and/or guarantor indicates that he/she cannot pay any or all the charges for services, an application for financial assistance will be given to the patient or guarantor to complete. Applications must be submitted within (90) days of receiving a Lourdes bill.

2. The application must be signed and proof of income must be submitted before a determination of eligibility is made. Proof of income may include a copy of the most recent paycheck stub with year-to-date totals, a letter from the employer, an unemployment letter, social security benefits, pensions, etc.. Patient Financial Counselors located at Lourdes will verify the above documentation. Resources, Bank Accounts, CD's, IRA's, etc. will be allowed according to New York Medicaid Guidelines. Property owned and used as the applicant's residence will not be considered as an asset. Other property will be considered an asset.

3. If it is determined by the Financial Counselor that the applicant may be eligible for any other program, i.e., Medicaid, Disability, Child Health Plus, etc., then the applicant will be informed that they must apply for those programs. The applicant must obtain a letter of denial or acceptance before a determination of PFAP eligibility will be made. Failure by the applicant/guarantor to complete the application requirements to determine eligibility will result in a denial of PFAP eligibility.

4. The hospital Financial Counselor will make the final determination of the percentage by which the charges will be reduced. The discount is calculated by locating the number in

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the family and the monthly gross income on the Lourdes Hospital Financial Assistance scale. A letter will be generated to the patient informing them of the date of eligibility and the amount of reduction of charges.

5. The Lourdes Patient Financial Assistance Program applies to all charges incurred for medically necessary services provided by hospital inpatient, outpatient and emergency services, as well as by Homecare, Hospice, and the Primary Care Network. This program does not apply to any charges billed by physicians who are not Lourdes employees, such as Radiologists and Anesthesiologists, or services provided by another company or health care provider.

6. If the patient and/or guarantor has insurance which covers part of the charges, and if he/she is eligible for PFAP, the remaining balance will be discounted.

7. Applications and supporting documentation will be maintained in the Lourdes Patient Accounting Department.

8. Patients and/or guarantors will be required to complete a new application annually to re-evaluate their eligibility, or sooner if their circumstances change to the extent that a new determination is warranted. The Patient Financial Counselors will maintain a database of qualified applicants based on date of eligibility. It is the patients/guarantors responsibility to re-apply when their eligibility expires.

9. If an applicant/guarantor receives PFAP, they must have paid at least 80% of the reduced charges before their eligibility will be reconsidered.

10. Any exceptions to the eligibility criteria will be discussed with the Director of Patient Accounts for determination of eligibility.

AUTHORIZATIONS:

Signature on File	President/CEO	8-15-02
John D. O'Neil	Title	Date
Signature on File	Dir., Patient Accounts	8-13-02
Tony Cruthis	Title	Date

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NY, Lewiston
Mount St. Mary's Hospital

MOUNT ST. MARY'S HOSPITAL AND HEALTH CENTER	Originating Department **Credit/Collections**			Policy #
	Original Effective Date July 1, 2004	Revision #	Revision Date	Page # 1
	Subject **Collection Practices**			
Inter-Departmental Policies and Procedures	Department Head Signature		President/CEO Signature	

POLICY:
It is the policy of Mt St. Mary's Hospital to ensure a socially just practice for billing for all patients receiving care at our facility.

PURPOSE:
To establish procedures and guidelines are followed by collection agencies doing business with Mt. St. Mary's Hospital

PROCEDURE:

A. Liens on personal residences are permitted only in the following circumstances:
1. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
2. The lien will not result in a foreclosure on a personal residence.
3. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.

B. Garnishments of wages are permitted only if:
1. The Patient does not qualify for charity or financial assistance as determined by Mt.St.Mary's Hospital Credit Department, and a court determines that the Patient's wages are sufficient for garnishment
2. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.

C. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.

D. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.

E. Interest charges on outstanding balances may only be assessed if:
1. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements and,
2. No add-on to minimum discount is applied in accordance with hospital policy.

F. Management is accountable to ensure that all collection policies follow the Federal Fair Debt and Collection Practices Act.

G. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the Collection agency of Ascenion Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

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NY, Lewiston
Mount St. Mary's Hospital

04
Federal Poverty Level Guidelines

Family Size	100% FPL Gross Monthly Income	100% FPL Gross Annual Income	133% FPL Effect Apr 1, 2004 Gross Monthly Income	133% FPL Gross Annual Income	185% FPL Gross Monthly Income	185% FPL Gross Annual Income	200% FPL Gross Monthly Income	200% FPL Gross Annual Income
1	$775.83	$9,310.00	$1,031.86	$12,382.30	$1,435.29	$17,223.50	$1,551.67	$18,620.00
2	$1,040.83	$12,490.00	$1,384.31	$16,611.70	$1,925.54	$23,106.50	$2,081.67	$24,980.00
3	$1,305.83	$15,670.00	$1,736.76	$20,841.10	$2,415.79	$28,989.50	$2,611.67	$31,340.00
4	$1,570.83	$18,850.00	$2,089.21	$25,070.50	$2,906.04	$34,872.50	$3,141.67	$37,700.00
5	$1,835.83	$22,030.00	$2,441.66	$29,299.90	$3,396.29	$40,755.50	$3,671.67	$44,060.00
6	$2,100.83	$25,210.00	$2,794.11	$33,529.30	$3,886.54	$46,638.50	$4,201.67	$50,420.00
7	$2,365.83	$28,390.00	$3,146.56	$37,758.70	$4,376.79	$52,521.50	$4,731.67	$56,780.00
8	$2,630.83	$31,570.00	$3,499.01	$41,988.10	$4,867.04	$58,404.50	$5,261.67	$63,140.00
	For family units of more than 8 members, add $3,180 for each additional member.							
	100%		80%		70%		60%	

1. Locate family size in left hand column,.
2. Move horizontally to the right on the line located in GROSS family income to the income eligibility amount.
3. Example: A family of 4 (2 adults, 2 children) earning an annual income of $33,000 annually is elig for 70% discount

Effective 7/1/04

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NY, Lewiston
Mount St. Mary's Hospital

Addendum To Collection Agency Services Agreement

Mt. St. Mary's Hospital and Security Credit Systems for mutual consideration hereby acknowledged, agree, effective this First day of July 2004, to amend the current collection services agreement between the parties to include the following:

1. Mt. St. Mary's Hospital has adopted a new Collection Practice Policy intended to further ensure socially just billing and collection practices for Mt. St. Mary's Hospital's uninsured patients.

2. A copy of the Policy has been provided to Security Credit Systems

3. Subject to Paragraph 4 of this Addendum, Security Credit Systems agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured Mt. St. Mary's Hospital Patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured Mt. St. Mary's Hospital patient or person financially responsible referred to Security Credit Systems for purposes of collecting amounts owed to Mt. St. Mary's Hospital; and
   b. All legal proceedings, of whatever kind of nature, against any uninsured Mt. St. Mary's Hospital patient or person financially responsible referred to Security Credit Systems for purposes of collecting amounts owed to Mt. St. Mary's Hospital.

4. Security Credit Systems agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from Mt. St. Mary's Hospital.

Hospital Officer or Administrator	(Signature)	Collection Agency Representative
PAUL E BEZER		PATRICIA GAMMALO
Hospital Officer or Administrator	(Print Name)	Collection Agency Representative
VP FINANCE / CFO		Sales + Marketing
Title		Title
6/30/04		6-30-04
Date		Date

COPY

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NY, Troy
Seton Health System, Inc.

TITLE: Seton Health Financial Assistance Program

POLICY# 113

PURPOSE: To ensure that patient's of Seton Health that are unable to meet their financial liability are provided assistance if qualified.

POLICY: Seton Health will provide Financial Assistance to patient's who are experiencing financial hardship that precludes them from meeting the financial responsibility for the services rendered at one of Seton Health's facilities. The ultimate determination of assistance will be based upon the most recently published Federal Poverty Guidelines. This program is intended to be a temporary assistance for our patient's and should not be viewed as an alternative to health insurance.

PROCEDURE: **COVERED SERVICES**

All medically necessary hospital services are eligible for coverage under this policy, including any co-payment, co-insurance or deductibles.

All physician services rendered by an employed physician of Seton Health are eligible for coverage under this policy.

Emergency room services are eligible for coverage under this policy.

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ELIGIBILITY

Eligibility will be determined by comparing the household income, either current or for the prior income tax period to the Federal Poverty levels for the period of application. Those patients/guarantors who's income falls below 250% of the Federal Poverty level for their family size will be deemed eligible. Financial Assistance will be provided as follows:

Less than 150% of FPL will be granted 100% assistance
150% to 200% of the FPL will be granted 75% assistance
200% to 250% of the FPL will be granted 50% assistance
250% to 300% of the FPL will be granted 25% assistance.

It is assumed that patients approved for less than 100% assistance will make ever effort possible to pay the remaining owed balance to Seton Health within a reasonable time. Additionally, during the application process, Seton Health's Financial counselors will review the guarantor's financial situation and screen them for possible future coverage under one of the many State/County sponsored health insurance initiatives.

As part of the application process patients may be required to provide copies of bank statements, W2 forms, current pay stubs or other documentation deemed necessary by Seton Health to make a decision on eligibility.

All applications should be completed and returned to the Patient Financial Services Department as soon as possible. The Patient Financial Services Department will process all applications within 5 business days of receipt and notify patients/guarantors of our decision by phone and mail. Determination of coverage will be deemed in effect for a 90 days period from the date of approval unless the patient/guarantors financial situation significantly changes.

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NY, Troy
Seton Health System, Inc.

APPROVALS

All completed applications will be processed by designated employees of Seton Health. Should it be determined that a patient is eligible the completed application will be presented to the Collection Manager for final approval and signature. Should the patient feel that their application was denied in error they could request a review, which will be completed by the AVP of Patient Financial Services. This review will be completed within 5 business days of receipt.

Once approved all open accounts covered by the application will be relieved consistent with Seton Health allowance procedures.

_____
Gino J. Pazzaglini, FACHE
President/CEO

Revised 5-1-04

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Good Samaritan
Regional Medical Center

BUSINESS OFFICE
POLICY AND PROCEDURE

DATE ISSUED: 06/12/00	SUBJECT: FS PO 005 – Community Care Program	PAGE: 1 of 4
REVISED: 05/01/02, 05/12/03		
SUPERSEDES:	APPROVED BY: 6/03 Sr. Vice-President/CFO Date	REVIEW DATES: 06/02/03
RELATED POLICIES: Administrative Policy & Procedure – Community Care Program		

POLICY:

The Good Samaritan Regional Medical Center, in accordance with its Mission to care for the poor and to respond to the healthcare needs of its community, shall offer assistance with payment for necessary healthcare service for patients who are uninsured or under-insured.

PROCEDURE:

The Business Office, in conjunction with other appropriate departments (i.e. – Admissions, Case Management and Patient Representative) will have the responsibility for determining the financial ability of patients to meet their responsibilities to the Good Samaritan Regional Medical Center. All patients who are uninsured or possibly under-insured, as determined by the insurance verification process, shall be made aware of the Community Care Program as a source of assistance.

1. **INPATIENTS**

   A. All uninsured or under-insured patients shall be contacted by a Patient Accounting Clerk/Financial Counselor prior to an elective admission or as soon after a direct admission as possible (preferably by the next business day) but in all feasible cases, prior to discharge, to discuss assistance with cost of hospital services.
   B. Eligibility for Medical Assistance will be explored prior to application for Community Care. Assistance with application to the Department of Public Welfare will be provided when appropriate.

2. **OUTPATIENTS/EMERGENCY DEPARTMENT PATIENTS**

   A. All uninsured or under-insured patients shall be presented with a brochure describing the Community Care Program at the time of registration. Application for Community Care Program maybe made after services have been completed.

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PA, Pottsville
Good Samaritan Regional Medical
Center

3. GUIDELINES FOR ELIGIBIILTY

A. The following guidelines will be used to determine a patient's qualifications for the Community Care Program:

1. Proof of Income:
For employed individuals, a current pay stub with the name of the employee printed on it may be used as "proof of income". When the current pay stub is unavailable, prior year Federal Tax Return or a letter from the employer (on employer letterhead) can be used to substantiate current income.

2. Types of Income:

Wages/Salary	Veterans Administration Payments
Social Security Payments	Unemployment Compensation
Public Assistance	Income from Investments
Pension	Strike Benefits
Alimony/Child Support	Military Allotments
Insurance/Annuities	Training Stipends

An adjustment to gross income based upon unpaid healthcare bills, unrelated to the Good Samaritan Regional Medical Center, is also considered in the eligibility determination. In order to qualify for this adjustment, the patient must provide proof of outstanding patient owed balances.

B. Proof of Dependents:
Proper verification of the number of dependents may be obtained from the Federal Income Tax Return. Dependents are those persons who:

1) Are supported by the guarantor – claimed and allowed as dependent exemption on income tax return.
2) May or may not be related.
3) May or may not be living at home.

4. FORM:

A. The Community Care application must be completed and signed by the patient/responsible party. For outpatients, particularly in the Emergency Department, this form may be completed by telephone and documented on the application form.

5. ELIGIBILITY DETERMINATION:

A. A matrix of gross income and number of dependents based upon Annual Poverty Income Guidelines, published by the Department of Health and Human Services, will be used as a guide to determine the appropriate allowance percentage. Patients receiving less than 100% Community Care allowance will be granted the opportunity to set up a term agreement with the Good Samaritan Regional Medical Center for the balance due.

6. FORMULA

A. The following formula will be used to determine the amount of the medical payment adjustment to gross income:

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1) Total outstanding patient liabilities of all medical bills with the exception of Good

Samaritan Regional Medical Center bills.

2) Reduce gross income submitted by applicant by Item 1 above.
3) Compare calculated gross income and number of dependents to Community Care Program Scale (Attachment) to determine percentage payable by the patient.

7. SCOPE OF APPLICATON:

A. Each application for Community Care Program shall be applicable for only one particular date of service, but may be used at the discretion of the Director of Patient Accounts for dates of service that occur within 30 days of the original application date.

8. OTHER COMMUNITY CARE ALLOWANCES:

A. In addition to patients who qualify through the normal application process, patients meeting the following criteria may also be considered for the Community Care Program:

1) Patient is deceased; the credit investigation indicates "no estate" and there is no insurance.
2) Patient is experiencing unusual medical, financial and/or humanitarian circumstances, accompanied by a reasonable doubt as to the patient's ability to pay. These circumstances will be thoroughly researched and documented and must be approved by the Director of Patient Accounts and/or the Sr. Vice President Finance/CFO.

9. APPROVAL CRITERIA:

A. Accounts to be allowed to Community Care will require the following approvals:

ACCOUNT BALANCE	APPROVAL AUTHORITY
$ 0 - $1,000	Patient Accounting Representative
$1,001 - $10,000	Director of Patient Accounts
$10,001 and above	Director of Patient Accounts & Sr. Vice President Finance/CFO

The signature and date of the appropriate level of authority approving the Community Care Allowance is to be recorded on the Community Care Application Form. In the absence of the Director of Patient Accounts, the Director of Financial Seravices would assume his/her approval responsibilities.

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COMMUNITY CARE SCALE
PERCENTAGE PAYABLE BY PATIENT
EFFECTIVE 2-11-03

Total Income Less Deductions	Number of Dependents									
DOLLARS	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0 - 8,980	0	0	0	0	0	0	0	0	0	0
8,981 – 12,120	0	0	0	0	0	0	0	0	0	0
12,121 – 15,260	10	0	0	0	0	0	0	0	0	0
15,261 – 18,400	20	10	0	0	0	0	0	0	0	0
18,401 – 21,540	30	20	10	0	0	0	0	0	0	0
21,541 – 24,680	45	30	20	10	0	0	0	0	0	0
24,681 – 27,820	60	45	30	20	10	0	0	0	0	0
27,821 – 30,960	75	60	45	30	20	10	0	0	0	0
30,961 – 34,100	90	75	60	45	30	20	10	0	0	0
34,100 – 37,240	100	90	75	60	45	30	20	10	0	0
37,241 – 40,380	100	100	90	75	60	45	30	20	10	0
40,380 – 43,520	100	100	100	90	75	60	45	30	20	10
43,521 – 46,660	100	100	100	100	90	75	60	45	30	20
46,600 – 49,800	100	100	100	100	100	90	75	60	45	30
49,801 – 52,940	100	100	100	100	100	100	90	75	60	45
52,940 – 56,080	100	100	100	100	100	100	100	90	75	60

COMMUNITY CARE SCALE
PERCENTAGE PAYABLE BY PATIENT
EFFECTIVE 5-1-02

SUBJECT: FS PO 005-COMMUNITY CARE PROGRAM

Total Income Less Deductions	Number of Dependents									
DOLLARS	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0 - 8,860	0	0	0	0	0	0	0	0	0	0
8,861 – 11,940	0	0	0	0	0	0	0	0	0	0
11,941 – 15,020	10	0	0	0	0	0	0	0	0	0
15,021 – 18,100	20	10	0	0	0	0	0	0	0	0
18,101 – 21,180	30	20	10	0	0	0	0	0	0	0
21,181 – 24,260	45	30	20	10	0	0	0	0	0	0
24,261 – 27,340	60	45	30	20	10	0	0	0	0	0
27,341 – 30,420	75	60	45	30	20	10	0	0	0	0
30,421 – 33,500	90	75	60	45	30	20	10	0	0	0
33,501 – 36,580	100	90	75	60	45	30	20	10	0	0
36,581 – 39,660	100	100	90	75	60	45	30	20	10	0
39,661 – 42,740	100	100	100	90	75	60	45	30	20	10
42,741 – 45,820	100	100	100	100	90	75	60	45	30	20
45,821 – 48,900	100	100	100	100	100	90	75	60	45	30
48,901 – 51,980	100	100	100	100	100	100	90	75	60	45
51,981 – 55,060	100	100	100	100	100	100	100	90	75	60

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4.9

BAPTIST HOSPITAL
POLICIES AND PROCEDURES MANUAL

Title: Private Pay OB Admissions		
Originator: Admission Services - OB	**Approved by:** Debra L. Cantrell, RN	
Policy: 001	**Written:** 3/96	**Revised:** 2/02
Scope:	**Page:** 1 of 1	
References:		

POLICY:

Payment arrangements will be made prior to admission for all Private Pay OB Admissions unless these are emergent admits

PROCEDURE:

1. Doctors Office will notify OB Admissions by mail or fax of any patient not covered by maternity insurance.

2. Financial Counselor will notify Patient to make her aware of her options, i.e., OB package plan.

3. If it is determined that patient will need counseling for TennCare coverage or charity, the financial counselors will the make her an appointment with the DHS worker.

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TN, Nashville
Saint Thomas Health Services
System

6.1

BAPTIST HOSPITAL
POLICIES AND PROCEDURES MANUAL

Title: Determination for TennCare Application		
Originator: Pre-admissions	Approved by: Debra Cantrell, RN	
Policy:	Written: 1/94	Revised: 02/02, 10/01, 6/99, 7/96
Scope: Hospital Wide	Page: 1 of 1	
References:		

POLICY:

Admissions with "PP" Private Pay financial class will be evaluated for TennCare eligibility. Referral to onsite DHS worker will be provided.

PROCEDURE:

1. All private pay admissions will be assessed to determine if existing healthcare coverage. If no healthcare coverage determined evaluation should be confirmed if a TennCare application is pending with State of Tennessee.

2. If evaluation notes pended TennCare application, financial counselor will contact State to determine pending status, assistance to complete or eliminate pending status will be provided. If application can be completed financial status should be changed to appropriate MCO and pre-admission process completed.

3. If patient evaluation appears within TennCare parameters and no pending application is determined referral to onsite Department of Human Service representative should be done.

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TN, Nashville
Saint Thomas Health Services 6.7
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BAPTIST HOSPITAL
POLICIES AND PROCEDURES MANUAL

Title: Visitation to Patient/Family of Private Pays Urgent/Emergent Admissions		
Originator: Pre-admissions	Approved by: Debra Cantrell, RN	
Policy:	Written: 1/95	Revised: 02/02, 10/01, 6/99, 7/96, 6/95
Scope:	Page: 1 of 1	
References:		

POLICY:

Financial Counselors will monitor daily admissions of all Private Pay admissions and attempt contact with the patient or family to determine insurance, charity qualifications or external government resource funds.

PROCEDURE:

1. Financial Counselors will review all inpatient private pay financial class admits each morning.

2. If patient employer is listed, phone contact to validated employment will be completed and determination via employer if health insurance benefits exist will be performed.

3. If insurance information is obtained, information will be entered in computer and verification of benefits performed, forwarding to Utilization Review when applicable.

4. Patient contact in Intensive Care Units will be limited until patient improves, family contact will be primary in these cases.

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Saint Thomas Health Services
System

7.8

BAPTIST HOSPITAL
POLICIES AND PROCEDURES MANUAL

Title: Financial Assistance on Medicare Denial Notification		
Originator: Admission Services	Approved by: Debra Cantrell, RN	
Policy:	Written: 5/95	Revised:02/02, 3/99, 7/96
Scope: Departmental	Page: 1 of 1	
References:		

POLICY:

Upon Medicare determination of non-coverage and issuance of correct documentation per existing Medicare guidelines.

PROCEDURE:

1. Utilization Review staff will be responsible for finalizing the need to administer a Medicare denial notification per existing Medicare guidelines.

2. Utilization Review staff will forward a copy of the denial notification to the Financial Counselor and the department secretary.

3. The Financial Counselor, in accordance with the three day grace period, will contact the patient or family to determine plans for continuing hospitalization.

4. If the patient is planning further hospital stay a deposit will be determined and requested.

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TX, Austin
Seton Healthcare Network

Charity Care (Uncompensated Services)

Policy Number: 4000.04

Revision Draft

Category: **Finance System**

Origination Date: 07/01/76

Policy Revision By Board: 04/09/03

Review by Senior Leadership Team: 04/09/03

Approved By: Charles J. Barnett, President and CEO

I. POLICY

Consistent with the mission of Seton and as an Ascension Health sponsored health care organization, it is Seton's policy to provide medically necessary services within a defined benefit structure to eligible patients who are financially or medically indigent; however, the amount of charitable services provided will be subject to Seton's financial ability to absorb the cost of such services, while ensuring financial viability. Every effort will be made to educate professional and medical staff and the public, as to the criteria and processes followed in the application of this policy. Seton will seek assistance in funding charitable services from available sources.

Texas State Law requires nonprofit hospitals to have polices and procedures in place for the admission of financially indigent and medically indigent persons. Seton may determine that a person is financially or medically indigent after health care services have been provided. The statute defines financially indigent and medically indigent as follows:

> "Financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered, based on the network's eligibility system.
>
> "Medically indigent" means a person whose medical or hospital bill after payment by third-party payers exceeds a specified percentage of the patient's annual gross income, in accordance with the network's eligibility system, and the person is financially unable to pay the remaining bill.

Seton's eligibility process includes income levels and means testing indexed to the federal poverty guidelines. Seton's established eligibility system sets the income criteria for charity care at or above that required by counties under the Indigent Health Care and Treatment Act. The policy is in accordance with the laws of the State of Texas.

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1 of 9

Seton may:

- Specify and/or limit services that are subject to charity care through a defined benefit structure
- Restrict the provision of non-emergency charity care to patients residing in the defined service area
- Provide medical case management to ensure that services requested under the provisions of this policy are medically necessary.

For purposes of determining eligibility for financial assistance, income includes total annual/monthly cash receipts before taxes from all sources, including but not limited to:

- Monetary wages and salaries before any deductions
- Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses)
- Net receipts from non-farm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership , after deductions for business expenses)
- Social Security
- Railroad retirement
- Unemployment compensation
- Strike benefits from union funds
- Workers' compensation
- Veterans Benefits
- Public Assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, etc.)
- Training stipends
- Alimony or child support
- Military family allotments or other regular support from an absent family member or someone not living in the household
- Pensions (private, government, military retirement, annuities)
- College or University scholarships, grants, fellowships and assistantships
- Dividends and interest
- Rental income
- Periodic receipts from estates or trusts
- Net gambling or lottery winnings
- For purposes of determining financial eligibility, income does not include:
- Capital gains
- Proceeds from the sale of property, house or car
- Tax refunds
- Gifts, loans, or one-time insurance payments
- Non-cash benefit programs such as food stamps, school lunches, and housing assistance
- Income of Visa sponsors, to include all of the above as applicable

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Assets essential for daily living, including primary residence, automotive vehicles utilized for routine transportation, retirement funds, and college tuition savings will be excluded from consideration. Cash and/or other assets that can be converted to cash will be considered when assessing eligibility, including but not limited to:

- Checking, savings and money market accounts
- Stocks, bonds, and other non-retirement investments
- Summer/vacation/lake homes or other "secondary residences"
- Collector automobiles
- Boats, campers, and other similar luxury items

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Requests/Consideration for charity assistance may occur:
a. Prior to or at the time of treatment
b. Subsequent to treatment and/or during the collections process

II. PROCEDURE

Seton utilizes the Federal Poverty Income Level (FPIL) income guidelines to determine financial eligibility.

A. PHILOSOPHY

1. Families at or above 100% of the FPIL will be expected to pay at least a portion of their hospital bill. Co-pays and deductibles are due prior to or at the time of service. Emergency Medical Treatment and Active Labor Act (EMTALA) requirements and related governmental guidance will be followed for the collection of co-pays and deductibles for non-admitted Emergency Room (ER) visits.
   a. Families with income levels up to 200% of the FPIL will be asked to make a minimal co-payment for services received.
   b. Families with income levels above 200% and below 375% of the FPIL will be expected to pay a larger deductible
   c. Families with income levels above 375% of the FPIL will be expected to satisfy their negotiated financial obligation to Seton Healthcare Network in full as outlined in Patient Financial Policy 4000.09, unless they qualify as medically indigent.
2. The amount a family can contribute toward its hospital bill will vary based on two factors:
   a. Total gross family income from all sources
   b. Number of family members, calculated as follows:

Adults-- include the patient, the patient's spouse, and any dependents
Minors-- include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father
International Visitors with nonimmigrant visa (e.g., student, exchange or employment)— include the visitor and sponsor

3. Charity assistance should not subsidize a family's lifestyle (i.e., a family who owns/is buying an expensive house or car should not pay a smaller portion of its hospital bill than a same size, same income family that does not own a similar house or car). Lifestyle

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factors, such as housing and transportation, are therefore not considered in the charity calculation. Available assets that are convertible to cash and unnecessary for daily living will be taken into consideration when appropriate (e.g., ownership of a second home, or other assets above and beyond those required to support a socially just lifestyle).
4. As income increases, a family can contribute a larger amount of its income toward its hospital bill.
5. The guidelines and documentation requirements will be consistent within the network. Brackenridge Financial Assistance Plan (BFAP) will be utilized for those patients who reside in the City of Austin, determined by defined zip codes. Seton Charity Program (SCP) will be utilized for all other patients requiring financial assistance as well as for Austin residents who do not qualify under BFAP.
6. For Brackenridge Financial Assistance Plan (BFAP) and in situations where a patient is unable to provide proof of income, Seton may verify the patient's income by:
a. Obtaining the patient's written or verbal attestation that the income reported for charity consideration purposes is correct.
b. Documenting in the account an acceptable reason the patient is unable to provide proof of income

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7. Applicants for SCP must complete the Financial Assistance Application form, and should provide one or more of the following to document proof of income as applicable:

- Check stubs from the most recent month for each working family member
- IRS Form W2
- Income Tax Return from the most recent year
- Letter from employer on company letterhead verifying compensation
- Letter from unemployment office
- Proof of Social Security Income
- Bank statements showing routine amount of fixed income deposits

8. Proof of participation in public benefit programs such as Medicaid, County Indigent Health Program (CIHP), Temporary Assistance for Needy Families (TANF), Women in Community Service (WICS), Children's Health Insurance Program (CHIP), Austin Travis County Medical Assistance Program (MAP), Federally Qualified Health Clinics (FQHC's), etc. indicates that the patient has been deemed financially indigent, and further proof of income is not required.

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9. Assumed Seton Charity Program (Assumed SCP) may be applied when insufficient documentation exists but the information gathered supports indigence (e.g., undocumented migrant workers, patients who expire with no estate, Medicaid exhausted days/benefits, homeless, etc.).
10. Accounts of patients who expire and are found in the collection process to have no estate from which to collect and no resources for lien attachment will be processed for financial eligibility determination purposes based on zero annual income.

11. If a determination is made that a patient has the ability to pay the remainder of the

bill, that determination does not preclude a re-assessment of the patient's ability to pay upon presentation of additional documentation and/or a change in circumstances.
12. During the verification process, Seton may treat an account under consideration for charity as a self-pay account in accordance with established procedures.
13. Seton may elect to run a credit report to verify available resources and/or assets.
14. Falsification of information may result in denial of the financial assistance request. If, after a patient has been granted charity care, Seton finds material provision(s) of the application to be untrue, charity care status may be revoked and full collections may ensue.
15. Nonimmigrant international visitors such as those with employment Visa, student and exchange visitor Visa, etc. are not eligible for charity care as the terms of the visa require that participants have sufficient funds to cover all expenses and/or sponsorship.

16. Appeals and/or extenuating circumstances will be referred to the Vice President of Finance and CFO for consideration.

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B. DETERMINATION OF FINANCIAL INDIGENCE
Financial and Admissions Counselors, Customer Service Representatives, and Bad Debt Coordinators will utilize internally developed tools to calculate a family's obligation for its hospital bill. To calculate the obligation, the employee will interview the family and determine:
1. Total gross monthly/annual family income from all sources, with supporting documentation as outlined above
2. Number of family members
Upon completion of the interview, the employee will calculate income as a percentage of the FPIL. Once this percentage has been determined, the employee will calculate the family's personal obligation for the hospital bill. The charity level determination will be documented in the Patient Accounting system. The patient's obligation will be notated in the Admission or Collection Notes screen to indicate that full or partial charity has been approved. Financial Counselors may grant approval for amounts up to $5,000. Charity requests ranging from $5,000 to $10,000 will be reviewed for approval by the Manager; requests greater than $10,000 will be referred for approval to the Director, Vice President of Finance, or CFO per authorization levels outlined in Administrative Policy 1000.02. Patients will be notified in writing immediately upon determination of the decision, and no later than two weeks after receipt of a complete application. This written notification will delineate both the amount of financial assistance approved as well as any remaining balance for which the patient may be responsible.

C. MEDICAL INDIGENCE
Patients with income above 375% of the FPIL may request assistance based on medical indigence:

- To be considered for classification as a medically indigent patient, the amount owed by the patient after payment by all third-party payers must exceed ten

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percent (10%) of the patient's annual income, and the patient must be unable to pay the remaining amount owed.

- Yearly income must be between 375% and 500% of the FPIL.
- The patient's remaining bill must be greater than 50% of the patient's disposable monthly income.

To ensure that medical indigence assistance does not subsidize lifestyle choices, standard allowances consistent with federal and state financial means testing guidelines will be utilized for clothing, food, housing, utilities and transportation when calculating disposable income.
Authorization and notification processes outlined above apply for both medical and financial indigence.

III. ACCOUNTABILITY AND CONTROL

1. The Chief Financial Officer is responsible for the financial administration of this policy.
2. The Chief Medical Officer is responsible for administering the benefit design and clinical decision making components of this policy.
3. Decisions regarding limitations of charity care services are made by the Seton Healthcare Network President & CEO or designee.
4. Senior Leadership Team (SLT) and Leadership Team (LT) members are responsible for the operational management of the charity care program, in accordance with Seton's policy and approved operating budget limitations, as delegated by the network President & CEO.
5. The Directors of Patient Access and Patient Financial Services are responsible for maintaining the internally developed tools so that they reflect current FPIL values, and for ensuring that the tools are utilized and applied appropriately and that current information is posted in all patient access and other appropriate public areas.

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Ascension Policy 16
Impact on SETON Administrative Policy for Charity Care/Uncompensated Services

Ascension Policy 16	SETON Administrative Policy	Revision Required for Compliance	Status
Policy applies to all non-elective services	Medically necessary services	None required	
Application to international patients will be defined by each hospital	Does not address	Address international patients	Drafted for review by ICWG
Patients who do not qualify for charity care but need financial assistance are offered appropriate extended terms or other payment options that take into account the patient's financial status	Medical indigence in charity policy Payment arrangements in Patient Financial Responsibility policy	None required	
Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.	Collection steps are delineated in SPS and collection agency contracts	None required	
Financial counselors are available to all counselors	Financial counselor availability is addressed in both Charity and Patient Financial Responsibility policies	None required	
Information is posted	Information is posted, but signage is not addressed in policy per se	Address information posting	Included in Draft Revision
Hospital programs that include nominal payments by patients designed to encourage patients to participate in their care are permissible	Nominal sliding-fee co-payment amounts	None required	
100% write-off up to 100% FPIL as minimum standard	100% write off up to 200%	None required	
100% to 200% FPIL sliding fee scale discount	200% to 375% FPIL sliding fee discount	None required	
Each hospital must establish a process for patients and families to appeal decisions regarding eligibility for financial assistance	Policy addresses referral of extenuating circumstances for consideration	Establish process and request participation from Mission Affairs	Included in Draft Revision

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Eligibility may be determined at any point in the revenue cycle	Requests/Consideration for charity assistance may occur: a. Prior to or at the time of treatment b. Subsequent to treatment and/or during the collections process	None required	
Means test should be based on eligible assets and based on eligible income	Based on income	Need to expand eligibility criteria to include assets test	In process
Liens on personal residences permitted only when patient is not complying with agreed upon payment arrangements. Lien should not result in foreclosure of personal residence. Liens pursued by collection agency must be reviewed and approved by executive hospital management	Liens are filed only in third party liability cases to secure SETON's position of interest in the settlement	None required	
Garnishment of wages permitted only if patient does not qualify for charity or financial assistance and if a court determines wages are sufficient for garnishment	No garnishment of wages	None required	
No hospital will pursue an involuntary bankruptcy proceeding against a patient as a result of its collection efforts on uninsured patients	Consistent with SETON philosophy. Copy of Ascension policy provided to collection agencies and addendum executed.	None required (?)	
No bench warrants/body attachments	Consistent with SETON philosophy. Copy of Ascension policy provided to collection agencies and addendum executed.	None required	
Interest may be charged only if patient does not qualify for charity and is not complying with payment arrangements	Interest-free payment arrangements	None required	
Management is accountable to ensure that all collection policies follow the federal Fair Debt and Collection Practices Act	Stipulated in contracts	None required	

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Amend hospital contracts with attached values based language for patient and family contacts		Contract amendments	In process

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PROVIDENCE HOSPITAL BUSINESS SERVICES POLICY AND PROCEDURE MANUAL EFFECTIVE DATE: 10/79	TX Waco POLICY 8830 C00 Providence Healthcare Network TYPE: CREDIT/COLLECTION
APPROVAL Cheri Sayers Department Director Philip Halford Vice President CFO Kent A. Clancy CEO	SUBJECT: CREDIT AND COLLECTION POLICY

GENERAL POLICY:

It is the policy of Providence Healthcare Network and Ascension Health to ensure a socially just practice for billing for all patients receiving care.

Providence Health Center and DePaul Center will control its accounts receivable by consistently executing reasonable and commonly accepted collection measures. The collection of patient accounts receivable begins prior to admission and continues until the accounts are either paid in full, determined to be uncollectible and written off to Bad Debt or determined to be eligible for a Full or Partial Charity Assistance Write Off.

All sources of funds will be tried before installment payments will be accepted, and if payment monitoring is made, it will stipulate that the account will be paid in not more than 36 months without management approval.

Any patient indicating an inability to pay for the hospital services will be screened for possible Charity eligibility. The determinations for charity care are made in accordance with Federal Poverty Guidelines as provided by the Department of Health and Human Services.

No Self-Pay Account is to be held more than 54 days from discharge or 54 days from the time all insurance balances are settled. Procedures are in place to achieve this objective. Any Self-Pay Account in which payments arrangements have not been established prior to 54 days will be written off as a Bad Debt and referred to a collection agency. The only exception is Medicare Patients whose self-pay account is held for 127 days.

Payment monitoring accounts that are in default will be reviewed and the patient contacted for payment. The patient will be notified of any failure to keep the payment contract, and the account will be written off as a Bad Debt to a third party collection agency after two installments are missed.

Omitted

REVISED DATES: 06/80, 01/81, 12/85, 10/96, 10/02, 05/04

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PROVIDENCE HOSPITAL BUSINESS SERVICES POLICY AND PROCEDURE MANUAL EFFECTIVE DATE: 10/79	POLICY: 8530.C00 TYPE: CREDIT/COLLECTION
APPROVAL _____ Department Director _____ Vice President,CFO _____ CEO	SUBJECT: CREDIT AND COLLECTION POLICY

TX Waco
Providence Healthcare Network

POLICY FOR THE UNINSURED:

For the purpose of this policy, "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:

- Qualify for Full or Partial Charity Care according to the guidelines in the Charity Policy 8530.C47
- Have a means to pay but qualify for a discount based on this policy.

1. This policy applies to all non-elective services provided at Providence Health Center and DePaul Center for inpatient or outpatient acute care. This policy does **not** apply to payment arrangements for elective procedures.

2. This policy does **not** apply to International patients.

3. Providence will strive to ensure the following:
   - Patients receive prompt access to charge information for services provided.
   - Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
   - Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
   - Outstanding balances on patient accounts are pursued fairly and consistently.
   - Availability of financial counselors.
   - Information is posted in the Admitting and Registration areas, including the Emergency Room, regarding financial assistance and charity care policies.

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REVISED DATES: 06/80, 01/81, 12/85, 10/96, 10/02, 05/04

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PROVIDENCE HOSPITAL BUSINESS SERVICES POLICY AND PROCEDURE MANUAL EFFECTIVE DATE: 10/79	POLICY: 8520.100 TYPE: CREDIT/COLLECTION
APPROVAL _____ Department Director _____ Vice President,CFO _____ CEO	SUBJECT: CREDIT AND COLLECTION POLICY

TX Waco
Providence Healthcare Network

4. Patients and families have the right to appeal decisions regarding financial assistance eligibility. In the situation where an appeal request is received after the final determination by the Business Service Director, the appeal will then be reviewed by either the Sr. VP - CFO or the VP of Business & Support Services. The patient will be notified once the appeal review is completed.

5. Eligibility for financial assistance may be determined at any point during the revenue cycle prior to placement with any third party collection agency.

6. **Intentionally omitted. (Uninsured Patients)**

7. Providence management is accountable to ensure that collections policies follow all applicable federal and state laws. All collection agency agreements will be amended to include the attached addendum that will incorporate Providence and Ascension collection policies and procedures regarding billing and collection practices for uninsured patients. This includes the values-based manner in which all contacts with patients and families are to be conducted.
See attached Addendum to Collection Agency Service Agreement.

Intent
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REVISED DATES: 06/80, 01/81, 12/85, 10/96, 10/02, 05/04

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PROVIDENCE HOSPITAL BUSINESS SERVICES POLICY AND PROCEDURE MANUAL EFFECTIVE DATE: 10/79	POLICY: 8530-047 TYPE: CREDIT/COLLECTION Providence Healthcare Network
APPROVAL Cherie Sykes Department Director Philip Lakom Vice President, CFO Lest H. Leahey CEO	SUBJECT: CHARITY WRITE-OFFS (SLIDING SCALE)

POLICY: It is the policy of Providence Health Center and Ascension Health to provide health care to the poor and indigent and ensure a socially just collections practice for all patients receiving care.

PROCEDURE:

1. Charity care may be granted for a patient's entire hospital bill, or a portion thereof, depending on a combination of factors.

2. Said combination of factors includes, but is not limited to: Income (e.g., alimony, government payments, inheritance, insurance, etc.); Expenses (e.g., mortgage/rent, utilities, debt, food, etc.); bank accounts; receipt of government assistance (State or Federal; e.g., food stamps, Medicaid, green card); employment status; and number of dependents in household.

3. A sliding scale, based upon 200% of the Department of Health and Human Services Guidelines for poverty, is used to help identify those persons eligible for charity care based on income. The sliding scale is as follows:

ANNUAL INCOME RANGE		PERCENTAGES OF CHARGES PATIENT MUST MAY PAY (BY NUMBER OF PEOPLE IN HOUSEHOLD)						
		1	2	3	4	5	6	7
$ -	$18,620.00	0	0	0	0	0	0	0
$18,621.00	$24,980.00	25	0	0	0	0	0	0
$24,981.00	$31,340.00	50	25	0	0	0	0	0
$31,341.00	$37,700.00	75	50	25	0	0	0	0
$37,701.00	$44,060.00	100	75	50	25	0	0	0
$44,061.00	$50,420.00	100	100	75	50	25	0	0
$50,421.00	$56,780.00	100	100	100	75	50	25	0
$56,781.00	$63,140.00	100	100	100	100	75	50	25

For family units with more than 8 members, add $6,360.00 for each additional member.

4. To apply for full or partial charity care, the patient should complete the following forms: Financial Statement (Attachment 1) and/or Charity Application (Attachment 2). Additionally, the patient should submit, upon request, the following information: three months payroll or pension stubs; spouse's last three months payroll or pension stubs; last three months' bank statements; last two years' income tax returns; a copy of the denial of Medicaid/ SSI benefits; a copy of patient's active food stamp card; a copy of the patient's active Family Practice Clinic Green Card; a copy of the patient's Housing Authority letter; and the patient's current credit report.

   These forms must be updated every 6 months for an application to remain valid.

8530c47.vsd

REVISED DATES: 08/95, 10/96, 06/98, 10/02, 05/04

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PROVIDENCE HOSPITAL BUSINESS SERVICES POLICY AND PROCEDURE MANUAL EFFECTIVE DATE: 10/79	TX Waco POLICY 8530 C47 Providence Healthcare Network TYPE: CREDIT/COLLECTION
APPROVAL Department Director Vice President,CFO CEO	SUBJECT: CHARITY WRITE-OFFS (SLIDING SCALE)

5. Any patient desiring information or who wishes to make application for full or partial charity care will be referred to the Patient Account Representative. The Patient Account Representative will send the patient the appropriate paperwork to complete, stipulating a deadline for return of said paperwork. Upon receipt of a completed application, the Patient Account Representative will compile all pertinent information into the patient account file, and forward all information to the Patient Accounts Manager for review for eligibility.

6. The Patient Accounts Manager will review the patient's application, and make a recommendation for approval or denial of the request. The application is then forwarded to the Director, Business Services, for approval or denial.

7. The Director will either approve or deny the application. The Director will send the application to the Senior Vice President, Finance, for final review and approval if the application is for charity care in excess of $7,500.

8. The Hospital's determination will be provided in writing to the patient. The letters (See attachments) will detail if the patient received full approval, partial approval (and in what amount), denial, or pending for further information.

9. If the application is pended for further information, the type of information required and whether or not a response is required from the patient will be indicated on the letter.

10. Patients who present at the Emergency Room will be treated regardless of financial status. However, elective admissions which are for charity service will be reviewed on a case by case basis.

11. Providence Health Center realizes the impossibility of covering every conceivable potential charity situation in a written policy. Every situation will be considered on the basis of information provided. A determination for charity assistance will be made based on the information provided as well as information gathered by staff.

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REVISED DATES: 08/95, 10/96, 06/98, 10/02, 05/04

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DRAFT

WI, Milwaukee
Columbia St. Mary's

Charity Care/Financial Assistance Policy Summary

Policy Statement:
Columbia St. Mary's will assist patients who are unable to meet their financial obligation for services rendered.

Purpose:
To ensure that all people have ready access to health care and to promote equity of care and good health in our community.
This policy is a guideline to protect the dignity and rights of out patients, and to operate in a fiscally prudent manner.

Charity Care/Financial Assistance Policy:
Policy will apply to Hospital and Physician Billing
Policy **does not** apply to elective procedures, including but not limited to cosmetic procedures.

1.) All patients with no insurance and incomes below the Federal Poverty guidelines will qualify for a 100% write-off of the bill.

2.) Hospital may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance to qualify for charity care.

3.) Patients will incomes over the Federal Poverty guidelines may be provided some level of write-off based on total income and dollar amount of patient responsibility. (See attached scale)

4.) The sliding scale of write-offs applies to both uninsured patients and patient responsibility after insurance.

5.) Sliding scale will include both an income and asset test. (See attached for asset test)

6.) CSM reserves the right to run a credit report on any individual applying for charity care or financial assistance.

7.) International patients are excluded from this policy.

Charity Care/Financial Assistance Procedure:

1.) **Application and documentation**
CSM will require patients to complete a Charity Care application and provide appropriate documentation. Documentation of both income and assets is required.

2.) **Documentation requirements will be waived for homeless patients.**
Reviewer's judgment and discretion will be used to evaluate circumstances.

3.) **Bankruptcies**
Obligations released through bankruptcy procedures will be classified as charity care.
Release by bankruptcy will be considered adequate documentation that the guarantor qualifies for charity care.

4.) **Appeal Process**
Patients may appeal a charity care determination.
Appeals will be reviewed by the Corporate Responsibility Committee or a sub-committee established thereby.

5.) **Collection Procedures for Charity Care or Financial Assistance Accounts**
Patients receiving charity care or financial assistance will not be subject to garnishment procedures.
Patients receiving charity care or financial assistance will not have a lien placed on their property.

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DRAFT

WI, Milwaukee
Columbia St. Mary's

Charity Care
All patients with no insurance and incomes below the Federal poverty guidelines will qualify for a 100% write-off of the bill.

Proposed Methodology for Financial Assistance

Patient Responsibility

Income > Federal Poverty Guidelines	0-$1,000	>$1,000-$3,000	>$3,000-$5,000	>$5,000-$10,000	>$10,000-$25,000	>$25,000-$50,000	>$50,000-$75,000	>$75,000
$0-$5,000	100%	100%	100%	100%	100%	100%	100%	100%
$5,000-$10,000	50%	60%	70%	80%	90%	100%	100%	100%
$10,000-$15,000	30%	50%	60%	70%	80%	90%	90%	100%
$15,000-$20,000	0%	0%	50%	60%	70%	80%	90%	100%
$20,000-$30,000	0%	0%	30%	30%	50%	60%	70%	90%
$30,000-$40,000	0%	0%	0%	30%	30%	50%	60%	80%
$40,000-$50,000	0%	0%	0%	0%	30%	40%	50%	70%
$50,000-$60,000	0%	0%	0%	0%	0%	30%	40%	60%

% Reduction Applied to Patient Responsibility

Federal poverty Guideline is: $ 9,310.00 - One person household

Asset Test
1.) IRA's will be excluded
2.) Other assets not too exceed $100,000 will be excluded
Assets include but are not limited to:
Equity in home
Equity in vehicles
Savings
Investment Accounts
3.) Assets in excess of $100,000 will be included as funds available for payment on outstanding balances
Amounts will be added to income for use in above scale.

Patients not eligible for Charity Care are eligible for a Prompt Pay Discount.

Patients are not eligible for more than one programmatic discount.
Cannot receive both Prompt Pay and Charity Care.

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WI, Milwaukee
Columbia St. Mary's

Assumptions for Charity Care/Financial Assistance Process:

1.) Sliding fee scale is based on funds available to fulfill patient obligation to CSM but also on the total dollar amount of patient responsibility.

2.) Many facilities base Charity Care on income and assets only. The sliding scale does not consider the dollar amount of patient responsibility.

3.) Income test based on gross income.
    Gross income does not consider expenses.
    Net income methodology necessitates decision on acceptable expenses.
    Decision required on:
        Expenses to be excluded from calculation of net income such as credit card expenses
        Level of expenses allowed for car payments, mortgage, rent, etc.

4.) Asset test is designed to determine funds available to settle outstanding balances.

5.) Process is designed to determine the amount of debt relief a patient is eligible to receive.
    A denial of Financial Assistance results in no reduction of patient liability.
    Denial will not result in a recommendation for liquidation of any assets or any lifestyle change.

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WI, Milwaukee
Columbia St. Mary's

Demonstration of Proposed Changes in Charity Care/Financial Assistance Policy

			Current Method	***Proposed Method***	***Additional Write-off***
Household Income	$	15,000			
Family Size		1.00			
Patient Account Balance	$	3,000.00			
Charity Care Adjustment			0%	60%	
Net Patient Responsibility			$ 1,800.00	$ 1,200.00	**$ 600.00**
Household Income	$	30,000			
Family Size		3			
Patient Account Balance	$	6,000			
Charity Care Adjustment			20%	70%	
Net Patient Responsibility			$ 4,800	$ 1,800	**$ 3,000.00**
Household Income	$	40,000			
Family Size		3			
Patient Account Balance	$	12,000			
Charity Care Adjustment			0%	50%	
Net Patient Responsibility			$12,000	$6,000.00	**$ 6,000.00**
Household Income	$	30,000			
Family Size		5			
Patient Account Balance	$	4,000			
Charity Care Adjustment			60%	70%	
Net Patient Responsibility			$ 1,600	$ 1,200	**$ 400**
Household Income	$	50,000			
Family Size		2			
Patient Account Balance	$	30,000			
Charity Care Adjustment			0%	50%	
Net Patient Responsibility			$ 30,000	$ 15,000	**$ 15,000**

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Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 2

If your system has implemented any changes recently to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the planned date of implementation of each such change.

Our Ascension Health Policy for Billing and Collection for the Uninsured (Ascension Health Policy) was approved by our Board of Trustees in December, 2003, with an implementation date of July 1st, 2004, for all hospitals, except for Section 7. Section 7, "Uninsured Patients with the Ability to Pay", includes provisions for a discount for all uninsured patients who do not qualify for charity or financial assistance. We have not implemented this section of our policy due to certain Medicare related issues. We are in discussions with CMS regarding these issues. We expect to conclude these discussions shortly.

The Ascension Health Policy establishes minimum standards, and many of our hospitals apply standards and procedures that are more generous than those described in the Ascension Health Policy. Some of our hospitals were required to change their policies and procedures when they adopted the Ascension Health Policy. However, many hospitals did not need to change their local policies and procedures to comply with the Ascension Health Policy because they were already meeting or exceeding the requirements of our Policy.

A small number of hospitals have reported delays in implementing a handful of the changes. The overwhelming majority have adopted all provisions (except Section 7) as of this date. These minor changes will be completed in July and August.

Attachment

- Listing of each location and the effective date of their recent changes in policies and procedures. If no change required, n/a is indicated.

Ascension Health - Confidential - Attorney/Client Privilege
Response to Chairman James C. Greenwood Request for Information

State	Location	Changes implemented to charity and collection policies and procedures with respect to uninsured / self-pay patients	Date of implementation or planned implementation
AL	**Birmingham**	Revised policy to incorporate all Policy #16 changes	May-04
AL	**Mobile**	Revised policy to incorporate all Policy #16 changes	June 30, 2004
CT	**Bridgeport**	Policy complete. Awaiting formal approval.	August, 2004
DC	**Washington**	Currently revising policy to incorporate all Policy #16 changes*	August 23, 2004
FL	**Jacksonville**	None	n/a
FL	**Pensacola**	None*	n/a
IL	**Chicago**	None	n/a
IN	**Evansville**	Currently revising policy to incorporate all Policy #16 changes	July 29, 2004
IN	**Indianapolis**	Revised policy to incorporate all Policy #16 changes	July 1, 2004
MD	**Baltimore**	None*	n/a
MI	**Detroit**	Revised policy to incorporate all Policy #16 changes	July 1, 2004
MI	**Grand Blanc**	None*	n/a
MI	**Kalamazoo**	Revised policy to incorporate all Policy #16 changes	July 15, 2004
MI	**Saginaw**	Revised policy to incorporate all Policy #16 changes	April 1, 2004
MI	**Tawas City**	Revised policy to incorporate all Policy #16 changes	July 1, 2004
NY	**Binghamton**	Policy complete. Awaiting formal approval.	July, 2004
NY	**Lewiston**	Revised policy to incorporate all Policy #16 changes	July 1, 2004
NY	**Troy**	Revised policy to incorporate all Policy #16 changes	July 1, 2004
PA	**Pottsville**	Currently revising policy to incorporate all Policy #16 changes*	September, 2004
TN	**Nashville**	Currently revising policy to incorporate all Policy #16 changes*	July, 2004
TX	**Austin**	Policy complete. Awaiting formal approval.	July, 2004
TX	**Waco**	Revised policy to incorporate all Policy #16 changes	May, 2004
WI	**Milwaukee**	Policy complete. Awaiting formal approval.	July, 2004

* Previously submitted in the July 16, 2003 request for information

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 3

Please produce for the record all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients.

Ascension Health Policy # 16, Billing and Collection for the Uninsured (Ascension Health Policy) was distributed widely to all Chief Executive Officers and Hospital board of trustee chairs on May 12, 2004. A copy of this memo is attached.

A conference call with CFOs and Vice Presidents of Mission was conducted on April 29, 2004 to review the elements of the new Policy. A copy of the agenda for that conference call and the timeline reviewed is attached. Also on April 6, 2004, a conference call was conducted with CFOs and Vice Presidents of Mission to review the reporting requirements included in the Ascension Health Procedure, Care of the Poor / Community Benefit Planning and Reporting, effective July 1st, 2004.

In addition, enclosed are copies of training materials used by those hospitals who made changes to their policies and procedures as they implemented the Ascension Health Policy or those who made no changes but have updated their training material. Many of our hospitals did not have to change their policies and procedures to adopt the Ascension Health Policy on Billing and Collection for the Uninsured because their current practices already met or exceeded the requirements of the Policy.

Because of the short time-frame permitted for us to collect this information from the hospitals, we have not been able to provide copies of every hospital's training materials. Also, in some of the smaller hospitals that have small numbers of staff, their training was done on a one-on-one basis. We have submitted no training documentation from these hospitals.

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 3

Attachments:

- May 12, 2004 Memo from Rex Killian, Senior Vice President & General Counsel to Health Ministry Chief Executive Officers and Health Ministry Board Chairs distributing Ascension Health System Policy # 16 Billing and Collection for the Uninsured

- Agenda, Ascension Health Policy # 16 and implementation timeline reviewed on the April 29, 2004 conference call

- Agenda and education materials for implementation of Care of the Poor / Community Benefit Planning and Reporting Procedure on April 6, 2004

- Selected training materials used by local hospitals related to policies and procedures for billing and collection for the uninsured for the following locations:

  - Mobile, Alabama
  - Pensacola, Florida
  - Indianapolis, Indiana
  - Detroit, Michigan
  - Troy, New York
  - Milwaukee, Wisconsin

To: Health Ministry Chief Executive Officers
Health Ministry Board Chairs

From: Rex Killian, Senior Vice President & General Counsel

Date: May 12, 2004

Subject: Ascension Health System Policies:
System Policy #16 - Billing and Collection for the Uninsured

Attached please find *System Policy #16 - Billing and Collection for the Uninsured* and an updated Table of Contents for your System Policies manuals. This policy should be distributed to the appropriate individuals at your health ministry. This policy was approved by the Ascension Health Board of Trustees at the December 10, 2003 meeting and is effective July 1, 2004. If you are maintaining a hard copy manual please insert this policy behind Tab 16 in your manual and replace the Table of Contents with the updated version attached.

:f you need covers, spines or tabs to assemble your manual, please contact Gerry Berviller in Legal Services at the National Office at 314.733.8281 or by e-mail at gberviller@ascensionhealth.org.

C: Shari Shane
Gerry Berviller

Ascension Health Policies
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SYSTEM POLICY#: 16	**SUBJECT: Billing and Collection for the Uninsured**
BOARD APPROVAL DATE:	**12/10/03**
EFFECTIVE DATE:	**07/01/04**
REVISION DATE:	

Chief Operating Officer and
Interim CEO, Ascension Health

POLICY

It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital or medical center and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does

not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
    f. Financial counselors are available to all Patients.
    g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
    a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
    b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
    a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments,

utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, <u>and</u> a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal

Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

DISCOUNTS FOR UNINSURED POLICY

CONFERENCE CALL

THURSDAY, APRIL 29, 2004

9:00 AM CDT

(DEPAUL CONFERENCE ROOM)

DIAL IN # 877.657.3835 ID 8261

AGENDA

1. Reflection ..... Tony Speranzo
2. Review Policy Components ..... Tony Speranzo & Kathy Arbuckle
3. Timeline for implementation ..... Tony Speranzo
4. AHA Guidelines and Confirmation Statement ..... Kathy Arbuckle
5. Other Items Related to House Investigation ..... Kathy Arbuckle
6. Other Miscellaneous Finance ..... Barb Potts
   - Year-end Audit Timetable
   - Tax issues

SYSTEM POLICY#: 16	**SUBJECT: Billing and Collection for the Uninsured**
BOARD APPROVAL DATE:	**12/10/03**
EFFECTIVE DATE:	**07/01/04**
REVISION DATE:	

Chief Operating Officer and
Interim CEO, Ascension Health

POLICY

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- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does

not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
    f. Financial counselors are available to all Patients.
    g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
    a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
    b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
    a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments,

utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, <u>and</u> a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal

Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

UNINSURED DISCOUNTS POLICY

IMPLEMENTATION TIMELINE

- Review policy requirements with CFOs and VPs Mission .....April 29, 2004
- Implement Charity care, financial assistance and billing and collection guidelines in Policy .....No later than June 30, 2004
- Meet with CMS regarding discounts for those with means to pay .....May 2004
- Implement discounts for those with means to pay (tentative date)..... July 31, 2004

Policy 9 Care For the Poor
Conference Call
Agenda
April 6, 2004
Dial-In #1-877-657-3835 Meeting ID #8127

I. Roll-call

II. Reflection

III. Policy 9
- Category V Intent
- "Not to exceed" phrase
- Answers to submitted questions
- Marty Rugh language around volunteer time
- General questions

IV. ISFP
- Where we are
- Expected level of detail

V. New Policy on Billing/Collections
- How do we get consistency with our collection agencies

VI. Hot line
- 1-314-733-8138 (telephone number set up for questions)
- policy9@ascensionhealth.org

VII. Ministry Configuration

Care of the Poor / Community Benefit Planning and Reporting

Charity care determined on a patient by patient basis:
- Category I – Charity Care (free or reduced fee care for individual patients)
- Category II – Unreimbursed Cost of Care provided to patients enrolled in public programs

Charity care determined on a programmatic basis:
- Category III – Community Benefit programs and services targeted to the poor
- Category IV – Community Benefit programs and services targeted to the general community

Category I: Charity Care (determined on a patient by patient basis)

Guidelines/Principles:

- Estimate of cost to provide services to patients who qualify for charity care
- Establish a guideline to define "poor".
- Bad debt cost of services related to certain bad debt write-offs:
  - Option 1 Formula:
    - **Cost of Bad Debt excluding the portion related to coinsurance and deductibles**
      - Patients who have a coinsurance payment or deductible are assumed to have insurance
  - Option 2 Formula:
    - **Identify the zip code average income that constitutes poor, and count all bad debts from those zip codes excluding the portion related to coinsurance and deductibles**
      - It is recognized that this may count people with the ability to pay who reside in these zip codes, but it also excludes people from other zip codes that may not be able to pay.
  - Bad debt should be net of reimbursement
- Charity Care should include the cost of services provided to charity care patients in acute and non acute care settings (e.g., ambulatory surgery centers, etc.)

Category II: Unreimbursed Cost of Care provided to patients enrolled in public programs

(determined on a patient by patient basis)

Medicaid

- Include losses (shortfall) from all Medicaid sources (e.g., Medicaid managed care products)

Guidelines/Principles:

- Medicare shortfall should not be reported
- Medicaid disproportionate share (DSH) payments should be considered Medicaid payment.
- Prior year settlements from Medicaid programs (such as Medicaid DSH) should be considered as an offset to the cost of care provided and, accordingly, increase or decrease the shortfall reported.

Category III – Community Benefit programs and services targeted to the poor
Category IV – Community Benefit programs and services targeted to the general community

Considerations:

- Category III:
  - Must respond to the needs of special populations, for example, the frail elderly, poor persons with disabilities, the chronically mentally ill, persons with AIDS, or those who find it hard to meet basic needs due to ongoing poverty.
- Category III or IV:
  - Should be quantifiable in terms of dollars and not included in Categories I or II
  - Generates a low or negative margin.
  - May be financed by philanthropic contributions, volunteer efforts, an endowment, grants, shortfalls, etc.
  - Provides a response to a unique or particular health problem in the community.
  - Would probably be discontinued if the decision were made on a purely financial basis. The decision to continue generally represents a mission commitment versus a business decision.
  - Would no longer be available, or would be insufficiently available in the community, or would be the responsibility of the government if not provided by the healthcare organization

Category III – Community Benefit programs and services targeted to the poor
Category IV – Community Benefit programs and services targeted to the general community

Guidelines/Principles:

- Report cost less any reimbursement received.
- Medical Education programs should be reported as a community benefit.
  - Medicare Graduate Medical Education (GME) payments should offset costs.
  - Medicare Indirect Medical Education (IME) payments should not be offset against the direct cost of medical education programs.
- Volunteering
  - Include employee reported volunteer time for hospital supported activities.
  - Examples:
    - Health screenings performed after hours or the replacement cost for employees performing volunteer activities
    - Personal volunteer time for organizational sponsored events
    - Board representation on management approved organization

Note: The program or service purpose and/or the targeted population to be served will determine whether the program is recorded as Category III or IV.

For Category III (Programs for Persons who are Poor), use your definition of "Poor".

Examples of Included/Allowable Category III and Category IV Programs/Services/Activities

Community Services
- Community Education and Outreach
- Screening
- Support Groups
- Counseling
- Self Help/Awareness
- Immunizations
- Community Clinics
- Patient Education

Medical Education (excludes GME payments)
- Physicians/Medical Students
- Scholarship/Funding for Professional Education
- Nurses
- Technicians
- Other Health Professionals

Community Building
- Physical Improvements
- Economic Development
- Support System Enhancements
- Environmental Improvements
- Leadership Development & Skills Training

Subsidized Health Services
- Collaborative Efforts in Preventive Medicine (not included in Category I or II)
- Women's & Children's Clinic
- Mental Health Clinic

In-kind/Donations
- Use of space by public organizations (In-kind)
- Volunteer time
- Donated equipment/medicines (donations)

What does this new process look like?

- VPs of Mission/ Integration fully engaged with all HM Senior Leadership during the Integrated Strategic Financial and Planning (ISFP) and budgeting process
- Care of the Poor / Community Benefit Plan strategies/goals tied to the Health Ministry (HM) Strategic plan
- All Senior Leadership fully aware of scope and financial commitment required to achieve Care of the Poor / Community Benefit goals
- Measurable goals developed and achievement of goals tied to executive compensation
- Financial resources allocated to support Care of the Poor / Community Benefit plan

Assessment Tool

The following tool was designed to assist you with both assessing where along a continuum your health ministry is currently and what additional steps may be necessary to more fully incorporate Care of the Poor / Community Benefit planning into the Integrated Strategic and Financial Planning Process.

1. Historically, who has been involved primarily in developing the Care of the Poor Plan?
   a. Community outreach staff, finance staff and planners
   b. VP Mission/Integration and community/outreach staff with participation from some key senior leadership team members
   c. VP Mission/Integration and community/outreach staff with participation from full Senior leadership team

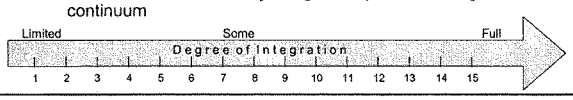
Assessment Tool (continued)

2. How involved has the VP Mission/Integration been in the overall HM strategic and financial planning process?
   a. Little involvement
   b. Some involvement
   c. Full involvement
3. How closely does the Care of the Poor / Community Benefit plan tie to the HM Strategic Plan?
   a. Not tied to the HM Strategic Plan
   b. Somewhat tied to the HM Strategic Plan
   c. Fully tied to the HM Strategic Plan
4. Does the Care of the Poor / Community Benefit Plan have measurable goals?
   a. No goals have metrics
   b. Some goals have metrics
   c. All goals have metrics

Assessment Tool (continued)

5. Are the Care of the Poor / Community Benefit Plan goals tied to Executive Incentive Compensation?
   a. No
   b. No, but is currently under active consideration
   c. Yes, it is approved and is either fully implemented or is approved for future implementation.

   Assign yourself the following points:
   a = 0 points
   b = 1 point
   c = 2 points
   Sum the score to determine your "general position" along the ISFP continuum



Possible Approaches to Move Along the Continuum

Approach 1:

- Using the Assessment Tools, determine (from your perspective) where you are along the continuum.
- Invite your HM CEO to complete the assessment tool.
- Invite other Senior Leadership members to complete the assessment tool.
- Meet with your CEO to discuss where the HM is along the continuum.
  - Develop a common understanding of where you are in the process
  - Develop a plan – in conjunction with the full senior leadership team – to achieve full integration.

Other approaches that you would like to offer?

Community Service Report

Sample B

Form to be used to report community service activities sponsored by your HM, such as: Health screenings; Educational programs; Support groups hosted at your HMs facilities

Department_____ Date_____

Manager completing form_____ Phone_____

Name of program_____

Date of event_____ Location of event_____

Program description_____

_____

Number of people who attended or number of people served_____

A. Types of personnel assigned	Number assigned	Hours Worked	Cost
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
		Total A.	$_____

B. Materials used/expended	Number(s) used	
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
	Total C.	$_____

C. Misc. items and expenses	Number(s) used	
_____	_____	$_____
_____	_____	$_____

D. Room usage expense ($50 for ½ day)_____	$_____
Catering/dietary costs_____	$_____
Total D.	$_____

Total Program expenses(A,B,C,D)	$_____
Subtract any program revenue or donations	-$_____
Net program cost	$_____

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MONTHLY MEETING
PATIENT ACCOUNTS REPRESENTATIVES

10/08/03

AGENDA:

- HIPAA / REGARDING REQUESTS TO SECURE PAYMENT
- MEDICARE AND MEDICAID PATIENT RESPONSIBILITY (See 9/19)
- FINANCIAL STATEMENT REVIEW
- MED ASSIST DISABILITY AND VOA

Discussion Notes:

PRESENT:

SIGNED: Cathy Hall DATE: 10-8-03
SIGNED: Latina Henderson DATE: 10-8-03
SIGNED: Donnie P. Miller DATE: 10/8/03

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10/08/03

Points of discussion:

RE: Financial Statement Review

Revised Financial Statement presented to Patient Accounts Representatives (shared with our MedAssist Representative, Social Work Services, Collection Agencies and Collection Attorney).

Changes discussed:

If assistance has been applied for, we added block to obtain Agency Name.

Purpose of "BUSINESS OFFICE USE ONLY" section – Patient Accounts Representative may make recommendation in this section, explain any item there may be some question about (such as no income listed, expenses exceed income, excessive medical expense, insurance premiums, but no insurance given).

Removed credit card and loan debt

Added "Primary" to telephone expense

Added "Clothing Allowance" to be recorded in shaded "Business Office Use Only" block, $25 per month per person allowed

Added "Policy Value" to Life Insurance section

Added Other Assets section

Discussed the importance of totalling income and expense columns, questioning any response there may be some question about.

Discussed the importance of asking the patient if he/she is offered group medical insurance and, if not enrolled, what is the reason.

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PROVIDENCE HOSPITAL
Post Office Box 851537
Mobile, AL 36685
(334) 633-1500

Reviewed by Review

********FINANCIAL STATEMENT********

PATIENT INFORMATION: 2nd line

Name	Social Security No.	Marital Status	Sex	Date of Birth

Address	Zip Code	Home Phone Number

Employer	Employer Contact	Employer Phone Number

Employer's Address	Zip Code
XXX	XXX

Spouse's Name	Social Security No.	Date of Birth

Spouse's Employer	Employer Contact	Employer Phone Number

Responsible Party
GUARANTOR INFORMATION: (if other than patient or spouse) Relationship to Pt: ____

Name	Social Security No.	Date of Birth	Home Phone Number

Address	Zip Code

Employer	Employer Contact	Employer Phone Number

DEPENDENTS: (excluding patient) & spouse

Name	Age	Relationship	Social Security No.
1.			
2.			
3.			
4.			
5. XXX		X	XXX

Have you applied for government assistance? ☐ Yes ☐ No - Agency - Where: Date Applied

If yes, what kind? ____

When was assistance applied for? ____

Recommendations: Shredded

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INCOME		EXPENSE	
Income Per Month	Personal Assets	Monthly Living Expenses	Other Monthly Expenses
Wages $	Cash on Hand $	Mortgage $	Visa
Social Security $	Savings Acct: $	Rent $	Balance Mo. Pmt. $
V.A. Pension $	Bank	Electricity $	Mastercard
Unemployment $	A/C #	Gas $	Balance Mo. Pmt. $
Worker's Comp. $	Balance $	Telephone $	American Express
Interest Income $	Checking Acct:	Water $	Balance Mo. Pmt. $
Dividend Income $	Bank	Groceries $	Bank Loans:
Child Support $	A/C #	Car/Truck/Boat Pmt. $	Balance Mo. Pmt $
Alimony Rec'd $	Balance $	Car/Truck/Boat Pmt. $	Balance Mo. Pmt. $
Rental Income $	CD's $	Day Care $	Medical:
Food Stamps $	Securities $	Alimony Paid $	Provider
Other Income $	Life Insurance $	Medical Insurance $	Balance Mo. Pmt. $
	Property $	Homeowners Insurance $	Provider
	Settlements $	Life Insurance $	Balance Mo. Pmt. $
	Inheritance $	Other $	Provider
	Other $	$	Balance Mo. Pmt. $
	$	$	Pharmacy Mo. Pmt. $
	$	$	Other $
TOTAL INCOME: $		TOTAL EXPENSE: $	

PROPERTY INFORMATION (home, land...)	VEHICLE INFORMATION			
Description:	Car:	Make	Model	Year
	Car:	Make	Model	Year
	Truck/ Boat	Make	Model	Year

In addition to the information requested above, I have provided the following as evidence of my income: (1) My last three bank statements; (2) IRS Form 1040 with Schedules and W-2 Statements. If I am unable to provide this information, Providence Hospital has my permission to request the information from my employer or any other source. To the best of my knowledge, I hereby certify that the above information is true and correct, and that this is a complete record of my assets and liabilities. Providence Hospital has my permission to investigate my credit history.

Date: _____ Signature of Patient or Guarantor: _____

Driver's License #: _____

Date: _____ Signature of Spouse: _____

Driver's License #: _____

Date: _____ Signature of Interviewer: _____

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MONTHLY MEETING
PATIENT ACCOUNTS DEPARTMENT

12/10/03

AGENDA:

- Med Assist Update
- New Financial Statement
- Credit Balances
- Alabama Organ Center
- Blue Bills Update
- Primary Billing Questions

Discussion Notes:

I will be available thru the holidays with the exception of Christmas Eve afternoon. I want to wish you all a HAPPY, SAFE CHRISTMAS AND NEW YEAR!!!

PRESENT:

SIGNED: Sabira Henderson DATE: 12-10-03
SIGNED: Kelly Ross DATE: 12/10/03
SIGNED: Janet Garcia DATE: 12-10-03
SIGNED: Tracey Pitts DATE: 12/10/03
SIGNED: Blue Stephen DATE: 12-10-03
SIGNED: Denise Shingfellow DATE: 12-10-03
SIGNED: [illegible] DATE: 12-10-03
SIGNED: Jonnie R. Mitchell DATE: 12/10/03
SIGNED: Phillip Nicholas DATE: 12-10-03

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Donna, would you allow me to ask you some YES or NO questions as follow up to our new Financial Statement / P & P Pt Accts Rep meeting Thursday?

1. On new policy regarding $50,000+ accounts for spouse signature, would it be necessary to obtain on Mcaid, Mcare, HMO, BC when the account balance will be much less after account allowances? Yes – Pass Exception for Mcare.

2. On Charity Care policy, does the CAP pertain to only patients that qualify for charity or any patient that may have a balance up to $19,999? I realize we discussed pre reg in our meetings, but wanted to make sure…if a self pay patient is scheduled for a $19,999 procedure we could advise him if paid at TOS we would accept $15,000 as PIF… Yes

3. Along that same line…a patient who has received a final bill for $19,999 and wants to make payment arrangements, do we write off 25%? Yes

4. If yes, do we write off to charity allowance? Yes

5. If no arrangement is made, unable to contact would we write off 25% prior to placement? NO

6. On the Financial Statement could we change page 2 under Property/Assets to read:
   PRIMARY RESIDENCE (DESCRIPTION OF PROPERTY)? We already obtain the patient's street address on page 1. ✓

7. May we put $ in the fields we are requesting amounts in? Cathy said she can imagine that under Social Security on page 2 a lot of our patients will put their SS # and in some cases they may even write yes or no in some of the blocks. ✓

I hope these questions are OK, I just wanted to make sure I had us all on the same page. Thank you!

☺

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Mobile, AL 36685
(251) 633-1500

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Providence Hospital

FINANCIAL STATEMENT

PATIENT INFORMATION

Name				Social Security Number
Date of Birth	Sex	Marital Status	Mailing Address (if different)	
Street Address		City	State	Zip
Employer		Employer Contact		
Spouse's Name				Social Security Number
Date of Birth	Spouse's Employer			Contact / Phone Number

RESPONSIBLE PARTY INFORMATION (if other than patient or spouse)

Name				Social Security Number
Date of Birth	Sex	Marital Status	Relationship to Patient	
Street Address		City	State	Zip
Employer		Employer Contact		

DEPENDENTS (Excluding Patient & Spouse)

Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number

ASSISTANCE

Have you applied for assistance? (Circle one) YES NO	If yes, Agency Name	

~ BUSINESS OFFICE USE ONLY ~

Recommendation:

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FINANCIAL STATEMENT

~ Page 2 ~

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INCOME (per month)		EXPENSES (per month)	
Wages $	Social Security $	Mortgage $	Rent $
V.A. Pension $	Unemployment $	Electricity $	Gas $
Worker's Compensation $	Child Support $	Water $	Primary Telephone $
Alimony $	Rental Income $	Groceries $	Food Stamps YES NO $
Retirement $	Other Income $	Day Care $	Alimony/Child Support $
Savings Account Bal $	CD's $	Medical Insurance $	Dental Insurance $
Checking Account Bal $	Annuity $	Homeowners Insurance (if not included in mortgage payment) $	
Other $	Other $	Student Loans $	Business Office Use Only
		Vehicle 1 $	Vehicle 2 $
		Medical Expenses: Provider:	Balance: $
		Medical Expenses: Provider:	Balance: $
		Pharmacy Expenses: Provider:	Balance: $
		LIFE INSURANCE: Policy Value: $	Monthly Premium: $
Total Income: $		Total Expenses: $	

PROPERTY / ASSETS

Real Estate:	Value	$
Primary Residence (description of property):		
Other Assets **(MUST BE ANSWERED)** Value $ Description:		

Year	Make	Model
Year	Make	Model

In addition to the information requested above, I have provided the following as evidence of my income: (1) My last three bank statements; (2) IRS Form 1040 with Schedules and W-2 Statements. If I am unable to provide this information, Providence Hospital has my permission to request the information from my employer and any other sources. To the best of my knowledge, I hereby certify that the above information is true and correct, and that this is a complete record of my assets and liabilities. Providence Hospital has my permission to investigate my credit history.

Date	Signature of Patient or Responsible Party
Date	Signature of Spouse
Date	Signature of Interviewer (if applicable)

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MONTHLY MEETING
PATIENT ACCOUNTS DEPARTMENT

01/14/04

AGENDA:

- HAPPY NEW YEAR, LET'S MAKE 2004 OUR BEST YET!!!
- REVIEW A/R ANALYSIS
- MIRACORP DECLINE
- SENIOR'S FIRST PAYMENT ERRORS
- GOING THE "EXTRA MILE" FOR OUR PATIENTS
- WORK COMP UPDATE RE ATTENTA/BRIDGEWAY
- MEDICAID PTFL ISSUES/CONCERNS

Discussion Notes:

Note: I will be off next Thursday and Friday (the 22nd and 23rd), I plan to come in on Saturday or Sunday to work on the $3,000+ bad debt.

PRESENT:

SIGNED: Denise C Stringfellow DATE: 1-14-04
SIGNED: Janet Garcia DATE: 1-14-04
SIGNED: [illegible] DATE: 1/14/04
SIGNED: Phillip D. Nelson DATE: 1/14/04
SIGNED: [illegible] DATE: 1/14/04
SIGNED: Cathy Shell DATE: 1-14-04
SIGNED: Latina Hardison DATE: 1-14-04
SIGNED: Gail Hopkins DATE: 1/14/04
SIGNED: Serena (Absent) DATE:

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01/14/04

Topics of Discussion

RE: **GOING THE "EXTRA MILE" FOR OUR PATIENTS**

I emphasized the importance of treating our patients and their families like our own.

How would you want your Mother or Father, Brother or Sister, treated if they were a patient at Providence or received a call or letter from us regarding their bill?

I reminded staff that patients who need our services are not well, they may have just received devastating news regarding their health, they're afraid and sometimes tend to lash out. I stressed the importance of listening and being patient and understanding. It's important that we make sure they know we want to help and will do whatever we can to work out a payment arrangement that is fair.

If financial information is needed it's important to keep in mind that some of our patients feel uncomfortable giving out personal information, we should assure them it is kept confidential and is necessary for us to complete our review of their request for assistance in order to determine what type assistance they qualify for.

We reviewed our Philosophy and Core Values.

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MONTHLY MEETING
PATIENT ACCOUNTS DEPARTMENT
March 31, 2004

Agenda:

- Reference Lab – Private Pay
- Billing and Payment Philosophy
- Scripting
- Physical Therapy Evaluations
- Proration – Days Covered
- MOM Care
- Medicare Complete – Online Status
- Insurance Information Received on Bad Debt Account
- Jeff Stein –RE: Medical Records/Packets
- Charity Care Review – DON'T BE TIMID…ASK!!!
- Commercial Review Prior to Patient Responsibility
- Worker's Comp – AlaMed/Focus
- "LET'S FOCUS"

SIGNED: Janet Lancin DATE: 3-31-04
SIGNED: Kelly Ross DATE: 3/31/04
SIGNED: Denise Stringfellow DATE: 3/31/04
SIGNED: Phillip D. Rhodes DATE: 3/31/04
SIGNED: Latrina Hardison DATE: 3/31/04
SIGNED: Cathy Shaw DATE: 3-31-04
SIGNED: Joann R. Mills DATE: 3/31/2004
SIGNED: Sarena Pitts DATE: 3/31/04
SIGNED: Gail (Sch) DATE:

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AL, Mobile
Providence Hospital

03/31/04

Discussion

RE: Charity Care Review ... DON'T BE TIMID, ASK!!!

Who supports patient if no income is listed?

If unemployed, what was prior occupation, earnings?

If spouse does not work, why?

If insurance premiums are listed, but no insurance given, what are premiums for? What kind of coverage does patient have, with what insurance company?

If any expenses appear to be excessive (such as a $100 phone bill), ask why?

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FL, Pensacola
Sacred Heart Health System

CHARITY INSTRUCTIONS

UNCOMPENSATED CARE APPLICATIONS

Patients complete Uncompensated Care Applications when they request financial assistance or have indicated an inability to pay for services. If the patient is a Medicare patient, they must also complete a Medicare Hardship Form as well as the Uncompensated Care Application.

MEDICAID ELIGIBILITY

Before sending the Application for Uncompensated Care, ask the following:

Does the patient have minor children living in the home?
Is patient pregnant?
Is patient a minor?
Is patient 65 or older?
Is patient totally and permanently disabled?
Is patient an alien?
Does patient receive AFDC or SSI?

If **yes** to any of these questions, then patient must apply for Medicaid through their local Department of Children and Family Office. (See attached reference listing) If they have already applied and have a valid denial, proceed with charity application process. (Note: Valid Medicaid denial means that they followed through with the process and were denied based on income, assets or did not meet eligibility criteria. If they were non-compliant in completing the Medicaid process- that is not a valid denial.) Medicaid can be retroactive for 3 months. The above applies to residents of Florida. Alabama Medicaid has its own eligibility requirements.

UNCOMPENSATED CARE PROCESS

CHARITY APPLICATION - If there is no possibility of any other payer and patient appears indigent, then proceed with releasing Application for Uncompensated Care and letter #1. Patient must return completed Application-signed and dated. If the Application is incomplete, unsigned or does not include all supporting documentation, the Application cannot be processed. Mail letter #2 to the patient marking what is still required for the Application to be considered. The Business Office Specialist must sign the Application as Hospital Representative, unless it is already signed.
PROOF OF INCOME – Patient must furnish proof of income for the last 12 months. (See attached letter #1)
PROOF OF RESIDENCY – Patient must provide proof of residency if living out of Escambia County. A copy of the following will justify residency: drivers license, identification card, utility bill, voter registration or signed statement attesting to patient's address.

COMPLETE CHARITY GUIDELINE WORKSHEET

*Enter number of people in family
*Poverty guidelines, (not a percentage of the poverty guideline), by number in the family
*Family income (include wages, SSI benefits, pensions, interest, dividends, child support, VA benefits, grants, student loans, unemployment compensation, retirement, settlements, food stamps and gifts.

Patient qualifies for charity assistance if their income is at or below the poverty guidelines. Sacred Heart Health System currently qualifies patients as long as their income does not exceed 200% of the poverty guidelines. Once you have completed the Worksheet **sign and date**.

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Sacred Heart Health System

PAPERWORK MUST BE STAPLED IN THE FOLLOWING ORDER:
Uncompensated Care Application
Proof of income/Residency
Accounts to be written off must include patient types
Charity Guideline Worksheet (Check to ensure the **poverty guidelines** for correct number of family members was used.)

After a determination is made as to eligibility, please enter an abbreviated note indicating charity approval or charity denial. (See attached list.)

MEDICARE HARDSHIP
If a patient has Medicare and qualifies for charity, their Medicare co-insurance and deductible can be written off to Medicare Hardship. The patient should complete an Uncompensated Care Application for any balances other than Medicare co-insurance and deductible. Example: oral medications) If **the patient has any balances that is not the Medicare co-insurance or deductible, it will be treated exactly like all other charity.** If the part of the patient's balance is not Medicare's co-insurance or deductible, you need to copy the Application, proof if income, Charity Worksheet and submit a separate charity packet that can be sent to Patient Accounts for write off. Follow the same instructions for charity, but include an explanation of the balance with the Application.

Business Office personnel will change he data mailer message to OH if inpatient and UH if outpatient. Balances will be written off after they have been transferred to Bad Debt.

UNCOMPENSATED CARE FACTS
***Eligibility period** – July 1st through June 30th of the following year. If bills are not written off by June 30th, then patient must re-apply.
***What Uncompensated Care covers**: Bills for the following: Sacred Heart Pensacola and Sacred Heart Emerald Coast, *Airheart, *Sacred Heart Medical Group and *Sacred Heart Home Care. (* Indicates billing system other than AS-400)
***What Uncompensated Care DOES NOT cover:** Bills for non Medical Group physicians, anesthesia, radiology, cardiology or pathology, etc. If patient received bills from other providers, they must contact the other providers regarding payment or possibility of charity care.
***Fraudulent Applications** If the patient's assets and income reported do not seem correct or you feel that the patient is not being truthful, you can deny the Application. You must document the AS-400 and request review by the Patient Accounts Manager prior to notifying patient that their Application was denied.

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Sacred Heart Health System
Special Joint Meeting of Finance Committee and Long Range Planning Committee

Policy on Discounts for the Uninsured

March 19, 2004

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Introduction

At the Ascension Health Board of Trustees meeting on December 10 and 11 of 2003, the Board approved Ascension Health's Policy on Discounts for the Uninsured, subject to working through CMS and other regulatory body requirements. This newly adopted policy is presented as an informational item to this committee for the purpose of informing the committee members about how our local health ministry policy complements the Ascension level policy. The information on the following slides compare each element of the Ascension policy to our internal policy at Sacred Heart Health System.

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Sacred Heart Health System

Ascension Health Policy on Discounts for the Uninsured

Foundational Values and Principles

- Our commitment to and reverence for human dignity and the common good
- Our special concern for and solidarity with poor and vulnerable persons
- Our commitment to distributive justice and stewardship

The Uninsured Population (consists of):

- Individuals qualifying for charity
- Those not qualifying for charity but qualifying for discounted bills based on a means test (financial assistance)
- Those with some means that are to be given a discount from full charges

SHHS Policy on Discounts for the Uninsured

- All SHHS policy components are the same as the Ascension policy

- All SHHS policy components are the same as the Ascension policy

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Ascension Health Policy on Discounts for the Uninsured

SHHS Policy on Discounts for the Uninsured

Overall Objectives

- Ensure socially just practices for each of the three components of the population
- Financial relief related to charity care and financial assistance individuals will be administered under Policy 9
- Will cover acute care services and non-elective procedures

- All SHHS policy components are the same as the Ascension policy
- All SHHS policy components are the same as the Ascension policy.

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Ascension Health Policy on Discounts for the Uninsured

Will NOT cover:

- Payment arrangements with providers of Medical Savings Accounts
- International patients
- Deductibles and coinsurance

SHHS Policy on Discounts for the Uninsured

- SHHS policy same as the Ascension policy
- SHHS does qualify the patient for charity; state regulations allow charity write-offs for international patients to be included in disproportionate share dollars
- SHHS does quality the patients for charity, for example, in cases where patients have high deductibles or coinsurance payments

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Ascension Health Policy on Discounts for the Uninsured	SHHS Policy on Discounts for the Uninsured
Charity Care (Policy 9)	
For individuals with financial means up to 100% of the federal poverty limits, 100% of their account will be written off	SHHS policy the same as the Ascension policy
For individuals with financial means from 100% to 200% of the federal poverty limits, each local health ministry will devise a sliding scale write-off policy. Health Ministry must provide some form of discount.	SHHS writes off 100% of balance
Health Ministry can adjust FPL based on local wage index compared to national wage index.	SHHS uses federal poverty limit
LHM may require uninsured to work with financial counselor, apply for Medicaid or other public programs to quality for charity.	SHHS policy requires uninsured to work with financial counselor
Packaging payment programs are acceptable	SHHS policy the same as the Ascension policy (ex: package pricing for OB deliveries)
Nominal charges may be charged to charity patients	SHHS does not charge charity patients

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Ascension Health Policy on Discounts for the Uninsured

SHHS Policy on Discounts for the Uninsured

Financial Assistance (Policy 9)

- Each LHM must have financial assistance policy
- Policy must address eligible income and assets
- Determinations may be made on a case-by-case basis; review panel must exist to provide patient an appeal forum
- LHM can require patient to apply for public financial assistance

- SHHS has a financial assistance policy
- SHHS policy addresses eligible income and assets
- SHHS makes determination on a case-by-case basis; SHHS has informal process because we average only one appeal per year
- SHHS does require patient to apply for public assistance; SHHS has financial counselors to assist

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Ascension Health Policy on Discounts for the Uninsured

Uninsured with Means to Pay (new policy)

- Policy must address minimum discounts
- Discount based on best paying payor
- Best paying payor must be ≥3% of hospital revenue (can average several to get 3%)
- Discount may be adjusted to reflect that there are no prompt pay or volume discounts that are typically provided to managed care payors
- Prompt pay discounts must be given to all patients

SHHS Policy on Discounts for the Uninsured

- Currently, SHHS does not provide a discount for these patients; SHHS will develop appropriate policy based on Ascension guidelines once they are formally adopted
- Current prompt pay discounts are given to patients: 20% for all inpatient and outpatient if paid within 30 days of negotiation; 35% for all outpatient surgeries if paid within 30 days of negotiation

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Sacred Heart Health System

Ascension Health Policy on Discounts for the Uninsured

Billing and Collection Practices for Uninsured

Each Local Health Ministry:

- Will ensure employees treat all patients with dignity, respect and compassion
- Will ensure patients receive prompt access to charge information
- Has a duty to advise patients of all financial policies in patient's community language
- Shall offer non-charity patients who need financial assistance extended payment terms or other payment options based on financial status
- Ensure outstanding balances are pursued fairly and consistently
- Make financial counselors available to patients
- Post financial assistance and charity information in the admitting, registration and ER areas

SHHS Policy on Discounts for the Uninsured

- SHHS policy same as the Ascension policy
- Generally offer 10 month repayment plan; time lines for excessive account balances will be adjusted accordingly
- SHHS policy same as the Ascension policy
- SHHS has a patient's rights and responsibilities brochure

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Ascension Health Policy on Discounts for the Uninsured

Billing and Collection Practices for Uninsured

Liens on personal residences should be permitted only:

- If patients don't qualify for charity or financial assistance
- Patient non-compliant with payment arrangements
- Lien must not cause a foreclosure
- Collection agencies must have hospital approval

Garnishments should be permitted only:

- If patient's don't qualify for charity or financial assistance
- A court rules that financial income is sufficient
- Collection agencies must have hospital approval

SHHS Policy on Discounts for the Uninsured

- SHHS policy the same as the Ascension policy

- SHHS policy the same as the Ascension policy

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Sacred Heart Health System

Ascension Health Policy on Discounts for the Uninsured	SHHS Policy on Discounts for the Uninsured
Billing and Collection Practices for Uninsured	
Collections of a bill will not cause personal bankruptcy	• SHHS policy the same as the Ascension policy
Eligibility can be determined ANY time in the cycle	• SHHS policy the same as the Ascension policy
No bench warrants will be pursued	• SHHS policy the same as the Ascension policy
Interest can be charged only if: • Patient's don't qualify for charity or financial assistance • Patient is non-compliant with payment arrangements • No add-on to minimum discount has been applied	• Currently, we do not charge interest on outstanding accounts
Collection policies must follow Fair Debt & Collection guidelines	• SHHS policy the same as the Ascension policy

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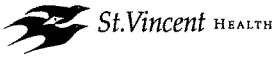

Uninsured & Underinsured Patient Management Program

Effective: July 1, 2004

Our Call to Action

Together we promise:

- ***Healthcare that works.***
- Healthcare that is safe.
- ***Healthcare that leaves no one behind.***

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St. Vincent Health Mission Statement

St.Vincent Health is a nonprofit, spiritually-centered health care system sponsored by Ascension Health. We are dedicated to the mission of improving the lives and health status of residents of Indiana through the provision of a continuum of holistic and high-quality healthcare services.

St.Vincent Health is compelled to make a positive and healing difference for those serviced by living the mission, vision and Core Values of Ascension Health while supporting the respective cultures and values of Network participants who share compatible but different core values

St.Vincent Health supports this mission by providing its participants with an improved access and ability to strengthen the quality of care and service coordination across the continuum in a values-focused environment with special concern for the sick and the poor.

St.Vincent Health will provide integrated healthcare services that prevent disease, promote wellness, and care for the sick and suffering. This will be carried out in a manner that is cost-effective and consistent with the Ethical and Religious Directives for Catholic Health Care Services approved by the National Conference of Catholic Bishops.

Our Call to Action

Together we promise:

Healthcare that works.

Healthcare that is safe.

Healthcare that leaves no one behind.

Core Values

The core values of St.Vincent Health are those of Ascension Health, namely:

Service of the Poor – generosity of spirit for persons most in need
Reverence – respect and compassion for the dignity and diversity of life
Integrity – inspiring trust through personal leadership
Wisdom – integrating excellence and stewardship
Creativity – courageous innovation
Dedication – affirming the hope and joy of our ministry

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Policy Statement

In accordance with our mission statement and Core Value of Service to the Poor and Ascension Health's (AH) Policy #9, it is the policy of St. Vincent Health (SVH) to establish and maintain a program whereby patients requiring emergency or urgent care with no insurance (uninsured) and with limited insurance (underinsured) are provided an opportunity to apply and be considered for financial assistance for their total charges or unpaid portion of their bill. SVH will create and maintain a process for effectively evaluating a patient's need for financial assistance without regard to race, color, religion, sex, age, national origin, citizenship or disability.

As stated in Policy #9, there are three types of patients as part of the uninsured population. These three patient types are as follows:

1. **Charity Care (CC):** Those who qualify as indigent under the HHS Poverty Guidelines;
2. **Financial Assistance Program (FAP):** Those who do not qualify as indigent, but have a demonstrated inability to pay for services; and
3. **Means to Pay:** Those with a demonstrated ability to pay for services (AH Policy #16)..

Using AH Policy #9 as a basis, the Uninsured and Underinsured Patient Management Program at SVH will constitute the following consideration:

A. Eligibility for governmental and local assistance programs:
   - Medicaid,
   - Medicaid/Medicare Disability, and
   - Federal, State and local grants or other healthcare assistance programs.
B. Charity care consideration based on household or family unit income level;
C. A sliding scale for those with incomes between 200% and 300% of the HHS Poverty Guidelines;
D. A discount for services for uninsured patients with income greater than 300% of the HHS Poverty Guidelines (AH Policy #16); and
E. Repayment terms for the unpaid, uninsured or underinsured portion of the bill.

Notification to the patient of this program will be conducted through signage in key waiting areas and access points, through patient statements/letters and telephone communication through all revenue cycle contact points.

Financial assistance will be provided by assessing the patient's household or family unit for their ability to pay. The income basis used for determining ability to pay will be the Federal HHS Poverty Guidelines as published annually at the following website:

http://aspe.hhs.gov/poverty/04poverty.shtml, (where 04= current year)

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The basis of this program is the truthful and accurate provision and submission of financial information from the patient and/or responsible party(ies). Patients and/or responsible party(ies) that intentionally misrepresent their household financial information will be automatically disqualified from any consideration whatsoever with regard to this program. Intentional misrepresentation determination is the sole right of SVH.

SVH reserves the right and authority to update, change or discontinue this program without any form of prior notification.

Accounting for the Uninsured & Underinsured Patient Management Program (UUPMP)

The financial impact of this program will be monitored and accounted for using a minimum of three specific transaction codes for the application of discounts and or adjustments to the account. These transaction codes are as follows:

Description	G/L Account
• Charity Care-Category I	Charity Care
• FAP Adjust-Category I	Charity Care
• Uninsured Discount	Administrative Adjustment

Screening Patients for Federal, State and Local Program Eligibility, Charity Care and Financial Assistance

An uninsured patient and/or the responsible party will be screened for financial assistance in the following manner:

1. Eligibility for Medicaid, Medicaid disability, Social Security disability and other Federal, State, HCI or local healthcare programs and/or grants.
2. Charity Care adjustment for those patients with documented income levels less than or equal to 200% of the HHS Poverty Guidelines (see chart on page 8).
3. Uninsured or Underinsured Patient Management Program as detailed in this document.

The criteria used for "A" above will be the established guidelines and policies provided by the governmental offices. Patients who appear to meet the criteria for any of these Federal, State or local programs **must apply for the programs and fulfill the application requirements for such programs and be denied coverage before being considered for "B" and/or "C" above**. If the patient fails to provide the Federal, State and/or local agency the information necessary to complete their application for assistance, they cannot be considered for "B" or "C" above. However, they will qualify for "D" above.

In some situations, insured patients may be eligible for the programs outlined in A, B and C above for the patient's liability portion of their bill and may be screened and assisted upon request.

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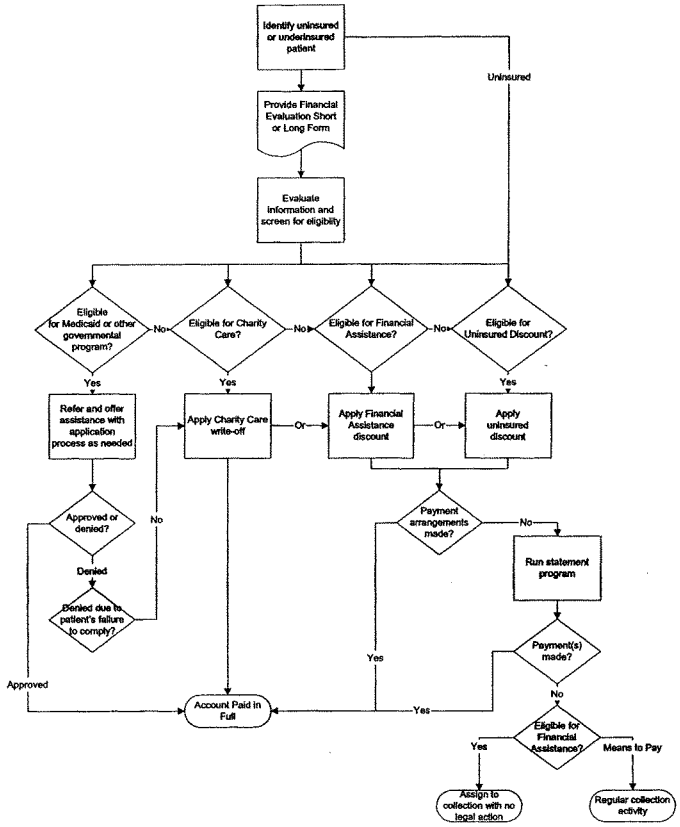
St. Vincent Health
Indianapolis, Indiana

IN, Indianapolis
St. Vincent Health
Uninsured & Underinsured
Patient Management Program

UUPMP Process Flow



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Medicaid Eligibility

If the patient appears to meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs, associates from the SVH ministry Financial Assistance Office (FAO) or their designee will:

- Inpatient - contact the patient and assist with the application process and ensure compliance with program requirements.
- Outpatient – contact the patient in person or by telephone and refer the patient to the appropriate program and provide a telephone number for assistance whenever possible.

If an inpatient case is denied coverage and we believe the denial of coverage was inappropriate, we will assist the patient in filing an appeal. If an outpatient is denied coverage and we believe the denial of coverage was inappropriate, at our discretion, we will assist the patient in filing an appeal.

Account balances for patients who receive services prior to the effective date of their Medicaid coverage will be written off as Charity Care. Account balances for services for a Medicaid recipient whose coverage ceases, is exhausted or receives services that are determined to be "non-covered services" by Medicaid will be written off as Charity Care.

Charity Care Eligibility

If the patient appears to meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs the patient must complete the application process and receive a denial before being eligible for Charity Care consideration.

If the patient's income level is less than 200% of the HHS Poverty Guidelines and does not meet criteria for Medicaid, Medicaid disability, Social Security disability and other Federal, State or local healthcare programs, they can be considered for Charity Care assistance. Charity care write-offs or adjustments may vary by type of service provided (see page 8).2

Patients who qualify for assistance will receive an identification card that will indicate their write-off or discount level within the SVH network of providers. Patients must reapply for Charity Care annually or whenever their financial situation changes significantly.

Account balances for patients who receive services prior to the effective date of Medicaid coverage will be written off as Charity Care. Balances for services for a Medicaid recipient whose coverage ceases or is exhausted will be written off as Charity Care.

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Financial Assistance Program (FAP)

Patients who meet the criteria of income between 200% and less than or equal to 300% of the HHS Poverty Guidelines will be eligible for a discount from total charges. They will also have a cap on their total liability for 12 months at 10% of their gross annual (calculated or anticipated) income (excluding co-payment amounts). Income is based on the total available or anticipated gross income for the household, regardless of the relationship between household members (see page 8).

Patients who qualify for assistance will receive an identification card that will indicate their discount level within the SVH network of providers. Patients must reapply for the FAP every six (6) months or whenever their financial situation changes significantly. Timing of reapplication may be adjusted or will be dependent on the individual's financial situation.

Discounts for FAP approved services are considered part of SVH's Charity Care program as Category I and are adjusted as partial Charity Care.

Means to Pay

Uninsured patients with income determination greater than 300% of the HHS Poverty Guidelines will be eligible for a discount from total charges of 20% at the time of final billing (see page 8). This discount from total charges will be considered an Administrative Adjustment and should be applied to the account with a specific transaction code to ensure ongoing reporting.

Insured patients with income determination greater than 300% are not eligible for a discount for their patient liability or non-covered services.

Appeal Process for Patients

If a patient wishes to appeal a determination with regard to Charity Care, Financial Assistance or Means to Pay, their written request and reason for an appeal should be directed to the Vice President – Finance responsible for the Revenue Cycle at St. Vincent Health or his/her designee with all pertinent forms and documentation. The Vice President of Finance or his/her designee will review the case and supporting documentation, discuss any and all pertinent issues with the patient, the responsible party and the locally sponsored ministry. A final decision with regard to the appeal will be issued in writing within 30 days of receipt of the written appeal.

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HHS Poverty and St. Vincent Income Guidelines

St. Vincent Health
2004 HHS Poverty Guidelines Calculation Table

Hospital Based Inpatient & Outpatient Services							
Household Size	Charity Care		Financial Assistance Program				Uninsured with Means to Pay
	100%*	200%*	225%	250%	275%	300%	>300%
1	[illegible]	[illegible]	$ 20,948	$ 23,275	$ 25,603	$ 27,930	
2	[illegible]	[illegible]	$ 28,103	$ 31,225	$ 34,348	$ 37,470	
3	[illegible]	[illegible]	$ 35,258	$ 39,175	$ 43,093	$ 47,010	
4	[illegible]	[illegible]	$ 42,413	$ 47,125	$ 51,838	$ 56,550	
5	[illegible]	[illegible]	$ 49,568	$ 55,075	$ 60,583	$ 66,090	
6	[illegible]	[illegible]	$ 56,723	$ 63,025	$ 69,328	$ 75,630	
7	[illegible]	[illegible]	$ 63,878	$ 70,975	$ 78,073	$ 85,170	
8**	[illegible]	[illegible]	$ 71,033	$ 78,925	$ 86,818	$ 94,710	
Classification	[illegible]	[illegible]	FAP3	FAP4	FAP5	FAP6	
Discount	100%	100%	90%	80%	70%	60%	20%
Discount Application	*1) Financial Assistance for the uninsured and Means to Pay discount is based on total charges.*						
	2) Insured discount is based on patient liability or balance due.						
Other Services Minimum Co-pay Amount (Patient Liability)							
Emergency Room	[illegible]	[illegible]	$75	$100	$125	$150	20% Discount
Employed or Participating Physician Office Visit	[illegible]	[illegible]	$25	$50	$75	$100	Full Charges

* - http://aspe.hhs.gov/poverty/04poverty.shtml, where 04= current year
** - For each additional person, add $3,180
*** - Maximum owed by any patient for 12 month period is 10% of gross household income for FAP hospital based inpatient and Outpatient services. There is no maximum for Other Services.

Evaluation of Applications

This program is primarily income based. However, extraordinary assets will be valued and added to the household or family unit's total income. Extraordinary assets are defined as those items over and above the basic needs of housing and transportation required for self-sufficiency. Examples of an extraordinary asset are: motorcycle (in addition to automobile), boat, four-wheeler, second home or additional land that is not used as part of a business or to provide income.

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Repayment of Patient Liability

SVH is not a financing institution and payment is due at time of service. In exchange for consideration and application of the FAP and Means to Pay program, patients are expected to pay their portion of discounted services at time of service or shortly thereafter.

In extenuating circumstances it may not be possible for patients to repay SVH providers within the locally sponsored ministry's designated timeframe. Therefore, provisions will be made with various lending institutions to provide monthly payment arrangements for patients who qualify for the FAP or Means to Pay, and are unable to pay in full within a reasonable timeframe. Patients will be referred to these financial institutions to make arrangement for payment (see page 16).

Collection of Unpaid Balances

When a patient and/or responsible party fail to pay their portion of the amount due, the account will be referred to a collection agency for collection. The amount of dollars due will be the amount of the debt as calculated under this program plus a collection fee, if applicable, and as set forth in the Consent for Treatment and Authorization for Payment document signed upon admission. If non-payment occurs, the healthcare provider **will not revert to full charges** as the amount of the debt.

Legal action for payment of unpaid balances will not be initiated against patients and/or the responsible party(ies) who qualify and are approved for FAP. However, the debt may be reported to the credit reporting agencies as an unpaid debt and will remain on the debtor's credit report until such time as the debt is paid in full.

Legal action will be initiated against those patients and/or responsible party(ies) who default on payment to SVH and have the Means to Pay (income greater than 300% of the HHS Poverty Guidelines). This legal action may include lawsuit, judgment, interest applied to the balance due as allowed by Indiana statute, property or estate lien(s) and garnishment of wages. Body attachments and foreclosure will not be used as a means to collect a debt regardless of the patient's income category.

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Appendix

Definitions:

Assets – Personal property and items of value owned by the patient and/or responsible party.

Elective Care – Care provided in non-urgent, non emergency situations. Healthcare services that benefits the patient and are not the result of a life threatening or health altering condition. Cosmetic or plastic surgery is considered elective care.

Emergency – A life threatening condition that requires immediate care from a licensed physician and nurses under the direction of a licensed physician.

Family Unit – Family unit consists of parent(s) with minor children residing at the current address listed on the registration form or adult child supporting a parent(s) within a single household.

Household Income – The total amount earned by all household members residing at one residential location. If there are multiple family units living in the household, then the family unit itself is to be counted for income and the other family units are excluded from total income calculations.

Income- Any and all dollars that assist the patient in self-sufficiency. Income can be the result of wages, investment income, rental income and other sources of cash for daily living expenses.

Support – If an applicant receives partial or full financial support from another individual within residence, then that individual's income is to be included in total gross income. If an applicant receives partial or full financial support from another individual outside the residence, then only the support amount is to be included in total gross income.

Uninsured – A patient and/or responsible party who does not have third party coverage or access to third party coverage through:

- their employer,
- spouse's employer,
- mother or father's employer, and/or
- significant other's employer

for healthcare services through no fault of their own and/or lack of availability through their employer.

Underinsured – A patient and/or responsible party who has third party coverage for healthcare services yet may have an extraordinary amount due that they cannot pay due to household or family unit income.

Urgent Care – Care that is not determined to be an emergency situation, but does require some level of attention to avoid further harm or deterioration of health in the near future.

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11/00

Financial Evaluation Long Form Cover Letter

June 9, 2004

RE: Patient –
Account Number –
Balance Due - $

Dear

In response to your recent request for financial assistance with your outstanding bill, the following documents are required:

- ☐ Completed Financial Evaluation Form (enclosed);
- ☐ A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s);
- ☐ A copy of your most recent three (3) paycheck stubs;
- ☐ A copy of your most recent three (3) bank statements for each account;
- ☐ A list of your outstanding medical debts and monthly pharmacy costs; and
- ☐ The name and telephone number for your Medicaid caseworker, if applicable.

Please return all documentation within the next ten (10) days to:

Should you have additional questions please contact me directly at (XXX) XXX-XXXX.

Sincerely,

Attorney-Client
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12/20

St. Vincent Health

Financial Evaluation Long Form

MR Number & Account Number to be completed by hospital personnel	MR Number:	Hospital:	Account Number:

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's Name:	Social Security Number:	Total Household Members:
Address:	Telephone Number: Home ( ) Work: ( )	
City/State/Zip:	Employer (Attach Employer Pay Stub)	

List ALL household member names	Date of Birth	Soc Sec Number	Relationship to patient	Monthly Income
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$

Monthly Income		Monthly Expenses	
Responsible Party's Gross Income (before taxes)	$	Rent/Mortgage/Homeowner's Insurance	$
Other Household Gross Income (before taxes)	$	Utilities (Electricity/Water/Gas)	$
Investment Income (Annuities/Stocks/Dividends)	$	Telephone	$
Child Support/Alimony Received	$	Child Support/Alimony Paid	$
Rental Property Income	$	Food (including cigarettes & alcoholic beverages)	$
Pension/Retirement/Unemployment	$	Car Payment (loan + insurance)	$
Other:	$	Medical & Pharmacy Bills	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$

Assets		Liabilities	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account Balance	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's/Retirement Funds	$	Auto Loan Balance	$
Value Auto/Boat/Motorcycle	$	Total Medical Bills (attach list)	$
Other:	$	Real Estate Taxes	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through St. Vincent Health. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by St. Vincent Health to obtain such assistance and will assign to St. Vincent Health, and upon receipt will pay to St. Vincent Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Vincent Health will result in the denial of this application. I also authorize St. Vincent Health to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party) _____ Date _____

C:\Data\Uninsured\Financial Evaluation Form.doc

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St. Vincent

Financial Evaluation Short Form
Account Balances Less than $300

[illegible]	[illegible]	[illegible]
		[illegible]

June 9, 2004

RE: Patient –
Account Number –
Balance Due - $

Dear

Please complete the information below and return this form to the address above.

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible] Home ( ) Work ( )
[illegible]	

List All Household Member Names	Date of Birth	Social Sec Number	Relationship to patient	Monthly Income
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$
			Total Monthly Income	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through St. Vincent Health. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by St. Vincent Health to obtain such assistance and will assign to St. Vincent Health, and upon receipt will pay to St. Vincent Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Vincent Health will result in the denial of this application. I also authorize St. Vincent Health to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party) _____ Date _____

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St. Vincent Health
Indianapolis, Indiana

IN, Indianapolis
St. Vincent Health
Uninsured & Underinsured
Patient Management Program

St. Vincent Health

Financial Evaluation Worksheet for Both Long and Short Forms

For Hospital Use Only

MR Number:	Account Number:	Hospital:
Patient Name:		Responsible Party Name:

Financial Evaluation

DOCUMENTATION PROVIDED	MEDICAID REFERRAL?: (Select only one item below)	EXPIRATION DATE / APPLICATION DENIED (Select only one item below)
O Financial Evaluation Short Form Note: Patient will not receive a UUPMP ID card for Short Form approval. Supporting Documents Attached Select as many as are applicable: ☐ Financial Evaluation Long Form ☐ Federal Tax Forms with appropriate attachments ☐ Self-Employed Patients or Responsible Party Worksheet ☐ 3 Paycheck stubs ☐ 3 Bank Statements ☐ List of medical debts ☐ Name & telephone number of Medicaid caseworker ☐ Other:_____	O Screened, not Medicaid eligible. O Medicaid eligible, referral made, Medicaid eligibility and/or application denied. MEDICAID APPROVAL PENDING? O Medicaid eligible, referral made and application submitted, Medicaid approval pending. Note: A UUPMP ID card will not be issued while Medicaid approval is pending. You must update the database to one of the first two Medicaid Referral selections above in order for an ID card to be issued. APPLICATION APPROVAL Approved for discount as follows: O CC1 (≤100%) O CC2 (>100% and ≤200%) O 90% FAP3 O 80% FAP4 O 70% FAP5 O 60% FAP6 Note: Patients who complete the Financial Evaluation Short Form will not receive a UUPMP ID card upon approval.	EXPIRATION DATE O 6 month authorization O 12 month authorization APPLICATION DENIED O Failure to apply, comply with data requirements and/or follow through with Medicaid application O Insufficient information or data provided O Income level determined to be "Means to Pay" (income > 300%) O Applicant provided inaccurate or false data O Other:_____

Comments:

Account Representative Signature:	Print Name:
Telephone & extension #:	Date:

C:\Data\Uninsured\Financial Evaluation Worksheet.doc

Attorney-Client
Privileged Information

St. Vincent HEALTH

SAMPLE

January 1, 2004

Mr. John Doe
1234 East Street
Indianapolis, IN 46062

RE: Financial Assistance Application

Dear Mr. Doe:

Your application for Financial Assistance has been reviewed and approved. The initial period of coverage expires 06/30/2004.

The identification cards provided below along with a photo ID (i.e. driver's license) will allow you or a household member listed on the card to receive services from St. Vincent Health affiliates at a discounted rate. You will be responsible for full payment for the following amounts:

Hospital Inpatient and Outpatient Acute Care	XX% of total services (up to 10% of your annual income)
Hospital Emergency Room Visit	$XX.00
Hospital Employed Physician Office Visit	$XX.00
Participating Physician Office Visit	$XX.00
Primary Care Clinic Visit	$XX.00

Should you have additional questions or should your financial situation change significantly from what you originally reported, please contact (317) XXX-XXXX.

Sincerely,

St. Vincent HEALTH — Financial Assistance Program

Name	SSN
Doe, John	123-45-6888
Doe, Jane	123-45-6888
Doe, Johnny	123-45-6888
Doe, Janie	123-45-6888

PATIENT LIABILITY

Hosp Acute%	ER	EmpDrOffice	PrimCareClinic
10%	$75	$25	$15
Expiration		Member ID#	Plan Code
06/30/2004		123456	U010

St. Vincent HEALTH — Financial Assistance Program

Name	SSN
Doe, John	123-45-6888
Doe, Jane	123-45-6888
Doe, Johnny	123-45-6888
Doe, Janie	123-45-6888

PATIENT LIABILITY

Hosp Acute%	ER	EmpDrOffice	PrimCareClinic
10%	$75	$25	$15
Expiration		Member ID#	Plan Code
06/30/2004		123456	U010

C:\Data\Uninsured\Identification Form Letter.doc

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110/.

SAMPLE

(Back Printing)

St. Vincent Health — Financial Assistance Program Please direct all inquiries to: (317) XXX-XXXX St. Vincent Health P.O. Box XXXX Indianapolis, IN 46280 Not all physician practices participate in this program. You will need to contact the physician's office where services were provided. THIS IS NOT AN INSURANCE CARD	St. Vincent Health — Financial Assistance Program Please direct all inquiries to: (317) XXX-XXXX St. Vincent Health P.O. Box XXXX Indianapolis, IN 46280 Not all physician practices participate in this program. You will need to contact the physician's office where services were provided. THIS IS NOT AN INSURANCE CARD

C:\Data\Uninsured\Identification Form Letter.doc

17/..

Proof of Income for
Self-Employed Patients/Responsible Party

Dear _____:

It is our understanding that you have requested financial assistance for your healthcare services and are unable to produce the normal routine documentation due to your self-employed status. Please provide the following information for the next eight (8) weeks:

Week	Business Income	Business Expenses	Your "Take Home" Pay
1	$.	$.	$.
2	$.	$.	$.
3	$.	$.	$.
4	$.	$.	$.
5	$.	$.	$.
6	$.	$.	$.
7	$.	$.	$.
8	$.	$.	$.
Total	$.	$.	$.

Return this information immediately after completion of the eight week period to:

[Insert Hospital name, address and department here]

Sincerely,

St. Vincent Health

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101

Financing Programs for Accounts Receivables

Objective: Reduce the amount of patient responsibility accounts receivable by offering financing options for our customers. The programs offered must be viewed as a positive by our patients and lead to an increase in customer satisfaction. Charge Card payments are promoted for payment in full. This financing in conjunction with a prompt pay discount is easy to implement and costs only the charge card administrative fee.

Concept: Patients will be encouraged to pay their accounts in full by selecting personal financing from a variety of options. The intent of the overall program is to remove obstacles for payment in full. The following options have been identified:

Option 1: A negotiated prompt pay discount for payment in full within the first statement cycle.

Option 2: Fifth Third Bank (5th/3rd) Loan program is a full recourse program that will buy any account with a balance over $ 1000. The interest charged on these accounts is based upon the variable rate at the time of the loan. St. Vincent shares in the spread earned on these accounts.

The check is paid directly to St. Vincent for the full amount of the receivable. Should the account go delinquent, St. Vincent will buy back the loan of the current balance, plus interest. The current default rate is approx. 15%. (This is based on defaults to date and probably is higher if we do not include active accounts) The account is set back up in the system, transferred to Bad Debt and forwarded to Hardamon & Associates to pursue legally. The program is very easy to implement and involves the following steps:

1. Completing the contract over the phone with the patient.
2. Mailing the contract to the patient.
3. Upon receipt of the signed contract, notifying Fifth Third.
4. Fifth Third remits account balance in full to St. Vincent.

Option 3: Personal Finance Company loan program is a no recourse program that will buy certain accounts subject to credit approval. The minimum eligible balance for this program is $250. Personal Finance charges no interest to the patients who are approved for this program if they can pay the account off within 12 months. They reimburse St. Vincent 96% of the accounts that establish a six month payment plan and 92% of the accounts that establish a 12 month payment plan.

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1a/.

Those patients who need to pay off the balance over a longer term have an interest rate structure based upon the length of term. This rate normally is higher than the rate charged by Fifth Third and is therefore not a very good option for our customers. St. Vincent is currently experiencing a 90% approval rate for this program. The program is easy to implement and involves the following steps:

1) An application is taken over the phone with the patient.
2) The application is faxed to PFC.
3) PFC returns application either approved or rejected within 15 minutes.
4) A contract is filled out by the St. Vincent associate and mailed to the patient.
5) The patient returns the signed contract to the St. Vincent associate.
6) The contract is picked up by PFC and a check issued to St. Vincent.

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MI, Detroit
St. John Health

Response to Question # 3 from St. John Health System

The Detroit hospitals utilize comprehensive training materials for all associates involved in the revenue cycle, including scheduling, insurance verification and details regarding specific input items required by their information systems. In order to be responsive to Question #3, those pages pertaining specifically to charity and uninsured patients have been excerpted from the full package of training materials and are presented on the following pages.

The information included to respond to Question #3 covers the following topics:

- Role of Financial Counselors
- Patient access
- Addressing the needs of the patient
- The Financial Counseling process
- Providing estimates of charges
- Payment plans
- Applications for financial assistance

Revenue Cycle Excellence – Patient Access

Financial Counseling Training

May, 2004

MI, Detroit
St. John Health

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Definition of Financial Counseling

Financial counseling is the process of assisting patients/families in meeting their financial obligations for care.

A Financial Counselor may:

→ interview patients and families to ensure accurate and comprehensive financial information is on file in the hospital systems

→ coordinate with insurance carriers and/or case managers to determine healthcare coverage and options

→ advise families of estimated charges for services

→ advise families of available financial assistance programs

→ assist families in the completion of financial screening and / or applications for assistance programs

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How Does Financial Counseling Fit Into The Financial Clearance Center Processes?

→ Financial Counselors **proactively** address the needs of a specified patient population:

- Patients with scheduled services (in-patient and out-patient visits) **AND an outstanding self-pay balance greater than $1000**
- Admissions, out-patient *procedures* or ED visits where the financial class is **self-pay**
- All patients with scheduled services (in-patient and out-patient visits) **AND an outstanding self-pay balance greater than $1000**
- Patients with a scheduled visit, admission or procedure AND a history of non-payment or a self-pay balance that has been coded to bad debt
  History of non-payment = payments not received within 30 days following the date of a self-pay invoice
- Patients with an **out-of-pocket or stop loss amount > $1000**
- Patients assigned a **charity care** status

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What Does the Financial Counselor Do?

- → Contacts the patient, parent or guardian to review financial obligations
- → Determine patient eligibility for public/private assistance programs
- → Assist patient with financial screening and/or application to public/private assistance programs
- → Collect information and develop payment plans
- → Assist the patient with application for charity care
- → Document all information in the system

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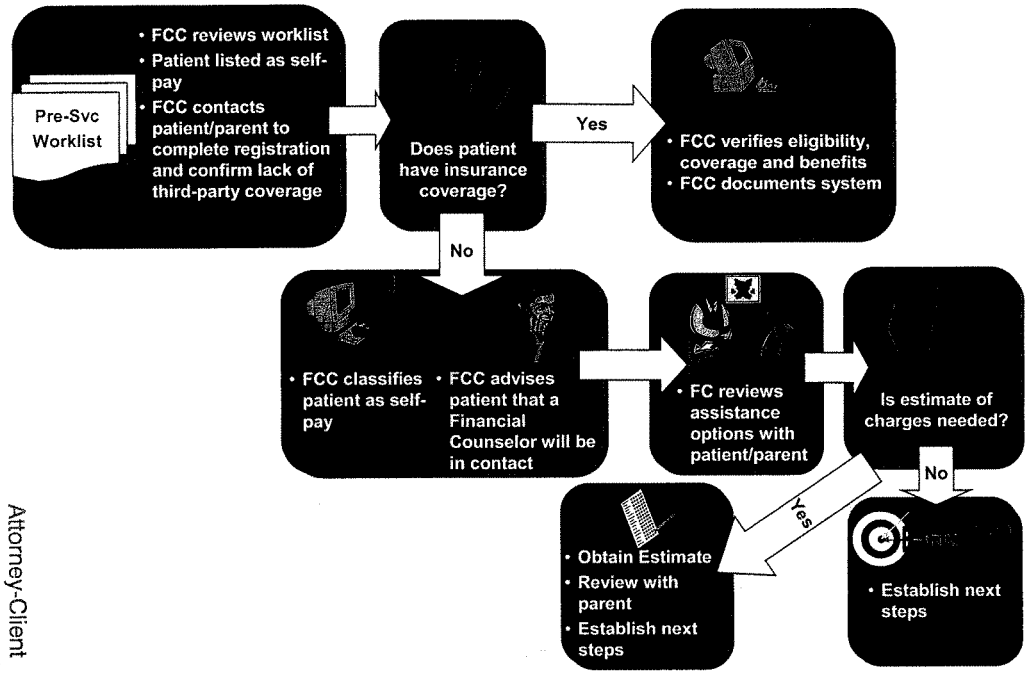
MI, Detroit
St. John Health

Financial Counseling Needs Determined By Financial Clearance Center (FCC) Rep During Pre-Processing



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The Worklist for Financial Counselors

→ Financial Counselors use an automated PART Worklist to pre-process scheduled patients

→ The worklist prints daily and is sorted by service groupings and payer

→ The worklist contains patients with visits scheduled two weeks out from current date, with the most recent dates appearing first

→ Only those patients with pre-processing requirements will appear on the report. This includes:

- Patients with required benefit verification
- Patients with required authorization
- Patients with referral
- **Patients with financial counseling requirements**
  - **self pay**
  - **charity care**
  - **over threshold / past balances**

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Financial Counseling Process

→ **Step #1** - Receive daily worklist

- Worklists are printed / distributed to Financial Counselors

→ **Step #2** - Prioritize accounts for intervention

- Direct admissions
- Walk-ins
- Date of scheduled service
- Amount of outstanding balance

→ **Step #3** - Determine the current/past history by reviewing:

- System notes
- Patient A/R balance
- Patient account history

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Financial Counseling Process (continued)

→ **Step #4** - Contact patient, parent or guardian (as applicable) and:

- Determine if the patient has any health care coverage (Note: at SJH&MC, the PBS Financial Clearance associate will check on line if insurance is present)
- Determine if patient has made prior application to public assistance programs

→ **Step #5** - If health insurance is present

- Contact the payor, collect & document:
  - effective date of coverage
  - eligibility
  - benefits (deductible, out of pocket)
  - policy limitations
  - referral or authorization requirements
- Obtain a referral/authorization if required
- Enter data to system

Please note:
This step may be transferred to financial clearance team

→ **Step #6** - If no health insurance is present

- Determine if the patient should apply for public assistance programs
- Assist patient with financial screening / application to appropriate programs

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Financial Counseling (continued)

→ **Step #7** - If the patient is not eligible for public assistance programs:

- Advise patient of full responsibility for payment of services
- Determine if patient wants an estimate of charges

→ **Step #8** - If the patient requests an estimate of charges

- Obtain the estimate of charges and communicate to the family
- Determine if:
  - the patient will pay 100% of the charges on the date of service
  - a payment plan is necessary
  - the patient requests or requires other assistance (e.g. charity care)

→ **Step #9** - If a payment plan is necessary

- Check if current payment plan is in effect
- Inform the patient that the plan is based on an ESTIMATE of charges
- Review payment terms with patient

Financial Counseling (continued)

→ **Step #10** - If the patient will apply for charity care (partial or full)

- Complete initial financial screening for those patients who are determined not to qualify for Medicaid
- Complete Charity Care application with the patient

Note: As of 5/04, this policy is in DRAFT form with expected completion date of 7/04

→ **Step #11** - Document

- document all actions taken and follow-up steps necessary

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MI, Detroit
St. John Health

PAYMENT PLANS

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Payment Plans are Developed Within Specified Guidelines

Example – to be coordinated Credit & Collection Policy

Account Balance Maximum	Initial Deposit	Minimum Monthly	Payment Months
$25- $500	Payment in Full		
>$500	$xx	$xx	12 months

- Supervisor approval required to extend payment period for an additional year
- Balances over $5,000 are referred to the Team Leader/Manager for Approval
- Payment plan set up cannot exceed 12 months

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MI, Detroit
St. John Health

ESTIMATING CHARGES FOR SERVICES

Attorney-Client
Privileged Inform

MI, Detroit
St. John Health

Attorney-Client
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Estimate of Charges Process

→ The Financial Counselor contacts the Patient Access Center Clinical Liaison

→ The clinician determines and documents the anticipated clinical needs that the patient will have over the course of treatment

→ The Financial Counselor completes the estimate using the online charge master/rate book for the specific anticipated patient services listed by the clinician

→ The Clinical Liaison and Financial Counselor sign off on the estimate document when complete

→ The Financial Counselor will summarize the estimated patient charges in the **ESTIMATE ONLY** patient letter and communicate to the patient

→ The estimate of patient charges worksheet is filed in the patient's financial record

→ All steps are documented in system

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Estimate of Charges Worksheet

ESTIMATE OF PATIENT CHARGES

PATIENT NAME: _____ MRN: _____
PRIMARY DIAGNOSIS: _____
PROCEDURE: _____ DATE: ___/___/____

Description	Amount/Unit	Total Charge
Pre-Op Resources		
OR Time		
Surgical Supplies		
ICU Days		
Step Down Days		
Post Acute Nursing Floor Days		
Radiology		
Physical Therapy/Rehabilitation		
Laboratory		
Pharmacy		
Specialty Consults		
Follow Up Office Visits		
Outpatient Care		
Other:		
TOTAL SUM OF CHARGES		

CHARGES ESTIMATED BY:

Clinician: _____ _____
___/___/___
(Print name) (Signature) (Date)

Financial Counselor: _____ _____ ___
/___/___
(Print name) (Signature) (Date)

To be prepared by CSB if estimated charges for services are not straightforward (e.g. Radiology procedures w/ multiple components

MI, Detroit
St. John Health

APPLICATION FOR ASSISTANCE

Medicaid, charity care, Hardship, VODI, FIA

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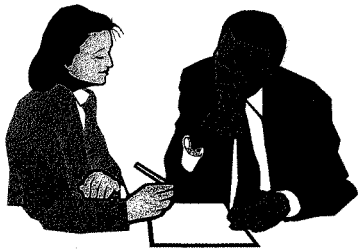
Application for Public/Private Assistance Programs

→ Financial Counselors identify pubic or private assistance programs that may be applicable for the patient situation

→ The Financial Counselor assists the patient in completing the appropriate applications

→ Coordination with the outreach worker may be necessary to determine application status



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Application for charity care

→ When the patient does not qualify for any private or public assistance programs, the Financial Counselor will prepare an application for charity care

- Complete the demographic & financial information
- Present information to the supervisor for approval and signature
- When approved, submit information via on-line process
- Communicate to the patient
- Document approval in system

To be coordinated w/current MA Application process

Attorney-Client

Voices of Detroit (VODI)

→ **The Voices of Detroit Initiative (VODI) program was designed to assist uninsured residents fo the cities of Detroit, Highland Park, and Hamtramck obtain health services and preventative care.**

→ **To qualify for the VODI program, an individual needs to be between the ages of 18-64, low income, and uninsured.**

→ **VODI Health Clinics:**

- **Mercy Primary Care Center** – 5555 Conner, (313) 579-4000
- **St. John Community Health** – 3000 Gratiot, (313) 567-7462
- **Northeast Health Center** – 5400 E. 7 Mile Rd, (313) 852-4231
- **Thea Bowman Community Health Center** – 20548 Fenkell Ave., (313) 255-3333

→ **Some of the services provided include:**

- Primary care visits including annual physicals, sick visits, and follow-up care
- Lab work of electrolytes, bun, Cr, glucose, UA, CBC, PSA, cholesterol, VDRL
- Coordinated referrals for mammogram and dental
- Pharmaceuticals
- Health education classes
- Care management

VODI does NOT cover surgery or emergency care
(Medicaid may be able to be processed to cover non-covered services)

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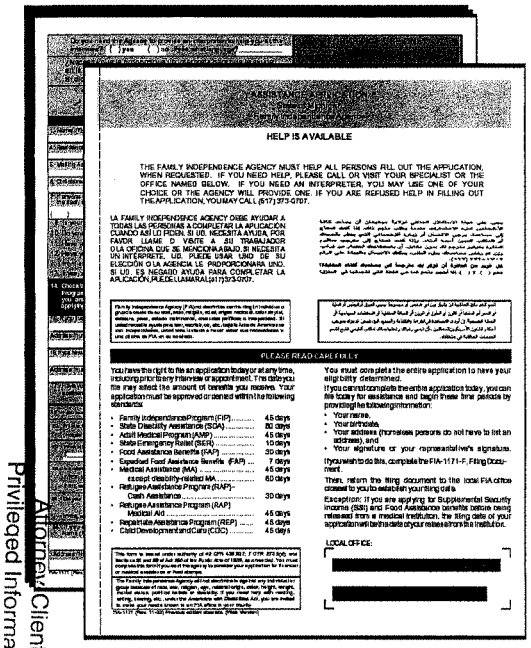
Family Independence Agency (FIA)



HELP IS AVAILABLE

THE FAMILY INDEPENDENCE AGENCY MUST HELP ALL PERSONS FILL OUT THE APPLICATION, WHEN REQUESTED. IF YOU NEED HELP, PLEASE CALL OR VISIT YOUR SPECIALIST OR THE OFFICE NAMED BELOW. IF YOU NEED AN INTERPRETER, YOU MAY USE ONE OF YOUR CHOICE OR THE AGENCY WILL PROVIDE ONE. IF YOU ARE REFUSED HELP IN FILLING OUT THE APPLICATION, YOU MAY CALL (517) 373-0707.

LA FAMILY INDEPENDENCE AGENCY DEBE AYUDAR A TODAS LAS PERSONAS A COMPLETAR LA APLICACIÓN CUANDO ASÍ LO PIDEN. SI UD. NECESITA AYUDA, POR FAVOR, LLAME O VISITE A SU TRABAJADOR O LA OFICINA QUE SE MENCIONA ABAJO. SI NECESITA UN INTERPRETE, UD. PUEDE USAR UNO DE SU ELECCIÓN O LA AGENCIA LE PROPORCIONARA UNO. SI UD. ES NEGADO AYUDA PARA COMPLETAR LA APLICACIÓN, PUEDE LLAMAR AL (517) 373-0707.

PLEASE READ CAREFULLY

You have the right to file an application today or at any time, including prior to any interview or appointment. The date you file may affect the amount of benefits you receive. Your application must be approved or denied within the following standards:

- Family Independence Program (FIP) ..... 45 days
- State Disability Assistance (SDA) ..... 60 days
- Adult Medical Program (AMP) ..... 45 days
- State Emergency Relief (SER) ..... 10 days
- Food Assistance Benefits (FAP) ..... 30 days
- Expedited Food Assistance Benefits (FAP) ... 7 days
- Medical Assistance (MA) ..... 45 days
  - except disability-related MA ..... 60 days
- Refugee Assistance Program (RAP) - Cash Assistance ..... 30 days
- Refugee Assistance Program (RAP) Medical Aid ..... 45 days
- Repatriate Assistance Program (REP) ..... 45 days
- Child Development and Care (CDC) ..... 45 days

You must complete the entire application to have your eligibility determined.

If you cannot complete the entire application today, you can file today for assistance and begin these time periods by providing the following information:

- Your name,
- Your signature,
- Your address (homeless persons do not have to list an address), and
- Your signature or your representative's signature.

If you wish to do this, complete the FIA-1171-F, Filing Document.

Then, return the filing document to the local FIA office closest to you to establish your filing date.

Exception: If you are applying for Supplemental Security Income (SSI) and Food Assistance benefits before being released from a medical institution, the filing date of your application will be the date of your release from the institution.

LOCAL OFFICE:

[redacted]

[redacted]

Privileged Information

Attorney Client

1300 Massachusetts Avenue
Troy, New York 12180

518/268-5000

NY, Troy
Seton Health System, Inc.

Katherine,

Per your request, please note the following changes/modifications made by Seton Health in Troy, NY.

We have modified our Financial Assistance Policy as follows:

The previous policy granted allowances to a maximum of 90% if the patient had income that was less than 100% of the FPL. The old policy also afforded allowances ranging from 10% to 80% if your income was between 101% and 200% of the FPL. The new policy provides a 100% allowance if your income falls below 150% of the FPL and also provides for allowances, in 25% increments should your income fall between 151% and 300% of the FPL. (new policy attached)

All staff has been trained, via in-servicing, on the changes either by the Director of Admitting, the Collection Manager or our VP of Mission Services. The training included copies of the income guidelines, revised applications, as well as the revised policy. All front-end staff have been educated at this time.

Also included is a copy of our self- pay brochure, which provides a comprehensive outline of all potential opportunities available to our uninsured or underinsured population.

Still in process is the inclusion of the addendum to our Collection Agency agreements.

Please let me know if you require anything further.

Sincerely,

Robert H. Seabury Jr.
AVP Patient Financial Services

Cc: Scott St. George CFO

Attorney-Client
Privileged Information

NY, Troy
Seton Health System, Inc.

TITLE: Seton Health Financial Assistance Program

POLICY# 113

PURPOSE: To ensure that patient's of Seton Health that are unable to meet their financial liability are provided assistance if qualified.

POLICY: Seton Health will provide Financial Assistance to patient's who are experiencing financial hardship that precludes them from meeting the financial responsibility for the services rendered at one of Seton Health's facilities. The ultimate determination of assistance will be based upon the most recently published Federal Poverty Guidelines. This program is intended to be a temporary assistance for our patient's and should not be viewed as an alternative to health insurance.

PROCEDURE: **COVERED SERVICES**

All medically necessary hospital services are eligible for coverage under this policy, including any co-payment, co-insurance or deductibles.

All physician services rendered by an employed physician of Seton Health are eligible for coverage under this policy.

Emergency room services are eligible for coverage under this policy.

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NY, Troy
Seton Health System, Inc.

ELIGIBILITY

Eligibility will be determined by comparing the household income, either current or for the prior income tax period to the Federal Poverty levels for the period of application. Those patients/guarantors who's income falls below 250% of the Federal Poverty level for their family size will be deemed eligible. Financial Assistance will be provided as follows:

Less than 150% of FPL will be granted 100% assistance
150% to 200% of the FPL will be granted 75% assistance
200% to 250% of the FPL will be granted 50% assistance
250% to 300% of the FPL will be granted 25% assistance.

It is assumed that patients approved for less than 100% assistance will make ever effort possible to pay the remaining owed balance to Seton Health within a reasonable time. Additionally, during the application process, Seton Health's Financial counselors will review the guarantor's financial situation and screen them for possible future coverage under one of the many State/County sponsored health insurance initiatives.

As part of the application process patients may be required to provide copies of bank statements, W2 forms, current pay stubs or other documentation deemed necessary by Seton Health to make a decision on eligibility.

All applications should be completed and returned to the Patient Financial Services Department as soon as possible. The Patient Financial Services Department will process all applications within 5 business days of receipt and notify patients/guarantors of our decision by phone and mail. Determination of coverage will be deemed in effect for a 90 days period from the date of approval unless the patient/guarantors financial situation significantly changes.

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NY, Troy
Seton Health System, Inc.

APPROVALS

All completed applications will be processed by designated employees of Seton Health. Should it be determined that a patient is eligible the completed application will be presented to the Collection Manager for final approval and signature. Should the patient feel that their application was denied in error they could request a review, which will be completed by the AVP of Patient Financial Services. This review will be completed within 5 business days of receipt.

Once approved all open accounts covered by the application will be relieved consistent with Seton Health allowance procedures.

_____
Gino J. Pazzaglini, FACHE
President/CEO

Revised 5-1-04

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Child H[illegible] Plus
800-698-4543
New York State program available for children under the age of 19 years who reside in New York State whose families are income qualified.
www.health.state.ny.us/nysdoh/chplus

Family Health Plus
877-934-7587
Public health insurance program for uninsured income eligible adults between the ages of 19 and 64 years old.
www.health.state.ny.us/nysdoh/fhplus

Healthy New York
866-432-5849
Health insurance plan for individuals, small employers, and sole proprietors.
www.ins.state.ny.us/healthny.htm

Healthy Women Partnership
518-268-5458
No cost or low cost Breast and Cervical Cancer Screening Program for women who are:

- 40 years of age or over (18 years of age or over for pelvic exam and pap tests)

- Have no health insurance
  or
- Have limited health insurance
  and
- Meet program income guidelines

8/5

Seton Health Syst[illegible] Inc.

SETON HEALTH
St. Mary's Hospital

Alternatives and Assistance for Individuals Without Health Insurance

Credit and Collections Department
55 Mohawk Street
Cohoes, New York 12047
518-268-4901

Insurance Coordinator
1300 Massachusetts Avenue
Troy, New York 12180
518-268-5458

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1520

eton Health System's Mission is to serve all ersons with special attention to those who ɔ not have access to healthcare. Everyday e assist individuals who do not have health surance with opportunities for enrollment, s well as financial assistance for medical ervices. Our financial counselors are here help you in a private and respectful setting

he following forms of payment are available:

Cash, checks, money orders, cashier's checks, Visa, MasterCard, American Express, Discover

Check-by-phone payments. To use this option, call toll-free 888-571-7949.

Installment Payment Plan for medical services. Please call the Seton Health Credit and Collection Department at 518-268-4901 or toll-free 888-571-7949. There are no finance charges on installment payment plans.

- Seton Health Charity Care/Financial Assistance offers reduced charges to eligible patients. Our Financial Assistance Program is not an insurance plan. It is intended to offer temporary assistance. Approval is valid for 90 days. For an application or more information about this program, please contact the Seton Health Credit and Collection Department at 518-268-4901.

- Seton Health can assist you with the application process for Child Health Plus, Family Health Plus, Healthy Women Partnership Program, and Medicaid enrollment. Please contact our Insurance Coordinator for enrollment opportunities at 518-268-5458.

You may also contact the Department of Social Services in your county of residence:

Albany County DSS
518-447-7300
162 Washington Avenue, Albany, NY 12210

Columbia County DSS
518-828-9411
25 Railroad Avenue, Hudson, NY 12534

Rensselaer County DSS
518-283-2000
133 Bloomingrove Drive, Troy, NY 12180

Saratoga County DSS
518-884-4140
152 West High Street, Ballston Spa, NY 12020

Schenectady County DSS
518-388-4470
487 Nott Street, Schenectady, NY 12308

Member of

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Child H[illegible] Plus

800-698-4543

Este programa del estado de Nueva York es disponible para los niños desde 19 años y menor que viven en el estado de Nueva York y tienen una familia que reúnen los requisitos necesarios de ingresos.

www.health.state.ny.us/nysdoh/chplus

Family Health Plus

877-934-7587

Este programa de seguro de enfermedad público es para los adultos sin seguros que reúnen los requisitos necesarios de ingresos y tienen entre 19 a 64 años.

wwww.health.state.ny.us/nysdoh/fhplus

Healthy New York

866-432-5849

Un plan de seguros de enfermedad para individuos, las empresas pequeñas, y los propietarios únicos.

www.ins.state.ny.us/healthny.htm

Healthy Women Partnership

518-268-5458

Un programa de costo mínimo o sin costo de las revisiones del cáncer de pecho y del cuello del útero para mujeres que:

- Tienen 40 años o más (18 años o más para el examen del pélvico y los exámenes de citología)
- No tienen seguro de enfermedad

O

- Tienen seguros de enfermedad restringidos

Y

- Cumplen con los requisitos de ingresos del programa

Rev 7/9/04 606-21b

SETON HEALTH

St. Mary's Hospital

Los Alternativos y La Asistencia Para Los Individuos Sin Seguro De Enfermedad

El Departamento del Crédito y Cobro
55 Mohawk Street
Cohoes, New York 12047
518-268-4901

El Coordinator de Seguros
1300 Massachusetts Avenue
Troy, New York 12180
518-268-5458

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SETON HEALTH

St. Mary's Hospital

La misión del sistema de Seton Health es servir a todas las personas con una atención especial a éstas que no tienen el acceso a los seguros de enfermedad. Todos los días ayudamos a los individuos que no tienen el seguro de enfermedad con las oportunidades de inscripción, también ayudamos con la asistencia económica para los servicios médicos. Nuestros consejeros económicos están aquí para ayudarle en un entoro privado y respetuoso.

Las formas siguientes de pago están disponibles:

- En efectivo, con cheques, con un giro postal, con un cheque bancario, con Visa, Mastercard, American Express, o Discover
- Pagar por cheque por el teléfono. Para utilizar esta opción, llame gratuitamente al 888-571-7949
- Pagar con un plan de financiación para los servicios médicos. Por favor, llame al Departmento del Crédito y Cobro al 518-268-4901 o gratuitamente al 888-571-7949. No hay cobros financieros al pagar con el plan de financiación

- El cuidado de caridad de Seton Health/La Assistencia Financiera ofrece a los pacientes elegibles precios reducidos. Nuestro Programa de la Asistencia Financiera no es un plan de seguros. Se trata de ofrecer la asistencia temporaria. La aprobación es válida por 90 días. Para una solicitud o más información acerca de este programa, por favor contáctese con el Departamento del Crédito y Cobro de Seton Health al 518-268-4901.
- Seton Health puede ayudarle con el proceso de solicitar para inscribir en los programas de Child Health Plus, Family Health Plus, Healthy Women Partnership Program, y Medicaid. Por favor, contáctese con el Coordinator de Seguros para las oportunidades de inscripción al 518-268-5458.

Member of ASCENSION HEALTH

También Ud. puede contactarse con el departmento de Servicios Sociales en su condado de residencia:

Albany County DSS
518-447-7300
162 Washington Avenue, Albany, NY 12210

Columbia County DSS
518-828-9411
25 Railroad Avenue, Hudson, NY 12534

Rensselaer County DSS
518-283-2000
133 Bloomingrove Drive, Troy, NY 12180

Saratoga County DSS
518-884-4140
152 West High Street, Ballston Spa, NY 12020

Schenectady County DSS
518-388-4470
487 Nott Street, Schenectady, NY 12308

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WI, Milwaukee
Columbia St. Mary's

CHARITY CARE

EXAPMLE 1

Patient is single with no dependents
Has an annual income of $12.985
Savings account of $150, Checking account $82.45
Patient rents and owns a 1995 Ford Taurus valued at $6000
He has no other assets
His CSM bills total $3,245

Total percent of Charity Care =

EXAMPLE 2

Patient has 2 dependents
Has an annual income of $35,900
Savings account of $2,000, Checking account $835.68
Owns home valued at $110,000 has $10,200 equity
Owns two vehicles, a 1997 Toyota value $3,500 and a 2000 Chevy
Value $4000
Has no other assets
His CSM bills total $10,500

Total percent of Charity Care =

EXAMPLE 3

Patient is homeless and did not file taxes in 2003
He receives help from family and lives in a shelter
He has no income and no assets
His CSM bills total $1,325

Total percent of Charity Care =

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WI, Milwaukee
Columbia St. Mary's

EXAMPLE 4

Patient has 4 dependents
Annual income for patient and spouse is $83.750
Savings account of $5000 and Checking account $1243.67
Owns home valued at $250,000 with equity of $100,000
Has stocks valued at $2000
Owns a Ford F150 Pick up truck valued at $8000
Owns a 2003 Jeep Cherokee valued at $20,000
Total of CSM bills is $55,320

Total percent of Charity Care =

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WI, Milwaukee
Columbia St. Mary's

CHARITY CARE WORK SHEET

1. Gross income_____
2. Minus poverty level for size of family_____
3. TOTAL_____

PATIENT'S ASSETS

1. Checking and savings_____
2. Home Equity_____
3. Equity in vehicles_____
4. Investment accounts(IRA's excluded)_____

TOTAL PATIENT ASSETS_____(over $100.000.00 YES___NO___)
MINUS $100.000.00 IF OVER_____
EQUALS: _____

TOTAL GROSS INCOME ***PLUS*** PATIENT'S ASSETS=_____

PATIENT'S RESPONIBILITY

1. Income-Federal Poverty Guidelines_____
2. Amount patient owes CSM_____
3. Percent of Patient's Charity Care_____

PATIENT'S ACCOUNT NUMBERS_____
_____

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Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 4

How are patients made aware of your charity policy and how is the substance of that policy made available to patients, eg., brochures, postings in the hospital or on the system website?

Our Ascension Health Policy # 16 Billing and Collection for the Uninsured (Ascension Health Policy) requires the following:

> *Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.*
>
> *Financial counselors are available to all Patients.*
>
> *Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.*

As stated in our data submissions last October, our hospitals have historically provided information regarding charity and financial assistance programs through the use of brochures, posters, information on billing statements and discussions with trained registrars and financial counselors. Our new Ascension Health Policy reinforces the need to have this information available to the public.

Some examples of newly developed materials are attached. This work is ongoing. For example, our hospitals in Milwaukee, Wisconsin are currently translating their charity care policy into Russian and into Hmong (language for the Laotian population), because of local community demographics. Copies of these two documents are not included as they are still under development.

Question # 4

Attachments:

- Examples of brochures, and other materials used to communicate the availability of charity and financial assistance programs from the following locations:

  - Bridgeport, Connecticut
  - Jacksonville, Florida
  - Baltimore, Maryland
  - Detroit, Michigan
  - Kalamazoo, Michigan
  - Binghamton, New York
  - Niagara Falls (Lewiston), New York
  - Troy, New York
  - Austin, Texas
  - Waco, Texas
  - Milwaukee, Wisconsin

ST VINCENTS BRIDGEPORT CT.
COPY OF SIGN POSTED
DEFINING UNINSURED

DISPLAYED -
CASE MGMT
CUST SVC. Collection
NCC
ADMITTING CEE.
ED (ENG.-SPANISH)!
(AMENDED OCT 03)

CT, Bridgeport
St. Vincent's Health Services, Inc.

If you meet the definition of "**uninsured**" as defined by Section 19a-673 of the Connecticut General Statutes, you may be eligible to have your balance(s) reduced. You are "uninsured" if you meet **all** of the following:

- You have one or more outstanding balances due to Saint Vincent's Medical Center.
- You have applied and been denied eligibility for any medical or health care coverage provided under Medicaid or State Administered General Assistance ("SAGA") due to failure to satisfy income or other eligibility requirements.
  - Proof of denial is required.
- You are not eligible for coverage for hospital services under any other health or accident insurance program (including workers' compensation, third-party liability, motor vehicle insurance).
- Your household income is at or below 250% of the Federal Poverty Income Guidelines.
  - Proof of income is required.

To find out if you qualify, please contact us. We are also available to assist you with the Medicaid/SAGA application process. You may contact us:

- By phone at 203-576-5409 or 203-576-5829, to speak with a Financial Counselor
- 8:00 AM – 4:30 PM, Mon.-Fri. or by appointment or walk-in in the Admitting office, 8:00 AM – 4:30 PM, Mon.-Fri.

ARE YOU HAVING PROBLEMS PAYING YOUR HOSPITAL BILLS?

If you are coping with a personal financial hardship, and are facing significant debts owed to St. Vincent's Medical Center, hospital "bed funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital for qualifying patients.

You may request to have your case for financial assistance presented to St. Vincent's Medical Center. The Director of Patient Access has the authority to grant free bed funds based on financial and personal need. To obtain further information, including an application, please contact our customer service representatives using the contact information above.

You will receive written notice of the outcome of your case, including reason(s) if your case is rejected. You may reapply for bed funds at any time. Additional funding may become available on an annual basis.

Other assistance options may also apply to your situation. The financial counseling process will indicate available options to assist you with your outstanding balance.

Additional support also may be available to you through your town's social service or local health department. With your written permission, your town representative can assist you with our application process, as well as determine if you qualify for any other assistance programs such as Food Stamps, HUSKY program, CONNPACE, etc.

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1/6
ENGLISH

St Vincents [illegible]
Copy of sign posted
Uninsured

CT, Bridgeport
St. Vincent's Health Services, Inc.

¿NO TIENE SEGURO?

Si usted satisface la definición de "no asegurado" según consta en la sección 19a-673 de los estatutos generales del estado de Connecticut, es posible que llene los requisitos para que se le reduzca(n) él(los) saldo(s). Usted califica como "no asegurado" si cumple todas las condiciones mencionadas a continuación:

- ☐ Usted tiene uno o más saldos pendientes de pago con el St. Vincent's Medical Center.
- ☐ Usted ha solicitado cualquier cobertura de seguro médico o de cuidado de la salud suministrada por Medicaid o Asistencia General Administrada por el Estado ("SAGA") y ha sido rechazado por no satisfacer los requisitos de ingresos u otros.
  - Se requiere prueba del rechazo.
- ☐ No tiene derecho a ningún seguro que cubra los servicios de hospitales debajo de ningún otro programa de seguro de salud o de accidentes (esto incluye la compensación de obreros, seguro de automóvil o responsabilidad de terceros).
- ☐ El ingreso de su familia equivale al 250% de las Directrices Federales de Ingreso de Pobreza, o menos.
  - Se requiere prueba de ingresos.

Llámenos para saber si usted llena los requisitos. También le podremos ayudar con el proceso de solicitud de Medicaid y SAGA. Puede comunicarse con nosotros:

- Por teléfono al 203-576-5409 or 203-576-5829, 8:00 AM – 4:30 PM, Lunes- Viernes
  Con cita o sin cita en el St. Vincent's Medical Center, 8:00 AM – 4:30 PM, Lunes- Viernes.

¿TIENE USTED DIFICULTADES CON EL PAGO DE SUS DEUDAS DEL HOSPITAL?

Si usted tiene dificultades financieras y está enfrentando deudas significantes con St. Vincent's Medical Center, puede haber "fondos de cama gratis" para cubrir los gastos (parcial o totalmente) a los pacientes que reúnan los requisitos, de los servicios prestados en el hospital a pacientes internados, pacientes no internados y servicios de emergencia.

Usted puede solicitar la presentación de su caso para asistencia financiera a St. Vincent's Medical Center. El Director tiene la autoridad de otorgar fondos de cama gratis basado en la necesidad financiera o personal. Para obtener más información, incluyendo una solicitud, sírvase llamar a nuestros representantes de servicio a clientes usando la información de contactos de arriba.

Usted recibirá por escrito aviso del resultado de su caso, incluyendo la razón o razones si su caso es rechazado. Usted puede volver a solicitar fondos de cama gratis en cualquier momento. Cada año se podrá disponer de fondos adicionales.

Podrá corresponder a su situación otra opción de asistencia. En el proceso de asesoría financiera, se le indicarán las opciones disponibles para ayudarle con su deuda.

También podrá tener a su disposición apoyo adicional por medio del departamento de servicios sociales o salud pública en su ciudad. Con su permiso por escrito, el representante de su ciudad o pueblo puede ayudarle con el proceso de la solicitud, así como determinar si usted reúne los requisitos de otros programas de asistencia, como por ejemplo los cupones de alimentos, el programa HUSKY, CONNPACE, etc.

Attorney-Client Privileged Information

CT, Bridgeport
St. Vincent's Health Services, Inc.

SAINT VINCENT'S HOSPITAL ADMINISTERS LIMITED FREE BED FUNDS FOR THOSE WHO QUALIFY. TO INQUIRE ABOUT THESE FUNDS CONTACT A FINANCIAL COUNSELOR AT 203-576-5409 OR 203-576-5829 MONDAY- FRIDAY 8:00 AM – 4:30 PM

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Privileged Information
3/6

CT, Bridgeport
St. Vincent's Health Services, Inc.

HOSPITAL DE SAINT VINCENT'S TIENE FONDOS LIMITADOS PARA LOS QUE CUALIFICAN. PARA INFORMACION LLAME A SERVICIO AL CLIENT AL 203-576-5409 OR 203-576-5829 LUNES - VIERNES 8:00 AM – 4:30 PM

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4/6

SAINT VINCENT'S MEDICAL CENTER
PATIENT FUNDS AVAILABLE

Saint Vincent's Medical Center has several funds available for patients who may need financial assistance with their hospital bills. These funds are to be used after all insurance sources have been exhausted. If you feel you may qualify for a particular fund, please contact a Financial Counselor in the Patient Access Services Office or call 576-5759 for an application.

The following funds are currently available:

The Baker Fund
Funds for Firefighters and Police Officers

The Conlin Fund
Patients not eligible for any Assistance Programs

The Harral Fund
St. Augustine's Parishioners

The Hubbell Fund
Alumni of St. Vincent's College or Bridgeport Hospital School of Nursing, who reside in Bridgeport and practice in the Nursing of the Sick

The Klein Fund
Pediatric patients not eligible for any Assistance Programs

Ladies of Charity
Funds for members of the Ladies of Charity Group

Charles and Mary Jones Fund for Aged Women
Aged women of Greek and Albanian Descent

Harry J. Bradbeck Fund
Patients using the services of the Emergency Department

CENTRO MEDICO DE SAN VINCENTE
FONDOS DISPONIBLES PARA PACIENTES

El Centro Medico de San Vincente tiene varios
ondos disponible para pacientes que requieran
uda financiera con su factura del hospital.
Los fondos seran utilizados despues de que todo
s fuentes del seguro se han agotado. Si usted
ea que pueda qualificar por algun fondo en
articular, favor de comunicarse con un
asejero Financiero en la oficina de Servicios
l Acceso de Paciente o llame al 576-5759 para
u aplicacion.

os siguiente fondos estan actualment disponible:

Fondo Panadero
Fondo para Bomberos y Policias

do Gonin
Para Pacientes que no son elegible para cualquier Programa de Asistencia

Fondo Parish
Miembros de la Parroquia San Augustin

Fondo Hubbell
Antiguos egresados de enfermeria de la Universidad de San Vincente
Colegio de Enfermeria de Bridgeport, que residen en la ciudad de Bridgeport y asiste
una de la ciudad de enfermos

Fondo Kelly
Pacientes pediatricos que no son elegibles para cualquier Programa de
Asistencia.

ugas de Caridad
Fondos para miembros de las Damas de Caridad.

ndo de Charles y Mary Dimas para Mujeres Ancianas
Mujeres ancianas de ascendencia griega y Albanesa

ndo Henry y Bridget
Usuarios utilizando los servicios del Departamento de Emergencia

(Continued)

NOTICE

You can ask for an estimate of charges for your inpatient or outpatient care. The estimate is based on your doctor's judgment of your condition and treatment plan, and our experience with cases that are similar to yours. **You must send a written request to:**

Ms. Charlotte Boyd
Director Patient Access Services
St. Vincent's
1800 Barrs Street
Jacksonville, FL 32204

Please note that an estimate of charges might be more or less than your final bill. Your condition and care is unique. The course of your treatment, your doctor's individual practices, and the need for additional procedures, goods, and services can affect on your final charges. After you are discharged, you have the right to request an itemized bill. **You can call to make that request:**

Patient Accounting Customer Service
(904) 308-7381

St. Vincent's provides charity care for those who meet specific federal income criteria. We can also work with you for special financial arrangements. If you need help with your bill, please ask to speak with one of our financial specialists. Read our brochure, "What You Should Know About Your Hospital Bill" for more information. You can pick up a copy in Admitting, PAT, or any outpatient area.

ST. VINCENT'S

Attorney-Client
Privileged Information

What If I Can't Afford To Pay All of My Bill Right Now?

St. Vincent's financial counselors will work with you on a reasonable payment plan.

Who Can Receive Charity Care?

Patients are eligible for charity care at St. Vincent's if their income falls below 200% of the federal poverty level, based on the size of their family. Your financial counselor can help determine if you are eligible for charity care at St. Vincent's.

What If I Don't Have Insurance But Don't Qualify For Charity Care?

Patients without insurance are eligible for discounts on their bill when they agree to a payment plan. Please talk with a financial counselor about this option.

Will I Get Calls From Bill Collectors?

If you pay your bill on time and according to the payment plan you work out with St. Vincent's, your account will not be referred to a bill collection agency. It is very important that you contact Patient Accounting immediately if you are unable to pay any portion of your bill. In most cases, St. Vincent's financial counselors will work with you to make other arrangements for you to pay what you owe. However, if you miss one or more payments and do not contact us, we may refer your bill to a bill collection agency.

How Do I Reach My Financial Counselor?

The name of your Financial Counselor is listed on the payment agreement. If you have not been assigned a Financial Counselor, or if you have not yet been admitted to the hospital, please call (904) 308-8355 or (904) 308-8013.

Attorney-Client Privileged Information

ST. VINCENT'S
Where The Experts Are™

Call St. Vincent's HealthLink at (904) 308-LINK or visit us online at www.jaxhealth.com.

What You Should Know About Your Hospital Bill

1536

ST. VINCENT'S
Where The Experts Are™

JUL-20-2004 TUE 06:02 PM BOOKE1 AND REIMBURSEMENT FAX NO. 904 308 3940 JUL 20 '04 06:19 PM P04

What You S[illegible] Know About Your Hospital Bill

Here are some common questions and answers you may have about your bill for services provided to you at St. Vincent's. In some cases, you may wish to contact your insurance company or the VA, Medicare or Medicaid office for specific information about what is covered under your insurance plan.

Financial counselors at St. Vincent's are available to answer questions about paying your bill or help you with insurance forms. Telephone numbers for the financial counselors are listed on the back of this brochure.

How Much Will I Have To Pay?

Unfortunately, the answer is "that depends." Some policies require only a small co-payment to the hospital, but others require that you pay a co-payment as well as a deductible amount. In addition, your policy may not cover certain services provided by a hospital. Or, it may not cover services at St. Vincent's at all. It's best for you to read and understand the limits and payments required by your insurance company before you have to use the hospital. This will be described in your policy. Our financial counselors can help you in determining how much your insurance company requires your co-pay or deductible to be for each visit.

When Will I Have to Pay?

You will be asked to provide a payment to St. Vincent's at the time you register or are admitted.

Depending on the insurance plan you have, you may be asked to pay anything from a few dollars up to a down payment of $500 or more when you arrive.

What Forms of Payment Does St. Vincent's Accept?

You can pay by cash, check, debit/check card or credit card. St. Vincent's accepts Visa, MasterCard, Discover and American Express. An ATM machine is located off the front lobby of the hospital.

Attorney-Client Privileged Information

Why Do I Have to Pay [illegible]ont?

St. Vincent's, like most other healthcare providers, collects the patient's portion of the bill at the time of service. We try to estimate what your cost will be when you are admitted to the hospital so that you can have a good idea of what you will have to pay.

If your admission to the hospital is planned in advance, our financial counselors will contact your insurance company and find out what they will cover and what your part of the bill will be. We will provide this information to you before you come in so that you can be prepared to pay your part when you arrive.

Why Doesn't My Insurance Pay For This?

Every policy is different and many have limits on what they will cover. You may be required to pay more for a service if you have not yet met your annual deductible, or if the service is not covered by your policy at 100%. Medicare and Medicaid also have limits on what they will pay for hospital and physician services.

What is a Co-Pay?

Most HMOs (Health Maintenance Organizations) and some other forms of insurance require patients to pay a small payment each time they visit a doctor or go to the hospital. This payment can be as little as $10 or may be as high as $50 or more, depending on your policy. This co-pay is required each time you visit the doctor or hospital.

What is a Deductible?

Some insurance policies, especially PPO's (Preferred Provider Organizations) and so-called "traditional" policies, require you and/or your family to pay a minimum amount per year toward your healthcare expenses. This deductible could be as little as $250 per year or as much as $1,000 or more. You must pay for all of your healthcare expenses until you have met this deductible amount. After you reach the deductible, your insurance company will then pay for most, or sometimes all, of your bill. You only have to meet your deductible once each year.

Be aware that your policy may requ[illegible] both a co-payment and a deductible. In t[illegible], you will be required to continue to pay a co-pay amount even after you have met your deductible.

What Things Are Covered By Insurance?

Typically, most insurance policies will cover hospital and physician charges when you are sick, including lab tests, x-rays and other tests. Many policies do not cover other services such as medicines, home health, nursing home stays, wheelchairs, etc. Please check your policy for details or call your insurance company if you have questions.

What Things Will I Be Responsible For Paying?

You will be responsible for paying any amount not covered by your insurance policy. This may include a co-payment, some or all of your deductible, and expenses that are not covered by your insurance policy.

What if I Have No Insurance Coverage?

Please notify our financial counselors and we will work with you to develop a reasonable payment plan. You may be eligible for charity care coverage or a discount.

What is an Insurance Discount Card?

There are companies now selling "discount cards" for hospital and doctor services to patients. These cards often cost as much as $60 per month or more ($720 per year) and promise to provide patients with discounts on their doctor and hospital bills.

St.Vincent's Medical Center does not participate in any of these discount card programs, Seton Pharmacy participates in one or more of these programs.

FL, Jacksonville
St. Vincent's Health System

FL, Jacksonville
St. Vincent's Health System

Attachment B-1

ST. VINCENT'S HEALTH SYSTEM
POST OFFICE BOX 45167
JACKSONVILLE, FLORIDA 32223-5167

September 17, 2003

Please complete and return the attached financial evaluation along with the following required documentation within 10 days so we can review your account for possible assistance.

In the event that we are already in receipt of your completed financial evaluation, please provide the following requested information:

(X) **Proof of income for the past 12 months** Please submit copy of last paycheck stub(s) or W-2 form for each family member, income tax return, profit and loss statement form if self-employed, forms approving or denying unemployment or workmen compensation, child support income, written verification of wages from employer, written verification from public welfare agencies, social security, pension, or any governmental agency which can attest to the status of income for the past 12 months.

(X) **Work history for the past 12 months** (date range of employment, salaries paid, and hours worked).

(X) Your signature and a witness signature on the financial evaluation (must be signed and dated by both).

(X) **If self-employed, you must provide a copy of your most recent tax return along with your profit and loss statement.**

(X) If unemployed and receiving no other source of fixed income and are supported by family or friends, please include this information as well, by filling out the Affidavit of Support.

Any proof of income is requested and would assist in expediting your request for financial assistance. Failure to provide any/all required information will be considered non-compliant and may result in your financial evaluation being denied.

Thank You,

Collection Representative
Patient Accounting Department
(904) 308-7381

Attorney-Client
Privileged Information

FL, Jacksonville
St. Vincent's Health System

Attachment B-2

CHARITY CARE ALLOWANCE WORKSHEET

Keyed:_____

zero print:_____

NAME
ACCT #

SECTION A - DISCRETIONARY ASSET OFFSET

LINE #	DESCRIPTION	AMOUNT
1	Total Assets (per application)	
2	Total family income	
3	Minimum Asset Retention	
4	50% of Line 1	
5	50% of Line 2	
6	Greater of Line 3, Line 4 or Line 5	
7	Maximum Discretionary Asset Offset (Line 1 minus Line 6, but not less than $0)	

SECTION B - EXCESS INCOME OFFSET

LINE #	DESCRIPTION	AMOUNT
1	Total Annual Family Income	
2	200% of FPL Income	
3	Excess Income (Line 1 minus Line 2, but not less than $0)	
4	Excess Income Adjustment Factor	X 75%
5	Maximum Excess Income Offset (Line 3 x Line 4)	

SECTION C - CHARITY CARE ALLOWANCE COMPUTATION

LINE #	DESCRIPTION	AMOUNT
1	Total Bill Balance	
2	3rd party payment/payable	
3	3rd party contractual adjustment	
4	Patient Responsible Balance (Line 1 minus Line 2 and Line 3)	
5	Maximum Discretionary Asset Offset (From Section A, Line 7)	
6	Lesser of Line 4 or Line 5	
7	Amount Subject to Charity Care Allowance (Line 4 minus Line 6)	
8	Excess Income Offset (From Section B, Line 5 but not to exceed Line 7)	
9	Charity Care Allowance (Line 7 minus Line 8)	

SECTION D - CHARITY CLASSIFICATION

To classify the charity care allowance as AHCA qualified or Non-AHCA qualified, enter the information in lines 1 through 5 below:

LINE #	DESCRIPTION	AMOUNT
1	Amount subject to charity care allowance (Line 7 above)	
2	Total family income	
3	25% of total family income	
4	200% of FPL	
5	400% of FPL	

Check the applicable circle:

- ○ AHCA Qualified - Line 2< Line 4
- ○ AHCA Catastrophic Qualified - Line 1>Line 3 and Line 2<Line 5
- ○ Non-AHCA Qualified - Neither of the AHCA Qualified boxes is checked

PREPARED BY:_____ APPROVED BY:_____

DATE:_____ APPROVED BY:_____

APPROVED BY:_____

Attorney-Client
Privileged Information

JUL-20-2004 TUE 06:00 PM BUDGET AND REIMBURSEMENT FAX NO. 904 308 3940 JUL. 20 '04 04:59PM P. 14

FL, Jacksonville
St. Vincent's Health System

ST. VINCENT'S

Attachment C

St. Vincent's Patient Accounting
P.O. Box 45167
Jacksonville, FL. 32232-5167

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____ **Patient Account #:**

Responsible Party Information

Name: _____ Home Phone: ( ) _____-
Street: _____ Alternate Phone: ( ) _____-
City: _____ Date of Birth:
State/Zip: _____ Social Security: _____-_____-

Qualifying Family Members *(Includes self, spouse, dependent children under age 18 living in household and/or full time students under age 25.)*

Name	Relationship	Date of Birth	Social Security Number

Employment Information **Spouse's Employment**
(Please provide for 12 months income. If employed more than twice within 12 months, provide on back.)

Employer's Name: Gross Income: _____ Per How Long:	Employer's Name: Gross Income: _____ Per How Long:
Former Employer's Name: Gross Income: _____ Per How Long:	Former Employer's Name: Gross Income: _____ Per How Long:

Total Other Income Per Month **Assets**

Alimony _____	AFDC	Cash, Savings, Checking Accounts
SS Benefits _____	Child Supp.	Total $
Unemploy _____	Military/VA	Investments $
Work Comp _____	Rental Prop.	Other Assets:
Pensions _____	Other Income	

I hereby certify that the above information is true and correct to the best of my knowledge. In accordance with s.817.50F.S., providing false information to defraud a hospital for goods and services is a misdemeanor in the second (2nd) degree. St. Vincent's can require income tax information or investigate wages with employer to validate eligibility.

Applicant/Guarantor: _____ Date:
Witness: _____ Date:

Provide Additional Information on Back

Attorney-Client
Privileged Information

MD, Baltimore
St. Agnes HealthCare, Inc.

Financial assistance programs are available to help qualified patients with their St. Agnes HealthCare bills.

Please call

410-368-2140

for information about these programs.

Health care that works. Health care that is safe. Health care that leaves no one behind.

Privileged Information

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MI, Detroit
St. John Health

ST JOHN HEALTH – Financial Assistance Application SAMPLE

Please find attached the St John Health Financial Assistance application. Please complete this application and return it to: _____

_____

The completed application will be reviewed for discount based on your income and number of persons in your family. The discount percentage can range from 10% to 100% adjustment of charges. Approval of financial assistance will not exceed one (1) year.

In order to qualify for charity consideration, please note the following:

- An application for Local, State or Federal Aid may be required.
- Proof of income must accompany the application for all working adults within the household. This should include the following: income tax returns for the previous year, current bank statements and recent pay check stubs of responsible party and other working adults in household.
- Other income sources should be reported and include: child support, alimony, workers compensation, retirement/pension, rental income, land contracts, social security, interest income, trust fund, public assistance, self employment income, unemployment compensation.

Program Exclusions

- Co Pays and deductibles
- Personal items, such as telephone and television expenses.
- Elective surgery procedures
- Infertility treatment
- Service covered by insurance in another health care network
- Out-of-country patients without administrative approval.
- Over-the-counter pharmaceutical items.
- Services approved/provided at other St John Health care facilities without re-application.

Your completed application will be reviewed by Patient Financial Services for discount consideration. When your application process is complete, you will be notified of the results by mail.

If you have any questions regarding this policy, please call _____.

Attorney-Client
Privileged Information 1/6

MI, Detroit
St. John Health

SJH FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Name:_____

Type of medical insurance (if applicable): _____

This information will be used by our St. John Hospital Patient Financial Services staff to help resolve your financial obligation to_____ Hospital. All information in this form will be kept confidential.

The following Items are required to consider this application for financial assistance. Send copies only, items will not be returned. Incomplete applications will be denied.

◆A copy of your most recent pay stubs for the last two months, including year-to-date earnings. (Household income=income of all working adults within the household)

◆A copy of your monthly income statement for self-employment or a copy of your general business ledger/business checking account summary.

◆If you do not receive pay stubs, a letter of employment verification on company letterhead stating your date of hire, hourly rate of pay, and year-to-date earnings.

◆A copy of your Social Security, disability, general assistance, or Aid to dependent children benefit letter. Proof of unemployment, child support, or alimony must also be included.

◆A copy of the most current Federal Income Tax return.

◆A copy of the most recent bank statements, both checking and savings.

◆If requested to apply, a copy of your Medicaid denial.
◆Other:

_____

_____

If you have no income, submit a notarized statement explaining how you are being supported financially.

MI, Detroit
St. John Health

SJH Financial Assistance Program

APPLICANT OR PATIENT INFORMATION:

pplicant: _____ **Relationship to patient:** _____

Address: _____ **Telephone:** _____

City/State/Zip: _____ **Birth Date:** _____

Soc Sec No: _____ **Spouse's Name:** _____

DEPENDENT INFORMATION:

NAME	BIRTH DATE	RELATIONSHIP

EMPLOYMENT/INCOME INFORMATION: **Applicant** *and* **Spouse/other**

Present Employer: _____

Employer Address: _____

City/State/Zip: _____

ross Pay: ☐Weekly ☐Biweekly ☐Monthly: _____

Hours scheduled per week: _____

Income from rental property: _____

Unemployment Income: _____

Social Security Income: _____

Pension/Retirement income: _____

Worker's Comp: _____

Alimony/Child Support income: _____

Other (Specify): _____

Motor Vehicles (include boats, motorcycles, trailers, RV's, ATV's, etc.)

Type of Vehicle	Year/Make/Model	Amount Owed	Monthly Payment

Attorney-Client
Privileged Information

MI, Detroit
St. John Health

SJH Financial Assistance Program

MONTHLY EXPENSES

House Payment/Rent	$_____
Property expenses not included above:	
Taxes	$_____
Insurance	$_____
Utilities:	
Electric	$_____
Gas	$_____
Water	$_____
Telephone	$_____
Cable	$_____
Food	$_____
Transportation:	
Car Payment	$_____
Auto Insurance	$_____
Buses/Taxi	$_____
Child Support	$_____
ost of day care	$_____
Health Insurance	$_____
Other Insurance	$_____
Total Medical Expenses	$_____
Credit Card Expenses	$_____
Bank Loans	$_____
Total Monthly Expenses	$_____

HOUSEHOLD ASSETS

House Value	$_____
Other property	$_____
Stocks/Bonds	$_____
Money Market	$_____
Investments	$_____
IRA/TSA/401K	$_____
Trust Fund	$_____

Checking Accounts:

Bank/Credit Union _____
Account Number_____
Current Balance$_____

Savings Accounts:

Bank/Credit Union_____
Account Number_____
Current Balance$_____

I understand that failure to complete this form in its entirety, including proof of income, may result in denial of this program. My signature on this form guarantees that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I do understand that I may be responsible for patient co-pays as determined by Patient Financial Services. Failure to satisfy my determined co-pay may result in denial of continued participation in the SJH Financial Assistance Program.

Signature _____ Date _____

Complete all sections of this form, sign, date, and return it within ten (10) business days.

If you have any questions concerning the completion of this application, please contact the SJH Financial Assistance Program at (XXX) XXX-XXXX Monday through Friday, between XXX am and XXX pm.

Mail this application to:
St. John Health
Attn: _____
27800 Dequindre, Warren, MI 48093-2468

Attorney-Client
Privileged Information

MI, Detroit
St. John Health

APPROVAL LETTER

SAMPLE

ST JOHN HEALTH

_____
Date:

Responsible party: _____

Patient Name: _____

Account Number: _____

This letter is in response to your request for consideration in our Financial Assistance Program. Your information has been reviewed and based on the guidelines of the program; you are eligible for a reduction of _____% .

This program **excludes** personal items, cosmetic procedures, infertility treatments, non-prescription pharmacy items, co-pays, deductibles, and services covered by health insurance in another health care network

Your approved discount will be applied to balances after all charges have been processed. The length of the approval period will not exceed one (1) year. This discount will not apply to accounts that have transferred to a collection agency. You will be responsible for _____% of the cost of services. **Failure to satisfy your patient pay portion after your approved discount, may result in the denial of continued participation in the SJH Financial Assistance Program.**

A card is attached that indicates your financial assistance approval rate and eligibility dates. Please present this card when registering at all points of entry for discount of charges. Thank you.

Sincerely,

Attorney-Client
Privileged Information

5/6

MI, Detroit
St. John Health

DENIAL LETTER

ST JOHN HEALTH

SAMPLE

Date: _____

Responsible party: _____

Patient Name: _____

Account Number: _____

This letter is in response to your request for consideration in our Financial Assistance Program. Your information has been reviewed and based on the guidelines of the program; you are **not** eligible to participate in the program.

Your request has been denied as _____
_____.

Please contact our office at _____ to discuss payment options to satisfy your account balance.

If you do not agree with the final determination, please contact our Patient Financial Assistance Support area at ___ - ___-_____ to appeal this decision.

Sincerely,

Attorney-Client
Privileged Information

6/6

MI, Kalamazoo
Borgess Health Alliance, Inc.

BORGESS
Medical Center
1521 Gull Road
Kalamazoo, MI 49048

MEMO

Date: 7/19/04
To: Katherine Arbuckle, VP Finance
From: Linda Collins, Director, Patient Financial Services
Subject: Charity and Collections for Self Pay/Uninsured

Attached are copies of the March 10, 2004 updated Charity Care policy with the new sliding scale guidelines approved last week, "Patient Payment Alternatives" brochure, "Answers to your insurance, billing and payment questions" brochure and a copy of the signage posted in the Emergency Room. Approximately one year ago, patient financial representatives were added to counsel inpatients and observation patients within 24 hours of admission. Representatives work with the patients to obtain any available alternative sources of payment. If no other sources of payment, patients are interviewed and asked to complete a financial evaluation to determine if charity care is appropriate. In addition, we also have onsite workers to assist patients in obtaining Medicaid coverage.

In January 2004, four patient financial counselors were moved to the main registration area to counsel all self pay patients and all patients we have verified after insurance.

All patient financial representatives have been trained on Billing and Collection for the uninsured.

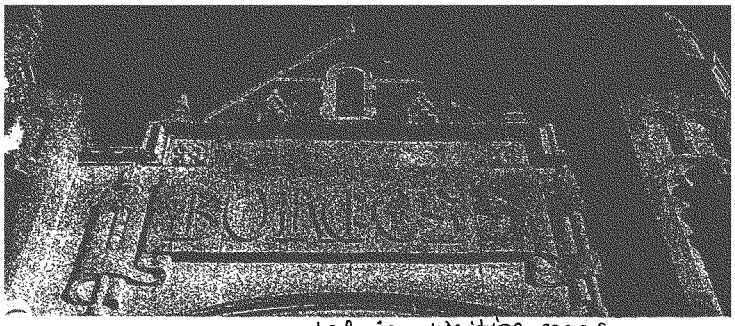
c: Rich Felbinger, Interim VP Finance and CFO
Linda Albery, COO

lc/jlw

Attorney-Client
Privileged Information

Important BILLING Note

If you think you will have trouble paying your Borgess Medical Center bill, help may be available. For more information, please call Patient Financial Assistance at 269.226.7281.



Signage posted in waiting rooms throughout the hospital

Attorney-Client Privileged Information

2/6

3orgess [redacted]cal Center is
ommitted to providing quality
ıealth care and service to all
ıatients. To continue in this
nission, it is essential that
ıayment be received for
ervices provided.

As a courtesy to our patients
and their families, Borgess
Medical Center will submit
our bill to insurance
ompanies according to the
isted guidelines. To do this
fficiently, it is important
hat accurate and complete
nsurance information be
presented at the time of
egistration.

Following are answers to
requently asked questions
bout billing and payment
or health care services.

Please bring these items
vith you to the hospital:

- Insurance card(s).
- Referrals or "pre-certification" numbers from your physician.
- Some services may require that you bring a method of payment, such as cash, check or credit card, for any co-pay or non-covered services.

Our Values

We are called to:

Service of the Poor
Generosity of spirit, especially for persons most in need

Reverence
Respect and compassion for the dignity and diversity of life

Integrity
Inspiring trust through personal leadership

Wisdom
Integrating excellence and stewardship

Creativity
Courageous innovation

Dedication
Affirming the hope and joy of our ministry

Attorney-Client Privileged Information

BORGESS
Medical Center

1521 Gull Road
Kalamazoo, MI 49048
(616) 226-7281

05/01

Answers to your insurance, billing and payment questions

Important Information for Families

BORGESS
Medical Center

1550

Helpful Information

- A patient requests a private room is responsible for the cost difference between the private and semiprivate room rate.
- A detailed patient account statement is available to the patient upon request.
- Please include the return copy of your statement with your remittance, noting your account number on the check or money order. Please do not send cash.

When am I responsible for obtaining approval from my health plan prior to receiving services?

Depending on your insurance plan, you may be required to contact your primary care physician or health plan for approval prior to receiving services. If your situation is truly an emergency (life-threatening), you or a family member must contact your physician or health plan within 24 hours. If you do not obtain health plan approval, all hospital charges may become your responsibility. While insurance companies cover Emergency Room charges for true emergencies (life-threatening situations) and many outpatient services, coverage differs. Your insurance company may require you to pay for emergency and urgent care services determined to be non-emergent (non-life-threatening).

Does the hospital participate with my health plan?

If Borgess "participates" with your health plan, that means that the hospital has an agreement with your insurance company to provide services for its members. You should check with your health plan to verify that the hospital, physician practice and care providers participate with your plan.

What if the hospital doesn't participate with my health?

Even if Borgess does not participate with your health plan, you may still receive services at the Medical Center. However, you should know that these services are considered "out-of-network" and may not be covered. You are responsible for paying the bill in full or for any balance not paid by your health plan. As a courtesy, we initially bill non-participating health plans. However, you are responsible for payment if the plan does not promptly respond to the claim.

Will you bill my insurance company?

Borgess will directly bill your insurance company and send you a statement after receiving the plan's determination of the amount covered. Depending upon the services provided, if your insurance plan requires payment of a co-pay and/or deductible, you may be requested to pay this amount at the time of service. Immediate payment enables Borgess to contain billing costs. However, if your insurance company has not responded to the claim within 45 days, you are responsible for assisting in obtaining payment from the insurance company.

Why aren't my doctor's charges included on my hospital bill?

As most physicians, radiologists, pathologists, anesthesiologists and emergency room physicians are not employed by the Medical Center, you (or your insurance company) may receive a separate bill for physician services. This separate physician billing practice is customary.

What are Medicare and CHAMPUS patient rights?

Borgess is required by the U.S. government to provide Medicare and CHAMPUS patients with specific information regarding their patient rights. If you have not received this information during your current hospital stay, please ask to speak to your unit's Care Manager or call (616) 226-7273.

How do I make a payment?

Payment in full at time of service or receipt of first bill.

Patients may pay by check, money order, cash or credit card. Borgess accepts Visa, MasterCard and Discover credit cards.

Contact Patient Financial Counselor

Patient Financial Counselors are available to assist with billing questions and provide information regarding other possible payment options. To learn more, please call (616) 226-7281 or toll-free 1-800-944-3345. Financial Counselors are available Monday through Thursday, 8 a.m.-6 p.m. and Friday, 8 a.m.-4:30 p.m.

Billing Information Numbers

Borgess Medical Center—Financial Assistance	(616) 226-7281
Borgess at Woodbridge Hills	(616) 324-8400
Kalamazoo Anesthesiology	(616) 345-8618
Kalamazoo Emergency Associates	(616) 552-4870
Kalamazoo Radiology	(616) 381-2920
Midwestern Pathology	1-800-535-3053
West Michigan Air Care	(616) 337-2505
Westside Lab & X-ray	(616) 372-7456

Attorney-Client Privileged Information

BORGESS MEDICAL CENTERS CREDIT POLICY

orgess Medical Center bills surance carriers according to formation given at registration.

the insurance company does not spond within sixty (60) days, you e asked to contact your insurance mpany to resolve any issues.

ny balances left after your insurance is paid the hospital are your sponsibility to pay. When paying f any balance, you have the llowing options:

Payment In Full

You can make payment in full through the following means:

- Cash
- Personal Check
- Money Order
- VISA, Mastercard and Discover

Send payment in full or make inquiries to:

BORGESS MEDICAL CENTERS
1521 Gull Road
Kalamazoo, Michigan 49048
269-226-7281
or
800-944-3345

2. Borgess No Interest Payment Plans

Account balances must be paid in full in three (3) months or less after you receive your first statement.

3. Borgess Financial Support Program

Patients who do not have the financial means to pay their entire hospital bill may apply for eligibility under the Borgess Financial Support Program.

You may be considered for an additional discount from your hospital bill if you are a resident of Michigan, not eligible for Medicaid, and your family income is at or below the federal poverty guidelines.

For information on No-Interest Payment Plans and the Borgess Financial Support Program, please call one of our customer service departments at (800) 944-3345.

4. Hospital Expense Loan Program

Complete the application information on the reverse side of this brochure and mail it to:

H.E.L.P. Financial Corporation
P.O. Box 6408
Plymouth, Michigan 48170
800-752-9613

Attorney-Client Privileged Information

5/6

BORGESS
Medical Center

PATIENT PAYMENT ALTERNATIVES

- Cash
- VISA, MasterCard & Discover
- Borgess No Interest Payment Plan
- Borgess Financial Support Program
- Hospital Expense Loan Program

1552

The Hospital Expense Loan Program

When a large medical expense arises, you and your family can be put under severe financial pressure. That is why Borgess Medical Center offers you **HELP**, the Hospital Expense Loan Program, which offers a number of payment benefits:

- **Low Interest Rate**

  HELP is a personal finance loan, but you pay an interest rate that is lower than most credit card programs or other sources of personal finance.

- **Affordable and Flexible Payments**

  You choose the monthly payment that best suits your budget. The types of payments that can be made available to you are shown on the next panel.

- **No Pre-Payment Penalties**

  You can always make double payments or pay off your HELP account early, with no interest or other penalties attached.

- **Five Year Payment Plans**

  You can choose to spread your payments out for up to five years.

- **Future Hospital Bills**

  As future hospital bills arise, you can simply charge them to your HELP account.

- **Easy Enrollment**

  You will not be subject to a formal credit check. For most people, if you have a source of income...YOU QUALIFY!

Examples of Monthly Payments That May be Available to You

HELP will provide you with a guaranteed line of credit for the full amount you currently owe Borgess Medical Center.

Amount Financed	Your Monthly Payment Under Our 1 Year Plan	2 Year Plan	3 Year Plan	4 Year Plan	5 Year Plan
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$400	$35.82	$19.11	$13.57	$10.83	$9.20
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$600	$53.73	$28.67	$20.36	$16.25	$13.81
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$800	$71.64	$38.22	$27.15	$21.66	$18.41
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$1,000	$89.55	$47.78	$33.94	$27.08	$23.01
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$1,200	$107.46	$57.33	$40.72	$32.49	$27.61
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$1,400	$125.37	$66.89	$47.51	$37.91	$32.21
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$1,600	$143.28	$76.44	$54.30	$43.32	$36.82
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$1,800	$161.19	$86.00	$61.08	$48.74	$41.42
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$2,000	$179.10	$95.55	$67.87	$54.15	$46.02
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$2,200	$197.01	$105.11	$74.66	$59.57	$50.62
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$2,400	$214.92	$114.66	$81.44	$64.98	$55.22
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$2,600	$232.84	$124.22	$88.23	$70.40	$59.83
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$2,800	$250.75	$133.78	$95.02	$75.81	$64.43
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$3,000	$268.66	$143.33	$101.81	$81.23	$69.03

TERMS AND CONDITIONS FOR HELP ACCOUNTS

Annual Percentage Rate...13.50%
Annual Fee...$10.00
Grace Period for Repayment of Balances of Purchases...0 days
Minimum Finance Charge...None
Method of Computing Balance of Purchases...Average Daily Balance (including new purchases)

It's Easy to Apply to the HELP Program

Step 1: **Complete the Application Below:**

Your Name:
Your Street Address:
Your City, State, Zip:
Your Social Security Number:
Best Phone Number to Reach You:
Other Family Members Who May Have Bills:
Hospital Account Numbers, If Known:

Step 2: **Pick the payment that best suits your budget.**

Step 3: **Circle the payment option you desire on the previous panel or on a payment sheet (if included).**

Step 4: **Mail this brochure and a payment sheet (if included) to:**

H.E.L.P. Financial Corporation
P.O. Box 6486
Plymouth, Michigan 48170

Attorney-Client
Privileged Information

Call us if you have any questions.
(800) 752-9613

If you are fo[illegible] eligible, your discount will apply to all charges ge[illegible]d by Lourdes. Some services received at Lourdes are provided by private physician groups, such as the services of a Radiologist, and are not covered because the bill you receive is not a Lourdes bill. The credit office will be happy to answer any questions and to help you clarify your charges.

To Apply for Lourdes Patient Financial Assistance Program:

1. Complete the attached application. Please include the names and dates of birth of each adult who is applying for assistance. If children under 21 are involved, we need the names and dates of birth of the parents as well as all children under 21 in the family.

2. We need proof of income for each adult who is applying for assistance. If married, proof of income for both adults is required. If minor children are involved, we need proof of income of the parents and any income of the children. Proof of income includes: two weeks of your most recent pay stubs, a letter from your employer, a copy of your unemployment stub, a copy of your Social Security benefits, a copy of monthly pension income or similar proof of monthly income.

3. We also need proof of any resources you may have. We do not consider the home you are living in as a resource. Resources include savings accounts, stocks, bonds, IRAs, property other than your residence, or other types of assets which are available to you. The Medicaid resource guidelines are used to determine resource limits.

4. Mail the completed application and all the required proofs to the address at the bottom of the application. We will contact you about your application once it has been reviewed. If you wish to speak with a financial counselor contact the cashiers office at Lourdes Hospital at 607-798-[illegible] or 798-5279

LOURDES

PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date: _____

Applicant's Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: ( ) _____

Date of Birth: _____

Family Members (List all members living in household and their date(s) of birth):

1. _____ DOB
2. _____ DOB
3. _____ DOB
4. _____ DOB
5. _____ DOB
6. _____ DOB
7. _____ DOB
8. _____ DOB

The following information is required to determine eligibility:

1. Proof of income (copy of one of the following):
   - A. Pay stubs for 2 weeks for each working member of household
   - B. Letter from employer
   - C. Unemployment statement
   - D. Social Security benefits, pensions

(Please complete both sides of application)

Attorney-Client Privileged Information

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2. Other Resources

A. Do you have savings, stocks, bonds, IRA, etc.? ☐ YES ☐ NO

B. Do you own property that you do not live in? ☐ YES ☐ NO

C. Do you have any other source of income? ☐ YES ☐ NO

If you answered YES for any of the items above, please attach proof.

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform Lourdes promptly of any changes in my needs, income, living arrangements or address.

_____

Applicant's Signature

_____

Relationship (if other than patient)

_____

Date

OFFICE USE ONLY

Discount % Approved_____

Date Approved_____

Approval Signature_____

Lourdes Hospital
Patient Financial Assistance Program
169 Riverside Drive
Binghamton, NY 13905
PHONE: 607-798-5506 or 798-5279
www.lourdes.com

Lourdes Patient Financial Assistance Program

INFORMATION

Lourdes was established by the Daughters of Charity over 75 years ago to serve the people of this area, especially the poor. Today, we continue our strong commitment to provide services to patients regardless of their ability to pay.

Patients and/or Guarantors are responsible for payment of bills for services provided by Lourdes. Lourdes has established the **Patient Financial Assistance Program** to help patients who meet the income and resources guidelines established by Lourdes, and **who are not eligible for any other available program,** such as Medicaid, Child Health Plus, Family Health Plus, etc. It can also be used to assist with any copays or deductibles of other programs. If, in our opinion, you are eligible for any other program, you must apply to that program and receive, in writing, an approval or denial before we can determine if you are eligible for the Patient Financial Assistance Program. This requirement enables us to serve as many people as possible with our limited funds. This program is available to the extent Lourdes' resources allow.

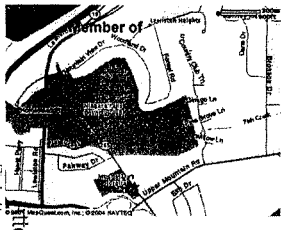
A financial scale based on federal poverty figures determines eligibility for the Patient Financial Assistance Program. How much your Lourdes bill will be discounted depends on how your gross income and resources compare with this financial scale.

LOURDES

Attorney-Client Privileged Information

Location

Just off the New York State Thruway I-190N, exit 25A, at the intersection of Military and Upper Mountain Roads, Mount St. Mary's Hospital and Health Center is easily accessible from all directions. We have safe and free parking. Bus routes stop at our door.



ASCENSION HEALTH

Attorney-Client
Privileged Information
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MOUNT ST. MARY'S
HOSPITAL AND HEALTH CENTER
Your hospital for life.™

INFORMATION FOR UNINSURED PATIENTS CONCERNING FINANCIAL ASSISTANCE PROGRAM

5300 Military Road
Lewiston, New York 14092

N.Y., Lewiston
Mount St. Mary's Hospital

QUESTION:

I don't have hospital/medical insurance?

ANSWER:

Depending on your financial situation, you may qualify for hospital insurance coverage through various state programs.

QUESTION:

How do I apply?

ANSWER:

Contact Mt. St. Mary's Hospital and Health Center's Credit Department who can assist you through the process.

QUESTION:

What if I don't qualify for state assisted programs? Is there other assistance available?

ANSWER:

Yes, depending on your financial status, Mount St. Mary's Hospital and Health Center has an assistance program which may qualify you for a discount of 25%-100% off your Hospital bill.

This policy applies to Hospital Services only; you may receive additional bills for professional services such as:

- Radiologists (X-ray)
- Cardiologist
- ER Physicians

To obtain more information please contact:

Credit Department
Monday - Friday
8:00am. - 4:00p.m.
298-2175 or 298-2189

MOUNT ST. MARY'S
HOSPITAL AND HEALTH CENTER
Your hospital for life.™

DRAFT

For Those Patients Who Are Uninsured
Financial Assistance Program

Depending on your financial situation, you may qualify for hospital insurance coverage through various state programs.

If you do not qualify, Mount St. Mary's Hospital has an assistance program where you may qualify for a discount of 25% - 100% off your hospital bill for hospital services.

Contact Mount St. Mary's Hospital's Credit Department for information:
Monday-Friday 8 a.m.-4 p.m. at 298-2179 or 298-2182

ASCENSION HEALTH

Attorney-Client
Privileged Information

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Child He. .l Plus
800-698-4543
New York State program available for children under the age of 19 years who reside in New York State whose families are income qualified.
www.health.state.ny.us/nysdoh/chplus

Family Health Plus
877-934-7587
Public health insurance program for uninsured income eligible adults between the ages of 19 and 64 years old.
www.health.state.ny.us/nysdoh/fhplus

Healthy New York
866-432-5849
Health insurance plan for individuals, small employers, and sole proprietors.
www.ins.state.ny.us/healthny.htm

Healthy Women Partnership
518-268-5458
No cost or low cost Breast and Cervical Cancer Screening Program for women who are:

- 40 years of age or over (18 years of age or over for pelvic exam and pap tests)

- Have no health insurance
  or
- Have limited health insurance
  and
- Meet program income guidelines

Rev 5/4/04 606-21

NY, Troy
Seton Health Syst) ic.

SETON HEALTH
St. Mary's Hospital

Alternatives and Assistance for Individuals Without Health Insurance

1559

Credit and Collections Department
55 Mohawk Street
Cohoes, New York 12047
518-268-4901

Insurance Coordinator
1300 Massachusetts Avenue
Troy, New York 12180
518-268-5458

Attorney-Client Privileged Information

SETON HEALTH
St. Mary's Hospital

eton Health System's Mission is to serve all ersons with special attention to those who ɔ not have access to healthcare. Everyday e assist individuals who do not have health surance with opportunities for enrollment, s well as financial assistance for medical ervices. Our financial counselors are here help you in a private and respectful setting

he following forms of payment are available:

Cash, checks, money orders, cashier's checks, Visa, MasterCard, American Express, Discover

Check-by-phone payments. To use this option, call toll-free 888-571-7949.

Installment Payment Plan for medical services. Please call the Seton Health Credit and Collection Department at 518-268-4901 or toll-free 888-571-7949. There are no finance charges on installment payment plans.

- Seton Health Charity Care/Financial Assistance offers reduced charges to eligible patients. Our Financial Assistance Program is not an insurance plan. It is intended to offer temporary assistance. Approval is valid for 90 days. For an application or more information about this program, please contact the Seton Health Credit and Collection Department at 518-268-4901.

- Seton Health can assist you with the application process for Child Health Plus, Family Health Plus, Healthy Women Partnership Program, and Medicaid enrollment. Please contact our Insurance Coordinator for enrollment opportunities at 518-268-5458.

Member of ASCENSION HEALTH

You may also contact the Department of Social Services in your county of residence:

Albany County DSS
518-447-7300
162 Washington Avenue, Albany, NY 12210

Columbia County DSS
518-828-9411
25 Railroad Avenue, Hudson, NY 12534

Rensselaer County DSS
518-283-2000
133 Bloomingrove Drive, Troy, NY 12180

Saratoga County DSS
518-884-4140
152 West High Street, Ballston Spa, NY 12020

Schenectady County DSS
518-388-4470
487 Nott Street, Schenectady, NY 12308

Attorney-Client Privileged Information

Child Health Plus

800-698-4543

Este programa del estado de Nueva York es disponible para los niños desde 19 años y menor que viven en el estado de Nueva York y tienen una familia que reúnen los requisitos necesarios de ingresos.

www.health.state.ny.us/nysdoh/chplus

Family Health Plus

877-934-7587

Este programa de seguro de enfermedad público es para los adultos sin seguros que reúnen los requisitos necesarios de ingresos y tienen entre 19 a 64 años.

wwww.health.state.ny.us/nysdoh/fhplus

Healthy New York

866-432-5849

Un plan de seguros de enfermedad para individuos, las empresas pequeñas, y los propietarios únicos.

www.ins.state.ny.us/healthny.htm

Healthy Women Partnership

518-268-5458

Un programa de costo mínimo o sin costo de las revisiones del cáncer de pecho y del cuello del útero para mujeres que:

- Tienen 40 años o más (18 años o más para el examen del pélvico y los exámenes de citología)
- No tienen seguro de enfermedad

O

- Tienen seguros de enfermedad restringidos

Y

- Cumplen con los requisitos de ingresos del programa

Rev 7/9/04 606-21b

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SETON HEALTH

St. Mary's Hospital

Los Alternativos y La Asistencia Para Los Individuos Sin Seguro De Enfermedad

1561

El Departamento del Crédito y Cobro
55 Mohawk Street
Cohoes, New York 12047
518-268-4901

El Coordinator de Seguros
1300 Massachusetts Avenue
Troy, New York 12180
518-268-5458

Attorney-Client Privileged Information

SETON HEALTH
St. Mary's Hospital

La misión del sistema de Seton Health es servir a todas las personas con una atención especial a éstas que no tienen el acceso a los seguros de enfermedad. Todos los días ayudamos a los individuos que no tienen el seguro de enfermedad con las oportunidades de inscripción, también ayudamos con la asistencia económica para los servicios médicos. Nuestros consejeros económicos están aquí para ayudarle en un entoro privado y respetuoso.

Las formas siguientes de pago están disponibles:

- En efectivo, con cheques, con un giro postal, con un cheque bancario, con Visa, Mastercard, American Express, o Discover
- Pagar por cheque por el teléfono. Para utilizar esta opción, llame gratuitamente al 888-571-7949
- Pagar con un plan de financiación para los servicios médicos. Por favor, llame al Departmento del Crédito y Cobro al 518-268-4901 o gratuitamente al 888-571-7949. No hay cobros financieros al pagar con el plan de financiación

- El cuidado de caridad de Seton Health/La Assistencia Financiera ofrece a los pacientes elegibles precios reducidos. Nuestro Programa de la Asistencia Financiera no es un plan de seguros. Se trata de ofrecer la asistencia temporaria. La aprobación es válida por 90 días. Para una solicitud o más información acerca de este programa, por favor contáctese con el Departamento del Crédito y Cobro de Seton Health al 518-268-4901.
- Seton Health puede ayudarle con el proceso de solicitar para inscribir en los programas de Child Health Plus, Family Health Plus, Healthy Women Partnership Program, y Medicaid. Por favor, contáctese con el Coordinator de Seguros para las oportunidades de inscripción al 518-268-5458.

Member of ASCENSION HEALTH

También Ud. puede contactarse con el departmento de Servicios Sociales en su condado de residencia:

Albany County DSS
518-447-7300
162 Washington Avenue, Albany, NY 12210

Columbia County DSS
518-828-9411
25 Railroad Avenue, Hudson, NY 12534

Rensselaer County DSS
518-283-2000
133 Bloomingrove Drive, Troy, NY 12180

Saratoga County DSS
518-884-4140
152 West High Street, Ballston Spa, NY 12020

Schenectady County DSS
518-388-4470
487 Nott Street, Schenectady, NY 12308

Attorney-Client Privileged Information

SETON

CHARITY CARE

SETON has a tradition of serving the poor, the needy and all who require health care services, without regard to a patient's ability to pay for health care costs. Through a variety of programs, SETON provides direct medical care, health screening, health promotion and education free of charge or at discounted rates. For information about charity care programs offered by SETON, eligibility policies of the programs, and/or assistance in applying for charity care, please contact SETON's Patient Financial Services Department located in the Admissions office, 324-7167.

PROGRAMAS BENEFICOS

La tradición de SETON es la de atender a los pobres, los necesitados y a todas las personas que tengan necesidad de servicios médicos, sin reparar en la capacidad del paciente para pagar el costo de la atención médica. Por medio de una variedad de programas, SETON proporciona atención médica directa, exámenes y educacion para promover la buena salud y lo hace por un precio minimo ó precio con descuento. Para mayor informacion sobre los programas benéficos de SETON, las reglas de eligibilidad para estos programas y/o para asistencia en como solicitar atención médica de beneficiencia, por favor, comuniquese con el Departamento de Servicios Financieros para Pacientes de SETON ubicado dentro de la oficina de Admisiones, 324-7167.

1 Texas Administrative Code §355.8065
Approved: SETON Legal Services 09/15/00; 08/01/03

Patient Sign # 2003.02.Eng/Spn

ASCENSION HEALTH

Attorney-Client
Privileged Information

TX, Waco
Providence Healthcare Network

NOTICE OF CHARITY CARE PROGRAM AND POLICIES

As a part of its mission, Providence Health Center provides care to patients without financial means to pay for hospital services. Charity care will be provided to all patients who present themselves for care at Providence Health Center without regard to race, creed, color, or national origin and who are classified as financially or medically indigent.

A financially indigent patient is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for services based, in part, on income and family size. The hospital uses poverty income guidelines issued by the U.S. Department of Health and Human Services to determine a person's eligibility for charity care as a financially indigent patient. A medically indigent patient is a person whose medical and hospital bills after payment by third party payers exceeds a significant percent of the person's annual gross income, in addition to other requirements, and is unable to pay the remaining bill.

Additional information concerning Providence Health Center charity care program and how to apply for charity care can be obtained from the hospital's admitting or business office.

PROVIDENCE HEALTH CENTER
6901 Medical Parkway
Waco, Texas 76712

Attorney-Client
Privileged Information

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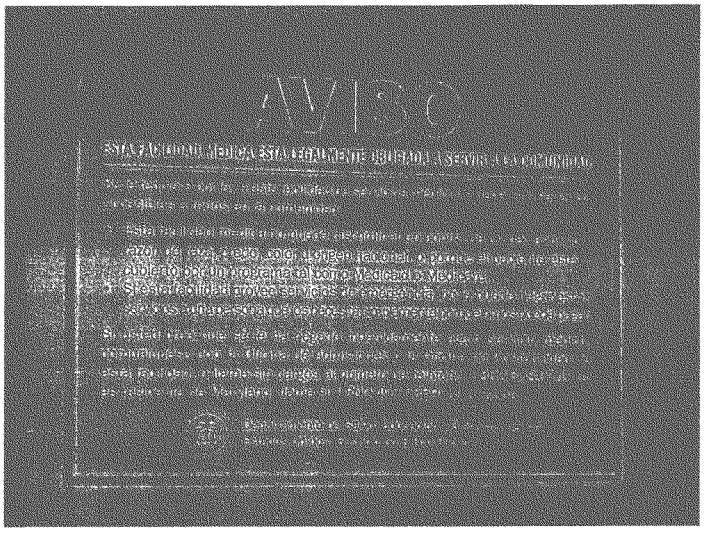
TX, Waco
Providence Healthcare Network



Attorney-Client
Privileged Information
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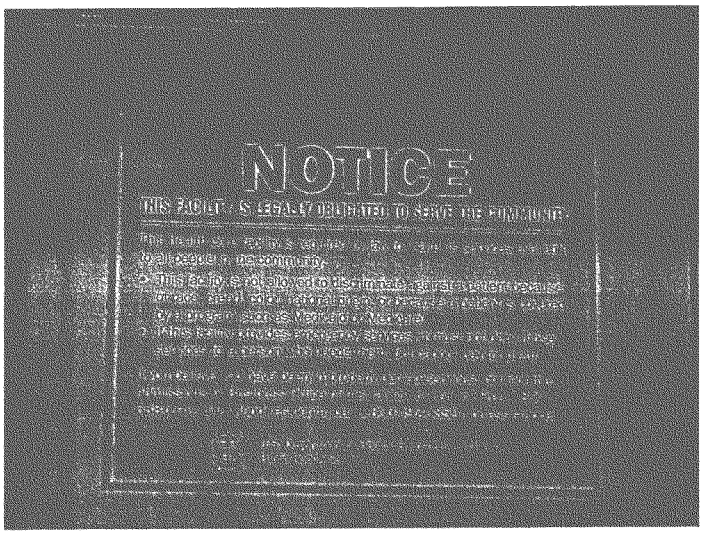
TX, Waco
Providence Healthcare Network



Attorney-Client
Privileged Information 3/9

TX, Waco
Providence Healthcare Network

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Privileged Information
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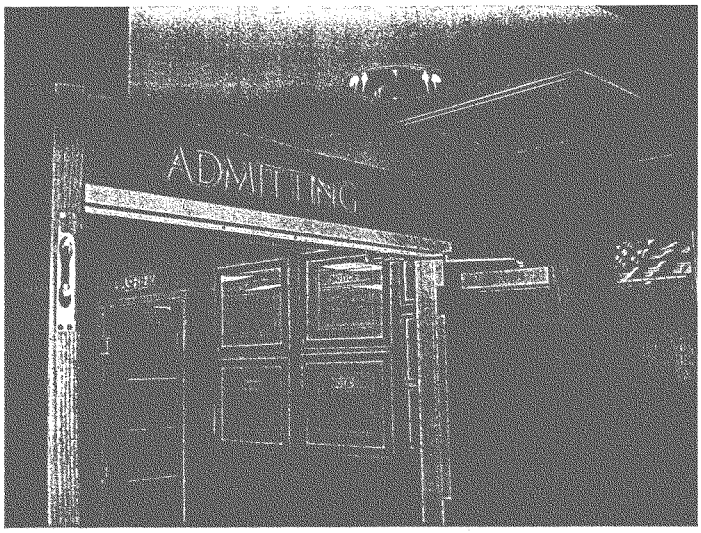
TX, Waco
Providence Healthcare Network



Attorney-Client
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TX, Waco
Providence Healthcare Network

PROVIDENCE *Healthcare Network*

PROVIDENCE HEALTH CENTER
6901 Medical Parkway
Waco, Texas 76712
(254) 751-4000

DEPAUL CENTER
301 Londonderry Drive
Waco, Texas 76712
(254) 776-5970

PROVIDENCE HOME CARE
528 Meadowlake Center
Waco, Texas 76712
(254) 399-2500

ST. CATHERINE CENTER
1700 Providence Drive
Waco, Texas 76707
(254) 755-4800

DATE:_____ Room#_____

PATIENT NAME:_____

ACCOUNT #:_____

Dear_____,

We need the following information filed out completely and returned to me by _____.

_____ Financial Statement (for payment arrangements only)

_____ Assistance Application

Please submit the following items, if applicable, with the above information by _____.

1.) Your last three months payroll or pension stubs

2.) Your spouse's last three months payroll or pension stubs

3.) Your last three months bank statements

4.) Your last two years income tax returns

5.) A copy of the denial from Medicaid/SSI benefits

6.) A copy of your active food stamp card

7.) A copy of your active Green Card (family practice)

8.) A copy of your Housing Authority letter

Your promptness in this matter is appreciated. If you have any questions please contact me at 254) 751-4062.

TX, Waco
Providence Healthcare Network

PROVIDENCE *Healthcare Network*

PROVIDENCE HEALTH CENTER
6901 Medical Parkway
Waco, Texas 76712
(254) 751-4000

DEPAUL CENTER
301 Londonderry Drive
Waco, Texas 76712
(254) 776-5970

PROVIDENCE HOME CARE
528 Meadowlake Center
Waco, Texas 76712
(254) 399-2500

ST. CATHERINE CENTER
1700 Providence Drive
Waco, Texas 76707
(254) 755-4800

Dear Sir/Madam:

Please find enclosed the application and list of information needed to assist you with your medical bills. This paperwork is needed to review for financial assistance for Hospital only. If you are unable to provide the requested paperwork, please explain at the bottom of this page.

YOUR COMMENTS:

_____

_____

_____

_____

_____

_____

Attorney-Client
Privileged Information

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TX, Waco
Providence Healthcare Network

CREDITOR #5	ADDRESS	MO. PAYMENT	TYPE ACCOUNT	BALANCE OWED
TOTALS		TOTAL $		TOTAL $

REAL ESTATE OWNERSHIP OTHER THAN RESIDENCE	MONTHLY PAYMENT	MORTGAGE COMPANY	BALANCE OWED

HAVE YOU OR ANY MEMBER OF YOUR FAMILY PREVIOUSLY BEEN A PATIENT AT PROVIDENCE HEALTH CENTER?

NAME: RELATIONSHIP: DATE:

MONTHLY BUDGET	
RENT/MORTGAGE	$
FOOD	$
UTILITIES	$
INSURANCE	$
MEDICAL	$
TOTAL CREDITORS, PREVIOUS PAGE	$
MISC.	$
MISC.	$
TOTAL EXPENSES	$
NET INCOME	$
MARGIN	$

ADDITIONAL COMMENTS:

Applicants for Financial Assistance (hospital care at no charge or at a charge less than the usual charge) must complete the Financial Statement above as well as the following additional items.

NAMES OF ALL MEMBERS OF HOUSEHOLD:

HEAD OF HOUSEHOLD _____ AGE _____ SPOUSE _____ AGE _____

DEPENDENT _____ AGE _____ DEPENDENT _____ AGE _____

DEPENDENT _____ AGE _____ DEPENDENT _____ AGE _____

DEPENDENT _____ AGE _____ DEPENDENT _____ AGE _____

TOTAL INCOME FOR HOUSEHOLD OVER MOST RECENT 12-MONTH PERIOD: $_____ TOTAL INCOME, MOST RECENT MONTH: _____

TOTAL INCOME, TWO MONTHS AGO: _____

ANNUAL INCOME: _____ TOTAL INCOME, THREE MONTHS AGO: _____

I hereby authorize this hospital, its agents, or any credit bureau or similar agency to investigate any references, statements or other data given by me or any other person pertaining to my credit and financial responsibility. I understand that all accounts are to be settled in full at discharge unless other arrangements are made and accepted by the hospital.

DATE: _____ SIGNATURE OF WITNESS: _____ SIGNATURE: _____

Attorney-Client Privileged Information

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WI, Milwaukee
Columbia St. Mary's

APLICACIÓN PARA EL PROGRAMA CUIDADO DE LA COMUNIDAD

Favor de escribir a máquina ó en letra de molde.
Toda la información debe estar completa.

Número de cuenta del paciente_____

Nombre del paciente Dirección

Ciudad/Estado/ Código postal Condado Sexo Mas. Fem.

Teléfono Fecha de nacimiento(m/d/a) NO.de Seguro Social Tiempo de Residencia

Persona responsable Parentezco No. de Seguro Social Tiempo de Residencia

No. de dependientes Nombres y edades de dependientes

Empleo, presente o pasado (paciente) Empleo, presente o pasado (esposo/a)

Dirección Dirección

Teléfono Tiempo de empleo Teléfono Tiempo de empleo

Ocupación(paciente) Ocupación(esposo/a)

Fuente de ingresos mensuales	**Paciente**	**Esposo/a**
Salarios, desempleo, Sueldo		
Fincas/Herencias		
Pensiones/Seguro Social		
Intereses/Beneficios		
Negocios/Rentas		
Sustento a niños/esposa		
Reclamos de lesiones		
Otros		
Ingresos mensuales totales		

Attorney-Client
Privileged Information

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WI, Milwaukee
Columbia St. Mary's

BIENES	NOMBRE	CANTIDAD
Ahorros		
Cuenta de Cheques		
Acciones/Bonos Valor al contado		
Seguro de Vida-Valor al contado		
Otros		
TOTAL DE BIENES		

PROPIEDADES-TIPO	AÑO	VALOR ESTIMADO	MODELO/TIPO
Hogar			
Negocio **			
Auto/ Troca			
Motocicleta			
TOTAL			

Yo certifico que la información de arriba es verdad y completa. Ud está autorizado a ponerse en contacto y obtener verificación de la información de cualquier medio del cual Ud lo crea pertinente tocante a esta aplicación. Cuando no hay ingresos reportados, explique cómo es que Ud está saliendo al tanto con sus gastos diarios en la sección de comentarios.

Si no llenó sus planillas de impuestos de _____ debido al nivel de sus ingresos, por favor firme aquí.

FIRMA_____

Paciente ó representante Legal Fecha

**Dirección (negocio)

Attorney-Client
Privileged Information

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WI, Milwaukee
Columbia St. Mary's

PROGRAMA DEL CUIDADO DE LA COMUNIDAD

Fecha:_____

Estimado Paciente:

El Hospital Columbia St. María ha revisado su aplicación para el programa del cuidado de la comunidad. Basada en la información proveída, su petición ha sido:

_____**Aceptada***

Columbia St. María se encargará de el _____% de su cuenta del hospital, etc. con la exepción de sus artículos personales, i.e., comidas para visita, renta de la televisión etc.**después de todas las opciones de pagos de terceras personas** (seguro médico, programas de asistencia del condado, estatal ó federal) **hayan sido utilizadas.**

El balance de la cuenta que Usted debe es $_____. Por favor haga su cheque a nombre de Columbia St. Mary's Columbia Campus / Milwaukee Campus / Ozaukee Campus (basada en el lugar que se le prestaron los servicios), Attn: Business Office, 2025 East Newport Avenue, Milwaukee ,WI 53211

Esta determinación de elegibilidad es solamente para los cargos del hospital: cualquier otro cobro que reciba el paciente será arreglado entre el paciente y el proveedor del servicio que le está cobrando, i.e., médicos, Radiología Diagnóstica, farmacia, ambulancia, etc.

Los servicios deben ser prestados dentro de 90 días de la fecha de aceptación. Ésta aplicación se puede renovar después de 90 días.

_____**Negada***

Razón por lo que ha sido negada:

_____

_____

***Pólica de Apelación**

Usted tiene el derecho de apelar la decisión inicial que le negó el Programa del Cuidado de la Comunidad. Usted tiene que mandar su cuestión por escrito, y su petición para una Audiencia de Apelación. Favor de mandar su apelación a la atención de Líder de Equipo, Oficina de Negocios.

Revisado por_____

Si Usted tiene alguna pregunta referente a ésta determinación por favor póngase en contacto con el Consejero de Finanzas en

_____

Attorney-Client
Privileged Information 3/94

WI, Milwaukee
Columbia St. Mary's

Date:

Patient Name:

Account Number(s):

Dear :

Enclosed please find a Charity Care Application that you have requested to possibly help reduce your bill(s).

Please fill out the form completely and send the following supporting documentation:

1. Most recent tax returns - Federal and State
2. Bank Statements - Checking, Savings and Investment Accounts
3. Copy of your most current paycheck with year-to-date gross earnings.
4. Documents of home/business mortgage & equity in home/business.
5. Documents of auto/truck loans & equity in vehicles.

Please send completed form and supporting documentation to:

Columbia St. Mary's
4425 N Port Washington Road
Glendale, WI 53212
Attn: Patient Accounts

If you are uncomfortable with sending this information through the mail or need help with filling out this form, please contact a Financial Counselor to set up an appointment to meet with you.

Financial Counselors:

Columbia Hospital
Joan - (414) 961-8174

St. Mary's Milwaukee
Nikisha - (414) 291-1098
Anitra - (414) 291-1097

St. Mary's Ozaukee
Kathy - (262) 243-7440

Thank you for your cooperation with this matter.

Sincerely,

Customer Service
Columbia St. Mary's Hospital
(414) 326-1900

Attorney-Client
Privileged Information 4/6

WI, Milwaukee
Columbia St. Mary's

	Columbia
	SMM
	SMO
	SHRI

Columbia St. Mary's
A Passion for Patient Care

Community Care Program Application

PLEASE TYPE OR PRINT: ALL INFORMATIN MUST BE COMPLETED

Patient Account Number: _____

Patient Name		Address	
City, State, Zip Code		County	sex ❑ Male ❑ Female
Telephone	Birth date (mm/dd/yy)	Social Security Number	Length of Residency
Responsible Party	Relationship	Social Security Number	Length of Residency
Number of Dependants	Name(s) & Ages of Dependents		

Present of Last Employer (patient)		Present or Last Employer (spouse)	
Address		Address	
Telephone	Length of Employment	Telephone	Length of Employment
Occupation (patient)		Occupation (spouse)	

ALL SOURCES OF INCOME	Patient	Spouse
Salaries, wages & Unemployment		
Pensions / Social Security		
Interests / Dividends		
Business / Rental		
Child Support / Alimony		
Estate OR Trust		
Injury Claims		
All Other / TSA		

Attorney-Client
Privileged Information

5/6

WI, Milwaukee
Columbia St. Mary's

Assets	Name	Amount
Savings		
Checking		
Stocks / Bonds-Cash Value		
Life Insurance-Cash Value		
All Other / TSA		
Estate OR Trust		
Injury Claims		
All Other / TSA		
TOTAL ASSETS		

Property-Type	Year	Estimated Value	Make/Model	Equity
Home				
Business				
Auto / Truck				
Motorcycle				
TOTALS				

I certify the above information is true and complete. You are authorized to contact and obtain, from any source, verification of the above information or any other information you deem necessary relative to this application to include a credit bureau report. Documentation is required with completed application. When no income is listed, explain how you are meeting your day to day expenses in the marked section.

Documentation of all income is required for the last 12 months, most current pay stub with year to date amount and current tax return.

If you did not file income tax returns for _____ due to your income level, please sign here
(year)

_____
Signature

_____ _____
Patient or Legal Representative Date

_____
****Address (Business)**

_____ _____
Interviewed By Date

Attorney-Client
Privileged Information
6/10

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 5

For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of poverty? Are there plans to change the discount percentage rates as charges rise?

Our Ascension Health Policy # 16 Billing and Collection for the Uninsured (Ascension Health Policy) was developed based on input from CEOs, CFOs, Vice Presidents of Mission, and Religious Sponsors from all of our hospitals. In various forums, we discussed the most prevalent practices, the socially just expectations, and surveyed current charity care sliding scale programs at the hospitals.

Our Ascension Health Policy has included a **minimum** requirement that any patient whose income is at 100% of the federal poverty levels (FPL) will be provided a 100% write-off of their account. Those patients at 101% to 200% of the federal poverty levels will be provided a sliding scale adjustment. These FPLs may be adjusted for regional differences based on Medicare wage-rate adjustments or other appropriate regional cost of living measures. We have determined that incomes in certain states have less ability to cover a patient's bill than in other states. For example, Bridgeport, Connecticut has a more expensive cost of living than Mobile, Alabama. Many of our hospitals exceed these minimum standards. When determining whether to be more generous than the Ascension Health Policy, local management considers local community standards and historical practices.

As circumstances changes, we will go back through our process.

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 6

Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?

The total amount we received for Medicare DSH, Medicare bad debt payments, Medicaid disproportionate share payments, and various local programs is less than the costs incurred in providing charity and uncompensated care and community benefit programs.

To reiterate testimony already given, Ascension Health provided $566 million in unreimbursed cost for charity and community benefit programs in fiscal year 2003 (unaudited). Included in this number is the following related specifically to the Data Reporting Group; **all amounts represent costs (not charges) and all related reimbursements have been deducted from the amounts, so that they all represent unreimbursed costs:**

- $141 million of services to patients qualifying for charity care programs
- $248 million of services provided to Medicaid patients
- $25 million of community programs aimed specifically at the poor
- $114 million of other community programs.

Medicare disproportionate share (DSH) payments are made to hospitals that serve low-income patients. In fiscal year 2003, the Ascension Health Data Reporting Group received $76.2 million in Medicare DSH payments. Payment is based on a threshold measure that includes the percentage of inpatient hospital days attributable to Medicare patients in the Federal Supplemental Security Income (SSI) program, and the percentage of inpatient days attributable to Medicaid patients. There is no measure for uncompensated care in the Medicare DSH payment formula. The $76.2 million of Medicare DSH payments increased fiscal year 2003 Medicare payments and paid for costs incurred serving the Medicare population, costs of which are not reported in the four categories of charity and community benefits reported above.

Medicare bad debt payments reimburse hospitals for costs incurred related to services to Medicare patients who do not pay their deductible and/or coinsurance. This reimbursement is considered additional Medicare revenue for payment of services to Medicare patients. Our most recent study indicates approximately $20.8 million of

Question # 6

Medicare bad debt requested reimbursements were filed in the most recent cost reports of the Data Reporting Group. These amounts are subject to audit by local Medicare Fiscal Intermediaries, and the ultimate reimbursement may be less than this amount.

Medicaid disproportionate share (DSH) payments are made to hospitals based on varying state requirements of eligibility, most commonly based on charity care or other measures of uncompensated care. In fiscal year 2003, the Ascension Health Data Reporting Group received approximately $22.9 million in Medicaid DSH programs. We account for these receipts as Medicaid revenue. The same reporting group reported that costs to serve the Medicaid population exceeded the amounts paid by the Medicaid program (including the Medicaid DSH payments) by $248.4 million (unaudited).

There are **various local programs** to assist our hospitals in their mission to serve the poor. Approximately six states included in the Data Reporting Group described such programs in our data submission to the Subcommittee last October. Reimbursement from these local programs, if designated to serve the poor, has been deducted from our reported uncompensated care for charity and other programs for the poor reported above. Regarding tax breaks, our hospitals are non-profit, tax exempt organizations. As a result, they do not incur tax liabilities that, under state or federal law, would be reduced on account of the amount of their charity and uncompensated care.

Conclusion

The total amount we received for Medicare DSH ($76.2 million), Medicare bad debt reimbursement ($20.8 million estimated maximum) is significantly less ($431 million) than the costs to deliver charity and uncompensated care and community benefit to the communities we serve.

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 7

Did the HHS / OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self-pay patients? What specific further guidance is needed?

Guidance provided in recent months has been helpful and encouraging. In addition to the guidance provided, we met with representatives from CMS and HHS on May 3rd and 4th.

However, we still have concerns regarding this guidance. We need assurances from CMS that the adoption of a discount for uninsured patients will not permit a Fiscal Intermediary to define "charges" as the discounted amount, rather than the posted, full charge amount.

CMS indicated in their February 19, 2004 Q&A document, and again in their testimony to the Subcommittee on June 24th, that "it is also important to note that in very limited circumstances, Medicare reimbursement could be affected by the "lesser of cost-or-charge," or "LCC" principle." In its testimony of June 24th, CMS stated:

> "Implementing a reduced charge program for uninsured patients could potentially trigger the LCC principle because if a hospital lowered charges for enough patients, a hospital's fiscal intermediary could take the position that a hospital's charges were not its posted, or stated, charges, but rather, the charges applicable to most of its patients who were receiving discounted services. If the FI did take that position, it could then invoke the LCC principle and pay the hospital that lower charge-based amount.
>
> Few providers are subject to the principle at all. The only example I am aware of is a pediatric or cancer hospital in its first year of operation, before it becomes subject to the TEFRA methodology...."

Based on this information, we believe we have correctly concluded that CMS has agreed that universal discounts to all patients, including those with the means to pay, could result in the determination that a hospital's "charges" are not the posted, full charge amount, but instead the discounted amount.

While we agree that most Medicare reimbursement is currently not driven by charges, these few exceptions may be an issue for Ascension Health in the future. With 150 health facilities in 20 states, it is likely that we will have just such a situation in the future, when a pediatric or cancer hospital opens. For example, in fiscal year 2003, we

Question # 7

opened a new Children's Hospital in Indianapolis. We are also planning the construction of a new Children's Hospital in Austin, Texas.

With our national geographical presence, we work with many different Fiscal Intermediaries in multiple markets. CMS has indicated that Fiscal Intermediaries might not interpret this rule consistently. This is problematic for a national health system, and we want clarity from CMS.

Finally, we are not certain that first-year cancer and pediatric hospitals are the only providers impacted by LCC provisions. We believe the impact of this could be more far-reaching than indicated by CMS. The following highlight some of our concerns.

1. Critical access hospitals are currently not impacted by LCC provisions. However, future regulations could change, and LCC provisions could be implemented at these cost reimbursed facilities.

2. Many State Medicaid reimbursement programs apply a "usual and customary charge" rule to charges and determine a payment based on a percentage of this amount. If all charges are discounted, Medicaid could conceivably apply the discount to the lower, discounted charge to derive a lower payment.

3. Many Medicaid reimbursement programs pay based upon a fee schedule with a lower of charge or fee schedule provision. Similar to the LCC provision, charges could be considered to be the lower, discounted amount, and reimbursement reduced.

4. Payments for new technology and outliers could conceivably be impacted by the Fiscal Intermediaries if they conclude charges are the discounted charges and not posted, or stated, charges.

5. Hospitals negotiate many payment arrangements with commercial insurers and managed care organizations using charges as a base, and a discount determined on that base. If the Fiscal Intermediary at a hospital were to conclude that charges were the discounted charges provided to the uninsured, commercial payors could take the position that their reimbursement formulas should be based on the discounted charges, rather than full charges. The Fiscal Intermediary interpretation/conclusion could create a significant commercial insurance payment issue for a hospital.

We have asked CMS for assurances that the adoption of a discount for uninsured patients should not be interpreted by a Fiscal Intermediary to restate posted charges.

Question # 7

Our meeting in May was positive, and we were optimistic that we would receive the assurance we were seeking.

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 8

Have you ever reviewed and investigated complaints from patients against any of your collection agencies?

Our new Ascension Health Policy # 16 Billing and Collections for the Uninsured (Ascension Health Policy) requires that any collection agency engaged by one of our hospitals must sign a commitment to honor the principles and requirements of our Ascension Health Policy. A copy of the Ascension Health Policy, including the amendment which the collection agency must sign, is attached as a copy.

Our practice is to always follow up with collection agencies when a patient has registered a complaint. Based on discussions with management at our hospitals, we believe patient complaints regarding collection agencies are infrequent. Most of the complaints involve questions regarding amounts owed to the hospital or whether insurance has already paid. These questions are not unusual due to the complexity of billing and patient accounting. Complaints about the conduct of collection agency staff are uncommon.

Attachment:

Ascension Health Policy # 16 Billing and Collections for the Uninsured with Amendment

SYSTEM POLICY#: 16	**SUBJECT: Billing and Collection for the Uninsured**
BOARD APPROVAL DATE:	**12/10/03**
EFFECTIVE DATE:	**07/01/04**
REVISION DATE:	

Chief Operating Officer and
Interim CEO, Ascension Health

POLICY

It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital or medical center and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does

not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
    b. Patients receive prompt access to charge information for any item or service provided.
    c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
    f. Financial counselors are available to all Patients.
    g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
    h. Hospital programs that include nominal payments by Patients designed to encourage Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
    a. At a minimum, Patients with income less than or equal to 100% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
    b. At a minimum, Patients with incomes above 100% of the FPL but not exceeding 200% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
    c. Eligibility for charity care may be determined at any point in the revenue cycle.
    d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.

6. Financial Assistance
    a. Patients with income greater than 200% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
    b. The assessment of a Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments,

utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
e. Eligibility for financial assistance may be determined at any point in the revenue cycle.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. This discount may be adjusted by the hospital in an amount up to 5% to reflect that there are not prompt pay or volume commitments that are typically provided for in negotiated insurance contracts.
   c. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   d. A prompt pay discount must be provided to all of these Uninsured Patients.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
      ii. The lien will not result in a foreclosure on a personal residence.
      iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital.
   b. Garnishments of wages are permitted only if:
      i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, <u>and</u> a court determines that the Patient's wages are sufficient for garnishment.
      ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
   c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
   d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
   e. Interest charges on outstanding balances may only be assessed if:
      i. The Patient does not qualify for charity or financial assistance, <u>and</u> the Patient is not complying with payment arrangements and,
      ii. No add-on to minimum discount is applied in accordance with Section 7b.
   f. Management is accountable to ensure that all collection policies follow the federal

Fair Debt and Collection Practices Act.

g. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

Questions for the Record to Ascension Health
Subcommittee on Oversight and Investigations
"A Review of Hospital Billing and Collection Practices"
June 24, 2004
As requested by Hon. James C. Greenwood, Chairman on July 14, 2004

Question # 9

Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse all other means of paying undiscounted charge master rates (except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?

Ascension Health's mission is to serve the poor. Our policies and procedures have been designed to serve the poor and provide charity assistance on a proactive basis. This can occur by the patient asking for assistance after seeing our publications or notices, by a registrar discussing payment options at registration, by a financial counselor discussing payment obligations with a patient during or after his/her stay, or when a patient calls the business office after receiving a bill that indicates financial assistance programs are available. As is stated in our new Ascension Health Policy # 16 Billing and Collection for the Uninsured, charity and financial assistance can be provided at any point in the revenue cycle. This can occur at scheduling, pre-registration or registration, while a patient is an inpatient, while a patient is in the emergency room, after discharge, and even after an account has been forwarded to a collection agency.

In order to provide charity care or financial assistance to those who are eligible, the patient or patient's family needs to be responsive and cooperate with the hospital in providing necessary information about their financial status. We want those who are eligible to have access to charity care, financial assistance or public assistance programs. However, in some cases, it is only when the patient is provided the bill and confronted with the dilemma that they cannot pay the bill that the most meaningful discussion will occur. We cannot attest that we never ask for full payment before offering charity or financial assistance, but we can attest that this would occur only when we believe we have communicated our assistance to the patient in a respectful, dignified way, and the patient has not responded that they need assistance.

Our Ascension Health System-wide Policy requires the following:

> *Each hospital must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.*

CATHOLIC HEALTH
INITIATIVES

A spirit of innovation, a legacy of care.

1999 Broadway
Suite 2600
Denver, CO
80202

Phone 303.298.9100
Fax 303.298.9690

July 22, 2004

Representative James C. Greenwood
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515-6115

Dear Representative Greenwood:

As requested I am submitting responses on behalf of Catholic Health Initiatives to the questions you sent in your letter of July 14, 2004 as a follow up to the Subcommittee on Oversight & Investigation hearing entitled: "A Review of Hospital Billing and Collection Practices". These responses are being submitted in writing as you have requested.

Catholic Health Initiatives remains committed to providing health care to the most vulnerable members of our communities, regardless of ability to pay.

Sincerely,

Kevin E. Lofton

Kevin E. Lofton
President & CEO

cc: The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight and Investigations

QUESTIONS FOR THE RECORD TO CATHOLIC HEALTH INITIATIVES

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
"A REVIEW OF HOSPITAL BILLING AND COLLECTION PRACTICES"
JUNE 24, 2004

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1. Please produce for the record a complete copy of all current written policies and procedures for your charity and collection practices with respect to uninsured/self-pay patients.

Response:

Each facility within Catholic Health Initiatives is expected to establish and implement policies and procedures based on the overarching Catholic Health Initiatives standards and guidelines, which are attached. CHI facilities are non-profit corporations in the states in which they operate and have fiduciary boards of directors, which are responsible for mission effectiveness and operational performance. Policies and procedures are maintained at each facility.

Attachment 1 - 1:
CHI Financial Standards and Guidelines Manual:
Section 5: *MBO and Third-Party Collection Agents and Self-Pay Protocols* (March 2004)*

Attachment 1 - 2:
CHI Financial Standards and Guidelines Manual:
Section 4: *Uninsured/Underinsured Patient Discounts (Charity Care)* (revised, June 2004), a revision of the previously submitted Standard

- Exhibits 1 – 9

Attachment 1 - 3:
CHI Financial Reporting Manual
Inhouse Collections Implementation Guide - Section 19 (February 2001)

- Education Materials

Attachment 1 - 4:
CHI Financial Reporting Manual
Prompt Pay and Third-Party Discounts – Section 18 (July 2002)

** Note: Catholic Health Initiatives uses the term "market-based organization" or "MBO" to include a configuration of one or more health care facilities that serve a defined geographical community.*

2. If your system has implemented any changes recently to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the date of implementation of each such change. If your system is planning changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients, please state the planned date of implementation of each such change.

Response:

Each facility within Catholic Health Initiatives is expected to comply with the following implementation dates in regard to the two recently-issued/revised standard documents referenced in the response to Question 1. More detailed information about the implementation dates is included in each referenced document. As noted above, policies and procedures for each facility, as well as individual implementation dates, are maintained at each facility.

Implementation by April 2004 – CHI Financial Standards and Guidelines Manual: Section 5: *MBO and Third-Party Collection Agents and Self-Pay Protocols* (Attachment 1 - 1)

Implementation by July 2004 – CHI Financial Standards and Guidelines Manual: Section 4: *Uninsured/ Underinsured Patient Discounts (Charity Care)* (Attachment 1 - 2)

Hospital management is presently re-evaluating all standards and guidelines documents to assure all aspects are clearly defined and stated and that the required and recommended practices are fair to all patients. An internal audit process is also being developed to monitor the consistent application of these policies across all CHI facilities.

3. Please produce for the record all training materials for system employees with respect to any recent changes to your charity and collection policies and procedures with respect to uninsured/self-pay patients.

Response:

Two national conference calls were conducted to orient key management-level employees at each facility to two recently-issued/revised standard documents noted above.

The first conference call was conducted on March 26, 2004, to review implementation requirements for the CHI Financial Standards and Guidelines Manual: Section 5: *MBO and Third-Party Collection Agents and Self-Pay Protocols (Attachment 1 – 1).* Subsequent to the call, a three-page Frequently-Asked Questions (FAQ) document was prepared and distributed to facility personnel in patient financial services.

Attachment 3 - 1:
MBO and Third Party Collection Agent and Self-Pay Protocols
Frequently Asked Questions
Prepared after March 26, 2004 Conference Call

A second conference call to discuss implementation requirements for the CHI Financial Standard: *Uninsured/Underinsured Patient Discounts (Charity Care)*, was conducted on June 24, 2004. Attached are the 40 slides used during the conference call and a two-page FAQ document that was developed after the June 24, 2004 call.

Attachment 3 - 2:
Catholic Health Initiatives: Charity Care Standards and Guidelines
Conference Call, June 24, 2004
Slides (40)

Attachment 3 - 3:
Questions/Answers: Charity Care Conference Call
June 24, 2004

During both conference calls, facilities were asked to conduct training sessions on site, utilizing both the standards document and the materials provided for the conference calls. As noted previously, policies and procedures for each facility, as well as individual implementation dates, are maintained at each facility.

Educational materials were first developed for hospital-based (inhouse) patient financial services staff in March 2001. Samples of educational materials are included in Attachment 1 – 3, Catholic Health Initiatives, Financial Reporting Manual *Inhouse Collections Implementation Guide – Section 19; Education for Inhouse Collections, Facilitator's Guide, March 2001; and Education for Inhouse Collections, Slides.*

4. How are patients made aware of your charity policy and how is the substance of that policy made available to patients, e.g., brochures, postings in the hospital or on the system website?

Response:

The processes by which Catholic Health Initiatives facilities are to make patients aware of our charity policies are outlined in the two recently-issued/revised standard documents noted above. This information was also submitted to the Subcommittee prior to the June 24, 2004 hearing.

As noted in the CHI Financial Standard: *MBO and Third-Party Collection Agents* standards document, each facility is required to perform a reasonable review of each inpatient account, prior to turning an account over to a third-party collection agent and prior to instituting any legal action for non-payment, to assure that the patient and patient guarantor are not eligible for any assistance program (e.g., Medicaid) and do not qualify for coverage through the facility's charity care policy. After having been turned over to a third-party collection agent, any account that subsequently is determined to meet the facility's charity care policy shall be returned immediately by the third-party collection agent to the facility for appropriate follow-up.

As noted in the CHI Financial Standard: *Uninsured/Underinsured Patient Discounts (Charity Care)* standards document, patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition. If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be made as soon as possible and can be made up to 18 months after the provision of such services.

Facilities are required to identify the availability of financial assistance in information booklets provided to patients and in general information provided on the MBO website. Facilities are to provide patients without Medicare/Medicaid, other local health care financial assistance or adequate health insurance either (1) packets of information to clearly indicate that the facility provides care, without regard to the ability to pay, to individuals with limited financial resources, and explain how patients can apply for financial assistance or (2) immediate financial counseling assistance from staff, including the presentation of an application for financial assistance.

Response to Question 4, continued

Facilities with remaining Hill-Burton obligations are required to clearly post signs containing the following words: "NOTICE-Medical Care for Those Who Cannot Afford to Pay" in admissions areas, business offices, emergency rooms and other appropriate areas. Facilities with Hill-Burton obligations are required to conspicuously post signs provided by the U. S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), printed in both English and Spanish. As required by Hill-Burton, facilities shall post and translate signs into languages other than English and Spanish if the other languages are used by 10% or more of the population in the MBO service area, based on census reports. Facilities without Hill-Burton obligations are required to clearly post signage in English to advise patients of the availability of financial assistance. Signs are to be posted in other languages in instances where 10% or more of the local population speaks a foreign language. Facility staff members are required to communicate the contents of signs to people who do not appear able to read.

As noted previously, the individual policies, procedures and communications materials for each facility, as well as individual implementation dates, are maintained at each facility.

5. For systems considering or using a "sliding scale" as part of your charity program, how were the discounts determined for each level of poverty?

Response:

CHI facilities are located in 68 communities in 19 states. Each community has very different social and demographic circumstances. The assignment of a discount level for each level of poverty varies by location to help ensure that as many uninsured patients as possible qualify for charity care.

HUD income guidelines are used to provide discount levels because they consider the economic conditions for each county in which CHI facilities are located and for the counties of residence of all patients. Catholic Health Initiatives ties discounts to the HUD Very Low Income guidelines because that level provides charity care discount eligibility that is consistent with 200% - 300% of the Federal Poverty Limit across all counties.

As a result, Catholic Health Initiatives provides a "sliding scale discount" which ranges from 130% - 195% of the HUD Very Low Income guidelines. This method provides a greater aggregate charity care discount. CHI hospitals use HUD Very Low Income guidelines because they are more inclusive than other poverty guidelines.

5-a. Are there plans to change the discount percentage rates as charges rise?

Response:

Catholic Health Initiatives will evaluate improvements to the discounting standards as warranted. At this time there are no plans to change the discount rates as charges are revised in future periods. HUD updates these income levels annually and thus, an increasing level of income will result from the required use of the updated HUD data. Of course, medical indigence would be considered in granting charity care to patients with income above these levels. On an annual or as-needed basis, management conducts reviews of policies, standards and guidelines to determine if changes are necessary, depending on circumstance and need.

6. The AHA states that in 2002 the nation's hospitals provided $22.3 billion in uncompensated care; that is, "charity and other care, for which no payment is received." That same year, Medicaid and Medicare disproportionate share hospital payments, as well as bad debt payments for Medicare patients, totaled $22.6 billion. Is the sum your system receives each year, from state and federal agencies for providing uncompensated care to the poor, through DSH funds, bad debt reimbursements and tax breaks, less or more than what it costs you to deliver charity and uncompensated care and by approximately how much?

Response:

To respond to this question, it is necessary to clarify the context, purpose and nature of DSH funds. The intent of DSH was never to pay hospitals for providing uncompensated care to the poor or to non-Medicare patients, whether charity or otherwise.

DSH was provided on the basis that poor Medicare patients consume more resources than patients who are not poor. The fixed payments of the Medicare Inpatient Acute Care Diagnosis Related Groups (DRGs) prospective payment system were based on the "average" Medicare patient with the related diagnosis. Hospitals serving a disproportionately large number of poor Medicare and other government-insured patients would be underpaid without the additional DSH payment.

Hospital DSH payments are determined for specific providers that meet a combined indigent factor threshold based on these two measures: (a) the percentage of the allowable inpatient acute care days for Medicare patients receiving Supplemental Security Income from the Social Security Administration divided by total allowable inpatient acute care Medicare days, (b) and the percentage of inpatient acute care Medicaid Eligible days divided by total hospital inpatient acute care days. DSH does not include a measure for uncompensated care.

Therefore, DSH was intended by Congress to mitigate the financial risk of qualifying hospitals (i.e., providers that serve a significant number of government-funded indigent patients), due to the fixed payments of the Medicare Inpatient Acute Care DRGs prospective payment system.

Over the past three fiscal years, Catholic Health Initiatives provided nearly $1.9 billion in community benefit to the poor and the broader community, averaging about 10% of total consolidated revenues each year. Of this amount, Catholic Health Initiatives facilities provided $300 million in direct subsidization of charity care. This is the estimated cost of providing the care, not what was charged. During the same three years, fiscal years 2001 through 2003, CHI facilities filed estimated DSH payments of $172 million to Medicare.

Response to Question 6, continued

It also is important to clarify that Medicare bad debt reimbursement does not represent "supplemental" payments. Medicare bad debt reimbursement represents reimbursement for the deductible and coinsurance amounts subtracted by the Medicare fiscal intermediary in processing net payments to a provider. These are payments which the Medicare beneficiary or secondary payer should have paid, but did not pay. Thus, they represent allowable Medicare bad debts. In actuality, the reimbursement of Medicare bad debts pays the provider a portion of the deductible and coinsurance amounts to which it is entitled.

All facilities within Catholic Health Initiatives comply with federal, state and local regulations governing the taxes and, as a result, make significant payments to such governing authorities in the normal course of business (e.g., income taxes, sales and use taxes, property taxes and payroll taxes). Because Catholic Health Initiatives is a tax-exempt organization, it does not estimate the amount of taxes not paid to federal, state and local governments by its facilities.

One CHI facility has estimated how its tax-exempt status benefits the community it serves. If Good Samaritan Health Systems, in Kearney, Nebraska, was a for-profit corporation, its estimated 2003 bill for federal, state, property and sales taxes would be $3,370,201. In fiscal year 2003, Good Samaritan Health Systems provided community benefit worth $28,321,935 to the residents of Kearney, more than eight times its tax liability. These health programs and services benefited the poor and broader community.

7. Did the HHS/OIG guidance over the past several months answer all the questions or concerns your system has with respect to charity, billing and collections for uninsured/self- pay patients? What specific further guidance is needed?

Response:

Catholic Health Initiatives is appreciative of the recent HHS/OIG guidance. This guidance from HHS/OIG has provided an opportunity for Catholic Health Initiatives to expand eligibility and to simplify the charity care documentation requirements for the facilities. However, the HHS/OIG guidance appears to require these decisions be made on a case-by-case basis on the basis of hospital charity care policies. Catholic Health Initiatives will continue dialogue with HHS/OIG officials on a hospital's ability to discount charges to the group of essentially middle-class patients who do not meet a hospital's charity policy but have no insurance and are unable to pay their medical bills.

The testimony of Lewis Morris, chief counsel of the HHS Office of Inspector General, before the Oversight and Investigations Subcommittee on June 24, 2004, appeared to reinforce the need for hospitals to make individual determinations of eligibility for charity or discounted care. When asked by the Chairman if hospitals could apply discounts across the board to anyone without insurance, Mr. Morris responded: ". . . There would need to be an individual determination." Catholic Health Initiatives would appreciate further clarification from HHS/OIG about a hospital's ability to discount charges to patients who may fall just outside of the charity care policies.

8. Have you ever reviewed and investigated complaints from patients against any of your collection agencies?

Response:

Yes. There is a process by which every patient complaint against a collection agency that alleges treatment not consistent with Catholic Health Initiatives Mission, Core Values and Standards of Conduct, or that alleges excessive treatment of an adverse nature, is investigated thoroughly and resolved as quickly as possible.

9. Does your system ever expect or require uninsured/self-pay patients to first exhaust or refuse all other means of paying undiscounted charge master rates (except any standard prompt pay discount) such as through a bank loan or credit card, before notifying or seeking to qualify the patient for your charity program?

Response:

Catholic Health Initiatives facilities require a patient (or a patient's guarantor) to explore other means of financial assistance, for example, insurance, liability coverage and coverage available under federal, state, local and county programs. The determination of charity care discounts, or other financial assistance, is based on a review of a patient's income and/or assets. If a patient is able to provide the necessary information to determine indigence, or medical indigence, a charity care discount will be provided.

CHI facilities do not ask patients to seek bank loans or credit cards or other forms of debt unless the financial capacity to do so is proven.

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Question 1

Attachment 1 – 1

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Definition of Standards and Guidelines

From time to time the Catholic Health Initiatives (CHI) National Finance Group issues financial, accounting and reporting directives to Market-Based Organizations (MBOs). The types of directives issued are as follows:

- *Standards:* MBOs are required to comply with and implement *Standards* on a timely basis. This is the most common type of directive.
- *Guidelines:* MBOs are not required to comply with or implement *Guidelines*. MBOs are encouraged to consider *Guidelines* as leading practices for potential implementation, when practicable.

Purpose of this Section and Effective Dates

- *Purpose:* This section of the CHI *Financial Standards and Guidelines Manual* (FSGM) provides standards for use by MBOs in regard to the management and oversight of MBO staff and third-party collection agents, including self-pay protocols.
- *Effective dates:*
  - **By April 1, 2004**: All written policies and agreements required in Section V of this document must be completed by April 1, 2004. A contract amendment (containing the terms listed in *Addendum A*) must be signed and implemented for every third-party collection agent or the existing contract(s) must be terminated. MBOs are encouraged to seek guidance from the Legal Services Group if there are issues or questions in this regard. Once the written policies and agreements are implemented, they are to be maintained thereafter at all times on a current basis. All future agreements with third-party collection agents must contain the provisions listed in *Addendum A*.
  - **By June 30, 2004**: The standards required in Section IV must be fully implemented throughout the MBO and maintained thereafter at all times on a current basis. To the extent the standards in Section IV impact the completion of the written policies and agreements in Section V, earlier implementation is required by April 1, 2004.

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Specific Topics Addressed in this Section

- Background
- Purpose
- Definitions: third-party collection agent; self-pay balance
- Management and oversight of MBO staff and third-party collection agents, including specific prohibitions
- Required written agreements and policies

Contacts for Questions Related to this Section

Please contact one of the following individuals about this section with questions or concerns:

- Related to technical matters:
  - J. Peter Savini, CHI Vice President, Patient Financial Services (610/594-5102 or at petersavini@catholichealth.net)
- Related to direction regarding the standards:
  - The National Vice President, Financial Services assigned to the MBO
- Related to legal requirements regarding contractual issues:
  - The Legal Services Group member assigned to the MBO

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

I. Background

As a Catholic healthcare provider and as a tax-exempt organization, Catholic Health Initiatives (CHI) is called upon to meet the needs of those who seek health care services in market-based organizations (MBOs). Such needs must be met without regard to a person's ability to pay for services received.

Self-pay patient account balances (i.e., either for uninsured patients or for co-payment / deductible obligations of insured patients) at most MBOs represent a significant and growing percentage of total accounts receivable balances. This economic reality needs to be acknowledged by each MBO, which also is responsible to simultaneously demonstrate respect for human dignity, foster a climate of social justice and acknowledge the full extent of regulatory requirements. Any failure to balance these responsibilities will result in increased costs being unfairly passed to all constituents in the communities served.

It is essential for MBOs to communicate to both MBO staff members and third-party collection agents the collection protocols and tactics that are approved by CHI. The protocols and tactics utilized by MBO staff and third-party collection agents must comply with the CHI standards outlined in this document.

II. Purpose

The purpose of this document is to establish CHI standards for appropriate MBO staff and third-party collection agency protocols and tactics. It is incumbent upon each MBO to take reasonable and immediate steps to ensure that all MBO staff and third-party collection agents consistently follow the collection protocols established through the standards contained in this document. Each MBO needs to ensure that the collection tactics prohibited by the standards contained in this document will not be used either by MBO staff or third-party collection agents.

Each MBO must ensure that consistency is achieved in the definition, communication, distribution and implementation of MBO staff and third-party collection agency protocols and tactics. MBO staff and third-party collection agents must follow the highest standards of ethics and integrity in providing collection services for self-pay balances.

III. Definitions

For the purposes of clarity in this document, the following definitions are included:

Third-Party Collection Agent:
A third-party collection agent is an external resource utilized *as a collection agent or as a representative acting in the name of the MBO*, engaged on a contractual basis, for the express purposes of following-up on and potentially collecting any patient accounts receivable balances (e.g., past-due balances, early-out accounts, etc.).

Self-Pay Balance:
A self-pay balance is any accounts receivable balance due from a patient and/or patient guarantor that is (a) a result of health care or other services provided, for which no insurance or other coverage was available, or (b) a balance remaining after all insurance payments have been received.

IV. Management and Oversight of MBO Staff and Third-Party Collection Agents, Including Specific Prohibitions

CHI MBOs, hospitals and other healthcare providers exist to provide health care services to persons in the communities served. The ability of an MBO to serve its patients well requires a relationship with each community that is built on both trust and compassion. This document is intended to strengthen MBO relationships within the communities, reassuring patients and patient guarantors, regardless of the ability to pay, of the provider's commitment to caring.

CHI Standard: Each MBO, in all policies and standards related to patient financial services as defined by CHI standards, shall direct its staff and third-party collection agents to continually assess each patient and patient guarantor's ability to pay or to be determined eligible for financial assistance (i.e., charity care). This Standard shall be applied as follows:

A. In regard to self-pay balances:

1. ***Fair Pursuit.*** Each MBO shall ensure that all patient and patient guarantor accounts are pursued fairly.

2. ***Ethics and Integrity.*** Each MBO shall ensure that all collection activities consistently reflect the highest standards of ethics and integrity.

3. ***Reasonable Payment Terms.*** Each MBO shall offer reasonable payment schedules and terms to each patient and patient guarantor with self-pay balances.

4. ***Eligibility for Assistance.*** Each MBO shall perform a reasonable review of each inpatient account, prior to turning an account over to a third-party collection agent and prior to instituting any legal action for non-payment, to assure that the patient and patient guarantor are not eligible for any assistance program (e.g., Medicaid) and do not qualify for coverage through the MBO's charity care policy. After having been turned over to a third-party collection agent, any account that subsequently is determined to meet the MBO's charity care policy shall be returned immediately by the third-party collection agent to the MBO for appropriate follow-up.

B. In regard to third-party collection agents:

1. ***Standards and Scope of Practices.*** Each MBO shall define the standards and scope of practices to be used by third-party collection agents acting on its behalf such that any standards and scope of practices, at a minimum, shall be consistent with the standards contained in this document.

2. ***Board-approved Policy.*** Each MBO shall have a board-approved policy indicating the particular actions consistent with the CHI standards (e.g., garnishments, liens, etc.) that may be pursued by either MBO staff or a third-party collection agent. Such policy shall indicate the circumstances under which each action may be pursued, the designated MBO staff member who may authorize each such action, and the periodic reporting which shall be made to the Board.

3. ***Statement Message.*** Each MBO shall require its third-party collection agents to include a message on all statements indicating that if a patient or patient guarantor meets certain stipulated income requirements, the patient or patient guarantor may be eligible for MBO or other financial assistance programs.

4. ***150-day Limit.*** Only under limited circumstances (i.e., when or if a payment or resolution is expected within 60 days) shall an MBO authorize a third-party collection agent to manage an account beyond 150 days from the date assigned to the third-party collection agent by the MBO.

5. ***Advance Settlement Approvals.*** Each MBO shall instruct its third-party collection agents to seek approval from the authorized and designated MBO staff member before any settlement, as a result of bankruptcy proceedings, shall be accepted.

6. ***Annual Adherence Audit.*** Each MBO or its designee shall be required to audit its third-party collection agents at least annually for adherence to these standards.

C. Specific Prohibitions:

1. ***Unemployed Without Significant Income / Assets.*** No MBO shall pursue any legal action for non-payment of any bills against any patient or patient guarantor who is unemployed and without other significant income or assets.

2. ***Principal Residence.*** No MBO shall pursue any legal action against any patient or patient guarantor by seeking a remedy that would involve foreclosing upon the principle residence of a patient or patient guarantor or taking any other action that could result in the involuntary sale or transfer of such residence, or informing any patient or patient guarantor that he/she may be subject to any such action.

3. ***Cooperating Efforts.*** No MBO shall send any unpaid self-pay account to a third-party collection agent as long as the patient and patient guarantor are cooperating with the MBO in efforts to settle the account balance.

4. ***Collection Tactics.*** Each MBO shall instruct both MBO staff and third-party collection agents that tactics such as charging interest, requiring patients or patient guarantors to incur debt or loans with recourse to the patient's or guarantor's personal or real property assets ("recourse indebtedness") or so-called "body attachments" (i.e., the arrest or jailing of patients in default on their accounts, such as for missed court appearances) are strictly prohibited.

V. Required Written Agreements and Policies

CHI Standard: Each MBO shall develop and maintain written policies and agreements in fulfillment of the appropriate business requirements related to third-party collection protocols as outlined in this document. This Standard shall be applied as follows:

A. ***Adherence to Standards.*** Each MBO shall obtain written agreements from each third-party collection agent to ensure adherence to the standards contained in this document. (See *Addendum A.*)

B. ***Core Values and Ethics.*** Each MBO shall require, in written agreements with all third-party collection agents, that the third-party collection agents shall incorporate into the training and orientation of their service representatives the CHI *Mission Core Values* and *Ethics at Work.*

C. ***Authority Related to Debt.*** Each MBO shall implement written policies defining and delineating the circumstances under which, and under whose, authority the debt of any patient or patient guarantor is advanced for collection to the third-party collection agent (i.e., no self-pay balances shall be sent to third-party collection agents as long as a patient or patient guarantor is cooperating in efforts to settle the balance).

D. ***Time and Criteria.*** Each MBO shall implement written policies with specific standards regarding (1) the length of time an account shall be managed by a third-party collection agent and (2) collection standards. These policies shall comply with CHI standards as included herein and in other documents.

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 5: MBO and Third-Party Collection Agents and Self-Pay Protocols

Addendum A

I. The parties to this agreement acknowledge and guarantee that the following collection tactics shall be prohibited:

1) Agents charging interest of any amount, on any account, at any time.

2) Seeking a bench warrant or so-called "body attachment" (i.e., seeking or securing the arrest or jailing of patients or guarantors who miss court hearings on their hospital debts).

3) Recourse indebtedness programs, requiring patients to incur debt or loans with recourse to the patient's personal or real property assets.

4) Recourse loans which become the obligation of the MBO upon default by the patient or patient guarantor.

5) Foreclosure upon a patient's/guarantor's principal residence or taking any other action that could result in the involuntary sale or transfer of such residence.

II. The CHI MBO and Agents agree that Agents shall seek approval from the authorized and designated MBO staff member before pursuing any of the following legal proceedings:

1) Garnishing wages, if there is evidence that the patient or patient guarantor has income and/or assets to meet his/her obligation.

2) Subject to the absolute restrictions of paragraph "I (5)" above, placing a lien on the patient's or patient guarantor's home.

3) Taking any legal action against any patient or patient guarantor who is unemployed and without other significant income/assets.

4) Pursuing any legal action against any patient or patient's guarantor not otherwise specifically prohibited above.

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Question 1

Attachment 1 – 2

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Definition of Standards and Guidelines

From time to time the Catholic Health Initiatives (CHI) National Finance Group issues financial, accounting and reporting directives to Market-Based Organizations (MBOs). The types of directives issued are as follows:

- ***CHI Standard*** MBOs *shall* (i.e., are required to) comply and implement a *Standard* on a timely basis. This is the most common type of directive.
- *CHI Guideline* MBOs are not required to comply or implement a *Guideline*. MBOs are encouraged to consider a *Guideline* as a leading practice for potential implementation, when practicable.

Purpose of This Section

The purpose of this section of the *CHI Financial Standards and Guidelines Manual* is to provide Market-Based Organizations with procedures related to (1) the determination of charity care for patients and (2) accounting treatment for the associated cost of the charity care provided to patients.

Significant Changes from Previous Documents (and Effective Dates)

Dates of Issuance

- This document was originally issued in 2002 as a section in the *CHI Financial Reporting Manual (FRM)*, titled *Provision of Charity Care to Patients* and updated in May 2003.
- The original document was updated and moved to the *CHI Financial Standards and Guidelines Manual* in September 2003.
- This document was issued in June 2004 and renamed *Uninsured / Underinsured Patient Discounts (Charity Care)*.

Update: June 2004

- This document has been significantly revised to more clearly outline and establish the types of discounts available to both uninsured and underinsured patients treated at MBOs. Although the following is a high-level summary of the revisions (including their effective dates) since the September 2003 document, it is important to read the entire document to ensure all revisions are incorporated at the MBO:
  - **Effective July 1, 2004** (earlier application encouraged):
    - Defines medical necessity **(II-A-4-a; pages 4-6 and 4-7)**.
    - Defines when an emergency room patient should be provided with charity care information **(II-A-7-a, pages 4-7 and 4-8)**.
    - Includes a standardized *CHI Patient Charity Care Discount Application Form* for use at all MBOs (can be modified for local programs and circumstances) **(Exhibit 2)**.

- Includes a standardized *CHI Charity Care Determination Checklist* for use at all MBOs (can be modified for local programs and circumstances) **(Exhibit 3)**.
- Provides a 100% charity care discount to be applied at 130% of the HUD very-low income level (i.e., establishing a new base) **(III-A-4; page 4-12)**.
- Establishes the top of the scale for charity care discount eligibility at 150% of the new base, effectively 195% of the HUD very-low income level **(III-A-11-b; page 4-15)**.
- Defines and addresses scenarios related to medical indigency for patients **(III-B; pages 4-16 and 4-17)**.
- Defines and incorporates the concept of presumptive charity care eligibility **(III-C; pages 4-17 through 4-19)**.
- Includes a standardized *CHI Patient Charity Care Discount Application Form – Presumptive Eligibility* for use at all MBOs (can be modified for local programs and circumstances) **(Exhibit 5)**.
- Requires the establishment of an MBO Charity Care Review Committee **(III-D; pages 4-19 and 4-20)**.

- **Effective July 1, 2005** (earlier application encouraged):
  - Requires the establishment of a reserve for charity care at all MBOs and provides sample accounting entries **(IV-E; pages 4-22 and 4-23)**.

Specific Topics Addressed in This Section

Standards and Guidelines are provided in this document for application by MBOs to the following:

I. Purpose and overview
II. Identifying patients unable to pay for needed services
III. Providing assistance to patients
IV. Recording charity care
V. Recording community benefit
VI. Other resources

Contacts for Questions Related to This Section

Please contact one of the following National staff members with any questions:

- The appropriate National Vice President, Financial Services, assigned to the MBO.
- J. Peter Savini, National Vice President, Patient Financial Services, 610/594-5102 or petersavini@catholichealth.net

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

I. Background – Purpose and Overview

As Catholic health care providers and tax-exempt organizations, MBOs are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

- Charity care traditionally has been defined as care provided to patients without expectation of partial or full payment for services as a result of a patient's financial inability to pay.

- Charity care may be provided to patients who are uninsured, underinsured or determined to be medically indigent. Recently, governmental direction has begun to focus on the need to consider medically indigent patients. Medically indigent patients are those patients:

  > ...whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses, in relationship to their income, [and] would make them indigent if they were forced to pay full charges for their medical expenses." *Source: FAQs A1 HHS (U.S. Department of Health and Human Services) 2/17/04*

The complete set of the HHS FAQs and answers, published on February 17, 2004, is included with this document as an attachment.

➢ **See attached Exhibit 1: *Frequently Asked Questions (FAQs), February 17, 2004, U.S. Department of Health and Human Services*** (5 pages, Word document).

Charity care does not include services for which an MBO has agreed to accept a reduced payment pursuant to a managed care arrangement. Each MBO is responsible for developing a policy statement, approved by the MBO board of trustees, and applicable procedures to identify patients who are eligible for charity care discounts. Eligibility must be determined as closely as possible to the point in time when care is provided to the patient.

As identified in The Catholic Health Association (CHA) publication, *Community Benefit Program, A Revised Resource for Social Accountability:*

> Jesus had a special affection for those on the margins of society because they are so often excluded from participation in the community and from its benefit. Today, a preferential option for the poor, of which charity care

is an expression, is a prime impetus of community benefit initiatives in Catholic health care.

Most MBOs are designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Providing care to the poor, without regard to a patient's ability to pay, is considered a significant indicator in determining whether an MBO meets the IRC community benefit requirement applicable to tax-exempt health care providers. By virtue of IRC Section 501(c)(3), MBOs receive special tax status exempting them from federal and state income taxes. This charitable nonprofit tax status also exempts MBOs from many state and local sales, use and property taxes.

MBOs, including all CHI direct affiliates, wholly-owned and controlled subsidiaries, are required to establish annual budgeted levels for both charity care discounts and community benefit (i.e., benefit provided to the poor and the broader community). MBOs are required to review actual experience for both charity care discounts and community benefit, in comparison to budgeted expectations, on at least a quarterly basis. Charity care discounts and community benefit provided by joint operating agreements between a CHI affiliate and another party or parties is subject to the language contained in governing documents at the time of formation or as subsequently modified and approved in writing.

The terms charity care and financial assistance are used interchangeably throughout this document. MBOs are encouraged to develop policies and procedures that contain terminology which reduces any stigma attached to the term "charity" and, thereby, reach those individual patients who meet the MBO's eligibility criteria for free or reduced-fee services.

It is important to distinguish between charity care discounts (i.e., care provided to patients without expectation of payment for those services) and waivers of patient deductibles and co-insurance obligations for patients who have third-party payment sources such as Medicare. If there is a third-party payor, the MBO is expected to bill full charges and collect appropriate reimbursement from the third-party payor for the services rendered. An MBO may waive patient co-payment obligations, upon determination in accordance with these Standards and Guidelines that a patient is financially unable to make the co-payment.

For services provided to Medicare beneficiaries, Medicare historically has reimbursed hospitals for a portion of bad debts (including co-payment amounts deemed uncollectible) if a patient was reasonably determined to be indigent. The establishment of consistent collection and bad debt processes is essential for all patient categories. MBOs shall submit information in Medicare cost reports about

both charity care discounts and uncollectible bad debts. More recently, additional clarification has been provided by HHS, as follows:

> ... if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent, the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts. *Source: FAQs A9 HHS 2/17/04*

II. Identifying Patients Unable to Pay for Needed Services

CHI Standard Each MBO shall establish a charity care policy consistent with these CHI Standards and Guidelines. In accordance with the policy, the MBO shall provide charity care to patients for all medically necessary or otherwise necessary services including, but not limited to, the following full range of services: patients treated at a hospital; residents in a long-term care center; residents in housing for the elderly; patients receiving home care; and other instances (as noted below).

This ***CHI Standard*** shall be applied to each type of service area as noted in the following Sections II-A through II-E:

A. Hospitals, Outpatient Surgical Services and Clinics

1. Consistent with the principles of Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care at a CHI hospital shall be treated without regard to a patient's ability to pay for care. CHI hospitals shall operate in accordance with all federal and state requirements for the provision of health care services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA).

   The following definitions of urgent and emergent care are provided for in this Standard:

   a) The definition of urgent care is that provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours, to avoid:

i. Placing the health of the patient in serious jeopardy or to avoid serious impairment or dysfunction; or
ii. Likely onset of an illness or injury requiring emergent services, as defined in this document.

b) The definition of emergent care is that provided to a patient with an emergent medical condition, further defined as:
   i. A medical condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain, psychiatric disturbances and/or symptoms of substance abuse, etc.) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
      - Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
      - Serious impairment to bodily functions, or
      - Serious dysfunction of any bodily organ or part.
   ii. With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

2. Patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition. If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be made as soon as possible but shall not exceed a period of 18 months after the provision of such services.

3. Charity care policies and procedures shall be established at each MBO to address any instances in which patients may be eligible for financial assistance when accessing services. The policies and procedures shall relate to the variety of services provided by the MBO to patients ranging from, for example, emergency and ambulance services to inpatient and outpatient elective surgery, diagnostic testing, and educational programs.

4. MBOs shall maintain documentation that includes an attestation from the patient's physician indicating appropriate medical necessity for all patients who apply for charity care discounts:

   a) Medical necessity is defined as any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening

of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

b) MBOs shall establish a procedure to assure that all medical necessity determinations are administered in a consistent manner.

5. MBOs with remaining Hill-Burton obligations shall clearly post signs containing the following words: "**NOTICE-Medical Care for Those Who Cannot Afford to Pay**" in admissions areas, business offices, emergency rooms and other appropriate areas. MBOs with Hill-Burton obligations shall conspicuously post signs provided by the U. S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), printed in **both** English and Spanish. As required by Hill-Burton, MBOs shall post and translate signs into languages other than English and Spanish if the other languages are used by 10% or more of the population in the MBO service area, based on census reports.

6. MBOs without Hill-Burton obligations shall clearly post signage in English to advise patients of the availability of financial assistance. Signs shall be posted in other languages in instances where 10% or more of the local population speaks a foreign language. Staff members shall communicate the contents of signs to people who do not appear able to read.

7. Sharing information about charity care is differentiated into two scenarios – one for an emergency patient and another for a non-emergency patient scheduling an admission or other procedure.

   a) Scenario – emergency patient:
      i. Patients receiving emergency services shall be treated in accordance with the CHI hospital's emergency services policy, developed in accordance with EMTALA and other requirements.
      ii. Consistent with CHI guidance (i.e., reasonable registration processes for the emergency department) and EMTALA requirements, CHI hospitals shall engage in reasonable registration processes for individuals requiring examination or treatment:

1) Reasonable registration processes shall include asking whether an individual is insured and, if so, the name of the insurance program utilized, if such inquiry does **not** delay screening or treatment.
2) Reasonable registration processes shall **not** unduly discourage patients from remaining for further evaluation. Therefore, discussions regarding financial issues shall be deferred until after the patient has been screened and necessary stabilizing treatment has been initiated.
3) Once EMTALA requirements are met, patients identified through the registration process as being without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures, including an application for such assistance, or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance.

b) Scenario – non-emergency patient scheduling an admission or other procedure:
   i. Upon registration, patients without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures, including an application for such assistance, or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance.

c) Under either scenario, the packet of information shall clearly indicate that the MBO provides care, without regard to ability to pay, to individuals with limited financial resources, and shall explain how patients can apply for financial assistance.
   i. For instances in which there are a significant number of patients not proficient in reading, writing or speaking English, additional information shall be provided (or assistance shall be made available) to complete necessary forms.
   ii. MBOs with 10% or more non-English speaking populations shall prepare informational notices in each of the languages that account for 10% or more of the total population.
   iii. To allow the MBO to properly determine charity care eligibility, documents provided by patients to the MBO shall be written in English.

iv. Records maintained by the MBO to substantiate eligibility for charity care shall be completed in English.
v. MBOs shall identify the availability of financial assistance in information booklets provided to patients and in general information provided on the MBO website.
vi. MBOs shall begin the process of assessing financial ability as soon as patients contact the hospital to schedule a procedure or when they register as an emergency patient (subject to the EMTALA requirements discussed above).

B. Long-Term Care Residential Services

1. The CHI charity care standard shall apply to long-term care services. Once admitted, patients shall not be denied service or residency due to a financial inability to pay. To be considered tax-exempt, MBOs shall operate in a manner designed to satisfy three primary needs of the elderly: housing, healthcare and financial security.

2. MBOs with long-term care residential services shall accept patients covered by Medicare and/or Medicaid. Prior to admission, potential patients shall complete application forms that include detailed financial information. Patients not covered by Medicare or Medicaid shall be responsible for making advance payments on a monthly basis for estimated services to be received. Patients shall be provided with a statement, shortly after the end of each month, to reconcile amounts billed to services rendered. Amounts payable to the CHI long-term care provider shall be paid within 10 days of receipt of a statement; credit balances shall be applied to subsequent months' amounts due.

3. If a resident's resources become depleted, the MBO shall provide assistance so the patient can apply for Medicaid coverage or other local financial assistance.

C. Homes/Apartments for the Aged and Disabled

1. The CHI charity care standard shall apply to services provided by MBOs that operate homes/apartments for the aged and disabled. Facilities sponsored by the U.S. Housing and Urban Development (HUD) accept residents in accordance with HUD guidelines, which consider income levels. MBOs that operate homes/apartments for the aged shall have stewardship obligations to assure the generation of sufficient resources to meet routine operating expenses, building upkeep and routinely set aside funds for capital needs and improvements.

2. MBOs shall identify, as part of the annual budget, the amount of charity care discounts provided to current residents who are no longer able to meet monthly rental payments. Tax exemption under IRC Revenue Ruling 72-124, however, requires that no resident shall be discharged due to a financial inability to pay.

3. MBOs that risk exceeding annual budgeted charity care discount reserves shall be responsible for raising additional funds from philanthropic sources, assisting residents in obtaining additional financial assistance or relocating them to alternate facilities within a reasonable amount of time.

D. Other Services

1. Physician practices or clinics that are an integral part of an MBO or its nonprofit subsidiaries shall adopt the CHI charity care standard. These organizations shall comply with the same charity care policy and procedures adopted by the MBO board of trustees for the tax-exempt healthcare provider.

E. Joint Operating and Joint Venture Agreements

1. A CHI-sponsored MBO under a joint operating agreement (JOA) shall adopt the CHI charity care standard unless adoption is not permitted by language contained in the applicable JOA.

2. The CHI charity care standard shall apply to both minority and majority-owned joint venture agreements (e.g., joint-venture ambulatory care centers) in accordance with the respective governing documents.

3. MBOs shall consider charity care obligations in agreeing upon the terms and conditions in JOAs and joint ventures.

III. Providing Assistance to Patients

A. Authorization and Methodology

CHI Standard The authorization of charity care discounts shall be restricted to patient financial services directors and/or other MBO management resources above the director level. Approval limits for charity care discounts shall be established by each MBO in accordance with the policy approved by the MBO board of trustees. Each MBO shall develop criteria to determine whether a patient is eligible for a charity care discount and the amount eligible

for write-off or discount. An established assessment methodology, applied consistently, shall be adopted by each MBO. The methodology shall consider income, family size, available resources and the likelihood of future earnings (net of living expenses) sufficient to pay for the health care services provided.

This ***CHI Standard*** shall be applied as noted in the following Sections III-A-1 through III-A-16:

1. Each MBO shall utilize the *CHI Standardized Patient Charity Care Discount Application Form*, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.
   - **See attached Exhibit 2: *CHI Standardized Patient Charity Care Discount Application Form*** (3 pages, *Word* document).

2. Each MBO shall utilize *CHI Standardized Charity Care Determination Checklist*, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.
   - **See attached Exhibit 3: *CHI Charity Care Determination Checklist*** (2 pages, *Word* document).

3. All available financial resources shall be evaluated before determining financial assistance eligibility. MBOs shall consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g., the parent of a minor child or a patient's spouse). The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs. Patients with health spending accounts (HSAs), formerly known as medical spending accounts (MSAs), are considered to have insurance; the amount that the patient has on deposit in the HSA is to be considered insurance and not eligible for any discount.
   - ***Note:*** The term "patient/guarantor" sometimes is used subsequently in this document to refer collectively to the patient as well as any such other person(s) having legal responsibility for the patient.

4. Eligibility for charity care discounts shall be determined based on 130% of the annually updated *HUD Geographic Very-Low Income Guidelines*, referenced later in this document, available assets and any extenuating circumstances. Thus, the standards of eligibility for the application of charity discounts must consider assets, as well as income. MBOs shall utilize 130% of the *HUD Geographic Very-Low Income* guidelines as a minimum (i.e., establishing a new base). MBOs shall not lower the income levels below the CHI-defined standard of 130% of the *HUD Geographic Very-Low Income* guidelines (i.e., the new base).

   a) The need for future services requiring financial assistance shall be assessed.

   b) Separate determinations of eligibility for charity care discounts shall be made for each date of service. Confirmation of continued eligibility shall be updated every 90 days for patients who require ongoing health care services.

   c) An individual's occupation may be indicative of eligibility for a charity care discount. Examples of low-paying jobs shall be developed for each MBO market. Some examples may include:
      - Day laborer
      - Farm worker
      - Migrant worker
      - Fast food service worker
      - Entry-level MBO employee (e.g., dietary worker, housekeeper, etc.)

   CHI Guideline In accordance with the preceding ***CHI Standard***, MBOs shall utilize 130% of the *HUD Geographic Very-Low Income* guidelines as a minimum (i.e., the new base). However, MBOs may determine, on a market-specific basis, that higher income levels for 100% charity write-off are more appropriate.

5. Information provided in the financial assistance application may indicate that a patient is eligible for financial assistance or insurance coverage not only for health care services but also other benefits. Financial counseling staff shall assist patients in applying for available coverage. MBOs that contract with organizations to assist patients in applying for federal, state or other assistance shall assure that such agreements are in writing and contain provisions requiring compliance with *CHI Standards of Conduct*, maintain patient confidentiality in accordance with the Health Insurance

Portability and Accountability Act of 1996 (HIPAA) requirements and delineate compliance with all applicable laws and regulations.

a) All information obtained from patients and family members shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and verbal communications. Assessment forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including the following evidence of:
   - Income from wages
   - Income from self-employment
   - Alimony
   - Child support
   - Military family-allotments
   - Public assistance
   - Pension
   - Social Security
   - Strike benefits
   - Unemployment compensation
   - Workers' compensation
   - Veterans' benefits
   - Other sources, such as income from dividends, interest or rental property

b) Copies of documents to substantiate income levels shall be obtained (e.g., pay check stubs, alimony and child-support documents).

6. For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year; these assets shall be evaluated as cash available to meet living expenses. Assets that shall not be considered as available to meet living expenses include: a patient's primary place of residence; adequate transportation; adequate life insurance; and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents:
   - Savings, certificates of deposit, money-market or credit union accounts
   - Descriptions of owned property

7. The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about

family members and/or dependents residing with the patient/guarantor, including the following information for all:

- Name, address, phone number (both work and home)
- Age
- Relationship

8. 8. In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor's legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor's most recently-filed federal income tax form shall be relied upon to determine whether an individual should be considered a dependent. The patient/guarantor shall provide employment information for the patient/guarantor, as well as any others for whom the guarantor is legally obligated in regard to the well-being of the patient. Such information shall identify the length of service with the current employer, contact information to verify employment and the individual's job title.

9. Assessment forms shall provide for a recap of average monthly expenses including:
   - Rental or mortgage payments
   - Utilities
   - Car payments
   - Food
   - Medical bills

10. Copies of rent receipts, utility receipts or monthly bank statements shall be requested. Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service to enable the MBO to properly record the related revenues, net of charity care.

11. Each MBO shall develop a sliding scale to provide up to a full discount of charges for patients with no third-party insurance and up to a full waiver of co-payments after third-party insurance proceeds, based on indigence. The following points shall be taken into consideration:

    a) The standards of eligibility for the application of charity discounts must consider assets, as well as income. Eligibility shall be based on 130% of the annually updated *HUD Very-Low Income Guidelines*. These HUD guidelines take into consideration family incomes that do not exceed 50% of the median family income for a geographic area

and shall utilize a sliding scale approach based on income and family size. The guidelines are available at the HUD Office of Policy Development and Research website at http://www.huduser.org/datasets/il.html. Data may be downloaded in PDF, Word or Excel file formats.

- **See attached Exhibit 4: *130% of the annually updated HUD Very-Low Income Guidelines as the new base (Updated January 28, 2004)***, including *Instructions* and *Application Example: Little Rock AR* (4 pages, *Excel* document).

b) When circumstances indicate the presence of severe financial hardship or personal loss, those patients with few resources and a high number of dependents shall receive higher levels of financial assistance. This shall be determined by the use of a sliding scale based on income and family size (as noted at *Exhibit II*). The maximum income level eligibility as defined on the sliding scale represents 150% of the new base, effectively 195% of the *HUD Very-Low Income Guidelines.*

12. Patients/guarantors shall be notified when the MBO determines the amount of charity care discount eligibility related to services provided by the MBO. Patients/guarantors shall be advised that such eligibility does not include services provided by non-MBO employees or other independent contractors (e.g., private physicians, physician practices, anesthesiologists, radiologists, pathologists, etc., depending on the circumstances.) The patient/guarantor shall be informed that periodic verification of financial status shall be required in the event of future services. Patient financial records shall be flagged to indicate future services shall be written off in accordance with the financial assistance determination. Patients/guarantors shall be informed in writing if financial assistance is denied and a brief explanation shall be given for the determination provided. A copy of the letter shall be retained in the confidential central file, along with the patient/guarantor's application.

13. Each MBO shall delineate, in accordance with the charity care policy approved by the MBO board, the management-level positions authorized approve discounts for charity care/financial assistance. Varying levels of approval authority shall be established for each management-level position. On a quarterly basis, the MBO shall report each account with a charity care discount threshold of $100,000 or more to the finance committee of the MBO board.

CHI Guideline In accordance with the preceding ***CHI Standard***, each account with a charity care threshold of $100,000 or more shall be reported to the finance committee of the MBO board. However, an MBO may reduce the threshold amount to a lower amount if it is deemed appropriate to do so.

14. Determining eligibility for charity care discounts shall be a continuing process. A retroactive review of accounts referred to outside collection agencies shall be conducted either annually or semi-annually to determine if any accounts would have been more properly recorded as charity care discounts and, if so, the MBO shall recall such accounts from the outside collection agency and reclassify them to charity, in accordance with generally accepted accounting principles.

15. If a fee or tuition amount is charged for an MBO-sponsored community health educational program, the MBO shall include a reference that financial assistance (sometimes referred to as a scholarship) is available. The name, address and phone number of the person responsible for determining eligibility shall be provided in promotional materials.

16. MBOs shall retain a central file by each patient/guarantor containing financial assistance applications. To assure confidentiality, applications for financial assistance shall not be retained with the patient account registration or detailed billing information. A listing of all charity care discounts shall be maintained by the accounting department, documenting patient names, patient account numbers, dates of service, brief descriptions of services provided, total charges, amounts written-off to charity, dates of write-offs and the names of the authorizing individuals. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

B. Medical Indigency

The decision about a patient's medical indigency is fundamentally determined by an MBO without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients do not have appropriate insurance coverage that applies to services related to neonatal care, organ transplants, cancer, burn care, long and/or intensive care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets and the payment of their medical bills would be seriously detrimental to their basic financial well-being and survival.

CHI Standard Each MBO shall make a subjective decision about a patient/guarantor's medically indigent status by reviewing formal documentation for any circumstance in which a patient is considered eligible for a charity care discount on the basis of medical indigency.

This ***CHI Standard*** shall be applied as noted in the following Sections III-B-1 through III-B-4:

1. The patient shall apply for a charity care discount in accordance with the MBO policy in effect.

2. The MBO shall obtain and/or develop documentation to support the medical indigency of the patient. The following are examples of documentation that shall be reviewed:
   - Copies of all patient/guarantor medical bills.
   - Information related to patient/guarantor drug costs.
   - Multiple instances of high-dollar patient/guarantor co-pays, deductibles, etc.
   - Other evidence of high-dollar amounts related to healthcare costs, such as the existence of an HSA that has been fully expended.

3. The MBO shall grant a charity care discount either through the use of the sliding scale approach referenced in *Exhibit II* or up to 100% if the patient has the following:
   - No material applicable insurance.
   - No material usable liquid assets.
   - Significant and/or catastrophic medical bills.

4. In most cases, the patient shall be expected to pay some amount of the medical bill, but the MBO shall not determine the amount for which the patient shall be responsible based solely on the income level of the patient.

C. Presumptive Charity Care Eligibility

There are occasions when a patient may appear eligible for a charity care discount, but there is no financial assistance form on file because documentation was lacking that would support the provision of financial aid. Such instances have resulted in a patient's bill being assigned to a collection agency and ultimately recognized in the accounting records as a bad debt expense, due to a lack of payment. This approach, however, results neither in a fair solution for the patient nor in an appropriate accounting of the transaction. Often there is adequate information provided by the patient or through other sources, which could provide the MBO with sufficient evidence

to provide the patient with a charity care discount, without needing to determine eligibility for medical indigency. This presumptive eligibility, when properly documented internally by MBO staff, is sufficient to provide a charity care discount to patients who qualify. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted to the patient by the MBO is a 100% write-off of the account balance.

CHI Standard Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g., homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.). MBOs shall grant only 100% charity care discounts to patients determined to have presumptive charity care eligibility. MBOs shall internally document any and all recommendations to provide presumptive charity care discounts from patients and other sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel.

This ***CHI Standard*** shall be applied as noted in the following Sections III-C-1 through III-C-5:

1. To determine whether a qualifying event under presumptive eligibility applies, the patient/guarantor shall provide a copy of the applicable documentation that is dated within 30 days from the date of service.

2. For instances in which a patient is not able to complete an application for financial assistance, the MBO may grant a 100% charity care discount without a formal request, based on presumptive circumstances, approved by the MBO director of patient financial services in accordance with MBO policy.

3. Each MBO shall utilize the *CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility*, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.

   - **See attached Exhibit 5: *CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility*** (1 page, *Word* document).

4. The determination of presumptive eligibility for a 100% charity care discount shall be made by an MBO on the basis of patient/guarantor income, not solely based on the income of the affected patient.

5. Individuals shall not be required to complete additional forms or provide additional information if they already have qualified for programs that, by their nature, are operated to benefit individuals without sufficient resources to pay for treatment. Rather, services provided to such individuals shall be considered charity care and shall be considered as qualifying such patients on the basis of presumptive eligibility. The following are examples of patient situations that reasonably assist in the determination of presumptive eligibility :
   - Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
   - Patient is homeless and/or has received care from a homeless clinic.
   - Patient is eligible for and is receiving food stamps.
   - Patient's family is eligible for and is participating in subsidized school lunch programs.
   - Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
   - Family or friends of a patient have provided information establishing the patient's inability to pay.
   - The patient's street address is in an affordable or subsidized housing development. In this case:
     - The MBO shall contact the individual state agency that oversees HUD Section 8 subsidized housing programs for low-income individuals.
     - The MBO shall maintain a listing of eligible addresses in their market.
       - **See attached Exhibit 6: *Listing of State Agencies – Updated: May 1, 2004*** (1 page, *Excel* document).
   - Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
   - Patient is deceased, with no known estate.

D. Charity Care Review Committee

CHI Standard Each MBO shall establish a Charity Care Review Committee to assist in the evaluation of subjective information related to patient accounts that do not clearly qualify under basic charity care discount eligibility criteria.

This ***CHI Standard*** shall be applied as noted in the following Sections III-D-1 through III-D-5:

1. The types of patient accounts to be reviewed by the Committee shall include, but not be limited to, the following:
   - Patients with extenuating circumstances (e.g., patients who may be medically indigent, patients who may have presumptive eligibility for a charity care discount, etc.).
   - Patients who have significant non-liquid assets
   - Patients whose eligibility exceeds 180% of the HUD Very Low Income Guidelines and thus are not eligible for charity care discounts on the sliding scale, but whose medical bills are so large that they are unable to pay.

2. The Committee shall be chaired by a senior management representative. At a minimum membership shall include a social worker and staff from mission/ministry, general accounting and patient financial services. Other members may be appointed to the Committee as deemed appropriate by the MBO.

3. The Committee shall meet as needed, depending on MBO size, nature of patient population and frequency and types of charity care discounts provided. For large MBOs, meetings will be required on at least a monthly basis and at times more often. For small MBOs, meetings may be required only once every one to three months.

4. The agenda for each meeting shall be comprised of patient cases requiring additional review and input by the Committee prior to the determination of charity care discount eligibility. For each patient case, the agenda will include a summary of the case, the financial situation of the patient and other pertinent information as necessary.

5. Documentation of the Committee's meetings shall be recorded. Actions related to specific patients shall be included in the central file as discussed at Item No. 12 in Section II-A of this document.

IV. Recording Charity Care

CHI Standard Each MBO shall properly distinguish write-offs of patient accounts between charity care discounts and bad debt expenses. Such amounts shall be recorded in accordance with generally accepted accounting principles and properly disclosed in financial statements and other reports.

This ***CHI Standard*** shall be applied as noted in the following Sections IV-A through IV-E:

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

A. Generally Accepted Accounting Principles

1. Section 7.2 of the AICPA *Accounting Guide* states the following, with regard to distinguishing bad debt expense from charity care: Distinguishing bad-debt expense from charity care requires judgment. Charity care results from an entity's policies to provide health care services free of charge to individuals who meet certain financial criteria. The establishment of a policy clearly defining charity care should clearly result in a reasonable determination. Although it is not necessary for the entity to make this determination upon admission of the individual, at some point the entity must determine that the individual meets its preestablished criteria for charity care. Charity care represents health care services that were provided but were never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.

2. Each MBO shall write off patient accounts in one of the following two categories:
   - Charity care discounts – consisting of:
     - Patients with no third-party payment source and for whom there is no expectation of payment

       ... Or ...
     - Medicare (and Medicaid if applicable in the particular state) patients who are determined to be financially unable to pay applicable co-payment obligations, in which case the unpaid co-payment qualifies as a charity care discount for the MBO and can be claimed on any filing for reimbursement as a Medicare (Medicaid) bad debt.
   - Bad debts – consisting of patients who have the ability to pay for health care services (including those with private insurance), where the patient or insurer does not pay the applicable obligation.

B. Financial Statement Disclosures

1. Section 2.4 of the American Institute of Certified Public Accountants (AICPA) *Audit and Accounting Guide for Audits of Providers of Health Care Services* includes the following guidance:

   > The level of charity care provided should be disclosed in the financial statements. Such disclosure is made in the notes to the financial statements and measured based on the provider's rates, costs, units of service, or other statistics.

2. Each MBO shall include information about charity care discounts in the consolidated year-end CHI community benefit disclosure. The annual charity care disclosure in *Note A to the CHI Audited Consolidated Financial Statements* states the following:

   > As an integral part of its mission, CHI accepts and treats all patients without regard of the ability to pay. A patient is classified as a charity patient in accordance with these Standards established across all entities. Charity care represents services rendered for which no payment is expected. Charity care is not included as revenues in the statements of operations and changes in net assets. The amounts of charity care provided, determined on the basis of charges, were $XXX million and $XXX million in 200X and 200X, respectively.

C. IRS Reporting

Each MBO shall include the information noted in the preceding Section IV-C of this document in the IRS Form 990 federal reporting and required state reporting. MBOs are encouraged to publicize this information in notices to the local community.

D. Charity Care Discounts

A line item for charity care discounts does not appear in the MBO statements of operations because the amount is netted against gross revenues. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care discounts and prior-period charity care discounts. The cost of providing charity care discounts to all patients is recorded in the appropriate natural expense classifications in the MBO statements of operations when expenses are incurred through payroll records or accounts payable. Where scholarships are provided for community health education programs, the waived tuition or fee amounts should be tracked and reported as part of the community benefit reporting process.

E. Reserves for Charity Discounts

There is a lag between the times when services are provided and the determination is made about the eligibility for a charity care discount or financial assistance. As a result, effective July 1, 2005, MBOs shall establish a reserve methodology for recording charity care discounts. (The September 2003 version of this document previously provided MBOs with guidance to begin to track the amount of charity care discounts granted, capturing the time

lag between the dates services were provided and financial assistance was granted and recorded in MBO financial records.) The following are the journal entries required in accounting for reserves for charity care discounts. MBOs shall utilize these accounting standards in general ledgers at all entities.

1. To record monthly adjustments to charity care:

Journal Entry	Dr	Cr	Description of Account
Charity care discounts	XX		Contra gross revenues account (statement of operations)
Reserve for charity care discounts		XX	Contra gross accounts receivable (balance sheet)

- Monthly recurring journal entries should be established for estimated charity care discounts.
- The amount recorded will be the difference (debit or credit) between the reserve for charity care discounts and the calculation of the required reserve performed by the MBO on a monthly basis.

2. To record charity care discounts:

Journal Entry	Dr	Cr	Description of Account
Reserve for charity care discounts	XX		Contra gross accounts receivable account (balance sheet)
Accounts receivable		XX	Balance sheet account

- This transaction should be recorded on the business day that the accounts were written off to charity care discounts. This may occur on any day of the month and may occur multiple times in each month.

3. To change the status of accounts receivable from bad debts to charity care discounts:

Journal Entry	Dr	Cr	Description of Account
Reserve for charity care discounts	XX		Contra gross accounts receivable (balance sheet)
Reserve for bad debts		XX	Contra gross accounts receivable account (balance sheet)

- This transaction occurs when an account that was written off as a bad debt expense is subsequently determined to be a charity care discount.

V. Recording Community Benefit

A separate document has been developed for use in determining and reporting community benefit by MBOs.

- **See the CHI *Community Benefit Handbook* in the CHI (General) section of the CHI Public Folders.**

CHA highlights the need for organizations to ensure that MBO charity policies are being implemented consistently and fairly. The following are suggested methods to assure that policies and procedures are implemented:

- Develop and periodically distribute questionnaires to gauge staff perceptions of charity policies, utilize the results to hold staff discussion groups or training sessions.
- Encourage discussion groups that allow staff to describe their perceptions of charity care discounts and to identify possible conflicting practices.
- Monitor staff adherence to MBO charity care policy and procedures.
- Include questions in patient satisfaction surveys to determine whether patients were made aware of MBO financial assistance policies and how patients perceived that offer of assistance.

Please refer to the sample community benefit disclosure included in the Notes to the CHI Consolidated Financial Statements, prepared annually.

- **See attached Exhibit 7: *Sample Community Benefit Disclosure in the Notes to the Financial Statements*** (2 pages, *Word* document).

VI. Resources

The Healthcare Financial Management Association (HFMA) Principles & Practices Board (P&P Board) Statement No. 15, *Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers*, is available at http://www.hfma.org/kn/statement15.htm.

Internal Revenue Service (IRS) Field Service Advice (FSA) 200110030, issued March 9, 2001, contains a listing of 14 factors that IRS agents can weigh when considering the charitable care policies and activities of a hospital. (Please note that the IRS has publicly disavowed any implication in FSA 200110030 that tax-exempt hospitals are obligated to provide any level of charity care.)

- **See attached Exhibit 8: IRS Field Service Advisory – Issue: March 9, 2001** (8 pages, *Word* document).

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Question 1

Attachment 1 – 2

Exhibit 1

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)

Frequently Asked Questions (FAQs) – February 17, 2004
U.S. Department of Health and Human Services (HHS) (5 pages)

EXHIBIT 1

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Frequently Asked Questions (FAQs) – February 17, 2004
U.S. Department of Health and Human Services (HHS) – Page 1 of 5

2/17/04 2:11 pm

Q1: Can a hospital waive collection of charges to an indigent, uninsured individual?

A1: Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Q2: What if a hospital wants to discount charges to patients with large medical bills?

A2: In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies. The separate issue of how Medicare reimburses for the uncollectible deductibles and coinsurance of Medicare beneficiaries will be discussed in answers below. The OIG advises that discounts to underinsured patients can raise concerns under the Federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other Federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG webpage.

Q3: Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A3: No, a hospital does not need permission before offering discounts. However, the Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

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Q4: Does offering discounts to the uninsured/underinsured affect a hospital's cost to charge ratio or Medicare cost apportionment?

A4: No, as long as the provider properly reports full charges on the Medicare cost report. This is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system.

Q5: How is the above any different than a hospital giving a discount to Blue Cross or any other insurer?

A5: For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances. The Medicare program sees no complications where a provider offers discounts or allowances to uninsured or underinsured patients versus allowing discounts or allowances to third-party payers.

Q6: Does the Medicare program's lesser of costs or charges (LCC) principle alter any of the above advice or prohibit hospitals from offering discounts to the uninsured or the underinsured?

A6: The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced. The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But the vast majority of services provided in hospitals in America today are not subject to the LCC principle. In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC. And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Q7: Will Medicare pay a hospital's bad debts for non-Medicare patients who don't pay their bills?

A7: No. Medicare does not pay the bad debts of non-Medicare patients.

Q8: Does Medicare provide any special compensation to hospitals that treat a large number of uninsured patients – especially those hospitals that have to write off a large number of bills for the uninsured?

A8: Yes. CMS makes payments – significant payments – to hospitals that treat a large number of low-income and uninsured patients. For example, the Medicare and Medicaid disproportionate share provisions paid $22 billion to hospitals last year. And under the rules we explain in Question 9, Medicare pays over $1 billion per year to hospitals for the bad debts of Medicare patients.

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Q9: Can a hospital be reimbursed by Medicare for a Medicare patient's unpaid deductibles or coinsurance? Are there special rules for this "bad debt" if the patient meets the hospital's indigency guidelines?

A9: Yes. In the case of Medicare patients generally, the program reimburses a hospital for a percentage of the "bad debt" of a Medicare beneficiary (i.e., unpaid deductibles or coinsurance) as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts. However, if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent (as we used that term in question 1), the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts. Hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to their income). In the case of a Medicare patient that is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance.

Q10: Can a hospital determine its own individual indigency criteria?

A10: Yes. It must, however, apply the criteria to Medicare and non-Medicare patients uniformly.

Q11: Does CMS have any requirements as to what documentation a hospital must secure in order to make an indigency determination? If so, what are those requirements?

A11: For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

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Q12: Are hospitals required to take low-income patients to court, or seize their homes, or send claims out to a collection agency when those patients don't pay their hospital bills?

A12: No. Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients. However, as we noted and explained more fully above in question 9, the Medicare program does contain a special feature that allows a hospital to be paid for its Medicare bad debts. If a hospital wants this special reimbursement adjustment, it must, at the very least, send the Medicare patient a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Q13: Can a hospital write off a Medicare patient's bill but take aggressive collection action against a non-Medicare patient who doesn't pay his/her bill?

A13: Again, this is a decision to be made by the hospital. If a hospital decides that it wants the special Medicare reimbursement allowing for payment of Medicare bad debts, however, then it must engage in uniform collection efforts for all patients, both Medicare and non-Medicare.

Q14: Can a hospital be subject to criminal sanctions or penalties if it writes off a patient's bill?

A14: As explained more fully on its webpage, the OIG advises that offering a discount to an uninsured patient will not implicate the Federal anti-kickback statute, so long as the discount is not linked in any way to referrals of Federal health care program business.

Q15: What if the hospital wants to write off a Medicare patient's deductible and coinsurance regardless of their income level? Is that permissible?

A15: Yes. If a hospital does not want to collect, but wants to write off the uncollected debt regardless of income level, as "charity care" or as a "courtesy allowance," Medicare rules don't prohibit that, but Medicare will also not reimburse these amounts. Furthermore, a hospital may also forgo collection of deductible and coinsurance amounts using its customary methods for determining indigency, according to the bad debt policy stated in the Provider Reimbursement Manual. Bad debt reimbursement policies are governed by Medicare, but, as we note in the answers to Questions 12 and 13, these apply only where a hospital which has unpaid Medicare coinsurance and deductibles wants Medicare reimbursement for them. Moreover, as explained in detail on its webpage, the OIG advises that under the Federal anti-kickback statute, there is an available safe harbor for waivers of Part A deductible and coinsurance amounts without regard to financial need. *Continued on next page...*

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Continuation of A15 from previous page ... In addition, hospitals have the ability to provide relief to Medicare beneficiaries who cannot afford to pay their hospital bills by waiving all or part of a Medicare cost-sharing amount, so long as the waiver is not advertised, not routine, and made after there has been a good faith, individualized determination of financial need or failure of reasonable collection efforts. Advertised cost-sharing waivers, routine waivers, or waivers not based on good faith, individualized determinations of financial need or failed collection efforts potentially implicate both the anti-kickback statute and the civil monetary penalties provision barring the offering of inducements to Medicare and Medicaid beneficiaries.

Q16: What steps can hospitals take to assist the uninsured? The underinsured?

A16: The Department of Health and Human Services notes with interest the many steps that state hospital associations such as the Hospital Association of New York State and the Florida Hospital Association, and community hospitals across the country, have taken recently to address the issue of charges to the indigent and medically indigent. As these hospitals have already discovered, they can take several steps to assist patients with payment for hospital care. For example, hospitals can ensure that all written policies for assisting low-income patients are applied consistently. In addition, hospitals can review their current charge structures and ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. Finally, hospitals could also implement written policies about when and under whose authority patient debt is advanced for collection. For example, a hospital could decide that only the CEO of the hospital can authorize collection action for a patient debt. As we have noted, this is a decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement for Medicare bad debts.

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Question 1

Attachment 1 – 2

Exhibit 2

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)
CHI Standardized Charity Care Form (4 pages)

EXHIBIT 2

Catholic Health Initiatives
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Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)
CHI Standardized Charity Care Form (Page 1 of 4)

Financial Assistance Application

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
Guarantor's Address	City, State, Zip	Home Phone #	Length of Residence
Previous Address (if less than 2 years at above)	City, State, Zip	Marital Status	# of Dependents in Household

List Names and Ages of Dependents in Household:

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address		
Job Title/Length of Employment		
Business Telephone #		
Hourly Rate		
Monthly Income Gross		
Monthly Income Net		
Other Income Source/Amount	Total Family Monthly Income	Total Family Income last 12 months

Have you applied for Medicaid or any other State/County Assistance? (check one)	Yes	No
Application Date	Caseworker Name/Telephone Number	

Have you filed Bankruptcy? Yes No	Chapter 7	Chapter 13	Date Filed	Date of Discharge
Are you a Homeowner? Yes No	Approximate $ Value	Approximate Balance on Loan	Years left on Loan	

Bank Name	Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance

AUTOMOBILE(S)				
1. Make:	Model:	Year:	Pymt Amount:	Balance Due:
2. Make:	Model:	Year:	Pymt Amount:	Balance Due:

Other Assets (Stocks Bonds, Property, Boat, Business, etc.)

Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	$			$	$
Charge Cards	$			$	$
	$			$	$
	$			$	$
Bank Loans	$			$	$
	$			$	$
School Loans	$			$	$

List Other Expenses Below:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$	MEDICATION	$	AUTO INS	$
UTILITIES	$	LIFE INSURANCE	$	OTHER	$
GAS (CAR)	$	MEDICAL BILLS	$	OTHER	$
TOTAL MONTHLY EXPENSE	$				

Note: Attach additional sheet if necessary. Important: income verification must be attached – W2, Pay Stub, Tax Return, etc.

(Continued)

EXHIBIT 2

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CHI Standardized Charity Care Form (Page 2 of 4)

CERTIFICATION

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill.**
3. **I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of _____ information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize _____ to perform a credit check for both guarantor/patient and spouse.**

Signature (Guarantor/Patient)	Date	Witness	Date
Signature (Spouse)	Date	Witness	Date

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1: Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.

2: Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.

3: Complete the guarantor's address, home telephone number and length of residence at this address.

4: Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-" in the dependent field.

5: List the names and ages of dependents.

6: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.

7: Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A".

8: Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A".

9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.

10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.

11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.

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12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".

13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.

15: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

(Continued)

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AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this section.

PLEASE READ THE FINE PRINT!!!!!!!

DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing _____ to obtain credit information and perform a credit check.

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Question 1

Attachment 1 – 2

Exhibit 3

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)
Charity Care/Extended Monthly Payment Checklist (2 pages)

EXHIBIT 3

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Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Charity Care/Extended Monthly Payment Checklist (Page 1 of 2)

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION
	1—The demographic information is completed for patient and guarantor (i.e., address, telephone number, etc.).
	2—The dependent information is completed (i.e., number in household, names, ages, etc.).
	3—The employment and income information is completed for patient/guarantor and spouse.
	4—A copy of most recent year's IRS Tax Return is attached.
	5—A copy of most current pay stub is attached.
	6—A copy of medical savings account balance (if any) is attached.
	7—If no income is documented, attach an explanation for how expenses are being met.
	8—If the patient/guarantor has filed bankruptcy, all questions are answered.
	9—If the patient/guarantor is a homeowner, all questions are answered.
	10—Information is completed for banking information (i.e., checking and savings accounts).
	11—Information is completed for automobile.
	12—Information is completed for other assets.
	13—The expense/monthly payment information is completed.
	14—Does all information look reasonable?
	15—Are there any luxury items listed that might prevent patient/guarantor from paying the bill (e.g., country club dues, maid or lawn service, boat, high cable bills, etc.)?
	16—Has the patient/guarantor and spouse signed and dated the form?
	17—Has the witness signed and dated the form?
	18—Compare the *Total Family Monthly Income* to the *Total Monthly Expenses*. Can the patient/guarantor afford to make monthly payments? If so, contact the patient/guarantor to establish payment arrangements. **STOP.**
	19—If the patient/guarantor cannot afford monthly payments, use the Poverty Guidelines Matrix to determine if the patient/guarantor qualifies for Charity Care.
	20—If the patient qualifies for Charity Care and the total discount is less than $2000, log on Charity Log, process discount and send acceptance for Charity Care letter to patient.
	21—If the patient qualifies for Charity Care and the total discount is over $2000, log on Charity Log and forward all information to Patient Account Manager to review and approve.
	22—If the patient does not qualify for Charity Care, send denial for Charity Care letter to patient/guarantor.
	23—If the application is incomplete, return application and all supporting documentation to patient with a letter indicating what is required and that it needs to be returned.
	24—The Patient Account Manager (see policy for approval levels) needs to approve and post discounts for discounts above $5000.

EXHIBIT 3

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Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Charity Care/Extended Monthly Payment Checklist (Page 2 of 2)

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION	
	25—The Patient Account Manager will return the Charity Log and all supporting documentation to the Financial Representative to send acceptance for a Charity Care letter to the patient.	
	26—The Financial Representative will send an acceptance for the Charity Care letter to the patient and return all information to the Patient Account Manager.	
	27—The Patient Account Manager selects this chart for Quality Review.	
Signature – Financial Representative		Date
Signature – Patient Account Manager		Date

Question 1

Attachment 1 – 2

Exhibit 4

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 6: Uninsured/Underinsured Patient Discounts (Charity Care)

Instructions for using the $130% of the annually updated HUD Very Low-Income Guidelines"
Presented on a geographic basis for CHI Market-Based Organizations

Exhibit 4

Catholic Health Initiatives
Financial Standards and Guidelines
Section 6: Uninsured / Underinsured Patient Discounts (Charity Care)

Instructions for using the "130% of the annually updated HUD Very Low-Income Guidelines"
Presented on a geographic basis for CHI Market Based Organizations

These guidelines are to be used to determine eligibility for full or partial charity care write off. Each MBO should determine the very low income guidelines that apply to the particular market. The HUD very low income guidelines for the counties in which CHI MBOs are located are provided in the following tables.

Each MBO needs to access the HUD website listed in Section III-A, Item Number 7-a of the *CHI Standards and Guidelines: Uninsured /Underinsured Patient Discounts (Charity Care)* to obtain the very low income limits for the county of residence for the charity care applicant and increase those income levels by 30%.

Once the very low income guidelines are located for the county of residence of the applicant, increase the amounts by 30% and insert the income limits by family size in the sliding scale developed by CHI (included as the third tab of this workbook). The amount for additional family members for families of more than eight people should be determined by subtracting the base amount for seven family members from the base amount for eight family members. Please note that the sample worksheet at the third tab of this workbook will automatically calculate the sliding scale for the 75%, 50% and 25% charity care discount levels.

This worksheet should be updated annually by each MBO.

Catholic Health Initiatives
Financial Standards and Guidelines
Uninsured / Underinsured Patient Discounts (Charity Care)

HUD Very-Low Income Guidelines

updated January 28, 2004

Facility (MBO) Name	County	In MSA	State	2004 Median Income	50% Income Limit - 1 person	50% Income Limit - 2 person	50% Income Limit - 3 person	50% Income Limit - 4 person	50% Income Limit - 5 person	50% Income Limit - 6 person	50% Income Limit - 7 person	50% Income Limit - 8 person
St. Vincent Health System	Pulaski County	*	AR	$ 55,100	$ 19,300	$ 22,050	$ 24,800	$ 27,550	$ 29,750	$ 31,950	$ 34,150	$ 36,350
St. Anthony North Hospital	Adams County	*	CO	$ 69,500	$ 24,450	$ 27,950	$ 31,450	$ 34,950	$ 37,750	$ 40,550	$ 43,350	$ 46,150
Centura Health	Arapahoe County	*	CO	$ 69,500	$ 24,450	$ 27,950	$ 31,450	$ 34,950	$ 37,750	$ 40,550	$ 43,350	$ 46,150
St. Anthony Central Hospital	Denver County	*	CO	$ 69,500	$ 24,450	$ 27,950	$ 31,450	$ 34,950	$ 37,750	$ 40,550	$ 43,350	$ 46,150
Penrose Community Hospital	El Paso County	*	CO	$ 62,100	$ 21,750	$ 24,850	$ 27,950	$ 31,050	$ 33,550	$ 36,000	$ 38,500	$ 41,000
St. Thomas More Hospital	Fremont County		CO	$ 48,000	$ 18,100	$ 20,700	$ 23,250	$ 25,850	$ 27,900	$ 30,000	$ 32,050	$ 34,100
Mercy Medical Ctr	La Plata County		CO	$ 56,700	$ 19,850	$ 22,700	$ 25,500	$ 28,350	$ 30,600	$ 32,900	$ 35,150	$ 37,400
St. Mary-Corwin Medical Center	Pueblo County	*	CO	$ 45,000	$ 18,100	$ 20,700	$ 23,250	$ 25,850	$ 27,900	$ 30,000	$ 32,050	$ 34,100
Mercy Medical Center	Canyon County	*	ID	$ 55,000	$ 19,250	$ 22,000	$ 24,750	$ 27,500	$ 29,700	$ 31,900	$ 34,100	$ 36,300
Mercy Health Network	Polk County	*	IA	$ 65,300	$ 23,400	$ 26,750	$ 30,100	$ 33,450	$ 36,150	$ 38,800	$ 41,500	$ 44,150
Central Kansas Medical Center	Barton County		KS	$ 46,100	$ 16,650	$ 19,050	$ 21,400	$ 23,800	$ 25,700	$ 27,600	$ 29,500	$ 31,400
St. Catherine Hospital	Finney County		KS	$ 47,800	$ 17,550	$ 20,100	$ 22,600	$ 25,100	$ 27,100	$ 29,100	$ 31,100	$ 33,150
St. Joseph Hospital	Fayette County	*	KY	$ 58,300	$ 20,400	$ 23,300	$ 26,250	$ 29,150	$ 31,500	$ 33,800	$ 36,150	$ 38,500
Our Lady Of The Way Hospital	Floyd County		KY	$ 30,600	$ 14,050	$ 16,050	$ 18,050	$ 20,050	$ 21,650	$ 23,250	$ 24,850	$ 26,450
Caritas Health Services	Jefferson County	*	KY	$ 58,200	$ 20,350	$ 23,300	$ 26,200	$ 29,100	$ 31,450	$ 33,750	$ 36,100	$ 38,400
Marymount Medical Center	Laurel County		KY	$ 37,400	$ 14,050	$ 16,050	$ 18,050	$ 20,050	$ 21,650	$ 23,250	$ 24,850	$ 26,450
Berea Hospital	Madison County	*	KY	$ 58,300	$ 20,400	$ 23,300	$ 26,250	$ 29,150	$ 31,500	$ 33,800	$ 36,150	$ 38,500
Flaget Hospital	Nelson County		KY	$ 52,300	$ 18,300	$ 20,900	$ 23,550	$ 26,150	$ 28,250	$ 30,350	$ 32,450	$ 34,500
St. Josephs Medical Center	Baltimore County	*	MD	$ 68,600	$ 24,000	$ 27,450	$ 30,850	$ 34,300	$ 37,050	$ 39,800	$ 42,550	$ 45,300
St. Joseph's Area Health Services	Hubbard County		MN	$ 46,500	$ 18,250	$ 20,900	$ 23,500	$ 26,100	$ 28,200	$ 30,300	$ 32,350	$ 34,450
LakeWood Health Center	Lake of the Woods County		MN	$ 43,800	$ 18,250	$ 20,900	$ 23,500	$ 26,100	$ 28,200	$ 30,300	$ 32,350	$ 34,450
Unity Family Healthcare	Morrison County		MN	$ 50,400	$ 18,250	$ 20,900	$ 23,500	$ 26,100	$ 28,200	$ 30,300	$ 32,350	$ 34,450
St. Francis Medical Center	Wilkin County		MN	$ 53,400	$ 18,700	$ 21,350	$ 24,050	$ 26,700	$ 28,850	$ 30,950	$ 33,100	$ 35,250
St. Johns Reg Medical Center	Jasper County	*	MO	$ 46,900	$ 16,400	$ 18,750	$ 21,100	$ 23,450	$ 25,350	$ 27,200	$ 29,100	$ 30,950
Good Samaritan Health Systems	Buffalo County		NE	$ 55,700	$ 19,500	$ 22,300	$ 25,050	$ 27,850	$ 30,100	$ 32,300	$ 34,550	$ 36,750
Alegent Health	Douglas County	*	NE	$ 64,000	$ 22,550	$ 25,750	$ 29,000	$ 32,200	$ 34,800	$ 37,350	$ 39,950	$ 42,500
St. Francis Medical Center	Hall County		NE	$ 52,300	$ 18,300	$ 20,900	$ 23,550	$ 26,150	$ 28,250	$ 30,350	$ 32,450	$ 34,500
St. Elizabeth Health Systems	Lancaster County	*	NE	$ 63,600	$ 22,250	$ 25,450	$ 28,600	$ 31,800	$ 34,350	$ 36,900	$ 39,450	$ 42,000
St. Mary's Hospital	Otoe County		NE	$ 52,700	$ 18,450	$ 21,100	$ 23,700	$ 26,350	$ 28,450	$ 30,550	$ 32,650	$ 34,800
St. Joseph Healthcare System	Bernalillo County	*	NM	$ 54,200	$ 18,950	$ 21,700	$ 24,400	$ 27,100	$ 29,250	$ 31,450	$ 33,600	$ 35,750
Mercy Hospital (Valley City)	Barnes County		ND	$ 49,200	$ 17,200	$ 19,700	$ 22,150	$ 24,600	$ 26,550	$ 28,550	$ 30,500	$ 32,450

data from U.S. Department of Housing and Urban Development
http://www.huduser.org/datasets/il.html

Catholic Health Initiatives
Financial Standards and Guidelines
Uninsured / Underinsured Patient Discounts (Charity Care)

HUD Very-Low Income Guidelines

updated January 28, 2004

Facility (MBO) Name	County	In MSA	State	2004 Median Income	50% Income Limit - 1 person	50% Income Limit - 2 person	50% Income Limit - 3 person	50% Income Limit - 4 person	50% Income Limit - 5 person	50% Income Limit - 6 person	50% Income Limit - 7 person	50% Income Limit - 8 person
Villa Nazareth Corporation	Cass County	*	ND	$ 60,700	$ 21,250	$ 24,300	$ 27,300	$ 30,350	$ 32,800	$ 35,200	$ 37,650	$ 40,050
Oakes Community Hospital	Dickey County		ND	$ 43,000	$ 16,800	$ 19,200	$ 21,600	$ 24,000	$ 25,900	$ 27,850	$ 29,750	$ 31,700
Carrington Health Center	Foster County		ND	$ 49,600	$ 17,350	$ 19,850	$ 22,300	$ 24,800	$ 26,800	$ 28,750	$ 30,750	$ 32,750
Mercy Hospital (Devils Lake)	Ramsey County		ND	$ 52,300	$ 18,300	$ 20,900	$ 23,550	$ 26,150	$ 28,250	$ 30,350	$ 32,450	$ 34,500
Lisbon Area Health Services	Ransom County		ND	$ 54,900	$ 19,200	$ 21,950	$ 24,700	$ 27,450	$ 29,650	$ 31,850	$ 34,050	$ 36,250
Saint Joseph's Hosp. & Hlth Ctr.	Stark County		ND	$ 50,500	$ 17,700	$ 20,200	$ 22,750	$ 25,250	$ 27,250	$ 29,300	$ 31,300	$ 33,350
Mercy Medical Center (Williston)	Williams County		ND	$ 50,800	$ 17,800	$ 20,300	$ 22,850	$ 25,400	$ 27,450	$ 29,450	$ 31,500	$ 33,550
Trihealth, Inc	Hamilton County	*	OH	$ 64,000	$ 22,500	$ 25,700	$ 28,950	$ 32,150	$ 34,700	$ 37,300	$ 39,850	$ 42,450
Good Samaritan Hospital	Montgomery County	*	OH	$ 57,700	$ 21,050	$ 24,100	$ 27,100	$ 30,100	$ 32,500	$ 34,900	$ 37,300	$ 39,750
St. Elizabeth Health Services	Baker County		OR	$ 43,300	$ 16,900	$ 19,300	$ 21,750	$ 24,150	$ 26,100	$ 28,000	$ 29,950	$ 31,900
St. Catherine's Residence	Coos County		OR	$ 44,900	$ 16,900	$ 19,300	$ 21,750	$ 24,150	$ 26,100	$ 28,000	$ 29,950	$ 31,900
Mercy Healthcare	Douglas County		OR	$ 46,700	$ 16,900	$ 19,300	$ 21,750	$ 24,150	$ 26,100	$ 28,000	$ 29,950	$ 31,900
Holy Rosary Medical Center	Malheur County		OR	$ 42,000	$ 16,900	$ 19,300	$ 21,750	$ 24,150	$ 26,100	$ 28,000	$ 29,950	$ 31,900
Mt. St. Joseph, Inc	Multnomah County	*	OR	$ 67,900	$ 23,750	$ 27,150	$ 30,550	$ 33,950	$ 36,650	$ 39,400	$ 42,100	$ 44,800
St. Anthony Hospital	Umatilla County		OR	$ 50,000	$ 17,500	$ 20,000	$ 22,500	$ 25,000	$ 27,000	$ 29,000	$ 31,000	$ 33,000
St. Joseph Regional Health Network	Berks County	*	PA	$ 61,700	$ 21,600	$ 24,700	$ 27,750	$ 30,850	$ 33,300	$ 35,800	$ 38,250	$ 40,700
St. Mary's Healthcare Center	Hughes County		SD	$ 58,500	$ 20,500	$ 23,400	$ 26,350	$ 29,250	$ 31,600	$ 33,950	$ 36,250	$ 38,600
Gettysburg Memorial Hospital	Potter County		SD	$ 43,300	$ 15,900	$ 18,150	$ 20,450	$ 22,700	$ 24,500	$ 26,350	$ 28,150	$ 29,950
Memorial Health Care System	Hamilton County	*	TN	$ 50,900	$ 17,800	$ 20,350	$ 22,900	$ 25,450	$ 27,500	$ 29,500	$ 31,550	$ 33,600
Care Center at Bothell	King County	*	WA	$ 71,900	$ 27,250	$ 31,150	$ 35,050	$ 38,950	$ 42,050	$ 45,200	$ 48,300	$ 51,400
St. Francis Medical Center (FHS)	King County	*	WA	$ 71,900	$ 27,250	$ 31,150	$ 35,050	$ 38,950	$ 42,050	$ 45,200	$ 48,300	$ 51,400
Care Center of Tacoma	Pierce County	*	WA	$ 62,100	$ 21,750	$ 24,850	$ 27,950	$ 31,050	$ 33,550	$ 36,000	$ 38,500	$ 41,000
St. Clare Hospital (FHS)	Pierce County	*	WA	$ 62,100	$ 21,750	$ 24,850	$ 27,950	$ 31,050	$ 33,550	$ 36,000	$ 38,500	$ 41,000
St. Joseph Medical Center (FHS)	Pierce County	*	WA	$ 62,100	$ 21,750	$ 24,850	$ 27,950	$ 31,050	$ 33,550	$ 36,000	$ 38,500	$ 41,000
Good Samaritan Health Center	Lincoln County		WI	$ 53,600	$ 18,750	$ 21,450	$ 24,100	$ 26,800	$ 28,950	$ 31,100	$ 33,250	$ 35,400
Franciscan Villa	Milwaukee County	*	WI	$ 63,800	$ 23,500	$ 26,900	$ 30,250	$ 33,600	$ 36,300	$ 39,000	$ 41,650	$ 44,350

data from U.S. Department of Housing and Urban Development
http://www.huduser.org/datasets/il.html

Exhibit 4

Catholic Health Initiatives
Financial Standards and Guidelines
Uninsured / Underinsured Patient Disocunts (Charity Care)
Application Example: Little Rock AR

Charity Care Eligibility at HUD Geographic 130% of Very Low Income Guidelines - 2004

This sliding scale chart applies to accounts as follows for patients/guarantors who are either:

1) **Uninsured who have met the charity eligibility criteria**

OR

2) **Underinsured whose income meets the charity eligibility criteria**

All patients must apply for charity and provide required documentation.

Size of Family	Gross Annual Income (Less than or Equal to)			
	Base	116.7% of Base	133.4% of Base	150% of Base
1	$ 25,090	$ 29,280	$ 33,470	$ 37,635
2	$ 28,665	$ 33,452	$ 38,239	$ 42,998
3	$ 32,240	$ 37,624	$ 43,008	$ 48,360
4	$ 35,815	$ 41,796	$ 47,777	$ 53,723
5	$ 38,675	$ 45,134	$ 51,592	$ 58,013
6	$ 41,535	$ 48,471	$ 55,408	$ 62,303
7	$ 44,395	$ 51,809	$ 59,223	$ 66,593
8	$ 47,255	$ 55,147	$ 63,038	$ 70,883
		ADD		
For each additional family member	$ 2,860	$ 3,338	$ 3,815	$ 4,290

Write-off Eligibility	100%	75%	50%	25%

Notes:

1. Patients are eligible for partial discounts as income increases up to 150% of the Base, essentially 195% of the HUD Geographic Very Low Income Guidelines. Income increases in the three columns (to the right of the base column) containing the HUD Geographic Low Income amounts are calculated by adding increments of 16.7% to the base gross annual income.

2. In the example above, for St. Vincent Health System, Pulaski County, Arkansas 130% of the HUD very low incomes based on family size are the base incomes eligible for 100% charity write-off.

3. Each MBO should modify the above example by changing the base column to reflect their specific HUD Geographic Area Very Low Income Guidelines plus 30%.

4. The incremental income level for each additional family member should be based on the incremental amount between 7 and 8 family members.

Examples - A family of four with gross annual income that does not exceed $35,815 would be eligible for a 100% charity write-off. That same family of four would be eligible for the following charity discounts in accordance with the following sliding scale example.

Income between		Discount
$ 35,815	$ 41,796	75%
$ 41,796	$ 47,777	50%
$ 47,777	$ 53,723	25%

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Question 1

Attachment 1 – 2

Exhibit 5

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)

CHI Standardized Patient Charity Care Discount
Application Form – Presumptive Eligibility

EXHIBIT 5

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)
CHI Standardized Patient Charity Care Discount
Application Form – Presumptive Eligibility

My name is (please print): _____ _____ _____
LAST FIRST MI

I am: _____ The Patient _____ The Patient's Guarantor

_____ Neither (Please state your relationship to the Patient: _____)

Instructions:
1. ***Please indicate that the Patient is eligible for charity care discount because the Patient is in one or more of the following categories.***
2. ***More than one copy of this form may be required if it is to be completed by more than one individual (e.g., Patient, Guarantor, etc.).***

Please initial if category is applicable	#	Is relevant document attached? Yes	No	Category
	1			Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
	2			Patient is homeless and/or has received care from a homeless clinic.
	3			Patient is eligible for and is receiving food stamps.
	4			Patient's family is eligible for and is participating in subsidized school lunch programs.
	5			Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
	6			Family or friends of a patient have provided information establishing the patient's inability to pay.
	7			The patient's street address is in an affordable or subsidized housing development.
	8			Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
	9			Patient is deceased, with no known estate.
	10			Other – ***Provide explanation:***

Signature _____ Date _____

Authorized by: _____ Date _____

Title: _____

Question 1

Attachment 1 – 2

Exhibit 6

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Uninsured/Underinsured Patient Discounts (Charity Care)

Listing of State Agencies
HUD Section 8 Subsidized Housing Programs
Updated May 1, 2004

Catholic Health Initiatives
Financial Standards and Guidelines
Uninsured / Underinsured Patient Discounts (Charity Care)

Exhibit 6

Listing of State Agencies

HUD Section 8 Subsidized Housing Programs

Updated: May 1, 2004

Agency	Address	Phone	Fax
Colorado Housing and Finance Authority	1981 Blake Street/ Denver, CO 80202-1272	(303) 297-2432	(303) 297-0911
Idaho Housing and Finance Association	PO Box 7899/ 565 West Myrtle/ Boise, ID 87307-1899	(208) 331-4882	(208) 331-4801
Iowa Finance Authority	100 East Grand Avenue, Suite 250/ Des Moines, IA 50309	(515) 242-4990	(515) 242-4957
Kansas Housing Resources Corporation	1000 SW Jackson St. Suite 150/ Topeka, KS 66612	(785) 296-5865	(785) 296-8985
Kentucky Housing Corporation	1231 Louisville Road/ Frankfort, KY 40601	(502) 564-7630	(502) 564-7322
Maryland Department of Housing and Community Development	100 Community Place/ Crownsville, MD 21032-2023	(410) 514-7007	(410) 987-4070
Minnesota Housing Finance Agency	400 Sibley Street, Suite 300/ St. Paul, MN 55101	(651) 296-7608	(651) 296-8139
Missouri Housing Development Corporation	3435 Broadway/Kansas City, MO 64111	(816) 759-6600	(816) 759-6828
Nebraska Investment Finance Authority	1230 O Street, Suite 200/ Lincoln, NE 68508	(402) 434-3900	(402) 434-3921
North Dakota Housing Finance Agency	Mailing address: PO Box 1535/ Bismarck ND 58502-1535 Office location: 1500 East Capitol Avenue/ Bismarck, ND 58501	(701) 328-8080	(701) 328-8090
Ohio Housing Finance Agency	57 East Main Street/ Columbus, OH 43215-5135	(614) 466-7970	(614) 644-5393
Oregon Housing and Community Services Department	1600 State Street/ Salem, OR 97310-0302	(503) 986-2000	(503) 986-2020
South Dakota Housing Development Authority	221 South Central/ PO Box 1237/ Pierre SD 57501-1237	(605) 773-3181	(605) 773-5154
Tennessee Housing Development Authority	404 James Robertson Parkway, Suite 1114/ Nashville, TN 37423-0900	(615) 741-2400	(615) 741-2400
Washington State Housing Finance Commission	1000 Second Avenue/ Suite 2700/ Seattle, WA 98104-1046	(206) 464-7139	(206) 587-5113
Wisconsin Housing and Economic Development Authority	PO Box 1728/ Madison, WI 53701-1728	(608) 266-7884	(608) 267-1099

Question 1

Attachment 1 – 2

Exhibit 7

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)

Sample Community Benefit Disclosure in the Notes to the Financial Statements (2 pages)

EXHIBIT 7

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Sample Community Benefit Disclosure in the Notes to the Financial Statements (Page 1 of 2)

Catholic Health Initiatives
Notes to Consolidated Financial Statements
June 30, 200X

#. Community Benefit (Unaudited)

In accordance with its mission and philosophy, CHI commits substantial resources to sponsor a broad range of services to both the poor as well as the broader community. Community benefit provided to the poor includes the cost of providing services to persons who cannot afford health care, due to inadequate resources and/or who are uninsured or underinsured. This type of community benefit includes: traditional charity care; unpaid costs of Medicaid and other indigent public programs; services such as free clinics and meal programs for which a patient is not billed or for which a nominal fee has been assessed; and cash and in-kind donations of equipment, supplies or staff time volunteered on behalf of the community.

Community benefit provided to the broader community includes the costs of providing services to other populations who may not qualify as poor but may need special services and support. This type of community benefit includes: unpaid costs of Medicare and other programs for seniors; services such as health promotion and education, health clinics and screenings, all of which are not billed or can be operated only on a deficit basis; unpaid costs of training health professionals such as medical residents, nursing students and students in allied health professions; and the unpaid costs of testing medical equipment and controlled studies of therapeutic protocols.

A summary of the community benefit provided to both the poor and the broader community is contained on the following page:

EXHIBIT 7

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

Sample Community Benefit Disclosure in the Notes to the Financial Statements (Page 2 of 2)

Community Benefit (Unaudited – Continued)

	200X	200Y
	(In Thousands)	
Community Benefit Provided to the Poor:		
Cost of charity care provided	$ xxx,xxx	$ xxx,xxx
Unpaid costs of Medicaid and other indigent care programs	xxx,xxx	xxx,xxx
Non-billed services for the poor	x,xxx	x,xxx
Cash and in-kind donations for the poor	x,xxx	x,xxx
Other benefit provided to the poor	x,xxx	x,xxx
	xxx,xxx	xxx,xxx
Community Benefit Provided to the Broader Community:		
Unpaid costs of Medicare and other senior programs	xxx,xxx	xxx,xxx
Non-billed services for the community	xx,xxx	xx,xxx
Education and research provided for the community	xx,xxx	xx,xxx
Other benefit provided to the community	xx,xxx	xx,xxx
	xxx,xxx	xxx,xxx
Total Community Benefit	**$ xxx,xxx**	**$ xxx,xxx**

'he above summary has been prepared in accordance with the policy document of the :atholic Health Association of the United States, *Community Benefit Program—A 'evised Resource for Social Accountability.* Community benefit is measured on the basis ıf total cost, net of any offsetting revenues, donations or other funds used to defray cost. 'he community benefit was xx.x% of total revenues in 200X and xx.x% of total revenues n 200Y.

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Question 1

Attachment 1 – 2

Exhibit 8

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured/Underinsured Patient Discounts (Charity Care)

Internal Revenue Service (I.R.S.)
Field Service Advisory
Issue: March 9, 2001
February 5, 2001

EXHIBIT 8

Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

IRS FSA 200110030
2001 WL 234018 (IRS FSA)
(Publication page references are not available for this document.)
Page 1 of 8

Internal Revenue Service (I.R.S.)
Field Service Advisory
Issue: March 9, 2001
February 5, 2001

Section 501 -- Exemption From Tax on Corporations, Certain Trusts, etc. (Exempt v. Not Exempt)
501.00-00 Exemption From Tax on Corporations, Certain Trusts, etc. (Exempt v. Not Exempt)
501.03-00 Religious, Charitable, etc., Institutions and Community Chest
501.03-11 Hospitals and Health Clinics (See Also 0501.06-03)

CC:TEGE:EOEG:EO2
FREV-106773-01

MEMORANDUM FOR JUDITH PICKEN AREA COUNSEL (GREAT LAKES & GULF COAST AREA) CC:TEGE:GLGC

FROM: Assistant Chief Counsel (Exempt Organizations/Employment Tax/Government Entities) CC:TEGE:EOEG:EO2

SUBJECT: Exempt Hospitals' Compliance with Treas. Reg. § 1.501(c)(3)-1(c).

This Field Service Advice responds to your request for interim guidance on the legal criteria for hospitals to qualify for exemption under section 501(c)(3). Field Service Advice is not binding on Examination or Appeals and is not a final case determination. This document is not to be used or cited as precedent.

DISCLOSURE STATEMENT

Field Service Advice is Chief Counsel Advice and is open to public inspection pursuant to the provisions of section 6110(i). The provisions of section 6110 require the Service to remove taxpayer identifying information and provide the taxpayer with notice of intention to disclose before it is made available for public inspection. § 6110(c) and (i). Section 6110(i)(3)(B) also authorizes the Service to delete information from Field Service Advice that is protected from disclosure under 5 U.S.C. § 552 (b) and (c) before the document is provided to the taxpayer with notice of intention to disclose. Only the National Office function issuing the Field Service Advice is authorized to make such deletions and to make the redacted document available for public inspection. Accordingly, the Examination, Appeals, or Counsel recipient of this document may not provide

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Financial Standards and Guidelines Manual
Section 4: Uninsured / Underinsured Patient Discounts (Charity Care)

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2001 WL 234018 (IRS FSA)
(Publication page references are not available for this document.)

a copy of this unredacted document to any taxpayer or its representative. The recipient of this document may share this unredacted document only with those persons whose official tax administration duties with respect to the case and the issues discussed in the document require inspection or disclosure of the Field Service Advice.

You have requested preliminary advice and guidance on case development concerning the following issue.

ISSUE

Whether a hospital whose stated policies are to provide health care services to individuals regardless of their ability to pay satisfies the charity care requirement of the community benefit standard under the operational test in Treas. Reg. § 1.501(c)(3)-1(c)?

CONCLUSION

A hospital's stated policies to provide health care services to the indigent are not sufficient to satisfy the charity care requirement of the community benefit standard under the operational test in Treas. Reg. § 1.501(c)(3)-1(c), unless the hospital demonstrates that such policies actually result in the delivery of significant health care services to the indigent.

LAW AND ANALYSIS

Section 501(a) generally provides that organizations described in section 501(c)(3) shall be exempt from federal income tax. Section 501(c)(3) describes organizations organized and operated exclusively for charitable or other specified purposes. Treas. Reg. § 1.501(c)(3)-1(a)(1) and Treas. Reg. § 1.501(c)(3)-1(c), respectively, set forth an organizational test and an operational test to determine whether an organization qualifies for exemption under section 501(c)(3). An organization must meet both the organizational test and the operational test to qualify for exemption under section 501(c)(3). Levy Family Tribe v. Commissioner, 69 T.C. 615, 618 (1978); Treas. Reg. § 1.501(c)(3)-1(a)(1).

A. Promotion of Health as a Charitable Purpose

Section 501(c)(3) uses the term "charitable" in its generally accepted legal sense. Nationalist Movement v. Commissioner, 102 T.C. 558, 576, aff'd, 37 F.3d

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EXHIBIT 8

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2001 WL 234018 (IRS FSA)
(Publication page references are not available for this document.)

216 (5th Cir. 1994), cert. denied, 513 U.S. 1192 (1995); Treas. Reg. § 1.501(c)(3)-1(d)(2). Accordingly, the courts have looked to the law of charitable trusts to ascertain what activities are charitable for purposes of section 501(c)(3). See, e.g., Redlands Surgical Services v. Commissioner, 113 T.C. 47, 73 (1999), appeal docketed, No. 99-71253 (9th Cir., Sept. 17, 1999); Sound Health Association v. Commissioner, 71 T.C. 158, 178 (1978). Based on the law of trusts, the courts and the Service have ruled that the promotion of health is a charitable purpose under section 501(c)(3). See, e.g., Redlands Surgical Services, 113 T.C. at 73; Sound Health, 71 T.C. at 178; Rev. Rul. 69-545, 1969-2 C.B. 117. See also Restatement (Second) of Trusts § § 368, 372 (1959); 4A Austin W. Scott & William F. Fratcher, The Law of Trusts § § 368, 372 (4 superth ed. 1989).

B. Requirements of Community Benefit Standard

A hospital or other health care organization does not automatically qualify for exemption under section 501(c)(3) merely because it promotes health. See Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. 687, 692 (1979), aff'd, 625 F.2d 804 (8th Cir. 1980) ("We do not believe that the law requires that any organization whose purpose is to benefit health, however remotely, is automatically entitled, without more, to the desired exemption."); Sonora Community Hospital v. Commissioner, 46 T.C. 519, 525-526 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968) ("While the diagnosis and cure of disease are indeed purposes that may furnish the foundation for characterizing the activity as ''charitable,' something more is required."). Specifically, the courts and the Service require that a hospital or other health care organization must primarily benefit the community in order to qualify for exemption under section 501(c)(3). See, e.g., Redlands Surgical Services, 113 T.C. at 73; Geisinger Health Plan, 985 F.2d at 1219; Sound Health, 71 T.C. at 180-181; Rev. Rul. 69- 545, 1969-2 C.B. 117. The determination by the courts and the Service about whether a hospital satisfies the community benefit standard is based on all the facts and circumstances. See, e.g., Redlands Surgical Services, 113 T.C. at 92; Rev. Rul. 69-545, 1969-2 C.B. 117.

C. Charity Care Establishes a Community Benefit

The provision of free or subsidized care to the indigent is a significant indicator to the courts and the Service that a hospital promotes health for the benefit of the community. In Rev. Rul. 69-545, 1969-2 C.B. 117, the Service ruled that a hospital which operated a full-time emergency room, did not deny emergency care to those who could not afford to pay and met certain other

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requirements qualified for exemption. These charitable indicia outweighed the fact that the hospital ordinarily limited admissions to individuals who could afford to pay for their hospitalization and referred indigent patients requiring hospitalization to another hospital in the community that served indigent patients. By contrast, Rev. Rul. 69-545 denied exemption to a hospital that maintained an emergency room on a "relatively inactive basis" primarily for the convenience of its paying patients and instructed ambulance services to take emergency cases to other area hospitals. In Rev. Rul. 83-157, 1983-2 C.B. 94, the Service stated that operating a full time emergency room open to all, regardless of a person's ability to pay, "is strong evidence that a hospital is operating to benefit the community." In Rev. Rul. 98-15, 1998-1 C.B. 718, a material factor for the Service's conclusion that a hospital, which entered into a joint venture with a for-profit entity, furthered charitable purposes was that the hospital would use its partnership distributions "to help provide health care to the indigent."

.n Geisinger Health Plan, the court stated that "to qualify as a tax exempt charitable organization, a hospital must still provide services to indigents." 985 F.2d at 1217. In Redlands Surgical Services, the court stated that one of the indicia of community benefit is "whether the organization provides free care to indigents." 113 T.C. at 73. In Sound Health, the court ruled that a health care organization operated for charitable purposes, in part because it offered free emergency room care to the indigent and directed the ambulance company that it would treat any emergency patient. 71 T.C. at 172, 184. See Harding Hospital, Inc. v. United States, 505 F.2d 1068, 1077 (6th Cir. 1974) (Hospital's lack of "a specific plan or policy for the treatment of charity patients" was a factor for denying exemption under section 501(c)(3)).

D. Hospital's Activities Must Actually Produce a Community Benefit

A hospital will not qualify for exemption under the community benefit standard merely by stating that its policies are designed to provide health care services for the indigent. The operational test under section 501(c)(3) obligates an organization to engage "primarily in activities which accomplish one or more" exempt purposes. Treas. Reg. § 1.501(c)(3)-1(c)(1) (emphasis added). The hospital, therefore, must demonstrate that its charity care policies actually yield significant health care services to the indigent to qualify for exemption. See Redlands Surgical Services, 113 T.C. at 86-88; Geisinger Health Plan, 985 F.2d at 1219.

In Sound Health, the court stated that the policy behind the community benefit

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standard is "insuring that adequate health care services are actually delivered to those in the community who need them." 71 T.C. at 180-181 (emphasis added). In Geisinger Health Plan, the third circuit overruled a determination by the Tax Court that a health maintenance organization qualified for exemption under the community benefit standard. 985 F.2d at 1221, rev'g and remanding, 62 T.C.M. (CCH) 1656 (1991). The third circuit concluded that "the mere presence of the subsidized dues program" for the poor did not establish that the organization benefitted the community, because the amount of benefit the program actually conferred was minuscule. 985 F.2d at 1219-1220. In Redlands, a surgery center argued that, by changing its policy for performing surgery "from an economic to exclusively a medical decision," it "achieved its goal of providing complete access to ... care for all members of the Redlands community irrespective of their ability to pay." 113 T.C. at 86 (emphasis added). The court rejected this assertion, finding that the administrative record did not support the surgery center's claim that it actually provided any charity care. 113 T.C. at 86, 87. As further evidence of its charitable purposes, the surgery center stated that had "no requirement that patients demonstrate an ability to pay before receiving treatment." 113 T.C. at 87. The court also rejected this claim, finding that the record contained no evidence that the organization had communicated this policy to its patients. 113 T.C. at 87. See Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. at 692 (Organization denied exemption because it did not provide drugs for free or below cost to the indigent); Sonora Community Hospital, 46 T.C. at 524, 526 (Hospital denied exemption because it provided only minimal charity care).

Based on the foregoing, a hospital's mere assertions that it has a policy to provide health care services to the indigent is not sufficient to establish that the hospital meets the charity care requirement of the community benefit standard. Instead, the hospital also must show that it actually provided significant health care services to the indigent.

CASE DEVELOPMENT, HAZARDS AND OTHER CONSIDERATIONS

Set forth below are a series of questions to address when developing the factual record on the charitable care policies and activities of a hospital.

1. Does the hospital have a specific, written plan or policy to provide free or low-cost health care services to the poor or indigent?
2. Under what circumstances may, or has, the hospital deviated for its stated policies on providing free or low-cost health care services to the poor or indigent?
3. Does the hospital broadcast the terms and conditions of its charity care

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policy to the public?

4. Does the hospital maintain and operate a full-time emergency room open to all persons regardless of their ability to pay?

5. What directives or instructions does the hospital provide to ambulance services about bringing poor or indigent patients to its emergency room?

6. What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?

7. Under what circumstances does the hospital deny health care services to the poor or indigent?

8. Does the hospital operate with the expectation of receiving full payment from all persons to whom it renders services?

9. How and when does the hospital ascertain whether a patient will be able to pay for the hospital's services?

10. What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?

11. What is the hospital's policy on admitting poor or indigent patients as inpatients and outpatients?

12. Under what circumstances does the hospital refer poor or indigent individuals who require services to other hospitals in the area that do admit poor or indigent patients?

13. Does the hospital maintain separate and detailed records about the number of times, and circumstances under which, it actually provided free or reduced-cost care to the poor or indigent?

14. Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent? Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?

If you have any further questions, please call Don Spellmann at (202) 622-6010.

Assistant Chief Counsel (Exempt Organizations/Employment Tax/Government Entities)

By:

Elizabeth Purcell

Branch Chief Exempt Organizations, Branch 2

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Internal Revenue Code.

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Question 1

Attachment 1 – 3

Catholic Health Initiatives
Financial Reporting Manual
Inhouse Collections Implementation Guide – Section 19

Includes:

Education for Inhouse Collections
Facilitator's Guide
March 2001

Education for Inhouse Collections
Slides (19)

Catholic Health Initiatives
Financial Reporting Manual
Inhouse Collections Implementation Guide – Section 19

Purpose of This Section

The purpose of the *CHI Inhouse Collections Implementation Guide* is to provide each Market Based Organization (MBO) with a foundation on which to build policies and procedures for the establishment for the collection of "out-of-pocket" dollars. The *Guide* encourages the establishment of such requirements prior to, or at, the time services are rendered in an acute care, ambulatory, diagnostic or rehabilitative setting

Specific Topics Addressed in This Section

Collection of the patient portions of accounts receivable

Contacts for Questions Related to This Section

1. Specific questions about the philosophy and content of the *Guide* should be directed to either J. Peter Savini, CHI Vice President, Patient Financial Services or Colleen Blye, CHI Vice President, Financial Services. Pete can be reached at 610.594.5102 or petersavini@chi-east.org. Colleen can be reached at 610.358.4506 or colleenblye@chi-east.org.
2. Specific questions regarding the credit card aspects of the *Guide* should be directed to Jennifer Neppel, Director, Cash Management at 303.383.2670 or jenniferneppel@chi-national.org.

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CATHOLIC HEALTH INITIATIVES

INHOUSE COLLECTIONS IMPLEMENTATION GUIDE

CATHOLIC HEALTH INITIATIVES

INHOUSE COLLECTIONS IMPLEMENTATION GUIDE

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Inhouse Collections Implementation Guide

I. Purpose of the Guide

Background

One of the economic realities that faces health care providers today is the ever increasing amount of money that patients are expected to pay "out-of-pocket" for inpatient and outpatient services. As a result, the healthcare industry recognizes the need to collect payment for services efficiently and timely.

These out-of-pocket payments, commonly referred to as "co-insurance," "co-payments," "deductibles," and "patient portion," and the number of insurance plans that require them, have increased in virtually every market. This has had a direct financial impact on Catholic Health Initiatives' facilities. The amount of these payments is typically known prior to or at the time of service for many insurance plans. When the precise amount is not known until the total cost or coordination of benefits is known, patients are still generally aware that they have an out-of-pocket payment obligation.

In most of Catholic Health Initiatives' market based organizations, patients' out-of-pocket payments flow into accounts receivable as "self pay" and typically account for 25 to 30 percent of total accounts receivable. Concurrent with the growth of self pay receivables, Catholic Health Initiatives has reported increases in bad debt expense from $209 million in fiscal year 1999 to $296 million in fiscal year 2000. This represents a 41 percent increase in bad debt expense from fiscal years 1999 to 2000, up again after the 21 percent increase from fiscal year 1998 to 1999.

Purpose

The purpose of this guide is to provide each market based organization with a foundation on which to build policies and procedures that will enable the **collection of "out-of-pocket" dollars prior to or at the time services are rendered in an acute care, ambulatory (including physician practices), diagnostic, or rehabilitative setting.** Catholic Health Initiatives is called to face this economic reality while simultaneously demonstrating human dignity and social justice. Failure to balance these economic and social responsibilities will result in increased cost being passed on to all constituents in the communities we serve.

Despite the growth in self pay receivables and bad debt expenses, attempts to collect "out-of-pocket" expenses should not be made until appropriate financial and demographic information is collected and verified for each patient. This includes the use of advanced beneficiary notices (ABNs) as appropriate.

Timeline and Outcomes

Understanding the depth and breadth of this initiative, a phased implementation is deemed necessary. It is recognized that implementation can occur sooner in some areas while other areas will require additional time. Each market based organization should utilize the enclosed resources to facilitate **implementation of an inhouse collection process by April 2, 2001 for the hospital acute care, ambulatory (including physician practices), diagnostic and rehabilitative operations. All other offsite ambulatory (including physician practices), diagnostic and rehabilitative services should utilize the enclosed resources to facilitate implementation of an inhouse collection process by May 31, 2001.** A concerted effort to collect "out-of-pocket" payments prior to or at the time of service will result in:

- Increased cash
- Decreased expense (bad debt)
- Decreased cost (purchased services)
- Increased patient satisfaction (patients avoid future contact)

Continued collaboration within Catholic Health Initiatives, combined with timely controls and monitors, will lead to demonstrable results and yield a culture that will allow us to continue to move toward the creation of healthy communities.

Inhouse Collections Implementation Guide

II. Executive Summary

Background

Accounts receivable related to patient services is one of the largest assets of a health care provider. As an ongoing and continued focus on our accounts receivable reporting and recognition, we are addressing the need for inhouse collections. We recognize the management of the self pay accounts receivable and methods used to proactively collect known patient balances vary by market.

This guide includes materials to support the successful implementation of a guideline that will enable inhouse collection practices for acute care, ambulatory (including physician practices), diagnostic and rehabilitative services. Catholic Health Initiatives plans to develop guidelines for other care settings in the future.

The material is presented with an understanding of the diversity within Catholic Health Initiatives' market based organizations with regard to *people* (applicable FTEs) *process* (for example, patient flow, centralization vs. decentralization) and *technology* (for example, on-line insurance verification to include patient responsibility, central scheduling). The material in this implementation guide can be tailored to accommodate this diversity.

Guideline Goal

The goal of the guideline is to employ a consistent method for inhouse collection practices and develop a standard culture among Catholic Health Initiatives' markets. When this goal is consistently administered and routinely monitored, cash optimization and bad debt expense reduction should result. See actual guideline statement in Section III of this guide.

What Does an April 2, 2001 Implementation Mean?

- Recognition of the need for inhouse collections.
- Establishment of a multi-disciplinary team to begin to implement the enclosed guidelines.
- Completion of the market readiness assessment.
  - Identification of key controls and procedures.
  - Identification of necessary changes to existing controls and procedures, as well as an action plan to address such changes.
- Providing necessary training and education to our employees.
- Rollout of a communication and education program both internally to boards, physicians and employees as well as externally to patients and business community.
- Implementation of inhouse collections and credit card acceptance procedures in all areas based on an appropriate implementation schedule.
- Development of reports to monitor the status and effectiveness of the implementation.
  - Incorporate the outcome into an ongoing task force to facilitate ongoing process improvement (i.e., existing revenue management teams).

Critical Success Factors

Successful implementation will be dependent on six critical success factors:

1. ***Executive Sponsorship*** – The culture will emerge only if each market based organization board of directors, chief executive officer, corporate operating officer, chief financial officer, chief nursing officer and corporate responsibility officer define and support the concept. The presentation materials in Section V of this guide may be customized in order to reach the intended audiences.

2. ***Communication*** – To successfully establish the culture, key constituents must be informed prior to implementing the guideline. They include:
   - Patients
   - Physicians
   - Board of directors and finance committees
   - Employees

   Written communications can reach each of these groups (for example, orientation pamphlets, letters distributed by the marketing/communications department, internal hospital newsletters and external newspaper articles, as appropriate). Sample materials to be incorporated at your discretion are included in section VI of this guide.

3. ***Education and Empowerment of Middle Management and Staff*** – As the front line of service to *patients* and as liaisons to physician communities, these key employees need to be educated, trained and empowered. Senior management must provide ongoing support, reaffirmation and recognition.

4. ***Policies and Procedures*** – Each market based organization has distinct differences regarding how and when they capture and verify patient demographic and financial information. However, all market based organizations perform these functions, often prior to providing service. Refer to guideline enclosed (Section III).

   a. Prior to implementing the inhouse collection guideline, market based organizations should assess their readiness. Refer to a separate market readiness assessment enclosed (Section IV).

5. ***Resources to Assist with Implementation*** (specifically training & education) – When internal resources are not available to assist with the education and training aspects of implementation, external resources whose specialty is inhouse collections may be needed. Please work with the appropriate Vice President, Financial Services before engaging resources.

6. ***Key Performance Indicators*** – Controls and monitors will be needed to measure the effectiveness of this guideline. Performance metrics defined by service and location will help identify process improvement opportunities. Section VIII of this guide contains a sample report from the Meditech system. Sample reports from other systems used within Catholic Health Initiatives were not available to be included. However, these systems can meet this need.

The most important indicators to measure success in this area are:

- Cash collections from unbilled A/R, trended
- Service/locations generating inhouse cash
- Service/locations not generating inhouse cash
- Relationship between inhouse cash collections and bad debt referrals

The following sections of this guide contain materials that should assist you in addressing these critical success factors.

Internal Resource Contacts

Questions related to this guideline can be directed to any of the following individuals, depending upon the nature of the question:

- Administrative, compliance or general finance
  Colleen M. Blye, Vice President, Financial Services
  610/358-4506 or ColleenBlye@chi-east.org
  Marjorie E. Byrnes, Vice President, Financial Services
  612/324-9021 or MarjByrnes@chi-midwest.org
  Susan G. Crawford, Vice President, Financial Services
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  Blaine Petersen, Vice President, Financial Services
  253/428-8407 or BlainePetersen@chiwest.com
  Bob Reh, Vice President, Financial Services
  502/458-0045 or BobReh@chi-se.org

- Patient financial services (patient access and patient accounting)
  J. Peter Savini, Vice President, Patient Finance
  610/594-5102 or PeterSavini@chi-east.org

- Treasury Services (credit and debit card processing)
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We want to acknowledge the following team members for their efforts on this project:

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  Franciscan Health System, Tacoma, WA
- Daniel McElligott, Chief Financial Officer
  St. Francis Medical Center, Grand Island, NE
- Michael Loff, Vice President, Finance
  Mercy Hospital, Devils Lake, ND

Inhouse Collections Implementation Guide

II. Detailed Guidelines

Catholic Health Initiatives is committed to patient satisfaction and accountability in the collection process and, therefore, will be diligent in securing payment for services from payers or individuals, but will not delay or deny emergent or urgent services based on the patient's ability to pay. In no event shall the provision of services and care be based upon or affected by a patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, sexual orientation, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is significant to the provision of appropriate medical care to the patient. In addition, the market based organization shall not delay the provision of appropriate care and treatment for emergent or urgent services in order to inquire about the patient's method of payment or insurance status. The market based organization shall not request, or allow a health plan coordinator to request, prior authorization for services before the patient has received the appropriate care and treatment for emergent services or urgent care. This is consistent with the Emergency Treatment and Active Labor Act (EMTALA) and the model policy and procedure previously distributed by the CHI legal group.

Patients presenting for non-emergent services should be notified of their financial responsibility prior to admission/service. Payment for co-payments, co-insurance, deductibles and patient portion will be requested prior to acute care, ambulatory (including physician practices), diagnostic or rehabilitative services, or satisfactory payment arrangements will be made.

Patients requiring emergent services shall receive a medical screening and stabilization services (consistent with EMTALA) before being advised of their financial responsibility. Market based organizations need to also recognize the potential interplay of this Guideline and the Advance Beneficiary Notice (ABN) requirements. Review of the ABN Guidance Documents distributed by the CHI legal resource group is necessary.

Each department is responsible for ensuring appropriate controls over cash receipts and postings.

SCOPE

This guideline applies to all departments, which admit, register, counsel or provide care to patients in an acute care, ambulatory, diagnostic, or rehabilitative setting.

PURPOSE

The purpose of this guide is to provide each market based organization with a foundation on which to build policies and procedures that will enable the **collection of "out-of-pocket" dollars prior to or at the time services are rendered in an acute care, ambulatory (including physician practices), diagnostic, or rehabilitative setting.**

DEFINITIONS

Urgent Services: As used in this guideline, "Urgent Services" means services that are provided for a medical condition that is not life/limb threatening or likely to cause permanent harm, but for which prompt care and treatment (which HCFA defines as within 12 hours) should be provided in order to avoid:

a. Placing the health of the patient in serious jeopardy or to avoid serious impairment or dysfunction; or
b. The likely onset of an illness or injury that would require Emergent Services as defined by this guideline.

Emergent Services: As used in this guideline, "Emergent Services" means services furnished to a patient with an emergent medical condition as defined as:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either:
    a. Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
    b. Serious impairment to bodily functions, or
    c. Serious dysfunction of any bodily organ or part.
2. With respect to a pregnant woman who is having contractions:
    a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    b. That the transfer may pose a threat to the health or safety of the woman or her unborn child.

Co-payments: As used in this guideline, co-payment means a pre-determined fixed amount of "out-of-pocket" expenses a subscriber is expected to pay to the provider of care for emergent services, acute, diagnostic or rehabilitative services, usually on a per visit basis.

Co-insurance: As used in this guideline, co-insurance means a pro-rated amount of "out-of-pocket" expenses a subscriber is expected to pay to the provider of care. This amount is based on total charges and is usually determined when the claim is adjudicated.

Deductible: As used in this guideline, deductible means a predetermined fixed amount of "out-of-pocket" expenses a subscriber is expected to pay to the provider of care for inpatient services and/or in total for healthcare services received in a given year. Deductibles due from subscribers are withheld by insurers from payments to providers.

IMPLEMENTATION

It is the responsibility of all departments, which admit, register or provide ambulatory care to patients to implement and enforce this guideline.

PROCEDURE

Requests for payment for elective admissions and outpatient encounters should be made prior to or at the time service is rendered. Requests for payment related to emergent and urgent services should be deferred until individuals receive a medical screening and stabilization services, as required.

A. It is the responsibility of Patient Access, whether consolidated under one line of authority or spread across multiple lines of authority to:

1. Carefully *assess* patient benefits, eligibility and outstanding balances.
   - Patients with known outstanding patient liabilities will be made aware of such balances and payment requested, consistent with the procedures outlined below. This is contingent upon patient access having the necessary tools to determine patient liabilities. *This may take time to implement and be part of a phased implementation plan.*

2. *Determine* any patient liability

3. For acute, ambulatory diagnostic care or rehabilitative services/procedures, patients will be assessed to *determine their ability to make payment*. Each case must be assessed on an individual basis. Uninsured or underinsured patients should be assessed for possible Medical Assistance, Charity Care eligibility, or Hill Burton applicability, and will be referred to financial counseling to initiate applicable eligibility process.

   - When a patient presents for **non-emergent services** with **no** form of payment at all, the patient should be referred to a financial counselor for a financial assessment.
     a. At this time, a call should be made to the physician, to inform him/her of the possibility of delay or rescheduling of services due to financial concerns. Scheduling and pre-registering **non-emergent services** far enough in advance to facilitate the determination, communication and collection of the patient liabilities prior to or at the time of service is key to preventing such delays in service and maintaining physician relationship.

   - When a patient presents with emergent needs, medical screening and stabilization services will occur before any determination of their ability to pay or any request for payment is made.

   - Patients capable of paying who do not provide full payment must sign a financial accountability agreement indicating that they fully understand they will have a balance, and that they will be financially responsible for **ALL** services rendered. It is best to incorporate this accountability and responsibility within existing documents.

   - If and only if payment terms are warranted, the following applies:
     a. Payment in full within 90 days, no interest accrues.
     b. Payment in full within 12 months [only used for extenuating circumstances] no interest accrues. Payment terms should not exceed a twelve-month period. If a patient prefers, he/she may utilize a credit card or go externally for credit to pay the balance in full.

- The interim position of not accruing interest on payment terms needs further exploration and additional guidance will be provided in the future.

4. *Inform insured* patients of payer protocols and financial responsibilities, such as:
   a. Out-of-network/out-of-pocket expenses
   b. Non-covered or unauthorized services
   c. Referral(s) needed
   d. Signing financial accountability agreement
   e. Outstanding balances
   f. Advanced Beneficiary Notice, if required

   - For non-emergent acute care, ambulatory (including physician practices), diagnostic care or rehabilitative services/procedures, patients will be informed of their liability when the following qualifying factors apply:
     a. Patient receives a service that is not covered by insurance.
     b. Patient does not have full coverage.
     c. Patient has large out-of-pocket expenses, including Medicare deductibles or large percentage of charge liability.

   - For emergent services, medical screening and stabilization services will occur before any request for payment is made.

   - Patients, who present without a referral, when required, should be assisted to secure the referral from the primary care physician. If a referral is not secured, non-emergent services will be rescheduled or an alternative method of payment requested.

5. *Request immediate payment,* or notify the patient to bring payment on day of service. Forms of payment include cash, check, money order, and credit or debit cards. For those plans where the precise amount is not known (until total cost or benefit coordination is known), obtain a credit card impression and permission to charge once the amount of the liability is known. If patient/guarantor declines payment, defer to Section A-4 above.

6. *Authorization form* - When a patient agrees to provide credit card information to be used *for a future transaction,* the patient access representative and or financial counselor will enter an applicable query/reminder into the Hospital Information System, and have a completed form sent to the cashiers office for retention.

   The query/reminder will remain on the account until the primary payment is made.

   A system generated report will be run daily to capture accounts where primary payments have been made on accounts which have been "flagged".

On a daily basis the cashier will: a) receive the applicable report, b) retrieve the form completed at the access point to apply payments, c) confirm with the patient the dollar amount prior to charging, d) point of service charging and application to the system, and e) once the payment has been applied, the "flag" will be removed to prevent the account from again qualifying for the daily report.

NOTE: Support from Information Technology will be needed as system customization may be required to enable this functionality.

B. Each decentralized and centralized point of registration is responsible to implement and monitor specific cash receipt and reconciliation procedures. They are responsible and accountable to ensure all cash collected (regardless of form of payment), is secured, processed, reconciled and deposited on a daily basis.

The processes employed in cash receipt and reconciliation will depend largely on the relative technology available at the market based organization. The following is an approach for an organization that does not have the ability to implement cashiering functions at all registration points through the information system.

1. Each registration area will be responsible to pick up pre-numbered receipts (see sample Attachment A) and a log (see sample Attachment B) from the cashiering function to be utilized for tracking purposes. All pre-numbered receipts must be accounted for and, therefore, kept in a designated secured area (lockbox) for collection of cash, checks, money orders and/or credit or debit card payments.

2. The cashiering function is responsible for keeping a log indicating the following:

   a. Date, time, department and person who 'Receipts' and 'Log' are issued to
   b. The series of pre-numbered receipts issued
   c. Signature of person 'Receipts' and 'Log' issued to
   d. Date, time, department and person returning 'Receipts' and 'Log'

3. When a patient presents payment, the registration area is responsible to issue 'Receipt' and complete 'Log' information in the following manner:

   a. Receipts: (See sample attached – Attachment A)
      - Cash, Check or Money Order (use of a three part receipt form)
        One copy – placed in lockbox with cash or check attached
        2nd copy – customer copy
        3rd copy – kept in separate file with log

        - Two employees should count receipts (1 must be a supervisor if amount exceeds $_____) to confirm amount and affix their initials to the receipt copy.
        - Apply restrictive endorsement to the back of any check.

- Credit Card (use of a three part receipt form):
  Known Amount:
  Upon receiving credit card, follow the enclosed credit card acceptance procedures. The patient must sign the credit card slip printout/carbon. Credit card slip copy is given to patient. Original is to be
  attached to patient receipt and provided to cashier. The third copy is kept in a separate file with log.

  Unknown amount:
  Refer back to section A-5

- Debit Card (use of a three part receipt form):

  The patient must key in his/her personal identification number on pin pad. A receipt is prepared. The original is to be attached to patient receipt and provided to cashier. A second copy of the receipt is provided to the patient. The third copy is kept in a separate file with log.

- Voids: If you need to void a receipt, retain all 3 parts of the receipt and write void through the receipt and initial. All voids require a supervisor's signature as well.

b. Logs: (See Programmed Log – Attachment B)

- The following information will be placed on the 'Log' by each area for each receipt issued:
  Receipt #, Date, Patient Name, Account #'s, Amount Requested, Amount Collected and Initials.

  Note if a receipt was voided: Keep all 3 parts of the voided receipt and note accordingly on the log.

- Start a log for each new census date. This allows for a one-to-one match on log entries to cash collections for that specific day.

4. At the end of each shift, the cash drawer/lockbox, along with a daily cash balance sheet (see sample attached – Attachment C) and log sheet, should be balanced and all lock box items forwarded to the cashier for deposit and posting.

5. Other

   - Lockbox/Cash Drawer:
     Each department will have on site a lock box or cash drawer. It is in the best interest to ensure security of the cash collected that only the Leaders of each area and appointed designees have daily access. If security is a concern, the area may not want to have a secured cash drawer in the area or handle cash (example: emergency department). Alternative procedures need to be implemented to handle a patient who presents with cash in these areas that present a security concern.

- All accounts must be posted daily and a verification and reconciliation with the payments received.

- Appropriate signage should be posted at each registration area that is accepting patients to indicate that patients should request receipts for payments.

C. For those market based organizations with cashiering capabilities through the information system at all registration points the process may be modified as follows:

1. Steps 1 and 2 from above are eliminated.

2. Step 3 is modified as follows:
   - Patient presenting cash/check/money order
     - Amount is entered into system as cash receipt from patient.
     - System prints out receipt for patient that includes patient name, patient #, date, amount and cashier code.

   - Credit Card
     - Upon receiving credit card follow the enclosed credit card acceptance procedures.
     - Amount is entered into system as credit card payment from patient.
     - Give patient copy of credit card slip and system generated receipts that include patient name, patient number, date, amount and cashier code.

   - Debit Card
     - Patient must enter a personal identification number for processing of payment.
     - Amount is entered into system as debit card payment from patient.
     - Give patient copy of debit card slip and system generated receipts that include patient name, patient number, date, amount and cashier code.

3. Step 4 is modified as follows:
   At the end of each shift an automatic system report of all receipts is generated and reconciled to the cash drawer/lockbox and daily cash balance sheet and forwarded to the cashier for depositing.

   Note: In the case of market based organization with cashiering functions through the information system, it is important that access be limited only to cash receipts with no ability to post account adjustments of any sort.

ATTACHMENT A
Receipt for Inhouse Collections

CASHIER:

Please credit this $_____CASH/CHECK #_____ credit card (complete information below), debit card payment (circle applicable payment type) to patient account #_____for the patient_____
Last, First

To patient account #_____ for service date_____

To patient account #_____ for service date_____

To patient account #_____ for service date_____

To patient account #_____ for service date_____

This is the patient copay/deductible for service date_____ for services rendered by the Medical Center.

CREDIT CARD PAYMENT INFORMATION

VISA____ MASTERCARD____ DISCOVER____ AMERICAN EXPRESS____

Cardholder name:_____

Credit card #_____

Cardholder phone #_____

Expiration Date_____

ATTACHMENT B
LOG OF ALL INHOUSE COLLECTIONS

Date: _____

	Receipt #	Patient Name/Account #	Amount Requested	Amount Collected	Cash	Check	Credit Card	Debit Card	Initials
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									

ATTACHMENT C
MEDICAL CENTER
DAILY CASH BALANCE SHEET

DATE:_____ DEPARTMENT:_____

TOTAL DEPOSIT CASH:_____

TOTAL DEPOSIT CHECKS:_____

TOTAL DEPOSIT CREDIT CARD:_____

TOTAL DEPOSIT DEBIT CARD:_____

TOTAL DEPOSIT:_____

DEPOSITOR'S SIGNATURE:_____

WITNESS SIGNATURE:_____

CASHIER'S SIGNATURE:_____

BEGINNING CASH DRAWER BALANCE $_____

ENDING CASH DRAWER BALANCE $_____

LEADERS SIGNATURE_____

Inhouse Collections Implementation Guide

IV. Market Readiness Assessment Questionnaire

The following questionnaire should be completed by the MBO prior to implementing the program. It should be reviewed for each facility as necessary

Market Assessment Readiness Questionnaire

Prior to implementing the inhouse collection policy, market based organizations should assess their readiness. This should include a review of the following:

Issue	Responsible Party	Comments/Status/Outcome	Expected Completion Date
1. Verification that services is provided only after collection and retention of attending/consulting physician orders (scripts). Those orders are then compared to Local Medical Review Policies (LMRP) distributed by the Fiscal Intermediary.			
2. Review the Advanced Beneficiary Notice (ABN) Guidance documents distributed by the CHI Legal Resource Group. Understand the potential interplay of the applicable ABN Guidelines and the patient access procedures included in the Inhouse Collections Implementation Guide, focusing on the impact to Medicare beneficiaries.			
3. Procedures are in place to ensure that services are not rendered when ordered by excluded providers.			
4. Review the Emergency Treatment and Active Labor Act (EMTALA) Guidelines and model policies and procedures previously distributed by the CHI Legal Resource Group. Understand the potential interplay of the applicable EMTALA Guidelines and the patient access procedures included in the Inhouse Collections Implementation Guide, focusing on necessary processing changes.			
5. Review, and if necessary update, current Charity Care policies and procedures. Assess the current procedural capability to distinguish patients who are unwilling to pay from those who are unable to pay.			

Issue	Responsible Party	Comments/Status/Outcome	Expected Completion Date
6. Does the appropriate system and process integration exist between patient scheduling, patient registration and insurance verification in order to accurately ascertain patient liability? *(Refer to Inhouse Collections Implementation Guide – Section III, Section A-1 to 4.)*			
7. IS customization, or development, of patient communication material needed? This would include signage at applicable access points. (*Refer to Inhouse Collections Implementation Guide – Section VI.*)			
8. Is it necessary to produce material and signage in a language other than English?			
9. System and process design needed to: • Secure signed authorizations from patients to charge their credit or debit cards for the patient portion once the amount is known (if it is not known, prior to, or at the time of service). • Analyze system automation capability? (*Refer to Inhouse Collections Implementation Guide – Section III, Section A-6.*)			
10. Ability of the organization to implement a formal discharge policy in order to interview patients and secure missing financial and demographic data? A formal discharge policy is also necessary to facilitate request for payment related to emergent and urgent admissions.			

Issue	Responsible Party	Comments/Status/Outcome	Expected Completion Date
11. Inventory enabling technologies and devices including applicable insurance verification software, credit card access, ATM or debit card access, to identify existing capabilities and needs • Review *Credit Card Acceptance* section of Inhouse Collections Implementation Guide to ascertain participation opportunities and technical needs.			
12. IS customization, or development of, cash application, control and reconciliation procedures between access points, patient accounting and general finance needed? (Refer to Inhouse Collections Implementation Guide – Section III, Section B).			
13. Review policy and procedures, which establish patient payment terms and conditions. • Emphasize prevention of large balances being paid over extended periods *(i.e., ask for payment in full at the time of service, or establish payment terms which follow those referenced in the Inhouse Collections Implementation Guide – Section A-3).*			
14. Staff education/training needs; placing emphasis on the balance between patient advocacy and financial policy. • Review the most common MBO scenarios (financial/demographic/administrative), prepare appropriate responses.			
15. Customization, or development of, Key Performance Indicators, which provide monitoring and reporting capability by service and location.			

Inhouse Collections Implementation Guide

V. Sample Communication Tools

The following communication tools are provided for potential distribution by MBOs as part of the implementation process. MBOs are encouraged to utilize these documents and/or edit as necessary.

1. Sample Letter to Board of Trustees, Medical Staff and Employees
2. Sample Letter to Patients
3. Sample Internal Newsletter Article
4. Sample External/Community Newsletter Article
5. Sample Patient Guide Text
6. Sample Scripts
7. Examples of common objections and recommended responses

<MBO Letterhead>

MEMORANDUM

TO:	(name of facility)	Board of Trustees Medical Staff Employees
FROM:	(name of facility) CEO and CFO	
DATE:	to be determined	
SUBJECT:	Implementation of Revised Patient Payment Process	

(name of facility) is dedicated to providing quality care for our patients and community. As all health care providers face increasing economic challenges, (name of facility) actively searches for ways to reduce costs while maintaining quality health care services.

One way that we can achieve this goal is streamlining our patient billing procedures. An economic reality facing (name of facility) and all health care providers today is the amount of money that patients are expected to pay "out-of-pocket" for inpatient and outpatient services. These out-of-pocket expenses and the number of insurance plans that require them have increased in our market and throughout the country, resulting in a direct financial impact our facility and all market-based organizations within Catholic Health Initiatives.

Throughout our system, most patients' out-of-pocket payments flow into accounts receivable as "self pay" and typically account for up to 25 to 30 percent of total accounts receivable. Concurrent with the growth of self pay receivables, Catholic Health Initiatives has reported increases in bad debt expense from $209 million in fiscal year 1999 to $296 million in fiscal year 2000. This represents a 41% increase in one year, up again after the 21% increase from fiscal year 1998 to 1999.

To address this concern, effective April 2, 2001, (name of facility) will begin to collect the portion of the hospital payments for which patients are responsible (co-pays, deductibles, co-insurance) at the time a patient pre-registers for a procedure, registers as an outpatient or is admitted as an inpatient. In emergency situations, patients will receive all appropriate medical care prior to any request for payment. We believe that this new process will benefit our facility, patients and community in the following ways:

- ✓ It will reduce administrative and mailing cost of billing patients for health care services after they have been provided. This will enable (name of facility) to increase cash and decrease collection costs and bad debt expenses, allowing us to devote more resources to enhancing patient care.

- ✓ It will enable our patients to discuss their payment obligation with hospital staff in advance or at the time the hospital provides them with services. This will improve patient satisfaction by helping patients to better understand their payment obligations.
- ✓ It will improve patient convenience by eliminating the need to respond to bills and mail payments to the hospital.

In accordance with our mission, we will not delay or deny service or admission to a patient who cannot provide payment. Attempts to collect out of pocket expenses will not be made until appropriate financial and demographic information is collected and verified for all patients.

To assist in explaining this revised in-house collection process to our patients and key constituents, educational and communications tools are being developed for patients, employees, physician office staffs and the community. A copy of the patient letter is attached to this memo. In addition, detailed training and support will be provided to staff members involved in patient registration and billing, and a system-wide team of patient finance experts has developed a comprehensive implementation and resource guide.

(name of facility) and all Catholic Health Initiatives facilities are called to respond to today's economic reality while simultaneously demonstrating human dignity and social justice. Failure to balance our economic and social agendas will result in increased cost being passed on to all constituents in the communities we serve. We believe that this process will improve the efficiency of our services and enhance our ability to provide quality, compassionate care for our patients now and into the future.

If you have any questions, please contact (name, title and phone number).

Thank you for your commitment to our health care ministry and the communities we serve.

<Note: MBO Letterhead >

Dear (name of facility) Patient,

The staff at (name of facility) is dedicated to providing quality care to our patients and community. Like you, we are concerned about health care costs, and we are always searching for ways to reduce those costs while continuing to provide the highest level of care and services to our patients.

One way that we can achieve this goal is to streamline our patient billing procedures. Beginning April 2, 2001, (name of facility) will begin to collect the portion of hospital payments for which patients are responsible (also called co-pays, deductibles or co-insurance) at the time a patient pre-registers for a procedure, registers as an outpatient or is admitted as an inpatient. In emergency situations, patients will receive all appropriate medical care prior to any request for payment. This change will help (name of facility) to meet our financial responsibilities in a more timely manner and continue our mission to provide quality, compassionate health care to our community.

We believe that this new process, which is similar to those that have been adopted by many other Catholic and non-profit health providers, will benefit our patients and community in the following ways:

- ✓ It will reduce the administrative and mailing costs involved in billing patients after health care services have been provided. This will help (name of facility) devote more resources to enhancing patient care.
- ✓ It will enable patients to discuss their payment obligations with hospital staff in advance or at the time the hospital provides them with services. This will help patients better understand their payment obligations.
- ✓ For our patients, it will eliminate the inconvenience of responding to bills and mailing payments to the hospital.

If you pre-register for a hospital service, our staff will confirm your insurance information and, to the extent possible, inform you of your payment obligation in advance of admission or service. If you register at the time that you receive a hospital service or upon admission to the hospital, our staff will confirm your insurance information and, to the extent possible, inform you of your payment obligation and request that you provide payment at that time. Our staff will also explain convenient payment options, including cash, check, money order, credit cards or debit cards.

We believe that this process will enhance our ability to care for patients and improve the efficiency of our services, as it has for many other health providers. In accordance with the mission of (name of facility), please be assured that we will never delay or deny service or admission to a patient who cannot provide payment. If you have concerns about your ability to pay, please discuss them with our staff when you pre-register or are admitted.

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Thank you for choosing (name of facility) for your health care needs. As a faith-based community resource, we know that many people depend on us for their family's health care needs. In turn, we must depend on you and others who are able to pay for their care so that we may continue to provide important services for all of our patients. If you have any questions, please contact (name) at (phone number).

Sincerely,

President and Chief Executive Officer Vice President, Medical Services

<MBO Letterhead>

Sample Internal Newsletter Article

New Patient Payment Process Effective March 31

As the entire health care industry faces increasing economic challenges, (name of organization) is seeking new ways to reduce costs while maintaining quality health care services. One solution will go into effect March 31, when (name of organization) will begin to collect the portion of hospital payments for which patients are responsible – also called co-pays, deductibles or co-insurance – at the time a patient registers for a procedure or is admitted.

"One of the economic realities that we face is that the payments patients are expected to make out-of-pocket, as well as the number of insurance plans that require such payments, have increased," said (organization spokesperson). "This is happening around the country and throughout the Catholic Health Initiatives' system. In fact, within our system, out-of-pocket payments now account for 30 percent of total accounts receivable. This has contributed to a significant increase in the expenses related to bad debt. Collecting patient payments at the time of registration or admission will help alleviate these expenses and deliver some important benefits to the facility and patients."

The benefits of the new procedure include:

- Reduced administrative and mailing costs involved in billing patients after health care services have been provided. "This will enable us to devote more resources to enhancing patient care," said (organization spokesperson).
- An opportunity for patients to discuss their payment obligations with (name of organization)'s staff in advance or at the time that (name of organization) provides them with services. "This will improve patient satisfaction by helping them better understand their payment obligations," said (organization spokesperson).
- Increased convenience for patients by eliminating their need to respond to bills and mail payments to the hospital.

The new procedure does not mean that (name of organization) will turn away patients who are not able to pay. "In accordance with our mission, we will never delay or deny medically necessary service or admission to a patient who cannot afford payment," said (organization spokesperson). "In addition, patients will not be asked to pay out-of-pocket expenses until their financial and demographic information has been collected and verified. In some situations, non-emergent services may be re-scheduled pending appropriate payment arrangements or confirmation of the need for financial assistance."

Patients will receive a letter from (name of organization) informing them of this change in procedure. All staff members involved in patient registration and billing will receive detailed training in the new procedure, as well as ongoing support.

"I truly believe that this new payment process will improve the efficiency of our services and enhance our ability to provide quality, compassionate care to patients, including those who are able to pay and those who are not," said (organization spokesperson).

For more information on the new patient payment procedure, contact (name, title and phone number/e-mail address).

<MBO Letterhead>

Draft - Sample External/Community Newsletter Article

New Patient Payment Process at (name of organization) Begins March 31

As the entire health care industry faces increasing economic challenges, (name of organization) is seeking new ways to reduce costs while maintaining quality health care services for all our patients. One solution will go into effect March 31, when (name of organization) will begin to collect the portion of hospital payments for which patients are responsible – also called co-pays, deductibles or co-insurance – at the time a patient registers for a procedure or is admitted.

"One of the economic realities that we face is that the payments patients are expected to make out-of-pocket, as well as the number of insurance plans that require such payments, have increased," said (organization spokesperson). "This is happening around the country and throughout the Catholic Health Initiatives' system. In fact, within Catholic Health Initiatives, out-of-pocket payments now account for approximately 30 percent of total accounts receivable. Collecting patient payments at the time of registration or admission will help to reduce the administrative costs related to billing patients after they have received services and deliver some important benefits to patients and the facility."

The benefits of the new procedure include:

- Reduced administrative and mailing costs involved in billing patients after health care services have been provided. "This will enable (name of organization) to devote more resources to enhancing patient care," said (organization spokesperson).
- An opportunity for patients to discuss their payment obligations with (name of organization)'s staff in advance or at the time that (name of organization) provides them with services. "This will improve patient satisfaction by helping patients better understand their payment obligations," said (organization spokesperson).
- Increased convenience for patients by eliminating their need to respond to bills and mail payments to the hospital.

The new procedure does not mean that (name of organization) will turn away patients who are not able to pay. "In accordance with our mission, we will never delay or deny medically necessary service or admission to a patient who cannot afford payment," said (organization spokesperson). "In addition, patients will not be asked to pay out-of-pocket expenses until their financial and demographic information has been collected and verified. In some situations, non-emergency services may be re-scheduled pending appropriate payment arrangements or confirmation of the need for financial assistance."

Patients who are scheduled to receive services will be provided with a letter from (name of organization) informing them of this change in procedure. All staff members involved in patient registration and billing will receive detailed training in the new procedure, as well as ongoing support to enable them to answer patient questions. Financial counselors are also available to advise patients who may need financial assistance or qualify for charity care.

"I truly believe that this new payment process will improve the efficiency of our services and enhance our ability to provide quality, compassionate care to patients, including those who are able to pay and those who are not," said (organization spokesperson).

For more information on the new patient payment procedure, contact (name, title and phone number/e-mail address).

<MBO Letterhead>

Draft - Sample Patient Guide Text

Patient Payment Process

When registering for hospital services, patient registration staff will inform patients of their financial obligations to the best extent possible, since specific payment amounts may not be known in advance of a service or procedure. Patients should plan to pay the portion of hospital payments for which they are responsible – also called co-pays, deductibles or co-insurance – at the time of registration or admission.

This process of collecting patient payments at the time of registration or admission will help (name of organization) to reduce the administrative and mailing costs related to billing patients after they have received services, increase patient convenience by eliminating the need to respond to bills and mailing payments and enable (name of organization) to devote more resources to enhancing patient care.

In accordance with the mission of (name of organization), medically necessary care or admission will not be delayed or denied to a patient who cannot provide payment. Also, patients will not be asked to pay out-of-pocket expenses until their financial and demographic information has been collected and verified. In some situations, non-emergency services may be re-scheduled pending appropriate payment arrangements or confirmation of the need for financial assistance.

If you need assistance in arranging payment or cannot afford to pay for health care services, please ask to speak with one of (name of organization's) financial counselors.

For more information on patient payment procedures, contact (name, title and phone number/e-mail address).

Sample Scripts

PRE- REGISTRATION

		Scenario 1	*Scenario 2*	
Greetings	Staff	"Hello, may I please speak with Nancy Jones?		
Phone conversation		"Hello Mrs. Jones my name is [staff name]. I'm calling from [hospital name] to pre-register you for the procedure Dr. Smith has scheduled for you. Is this a convenient time?		
	Patient	"Yes, its ok."		
Determine Ability to pay	Staff	" Mrs. Jones, I see that you are already in our system. I'd like to verify the accuracy of the information and make any necessary updates. Could you verify your insurance for me?" [Patient states insurance company]		
		"OK, Mrs. Jones, I'm ready to take your information. Please tell me the ID number starting with the prefix" [verify other demographics]	Patient	"Oh heavens, my husband carries that card and he's not home. I know its Blue Cross. Its through his work." [An option here is to arrange a call back when the husband is home]
		"Mrs. Jones, [insurance company] requires an authorization number for this procedure, do you know if your physician has provided that?"	Staff	Ok Mrs. Jones, I can contact Blue Cross and get that information from them. May I verify that your husband's name is [name in the system] "Mrs. Jones, [insurance company] requires an authorization number for this procedure, do you know if your physician has provided that?"
	Patient	"I'm sorry, I have no idea. His staff told me they would take care of everything"	Patient	"I'm sorry, I have no idea. His staff told me they would take care of everything"
	Staff	"That's fine Mrs. Jones, we can verify that for you tomorrow. Does your insurance card mention a co-payment?"	Staff"	"Ok Mrs. Jones, we can verify that for you tomorrow. Do you know if your insurance coverage requires a co-payment?"
	Patient	"Yes, it says $ 15.00."	Patient	"I know it does, but I don't know that amount, I'm sorry."
Request immediate payment	Staff	"Thank you Mrs. Jones. Please be prepared to pay that amount when you come in tomorrow. For your convenience, you can pay by cash, check or credit card."	Staff	"Very well, Mrs. Jones. I can verify with Blue Cross what your out of pocket co- pay and co- insurance amounts are. Please be prepared to make the payment when you visit us tomorrow. For your convenience, we accept payment by cash, check or credit card.
	Staff	"Do you know if your insurance coverage also includes a deductible or co-insurance?"	Patient	Well alright, but what if the amount is more than I can pay – since we don't know today how much that will be?"
	Patient	"Oh yes. I know I have to pay for 20 % of the cost myself."	Staff	"If the amount is more than you can pay by cash or check, you can put the amount on a credit card"
	Staff	"Mrs. Jones, its great that you know so much about your coverage! In addition to the co-payment of $ 15.00, please also plan to pay the 20% when you come tomorrow."	Patient	"Oh, I'll put it on credit then"
	Patient	"Ok, I'll just plan to bring my check book."	Staff	That's great Mrs. Jones, we accept [list credit cards accepted]
	Staff	"Thank you very much Mrs. Jones. Do you have any questions about the payments or about where to come in tomorrow?"	Staff	"Thank you very much Mrs. Jones. Do you have any questions about the payments or about where to come in tomorrow?"
	Patient	"I understand the payments, but I'm not sure what area to report to in the morning."	Patient	"No, I can't think of any"
	Staff	"I'd be happy to help you with that. Your procedure is scheduled for [Provide time, department and directions re: where to park and what entrance to come in. Verify that the patient understands, or provide more detailed directions.]	Staff	"Ok, Mrs. Jones, thank you for speaking with me today and for choosing [hospital name] for your care. It is our privilege to serve you!" "Good-bye"
Closure	Staff	"Thank you for allowing me the time to review this with you today. Your check-in process tomorrow will now be very brief. Thank you for choosing [hospital name] for your care. It is our privilege to serve you!"		

INPATIENT / EMERGENT: OCCURS AFTER MEDICAL SCREENING AND STABILIZATION SERVICES

		Scenario 1	Scenario 2	
Greetings	Staff	[knock on door as you enter the patient room]		
	Staff	"Hello, Mrs. Jones, my name is [staff name]. I'd like to talk to you about payment for services for your stay, is this a good time?"		
	Patient	"Yes, I have health care insurance though, so I don't know why this is necessary"		
Determine Ability to pay	Staff	"You are correct, Mrs. Jones, your [insur. Company name] insurance does cover part of your care and services, but your plan also includes a co-insurance payment which you are responsible for."		
Request immediate payment		"The co-insurance portion is estimated to be [$ amount]. Would you like to pay for that with cash, check or credit card?"		
	Patient	" Credit card, of course, but my husband took that home because I was told not to keep any valuables with me"	Patient	"Well, I can write you a check, but not for that full amount"
	Staff	"Of course Mrs. Jones. That's fine. Would you please ask your husband to stop in at the [cashier, credit office, etc] when he visits today so that we can process the co-insurance payment?"	Staff	"I understand, we do also accept cash or credit card, Mrs. Jones." [If patient still can only make partial payment…] "How much are you able to pay today?"
	Patient	"Oh, sure"	Patient	[$]
	Staff	"Thank you for speaking with me today, Mrs. Jones. If you or your husband have any questions about what we've talked about today, here is my phone number, feel free to contact me" [leave card or brochure with your name/dept phone number] "Is there anything else I can do for you while I'm here, I have time." [If patient makes a clinical care request, tell her that you will let her care team know. Relay the request to the care team member as you leave the room.]	Staff	"Very well Mrs. Jones, I will apply the [amount of check] toward the [$] estimated and ask you to sign this financial agreement indicating you understand your responsibility for the balance." [review form and obtain signature] "Mrs. Jones, thank you for choosing [hospital name] for your care, its our privilege to serve you." "Are there any questions I can help you with?"
	Patient	"No, thank you"	Patient	"No, I don't think so"
Closure	Staff	"You're welcome, Mrs. Jones. Take care!"	Staff	"Again, my name is [staff name] and my phone number is on your copy of the financial agreement form. Feel free to call if you need any further information. Thank you!"

Examples of common objections and recommended responses

[Refer to hospital policy for specific procedures]

COMMON OBJECTION	RECOMMENDED RESPONSE
1. I've never had to do this before!	Oh, let me explain that we have had a change in procedure here. Much like your visit to the dentist or doctor office, we do now request payment for services at the time of your visit.
2. I can't pay for this	▪ We do have several available methods for payment. We accept cash, checks and credit cards. ▪ What are you able to pay for today? [If appropriate, refer to financial counselor for discussion of payment arrangements]
3. I didn't bring in my check book	I see. For your convenience, we also accept cash or credit card payment.
4. I can't pay in full	I understand, in addition to cash, we do accept payment by check or credit card. [If necessary, refer to financial counselor for discussion of payment arrangements]
5. Can I make payment arrangements?	Payments arrangements are reserved for those in financial need. Do you see yourself in that position? [follow hospital procedure for eligibility]
6. I can't afford to put this on my credit card	I understand we do also accept cash, or checks. Will one of those work for you?
7. My ex-husband is supposed to pay for all of our medical bills	I understand. Since you are the adult that brought your child in today, however, you are responsible for payment. I can certainly provide you with a receipt verifying your visit and the payment amount.
8. I only saw the doctor for 5 minutes, why is this amount so high?	▪ The % of charge amount includes hospital services and supplies, not just the professional component. ▪ The co-payment amount is a preset charge, set by your insurance company, for use of the emergency room.
9. My doctor told me not to worry about the bill	I see. Well, we do work in concert with your primary care physician. What are you able to pay today? [when applicable, explain charity care and eligibility, refer to financial counselor]
10. How do I apply for charity care/help?	There are eligibility requirements to apply for charity care. Do you believe you might qualify? [refer to financial counselor as appropriate]
11. I have a medical assistance application pending	I see. I will need you to provide information including your caseworker name and your case number in order to verify your application. Do you have that information with you? [follow procedure for self pay as appropriate]
12. This is work related and I don't have a claim number	I see. You do need to provide us with information of your employer's name/immediate supervisor name/accident date/...in order to verify coverage. Do you have that information with you? [follow procedure for self pay as appropriate]
13. This was the result of auto accident and it wasn't my fault. I don't owe anything.	I see. You will need to provide us with your claim number, 3rd party information, etc. [follow procedure for self pay as appropriate]

In-house Collections Implementation Guide

VI. Educational Materials Facilitator's Guide

The "Educational Materials Facilitator's Guide" is separately incorporated herein by reference. Please refer to "Sub-Category B" within this section of the CHI *Financial Reporting Manual*, Chapter XVIIII (19).

In-house Collections Implementation Guide

VII. Educational Materials – Power Point Presentation

The "Educational Materials – Power Point Presentation" is separately incorporated herein by reference. Please refer to "Sub-Category C" within this section of the CHI *Financial Reporting Manual*, Chapter XVIIII (19).

In-house Collections Implementation Guide

VIII. Credit Card Acceptance Guidelines

OVERVIEW

The purpose for this document is to provide guidelines for acceptance of credit cards and to communicate the new CHI negotiated merchant discount rates. The overall goal of this initiative is to improve the cash collection process through the use of credit cards, reduce costs and provide a convenient method of payment for those we serve.

In order to obtain the most favorable credit card acceptance terms for CHI, Treasury staff conducted a search for a national credit card processor. Wells Fargo Merchant Services has been selected to serve in this capacity. Wells Fargo will be responsible for processing MasterCard, VISA, American Express and Discover credit cards under a national CHI contract. Wells Fargo has also established the merchant discount rate for MasterCard and VISA. The merchant discount for American Express and Discover was negotiated separately with the respective organizations. Wells Fargo will also be responsible for maintaining and programming the point-of-sale (POS) terminals and provide training to CHI MBO staff.

Due to the potential volume of credit card transactions throughout Catholic Health Initiatives, Treasury staff was able to negotiate very favorable rates with each of the major credit card providers. With CHI net patient revenues of $5.0 billion, and a growing level of self-pay balances from co-insurance and deductibles, the potential amount of credit card volume should increase dramatically over the next several years.

CHI entities will now be able to accept credit cards at significantly reduced rates than previously arranged locally. All entities that currently accept credit cards will be afforded the opportunity to participate in this new arrangement. In addition, organizations not currently accepting credit cards will now be able to participate under the national credit card agreement. Entities participating in joint operating agreements should separately contact Treasury staff to set up the national credit card agreements.

In addition, all credit card transactions will settle in each entity's Mellon Bank account. This will further improve the collection of cash and will ensure that the funds are invested. Entities participating in joint operating agreements may have different settlement arrangements.

DEFINITIONS

Merchant Discount – The fee paid by a CHI entity (merchant) to accept credit card payments. The merchant discount is comprised of fees paid to the bank issuing the credit card, the credit card processor and the credit card company (e.g., VISA, MasterCard, etc.). Transactions are settled for the total dollar amount and the merchant discount is deducted from the CHI entity's Mellon Bank account via ACH at the end of every month. The CHI merchant discount is negotiated on a national scale and has the potential to decrease over time with increased volume.

Settlement - The amount of time from when the credit card payment is accepted to when the CHI entity receives the funds from the credit card processor in its Mellon Bank account.

Authorization – The process of verifying that the credit card has sufficient funds (credit) available to cover the amount of the transaction. An authorization is obtained for every credit card transaction.

Debit Card – A credit card whose funds are withdrawn directly from the cardholder's checking account. It requires the cardholder to enter a PIN number at the time of the transaction.

Point-of-Sale (POS) Terminal – The equipment used to capture, transmit and store credit card transactions electronically.

Chargeback – Chargebacks typically occur when a credit card purchase is disputed by the cardholder and the transaction amount is subsequently charged back to the merchant. Chargebacks can also occur if the merchant makes an error in the credit card transaction (e.g., transposed account number, missing expiration date, etc.). There are additional fees charged to the merchant for chargebacks.

Merchant Number – Identifying number assigned to each merchant (CHI entity).

Credit Card Processor – Wells Fargo Merchant Services has been selected as the national credit card processor for CHI. Wells Fargo will be responsible for processing MasterCard, VISA, American Express and Discover credit cards. They will set the merchant discount rates for MasterCard and VISA and will prepare the settlement transactions. In addition, Wells Fargo will be responsible for authorizations and the installation/training of the POS terminals.

CREDIT CARD ACCEPTANCE METHODS

A. Credit Card - Use of POS Terminal to Swipe Card

****Please note:** This is the **preferred** method of accepting MasterCard and VISA credit cards. It has the lowest CHI negotiated merchant discount rate **(1.66%)** and prevents manual errors that may result in chargebacks. Both American Express (CHI merchant discount – **2.7%**) and Discover **(1.67%)** charge the same merchant discount for all credit card acceptance methods (e.g. swiped, key entry or paper transaction slip).

1. Operational Procedures

   - Upon receiving the credit card from the patient, **swipe** the card through the POS terminal to obtain authorization (see Authorization/Approval Code section) and process the transaction.

2. Patient Signature

   - After the patient has signed the transaction slip, compare the signature written on the back of the credit card to the signature on the transaction slip. If the signatures do not match, call the Wells Fargo Automated Authorization Center at 1-800-626-4480 and request a code 10 authorization. The operator will then instruct the user on how to handle the situation.

   - If the credit card is not signed, request a current form of official identification such as a driver's license. Have the cardholder sign the credit card prior to the completion of the transaction. If they refuse, ask for an alternative form of payment (e.g., different credit card, cash, check).

B. Credit Card - Key Entry of Credit Card Number into POS Terminal

1. Operational Procedures

   - Patients may authorize CHI entities to charge their credit cards either through the mail, over the phone or at a later date. If the credit card is not present at the time of the transaction, it may be manually (keyed) entered into the POS terminal.

   - CHI Negotiated Merchant Discount Rate for MasterCard - **2.1%**, VISA - **2.1%,** American Express – **2.7%**, and Discover – **1.67%.**

C. Credit Card – Paper Transaction Slip (No POS Terminal)

****Please note:** This is the **most** expensive method to process credit card transactions. Due to the high merchant discount rate (4-6%) for MasterCard/VISA, it is recommended to lease, rent or buy the POS equipment in order to lower the cost of accepting credit card payments.

1. Operational Procedures – Patient Present

   - All of the information that would normally be imprinted from the credit card must be clearly written in the appropriate areas on the transaction slip.
   - The transaction date, dollar amount and a brief description of the goods sold or service rendered must be provided on the transaction slip.

2. Operational Procedures – Telephone or Mail Payments

   - All of the information that would normally be imprinted from the credit card must be clearly written in the appropriate areas on the transaction slip. "Mail Request" or "Phone Request" should be written on the signature line of the transaction slip. In addition, the transaction date, dollar amount and a brief description of the goods sold or service rendered must be provided.

3. CHI Negotiated Merchant Discount Rate for MasterCard and VISA - Approximately **4.0%-6.0%**

D. Credit Card - Debit Cards

1. Patients may use their debit cards to pay for goods and services. There are two types of debit cards: those with a VISA emblem on them and those without. Debit cards with the VISA emblem are actually processed as credit cards even though the funds are withdrawn from the patient's checking account. There is a slightly lower merchant discount than a regular VISA credit card. For those cards without the VISA emblem, they are actual debit cards and eligible for the lower merchant discount rate described below.

2. To receive this lower merchant discount, the card must be swiped and the patient enters a PIN number. This requires the CHI entity to purchase a PIN Pad, which is an additional piece of equipment attached to the POS terminal (approximate one-time cost - $270).

3. CHI Negotiated Merchant Discount – **$0.35** per transaction (For example, on a $100 charge, this results in a 0.35% merchant discount, by far the lowest fee of all payment methods.)

E. Credit Card - Recurring Transaction (Installment Payment Plan)

1. Patients may request that their credit card be used to pay for goods and services in installment payments.

2. The patient will need to complete and deliver to the CHI entity a written request for goods and/or services to be charged to their credit card account. The written request must at least specify the transaction amounts, the frequency of recurring charges and the duration of time for which the cardholder's permission is granted.

3. The CHI entity cannot impose a finance charge in connection with a recurring transaction.

4. For additional information and terms, refer to Section A-3 of the *Inhouse Collections Guide.*

AUTHORIZATION/APPROVAL CODE AND PROCESSING OF DENIED TRANSACTIONS

A. Authorization / Approval Code

1. All credit card transactions require an authorization. When the card is swiped, the toll-free number is automatically called in order to obtain the authorization code.

2. After the card is swiped, the terminal will prompt the user to key in the last four digits of the credit card. This will ensure that the account number embossed on the credit card matches the account number in the magnetic strip on the back of the card.

3. The authorization/approval code indicates the availability of credit on the card at the time of inquiry. It is not a promise or a guarantee that payment will be received.

B. Denied Transactions

1. If the transaction is **denied** the following options are available:

   - Inform the patient that the authorization/approval code was not granted.

   - Ask if there is an alternative form of payment (e.g., different credit card, cash, check) available to pay for the transaction.

   - Suggest that the patient contact his/her bank or credit card company to obtain additional information and the reason for the authorization denial.

C. Customer Service

1. For customer service regarding authorizations, please contact the following:

MasterCard/VISA	1-800-626-4480
American Express	1-800-528-5200
Discover	1-800-347-2000
Wells Fargo Merchant Services (general customer service)	1-800-451-5817

SUBMISSION/DEPOSIT OF TRANSACTIONS RECORDS

A. Electronic Submission

1. In order to qualify for the lowest merchant discount rate, all transactions and credit records must be properly completed and **electronically** submitted **daily**. Late submissions of credit card transactions may result in a high merchant discount fees and possible chargebacks.

2. Batches must be electronically submitted by 2 a.m. Central Time in order to receive the lowest merchant discount.

3. For each batch submitted, ensure that the merchant account number and all other information is included (i.e., date, amount, number of items, etc.)

4. The batch/deposit total must match to the settled/reconciled amount.

B. Submission of Paper Transactions

1. Paper transaction slips must be deposited daily in the CHI entity's local bank depository account. Since this is not an electronic method, the settlement time is significantly longer.

SETTLEMENT

A. Settlement for Payments Submitted Electronically

1. Settlement will generally occur on the second banking business day (48 hours) after the transaction is received. The settlement will occur via ACH and will be deposited directly into the CHI entity's Mellon Bank account. For those entities participating in joint operating agreements and not utilizing the CHI Cash Management Program, settlement will occur in the designated local depository. Settlement for Paper Transactions

B. **Settlement for Paper Transactions**

1. If paper transaction slips are used, the settlement will occur in 72 hours or more, depending upon the credit card company. The settlement will still occur via ACH and will be deposited directly into the CHI entity's Mellon Bank account. For those entities participating in joint operating agreements and not utilizing the CHI Cash Management Program, settlement will occur in the designated local depository.

C. **Settlement Transaction**

1. Wells Fargo Merchant Processing will initiate a single settlement transaction for MasterCard and VISA. American Express and Discover will prepare separate settlement transactions. This will result in three separate settlement transactions on the CHI entity's Mellon Bank or local bank statement if all four credit cards are accepted.

Catholic Health Initiatives
National Credit Card Acceptance Agreement:
Summary of Negotiated Merchant Discounts

MasterCard	Acceptance Method	Merchant Discount	Settlement
	Card Swiped through POS Terminal	1.655% + $.10 per trans.	24-48 hours
	Card Number Keyed Manually in POS Terminal	2.095% + $.10 per trans.	24-48 hours
	Paper Sales Draft – bank deposit	approx. 4-6.00%	72 hours or more
VISA	Acceptance Method	Merchant Discount	Settlement
	Card Swiped through POS Terminal	1.664% + $.05 per trans.	24-48 hours
	Card Number Keyed Manually in POS Terminal	2.084% + $.10 per trans.	24-48 hours
	Paper Sales Draft – bank deposit	approx. 4-6.00%	72 hours or more
American Express	Acceptance Method	Merchant Discount	Settlement
	All acceptance methods (e.g., swiped, keyed manually, paper)	2.7%	3-4 days
	Wells Fargo Processing Fee	$0.15 per transaction	
Discover	Acceptance Method	Merchant Discount	Settlement
	All acceptance methods (e.g., swiped, keyed manually, paper)	1.67%	24-48 hours
	Wells Fargo Processing Fee	$0.15 per transaction	

Catholic Health Initiatives
National Credit Card Acceptance Agreement:
MasterCard/VISA – Wells Fargo Merchant Services

Contact Name and Phone Number	Scott Gaulden, Ph. (817) 577-1291 Robin Watts, Ph. (303) 980-4838
Website	www.wellsfargo.com
National Agreement Conditions	Wells Fargo Merchant Services will be responsible for credit card processing for MasterCard, VISA, American Express and Discover. They will process all of the credit card transactions and establish the merchant discount rate for MasterCard and VISA. The merchant discount for American Express and Discover was negotiated separately with the respective organizations. Wells Fargo will be responsible for maintaining and programming the point-of-sale (POS) terminals and provide training to CHI entity staff. All CHI entities will participate under the national agreement. The total dollar amount of sales will be aggregated in order to determine the merchant discount. In order to participate in this agreement, entities' must reference Catholic Health Initiatives.
CHI Negotiated Merchant Discount/Fees	Acceptance Method — Merchant Discount **MasterCard** – Card Swiped through POS Terminal — 1.655% + $.10 per trans. **VISA** – Card Swiped through POS Terminal — 1.664% + $.05 per trans. **MasterCard** – Card Number Keyed Manually in POS Terminal — 2.095% + $.10 per trans. **VISA** – Card Number Keyed Manually in POS Terminal — 2.084% + $.10 per trans. **MasterCard and VISA** Paper Sales Draft – bank deposit — approx. 4-6.00% **American Express/Discover – Wells Fargo Processing Fee** $0.15 per transaction

Settlement	Settlement will occur in 48 hours (two banking days). All CHI entities **must** use their Mellon Bank account for settlement. (For those entities participating in joint operating agreements and not utilizing the CHI Cash Management Program, settlement will occur in the designated local depository.) This ensures that the funds are invested as soon as they settle and eliminates any delays in transferring funds from local depositories. Wells Fargo will require the CHI entity to provide their Mellon Bank account number and the bank's routing number **043000261.**
Conversion to CHI agreement if currently using Wells Fargo Merchant Services for credit card processing	• Contact Scott Gaulden at (817) 577-1291 or Robin Watts at (303) 980-4838. • Provide the representative with the current merchant account number and request that Wells Fargo affiliate the account with the CHI national agreement. • Change or verify that the entities' Mellon Bank account number is being used for settlement.
New Setup for those entities not currently accepting credit cards or using another bank or credit card company for processing	• Contact Scott Gaulden at (817) 577-1291 or Robin Watts at (303) 980-4838. • Request that they open a new merchant account under the Catholic Health Initiatives national agreement. • Provide the CHI entities' Mellon Bank account number and routing number (043000261) for settlement purposes. • Wells Fargo will discuss equipment needs with the CHI entity and will arrange for shipping and training, once received. • The New Setup takes approximately two weeks and includes the time for the POS terminals to be delivered.

Catholic Health Initiatives
National Credit Card Acceptance Agreement:
American Express (AMEX)

Phone Number	1-800-528-5200
Website	www.americanexpress.com
National Agreement Conditions	All CHI entities will participate under the national agreement. The total dollar amount of sales will be aggregated in order to determine the merchant discount. In order to participate in this agreement, entities' must reference the CHI **CAP Number 1050049485** when contacting AMEX.
CHI Negotiated Merchant Discount/Fees	Settlement — Merchant Discount 3Day Settlement — 2.70% AMEX does offer slightly lower merchant discount rates, but the settlement does not occur for 15 or 30 days. CHI has selected the 3 Day Settlement option as the standard term for all entities due to the improved cash collection time.
Settlement	Settlement will occur in 3-4 days and will be paid via ACH. All CHI entities **must** use their Mellon Bank account for settlement. (For those entities participating in joint operating agreements and not utilizing the CHI Cash Management Program, settlement will occur in the designated local depository.) This ensures that the funds are invested as soon as they settle and eliminates any delays in transferring funds from local depositories. AMEX will require the CHI entity to provide their Mellon Bank account number and the bank's routing number **043000261**
Conversion to CHI agreement if currently accepting American Express	• Contact AMEX at 1-800-528-5200 • Provide the representative with the current merchant account number and request that they **affiliate the account with the CHI CAP number 1050049485.** • Change or verify that the entities' Mellon Bank account number is being used for settlement. • Change to 3 day settlement, if not already set up • The CHI entity also needs to call Wells Fargo Merchant Services to provide them with the new American Express merchant account number.

New Setup for those entities not currently accepting American Express	• Contact AMEX at 1-800-528-5200 and request that they open a new account under the **CHI CAP number 1050049485.** • Provide the representative with the entities' Mellon Bank account number and routing number (043000261) for settlement purposes. • Request settlement to occur in 3 days. • If currently accepting other credit cards, provide the new AMEX merchant number to either of the Wells Fargo Merchant Processing representatives (Scott Gaulden ph. 817-577-1291 or Robin Watts ph. 303-980-4838) and request that the terminals be updated. If not currently accepting credit cards, contact Wells Fargo Merchant Processing at same phone number. • AMEX will send a Welcome Guide providing specific details on accepting their card.

Catholic Health Initiatives
National Credit Card Acceptance Agreement:
Discover

Contact Name, Phone Number and E-mail Address	Scott Draudt Ph. (303) 730-6511 scottdraudt@discoverfinancial.com
Website Address	www.discoverbiz.com
National Agreement Conditions	All CHI entities may participate under the national agreement. The total dollar amount of sales will be aggregated in order to determine the merchant discount. In order to participate in this agreement, entities' must reference the CHI Set Manager Number **601101306212166** when contacting Discover.
CHI Negotiated Merchant Discount/Fees	Settlement: 24-48 hours Merchant Discount: 1.67%
Settlement	Settlement occurs in 24-48 hours. All CHI entities **must** use their Mellon Bank account for settlement. (For those entities participating in joint operating agreements and not utilizing the CHI Cash Management Program, settlement will occur in the designated local depository.) This ensures that the funds are invested as soon as they settle and eliminates any delays in transferring funds from local depositories.
Conversion to CHI agreement if currently accepting Discover	• Contact Scott Draudt at Discover (Ph. (303) 730-6511) to coordinate the conversion. • A new merchant account number will need to be opened in order to affiliate with the CHI Set Manager Number **601101306212166.** • Discover will need the following information in order to convert the existing merchant relationship: o Existing merchant account number o Name and address of the CHI entity o Contact name at CHI entity o Mellon Bank account number to be used for settlement. o Mellon Bank routing number **043000261** o Name of credit card processing company – **Wells Fargo Merchant Services** • Discover will coordinate with the credit card processor to have the POS terminals updated. It is also required that the CHI entity call Wells Fargo Merchant Services to provide them with the new Discover merchant account number.

New Setup for those entities not currently accepting Discover	• Contact Scott Draudt at Discover (Ph. (303) 730-6511) to establish a new relationship. Scott will require the same information as listed above to establish a merchant account number. • Discover will send a new merchant account package that provides specific details on accepting their card.

Catholic Health Initiatives
National Credit Card Acceptance Agreement:
Credit Card Equipment

Contact Name and Phone Number	Wells Fargo Merchant Services Scott Gaulden, Ph. (817) 577-1291 Robin Watts, Ph. (303) 980-4838 Wells Fargo Merchant Setup, Ph. (800) 622-0842
Inventory	Wells Fargo will send out a survey to inventory the existing equipment that is currently being used for credit card processing. Wells Fargo will evaluate the survey and make recommendations for the lowest cost equipment available, taking into consideration projected volume, number of locations, etc. Periodically, refurbished and used equipment can be purchased at reduced rates.
Sample Equipment Costs – POS Terminal	Provided below are sample prices for a typical POS terminal. Hypercom T77 Terminal 1). Lease per terminal – $18 per month for 48 months 2). Rent per terminal - $31 per month (month-to-month arrangement) 3). Buy – approximately $500 By using a POS terminal, the merchant discount is significantly less than if paper drafts are used. The equipment costs may be lower depending upon the number of terminals leased or purchased. PIN Pads may also be purchased in order to accept debit cards. The cost for this item is approximately $270.

Catholic Health Initiatives

Education for Inhouse Collections

Facilitator's Guide

March 2001

Guidelines for Facilitators

Using this Guide

The Facilitator's Guide offers you user-friendly, step-by-step instructions for preparing for and presenting the Inhouse Collections Education program. Transparencies accompany the guide, and suggested comments for use when showing transparencies are noted.

Meeting Preparation

- Review the Catholic Health Initiatives Inhouse Collections Implementation Guide to familiarize yourself with the Inhouse Collections initiative. You may get a copy from your CFO.

- Ensure that the Organizational Readiness Assessment has been completed and "all systems are go" for Inhouse Collections implementation prior to facilitating this program. Your local CFO can give you this information.

- Make copies of participant materials for participants.

  1. Opening Prayer
  2. Inhouse Collections Scripts
  3. Examples of Common Objections and Recommended Responses
  4. Role play scenarios
     (Cut them into strips so that each participant has one or two scenarios for practice sessions. If your group is large, you may need to repeat scenarios among participants.)

Meeting Time

The estimated time to facilitate this program is 90-120 minutes, depending on the size of the group and amount of discussion.

Questions?

- For clarification of information regarding the Inhouse Collections content of this program, contact your local CFO.

- For information about the process of facilitating this education program or for additional copies of the guide and transparencies, please contact:
  Susan Anthony, CHI Program Development Manager,
  Mission Resource Group, at 859.594.3114 or
  santhony@chisvcs.org

Notes

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Catholic Health Initiatives
Education for Inhouse Collections

(Before start of session display Transparency 1: Catholic Health Initiatives – Education for Inhouse Collections)

I. Welcome and Objectives

A. **Welcome** participants to the session.

B. **Introduce** yourself, if necessary, and those attending if they do not already know one another.

C. **Share** an opening prayer to set the tone for the session. Suggestions may include (copies in Appendix):

- Parable of the Talents (Matthew 25)
- A Meeting Prayer

D. **Relate** your hope that participants will:
- Increase their understanding of inhouse collections.
- Learn some new customer service skills.
- Relax and have some fun while we learn together.

E. **Show** Transparency 2: ***Objectives*** and review.

F. **Ask** for questions.

II. Background and Overview of Inhouse Collections

A. **Introduce** this section by noting that Inhouse Collections is an organizational strategy that promotes both Service Excellence and our core organizational values.

B. **Show** Transparency 3: ***Farcus Cartoon*** to a set a light-hearted tone. Note that:

- Just like in the cartoon, we are offering a new approach.
- Keep an open mind.
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C. **Review** *Transparencies 4-7*: ***Background and Overview*** and review each in turn. Suggested comments may include:

Transparency 4:

- The amount of "bad debt" experienced by your MBO, if facts are known.

Transparency 5:

- Customers who are told what they owe and pay "up front" avoid personal "costs", e.g., lost time associated with monthly bills and the inconvenience and stress of remembering what they still owe.
- They also avoid unwanted letters or phone calls from patient accounts, if they forget or postpone payment.
- Our organization deserves to be paid for the services we provide, whether the responsible party is the government (Medicare/Medicaid), an HMO, an insurance company or the patients themselves.
- Bad debt and charity care are not the same.
- Bad debt means that a person who has the ability to pay is **unwilling** to pay what they owe. Please note: There are instances when those who do not have the ability to pay also end up on bad debt.
- Charity care is central to our mission and flows from our special concern for persons who are poor or medically indigent. At least 3% of net operating revenue is allocated to charity care.
- Frequently, charity care goes to the "working poor" – those who have low-paying jobs, have no employer-sponsored health insurance and make too much to qualify for public assistance.

Transparency 6:

- Research suggests that patients are increasingly concerned about the cost of health care and really do want to know what they will have to pay.

Transparency 7:

- The Inhouse Collections initiative can be a win/win for our patients and for us.

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- Our patients are informed and offered options to pay that meet their needs.

- We optimize revenue, decrease bad debt and reduce the cost of carrying bad debt and accounts receivable.

D. **Review** Transparency 8: ***Cultural Norms***.

- Note that paying for services in advance or at the time of service is common in every day life. For health care, however, this expectation is more recent.

- Solicit examples by asking:

  "From your own experience, what are some times you are asked to pay for a service at the time it is rendered or even pay a portion in advance?"

  "What makes this okay with you?

  Possible participant responses:
  - Home remodeling; house painting; landscaping (pay in advance).

  - Hair salon/ barber services; house or carpet cleaning; masseuse/massage; yard work; auto repair (pay at time of service).

  - People need to be paid on time just like we do;

  - People/businesses need to be paid on time for their labor and materials so that they can meet their financial obligations – salaries, supplies, rent, gasoline, power, etc.

    "Do the service providers seem reluctant or hesitant to ask for payment?"

    "How accustomed are customers to being asked for payment in health care settings?

    Is this increasing or decreasing? What are some examples?"

  Possible participant responses:

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- Customers are accustomed to paying for co-pays in doctor and dentist's offices, clinics, optometrist's office, etc.

- They are less accustomed to paying for service in hospital settings: outpatient diagnostic or treatment and acute care settings (ER and inpatient).

  "How accustomed are we in our roles to ask for payment?"

  "What makes it difficult?"

  "How can we become more comfortable?"

E. **Thank** respondents for their participation and ask for questions or comments before moving on.

F. **Transition** to Section III by noting that you will next discuss the use of scripts, which can help ease the transition to asking patients for payment and help you feel comfortable.

III. The Art of Scripting and Facilitator Role Play of Scripts

Note to facilitator: You may wish to review the article in the Appendix: ***Scripting: Finding the Right Words at Just the Right Time*** *in preparation for this section. Also please be sure to practice your role play in advance with a colleague and have the scripts down pat before attempting this in a group setting. This will model your commitment to the process.*

A. **Show** Transparencies 9-11: ***The Art of Scripting*** and ***Most Employees Like Scripts!*** and review each briefly.

B. **Distribute** copies of the ***Sample Scripts*** and ***Common Objections and Recommended Responses*** documents to the participants. (Copies are in the Appendix.)

C. **Allow** five minutes for participants to read the documents silently to themselves one or more times.

D. **Walk** through each of the scripts and common objections/responses documents, taking comments and questions about the content as you go along.

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E. **Tell** the group that you will now do two role plays using the scripts. Add that participants will have the chance to practice doing role plays later in the session.

- Inform the group that you will play the part of the employee who is registering (discharging) a patient.
- Ask for a volunteer to play the part of the patient or family member. (If desired, this can be set up in advance.)
- Tell the volunteer that he/she will do it twice – once as a well-informed and prepared-to-pay patient/family member and the second time as a person not prepared to pay.
- Ask the large group to watch and listen carefully and be prepared to give you feedback after each role play.
- Do the first role play and debrief.
- In debriefing, ask the group about your tone of voice, facial expression, your caring and compassion, gentle assertiveness, and about the options that you presented.
- Do the second role play and debrief.
- Thank volunteer and give him/her a small gift (badge of courage, candy bar, medal of honor, etc.) for his/her assistance.

F. **Ask** for questions about the scripts and role plays.

IV. Participant Role Plays

Note to facilitator: Just as in real life, the role plays will not match the scripts exactly. You may also feel free to develop your own role plays based on local market experiences and situations.

A. **Introduce** the role playing exercise as a fun and non-threatening way to practice the scripts and learn from one another.

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B. **Divide** the participants into groups of three persons each.

(Note: if you have less than six people you will need to do the exercise in the large group, as in the previous section.)

C. **Distribute** one patient scenario to each participant, ensuring that the small groups do not have duplicates.

D. **Review** Transparencies 12 and 13: ***Guidelines for Role Plays.***

E. **Allow** 10–15 minutes for the total exercise.

F. (Optional) **Repeat** the exercise with new groups of three, if time permits, so that each person has a chance to do a role play twice in the role of employee.

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G. **Ask** the group:

"How helpful was this exercise?"

"What were some of your learnings?"

"What questions and concerns do you still have?"

H. **Show** and **read aloud** Transparency 14: **Our Core Values** and leave on during the following discussion.

I. **Discuss** with the group the relationship of Inhouse Collections (and this education program) to CHI core values by asking questions, such as:

Note to facilitator: Please do not "hurry" this section. CHI is committed to integrating our values in all processes.

"From what you have learned today, how does the Inhouse Collections program reflect our core values of Reverence, Integrity, Compassion and Excellence?"

"What new behaviors did you learn that demonstrate these values in action?"

"How did this educational session reflect our values with you in your role? Ask for examples.

J. **Show** Transparencies 15–18: ***Our Core Values***, noting similarities among examples from the group and those contained on the transparencies.

Note to facilitator: If discussion of core values closely matches the information on Transparencies 15-18, skip showing them to avoid redundancy.

K. **Review** next steps with the group:

- Implementation schedule.
- Performance standards and accountabilities.
- Other issues pertinent to your MBO.

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V. Summary and Close.

A. **Show** Transparency 19: ***Summary*** and review.

B. **Ask** for final questions

C. **Thank** group for their participation and risk-taking.

Notes

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Appendix

The Parable of the Talents (Matthew 25)

It will be as when a man who was going on a journey called in his servants and entrusted his possessions to them. To one he gave five talents; to another, two; to a third, one-to each according to his ability. Then he went away.

Immediately the one who received five talents went and traded with them, and made another five. Likewise, the one who received two made another two. But the man who received one went off and dug a hole in the ground and buried his master's money.

After a long time the master of those servants came back and settled accounts with them. The one who had received five talents came forward bringing the additional five. He said, "Master, you gave me five talents. See, I have made five more.' His master said to him, 'Well done, my good and faithful servant. Since you were faithful in small matters, I will give you great responsibilities. Come, share your master's joy.

[Then] the one who had received two talents also came forward and said, 'Master, you gave me two talents. See, I have made two more.' His master said to him, 'Well done, my good and faithful servant. Since you were faithful in small matters, I will give you great responsibilities. Come, share your master's joy.'

Then the one who had received the one talent came forward and said, 'Master, I knew you were a demanding person, harvesting where you did not plant and gathering where you did not scatter; so out of fear I went off and buried your talent in the ground. Here it is back.' His master said to him in reply, 'You wicked, lazy servant! So you knew that I harvest where I did not plant and gather where I did not scatter? Should you not then have put my money in the bank so that I could have got it back with interest on my return? Now then! Take the talent from him and give it to the one with ten. For to everyone who has, more will be given and he will grow rich; but from the one who has not, even what he has will be taken away. And throw this useless servant into the darkness outside, where there will be wailing and grinding of teeth.'

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Meeting Prayer

Eternal God,
we are about to begin our education session
and we do so with the awareness
that without Your Divine Presence
here at the center of our meeting -
and also within ourselves -
our coming together will be empty.

Grace us with Your Wisdom and Vision;
gift us with Holy Humor and Humility
so that not only this gathering
but all our lives may be a meeting place
for your Kingdom.

Loving God bless us....
With patience to allow the unfolding of things in their own time,
With wisdom to act in the best interest of Catholic health ministry and the people we serve.
With openness to our own inner spirit and to others in this room,
With courage to share our inner thoughts and insights with others.
With confidence in ourselves and Your grace,

We ask this in your name.
Amen.

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Scripts and **Examples of Common Objections and Recommended Responses**

(Refer to ccscripts.doc)

Scripting, Finding the Right Words at Just the Right Time

By Lolma Olson and Diane Gage

- Have you ever fished for just the right words when a patient complains and come up tongue-tied?
- What do you say to make someone feel truly cared for and respected during an intrusive procedure?
- How many times have you wished you had identified if your patient had any additional needs *before* you left their room?

The art of scripting can give you just the right words to say at just the right time. Designed to be appropriate greetings and responses for specific types of interactions, scripting allows healthcare employees to present a consistent approach in meeting the needs of their customers. The opportunity for patients, family, visitors and physicians to experience warm, friendly and competent service increase when staff communicate in a welcoming, caring way. This includes giving clear messages, explanations, and instructions that are consistent throughout the organization at each juncture of the health care experience.

The technique of using predetermined communication has been part of other industries for years. Just think about your last airplane flight. The quiz by the ticketing personnel about the control you've had of your luggage, the safety demonstration by the flight attendant and the self-congratulatory announcement by the pilot when the airline has arrived on time or ahead of schedule are all based on scripts. Car rental agencies, hotels, fast food restaurants, oil changing franchises, attractions like Disney World and Sea World and many other organizations use scripts as a way to give their staff the perfect words to say at various points of the customer experience. It makes customers feel more secure in the personnel's expertise and confirms that they've made the right decision in entrusting their business to that specific organization.

Health care has been slow to adopt scripting partly because of the highly personal nature of health care and also because of reticence by some caregivers who feel that being told what to say is insulting and demeaning. But it doesn't matter how well-educated or well-intentioned we are, scripting can give anyone the extra edge needed to set up positive moments of truth—especially when a hospital staff member is busy, stressed, distracted, tired or upset.

An added benefit of scripting is increased customer loyalty. This type of staff development allows associates to have well-thought-out messages at their immediate disposal, living up to healthcare consumers' expectations that they will receive the very best service at *all* times.

Scripting can also help to change behavior. When employees say something over and over again, it frequently becomes part of their demeanor. While at first those who resist scripting may say the phrases in a syrupy or mechanical tone just to comply, patients typically still appreciate the message.

Nix the Naysayers

- After 20 years in healthcare, don't you think I know how to talk to my patients?
- I didn't go to college to toss my brain aside and act like a robot.
- Scripting sounds so phony; I prefer being real.
- You mean you have so little confidence in me, you have to tell me what to say?
- I want to be sensitive to my patients' individual needs, not rote.

Scripting: Finding the Right Words at Just the Right Time (cont.)

Any hospital that has instituted scripting as a service standard has heard these and many other reasons from employees who resist the concept of scripting. But experience shows that most employees who use scripting like the technique, because:

- Scripting gives staff a toolkit of messages to use at particular times and serves as a reminder to keep the customers' needs their top priority.
- Specific communication decreases patient/family anxieties and reduces problems and complaints in the long run.
- Preset responses, with the flexibility to customize them to meet their personality and the situation, help associates maintain composure during tense situations.
- Carefully thought-out greetings and responses put the customer at ease and make them feel like everything is under control.
- Scripting reminds staff to ask certain questions and saves time. For example, always asking the patient if there is anything else you can do *before* you leave the room reduces the use of the call button.
- Anticipating needs and setting a positive environment for their patients, their co-workers, and themselves makes staff feel good and helps the day go smoother.
- It provides consistency in their work and that of their co-workers.

Scripting does not take the place of genuine care and concern. It simply enhances communication. And it does not mean that all employees need to say the exact same thing, leaving little room for their personality to shine. Scripting is a guide meant to be personalized to meet the needs of the customer and the individuality of the caregiver.

Selecting Appropriate Phrases

Developing phrases or scripts takes time and thought to make sure they fit the culture of the organization and support your service initiative.

Involving staff in developing scripts makes a big difference when seeking employee buy-in. Consider forming a team with representatives from throughout the organization—from different departments and representing management and line staff—to work on organization-wide scripts and specific scripts for certain behaviors.

Tying your scripts to customer service standards and behaviors will help to hold staff accountable to use them with customers. It also makes sense to write the scripts by referring to your patient satisfaction surveys. For example, patient satisfaction is often tied to pain management that could be enhanced with the simple script, *"We are very concerned about your comfort during your stay. A nurse on each shift will be asking you to evaluate your level of pain and then take appropriate measures to minimize any discomfort you might be having."*

Taking patient satisfaction issues into consideration allows you to design your communication to support the types of questions your patients and family members will be asked regarding the perceptions and expectations of their care. Not only will such scripting help you satisfy and exceed their needs but your patient satisfaction measurements will no doubt show improvement as well.

Scripting: Finding the Right Words at Just the Right Time (cont.)

The types of organizational greetings and responses for the team to consider include:

- Telephone greetings
  - *Hello, this is (your name) in (MBO name). How can I help you?*
  - *May I place you on hold?*
- Greeting patients/families upon arrival
  - *Welcome, we were expecting you (use name if known).*
  - *Good morning (name) and welcome. How may we help you?*
  - *Everyone cares about you at (name of MBO). You'll be in good hands with (name of person or department).*
- Greetings in hallways and elevators
  Say "hello" or "good morning (afternoon, evening)" to everyone you pass in the hallways or meet on the elevators, including co-workers. (Even if you see them ten times a day!)
- Transferring a patient from one caregiver to another
  - *(Name of patient) I am going off duty now. I want you to meet (name of other caregiver); she/he will take good care of you this evening.*
  - *(Name of patient), (name of caregiver) will take you to (location). There you will have (name of procedure), which will (explain benefit/outcome).*
- Leaving patients rooms or completing a procedure
  - *Is there anything else you need before I leave?*
  - *Is there anything else you need before we're finished today?*
- Protecting privacy and confidentiality
  - *I'm closing the curtain so that you can have some privacy.*
  - *I'm talking low so that we can keep this conversation private.*
  - *Would you like your door closed to give you some quiet and privacy?*
- Other scripts to complement patient satisfaction surveys
  We want to provide you with excellent service. If you need anything or if something doesn't meet your needs, please give me a call. (Give business card or write name on a white board in the patient's room.)

Along with organization-wide scripts that provide consistency to your patients/families and physicians, it also helps if each department develops its own set of greetings and responses to meet their unique circumstances, yet which complement the overall tone and tenor of the organization's efforts. For example, a patient undergoing a test in Imaging, might be told, *"I am putting this blanket around you to make sure you are comfortable (and warm) during this procedure."* An Emergency Department patient waiting for the doctor might appreciate hearing, *"The doctor is just finishing up with another patient and should be with you within 10 minutes. Until then, is there anything else I can do for you to make your wait easier?"*

Props to Support Scripts

Words alone are often not enough to make our patients and families feel secure and well cared for. It may be helpful for nurse directors and managers to leave behind their business cards after (welcoming a patient/family to the organization for the first time) meeting a patient/family for the first time, using a script something like, *"It was a pleasure to meet you (patient's name). The nurses who are caring for you will provide you with excellent care and service. If you would like to reach me at any time during your stay, please feel free to call me. Here is my business card with the number to my direct line."*

Scripting: Finding the Right Words at Just the Right Time (cont.)

Some hospitals are finding that using white boards mounted in the patient rooms can help support verbal scripts. At change of shift, the nurse coming on board greets the patient and writes her /his name and telephone number on the board as a way to reinforce her availability to the patient and family.

Patient service brochures given to each individual when they enter their room that includes contact names and telephone numbers for the gift shop, chaplain, social services, pharmacy, housekeeping, cafeteria, administration and other pertinent services can also help the patient and family feel more at ease and in control.

Complaints Are Gifts

While no one likes to learn that something has gone wrong during a patient's say, those who succeed at customer service look at a complaint as a gift. If corrected immediately, the information and knowledge patient impart about service, systems, or communications breakdowns can help the organization make necessary corrections, save time in the long run – and can mitigate potential legal action.

Scripting for service recovery is paramount. Confrontation, stress, anger and humiliation can cloud otherwise clear thinking. Giving staff members a bank of responses to use when patients are confrontational, irate, complaining and unhappy provides associates with the support they need during critical times. It can also help preserve your positive reputation in the community—since all of us know that customers are much more likely to relay a negative experience to friends, neighbors, associates—and sometimes anyone who will listen—than they are a positive one.

The first natural reaction when someone complains is to defend ourselves or the organization, but we all know that when we feel slighted, we want empathy and understanding, not excuses. An employee who is found at fault for something does not need to become defensive nor accept blame for something that he or she did not do. What that staff member needs to know is how to make the patient, family member or physician feel cared about using a phrase such as, *"I'm sorry that we did not live up to your expectations. Let me understand what you experienced and see how I can help correct the situation."*

Apologies or promises to ameliorate a situation are what most individuals want when a service issue arises, but tangible expressions of regret can also reinforce the message. Some hospitals have set up a "make it right" fund, giving staff members the freedom to spend up to a certain amount of money for service recovery without asking for a supervisor's authorization. This may be buying a flower or a treat from the gift shop to make up for a service glitch like a delayed procedure, or giving a patient cash to replace the slippers that have become lost during the hospital stay. A service recovery fund is often made available on the honor system through the Gift Shop, Cafeteria, or Emergency Department (because it is open 24 hours).

Baptist Hospital in Pensacola, a leader in service excellence, provides on-the-spot service recovery by giving each staff member access to a $250 line of credit in the emergency department to help replace a lost article. Each employee also has access to a $20 line of credit in the gift shop to purchase flowers, a magazine or candy bar to help ease a tense situation.

Healthcare leaders who have instituted these types of policies reinforce that their staffs do not take undue advantage of service recovery funds and, in fact, typically spend far less than what is first expected. Baptist employees spend $7,500 a year on service recovery and their customer satisfaction is among the highest of any hospital in the country.

Scripting: Finding the Right Words at Just the Right Time (cont.)

Connecting to Our Customers

Scripts are just one tool in strengthening a service-focused culture. In today's fast-paced, often impersonal world, we can easily and quickly disconnect from each other. That chasm can be bridged by building relationships, one interaction at a time. Scripting provides brief connections with our customers that, without a doubt, lets them know we care and are concerned that their experience at your organization goes as well as humanly possible. ◆

Lolma Olson is president of Sage Consulting, the CHI consulting firm of choice working with MBOs to customize and implement the CHI Service Excellence Model.

Diane Gage is vice president of CHI's customer and market strategy team, which works with MBOs to develop a culture of service excellence.

For information on a presentation of the CHI Service Excellence Model, call Diane Gage at 303-383-2617.

Participant Role Plays:
Pre-Registration

Pre-registration Role Play 1:
You are scheduled to have an extensive outpatient Radiology procedure tomorrow. The hospital is on the phone to verify information. You have recently signed up for a managed care plan and are unsure of your benefits, but know you have an annual deductible and small co-payment for tests.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. New Policy who is scheduled for lab tests and you are calling to register and verify my information.

Pre-Registration Role Play 2:
You are the parent of four children, work for a company that does not offer health insurance, and you cannot afford to pay for it out of your own pocket. Your children are insured through the State CHIP program. You are scheduled for outpatient hand surgery, which has been planned for the last six weeks. If you don't have the surgery, you won't be able to work. The hospital is calling to register you, you aren't sure what to tell them, other than that you will pay – somehow.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Medically Indigent who is scheduled for outpatient hand surgery, and you are calling to register me for the procedure.

Pre-Registration Role Play 3:
You are scheduled for outpatient surgery as a result of an injury to your shoulder following a neighborhood baseball game. You have applied for Medicaid, but have not yet been approved. The hospital is calling you to verify your information.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Athlete and am scheduled for outpatient surgery the day after tomorrow for a severe shoulder injury. You are calling me to verify my information.

Participant Role Plays:
Outpatient

Outpatient Role Play 1:
You have just arrived in the outpatient radiology department. You are scheduled for a CAT Scan in 5 minutes. There is a possibility that the pain in your back may indicate that your cancer has spread to your bones, and you are quite anxious. You were told when you registered by phone that your co-pay is $50.00 and co-insurance is $150.00, which you have to pay when you arrive; however, your spouse has the check book and credit cards and you only have $50.00 cash.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Anxious who has arrived in outpatient radiology for a scheduled CAT Scan. I have a $50.00 co-pay and $150.00 co-insurance fee that I learned about when I pre-registered.

Outpatient Role Play 2:
Your doctor scheduled you for cataract surgery, and you have just arrived in outpatient surgery. You are independent, but somewhat hard of hearing. You do not want your daughter-in-law who drove you to know your financial affairs. You asked her to stop by the bank so you could withdraw some cash, but she said you would not need cash today and refused to stop. You do not like to use a credit card, and aren't sure of your check book balance. You hope that the hospital will send a bill to your home.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Private who has just arrived for outpatient cataract surgery. My daughter-in-law drove me in. I do not know anything about my insurance, except that I will owe something for the surgery – it is not all covered by Medicare.

Outpatient Role Play 3:
This is your first visit to the outpatient chemotherapy center. You will have to come once every one or two weeks for the next three months or so. You have heard that chemotherapy really makes you very nauseous and you are worried and afraid. You are covered by an HMO through your employer. However, the bill is the last thing on your mind. You just hope that everything will go okay.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Frightened and this is my first of 12 visits to the outpatient chemotherapy center. You are expecting me as my appointment was scheduled in advance. My HMO covers all but a $25.00 co-pay per visit.

Participant Role Plays:
Inpatient

Inpatient Role Play 1

You are a senior who was admitted to the hospital for gall bladder surgery. You have standard Medicare Parts A and B. You and your spouse are already stretched financially with monthly health care expenses – your prescription drug fees are over $250/month and Part B costs $50.00/month. You contacted Medicare before the surgery and learned you will owe $792 deductible for this hospital procedure under Medicare Part A. You also were told that you would owe a $100 deductible and 20% of charges for physician services, under Medicare Part B. Your doctor told you not to worry about the bill.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Seniorcitizen with standard Medicare Parts A and B, and am being discharged following gall bladder surgery. I have not yet paid any of the Medicare Part A and Part B deductibles and co-pays or non-reimbursed charges, such as TV, phone.

Inpatient Role Play 2

You are new parents, who delivered a healthy baby girl following an emergency cesarean section. At the time you pre-registered for your hospital stay, you paid all of the "self-pay" portions required by your insurance company for a normal delivery. It took you six months to save the money. Now you and the baby are ready to be discharged, and you are concerned about the impact of the additional fees on your family and budget. You hope that the hospital will be able to tell you what you still owe and give you time to pay it off. You can't afford to put the bill on your credit card.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Newparent and am being discharged with my baby following an emergency cesarean section delivery. We were in the hospital three days. At the time of pre-registration, I paid all of the self-pay portions for a normal delivery.

Inpatient Role Play 3

You are the CEO of a major local corporation and member of the hospital board of directors who was admitted through the ER for chest pain. Following extensive tests, you had bypass surgery to replace four blocked arteries and will be discharged tomorrow. While you are not fully acquainted with the details of your company's health plan, you believe that it will cover all but a minimal amount and that the hospital will probably absorb the remaining fees as a courtesy for your many years of service on the board.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. VIP and am the CEO of a local company and member of the hospital board of directors. My health insurance plan requires $50 ER co-pay, $500 deductible that has not been met and 10% co-payment for all tests and surgeries.

Participant Role Plays:

Emergency Room

Emergency Room Role Play 1

You were brought to the ER in an ambulance following a fall off a ladder at work where you sustained minor head and knee injuries. You were treated and released in the care of your spouse. You have excellent health insurance coverage. Your insurance card indicates that your co-pay is $50.00 for the ER visit. However, you think this is a Worker's Comp situation.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Worker and am being discharged from the ER following a minor accident at work. My insurance card indicates that I must pay a deductible of $50.00 per ER visit. It is unknown if this qualifies for worker's comp.

Emergency Room Role Play 2

You are the parent of a two-year-old son who was experiencing difficulty breathing. You brought your son to the ER where he was diagnosed with asthma, treated and released, with follow up instructions to see a pediatric pulmonary specialist. You are currently employed by a small home remodeling company, which does not offer health insurance. You are not able to afford to purchase it yourself for your family of five. (You, your spouse and three children.) You don't have the money to pay and have heard the hospital offers charity care.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Vulnerable and have no health insurance to pay for the ER visit for my two-year-old son, who was treated and released for asthma. I also was instructed that my son see a specialist for ongoing care.

Emergency Room Role Play 3

You were brought to the ER at 1:00 a.m. by a bystander following an attack by a drug-crazed thug who stole your wallet, which contained your credit cards, cash and identification. You were treated for stab wounds to your arm and hand. You just took a job in this town and a co-worker whom you do not know well has agreed to pick you up and take you to your apartment. You do not have the details of your health insurance plan or what it covers. It is now 8:00 a.m.

Before beginning the role play, read the following to your partner:
I am Mr./Ms. Victim and am being discharged from the ER following stab wounds. I have no identification or cash.

Catholic Health Initiatives

Education for Inhouse Collections

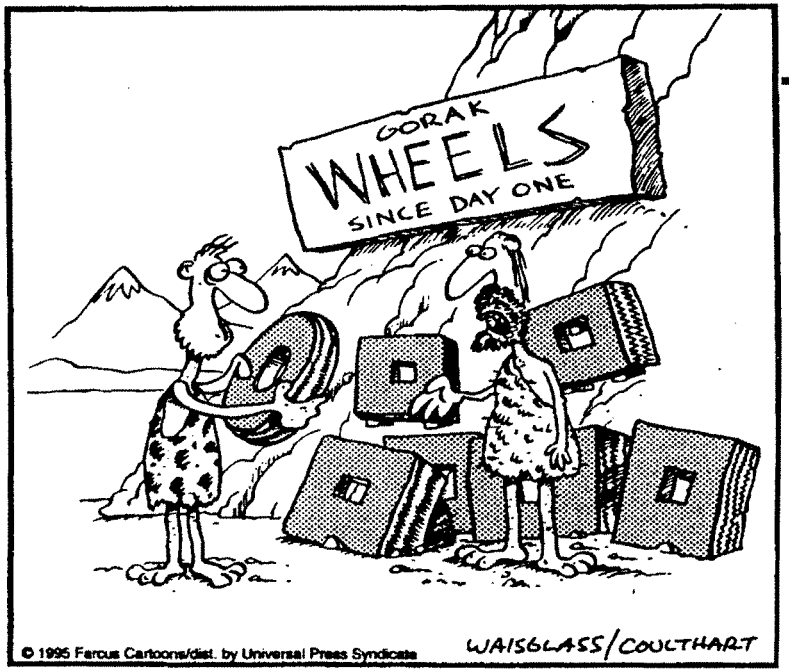
CATHOLIC HEALTH
INITIATIVES

Objectives

- Discuss the Inhouse Collections strategy and how it relates to core values and service excellence.
- Review the role of "scripting" in supporting employees and promoting service excellence.
- Present scripts of respectful ways to ask for "self-pay" portions of service charges.
- Gain confidence in using scripts through practice and role playing.

Farcus

by David Waisglass
Gordon Coulthart



"That's not how we do things here."

CATHOLIC HEALTH
INITIATIVES

Background and Overview

- The out-of-pocket (self-pay) share of health care costs has increased significantly for patients in recent years.
- CHI ***bad debt*** expense has also risen sharply as "self pay" dollars have increased.
  - FY 2000 = 41% increase ($296 million)
  - FY 1999 = 21% increase ($209 million)

1747

Background and Overview

- It is less "costly" for customers and our organization if we collect "self pay" dollars at the point of service or at discharge.
- Failure to collect "self pay" dollars reduces our ability to improve services or invest in new programs to meet community needs.
- Bad debt and charity care *are not* the same.

Background and Overview

Research has shown:

- Most patients (68%) prefer to know about their financial obligations ***at or prior to discharge.***
- Over one-third want to know about financial obligations ***prior to admission***.
- Uncertainty and confusion about financial obligations are a frequent source of customer dissatisfaction.

Background and Overview

The Inhouse Collections Program:

- Is a strategy to move patient billing from the back end to the front end of customer service.
- Integrates our commitment to customer satisfaction, service excellence and performance improvement.
- Reflects a practical way for us to demonstrate ***values in action.***

1750

Cultural Norms

- Asking for payment in advance or when services are rendered is common in every day life.
- Asking for similar payments for health care services is more recent.

1751

The Art of Scripting

- Is used by many types of service businesses, e.g, Disney, McDonalds, airlines, hotels.
- Gives you the "right words" for a specific situation.
- Can provide clear, consistent and "caring" messages at all points of the "service experience."

Most employees like scripts!

The technique of scripting. . .

- Can be used throughout an organization.
- Provides a "tool kit" of messages.
- Decreases patient and family anxiety and helps them feel in control.
- Helps employees maintain composure in tense situations.

Most employees like scripts!

The technique of scripting. . .

- Reminds staff to ask certain questions and saves time.
- Anticipates needs and sets a positive environment for patients, co-workers.
- Makes employees feel good and helps the day go smoother.
- Provides consistency in a department's work.

Guidelines for Role Plays

- This is PRACTICE!
- No one expects you to be an expert.
- Goal is to make you *familiar* with the scripts and "what to say."
- Some are more difficult than others.
- We are here to learn *from* and *with* each other.

Guidelines for Role Plays

- Three roles: employee, patient and observer
- Each person takes a turn playing *each role* in the small groups.
- Observer is silent until the role play is finished, then gives feedback.
- After the first role play, switch roles.

1756

Our Core Values

Reverence

Profound respect and awe for all of creation, the foundation that shapes spirituality, our relationships with others and our journey to God.

Integrity

Moral wholeness, soundness, fidelity, trust, truthfulness in all we do.

Compassion

Solidarity with one another, capacity to enter into another's joy and sorrow.

Excellence

Preeminent performance, becoming the benchmark, putting forth our personal and professional best.

Our Core Values

- We show ***Reverence*** to customers and employees when we:
  - Respectfully inform our customers of financial obligations; *no surprises*.
  - Eliminate the inconvenience of monthly billing for small dollar amounts.
  - Give employees the opportunity to learn new skills in a "safe" environment.

Our Core Values

- We demonstrate ***Integrity*** to customers and employees when we:
  - Operate with sound business practices that enhance our ability to meet community needs.
  - Are able to ask for "self pay" dollars without embarrassment or hesitation.
  - Provide training on "how to" respectfully ask for money.

Our Core Values

- We show ***Compassion*** for patients and employees when we:
  - Offer payment options that best meet individual needs and circumstances.
  - Refer patients to financial counseling, when appropriate.
  - Support co-workers in learning new skills and competencies.

Our Core Values

- We demonstrate ***Excellence*** in service to customers and employees when we:
  - Satisfy patients' "desire to know."
  - Make it easier for patients (and our organization) to meet financial obligations.
  - Build employee confidence to make an important contribution to organizational success.

1761

Summary

- Gave overview of Inhouse Collections and why it is important
- Reviewed scripting as a helpful technique to ensure caring and consistent communications.
- Participated in role plays to improve skills and comfort level.
- Discussed next steps.

1762

1763

Question 1

Attachment 1 – 4

Catholic Health Initiatives
Financial Reporting Manual
Standards and Guidelines: Prompt Pay and Third-Party Discounts
Section 18

Catholic Health Initiatives
Financial Reporting Manual
Standards and Guidelines: Prompt Pay and Third-Party Discounts
Section 18

Purpose of this Section

This section of the Financial Reporting Manual (FRM) provides standards and guidelines to Market-Based Organizations (MBOs) about the offering of prompt pay discounts and third-party discounts for services rendered to patients. This section also provides standards and guidelines related to the proper recording of prompt pay discounts and third-party discounts in the MBO financial statements.

Significant Changes from Last Year

This is a new section of the FRM.

Specific Topics Addressed in this Section

Standards and guidelines are provided for application by MBOs about (1) the offering of discounts to patients and third-party payors and (2) the recording and accounting for discounts.

Contacts for Questions Related to this Section

Please contact one of the following individuals about this section with any questions:

- J. Peter Savini, Vice President, Patient Financial Services @ (610) 594-5102 or at petersavini@chi-east.org
- The CHI Vice President, Financial Services assigned to the MBO.
- David A. Fantz, Vice President, Financial Management @ (303) 383-2667 or at davefantz@chi-national.org

Catholic Health Initiatives
Financial Reporting Manual
Standards and Guidelines: Prompt Pay and Third-Party Discounts
Section 18

Background – Purpose and Overview

Communication is essential to patients, third-party payors and the health care community as a whole about the availability and implementation of discounts. Communication must comply with the appropriate procedural CHI standards and guidelines, outlined in this document. For purposes of this document, the following definitions are presented:

Prompt payment discount
A prompt pay discount is offered to a patient who is responsible for 100% of the patient account, in exchange only for prompt remittance by the patient for full payment of the obligation (i.e., payment prior to service, at discharge or within a specified number of days following the date of the initial self-pay billing statement).

Third-party discount
A third-party discount is offered to a third-party payor that does not have an effective contract with the MBO, for the purpose of expediting payments (i.e., payment within a specified number of days following the date of the initial bill) and/or avoiding a retrospective claim audit.

The purpose of this document is to establish CHI Standards and Guidelines for application to prompt pay and third-party discounts. MBOs cannot offer patient discounts in a manner prohibited by law (e.g., discounts used in connection with marketing healthcare services to potential patients or discounts that may influence patients to select an MBO or related entity) or by contractual limitations (e.g., prohibitions contained in HMO contracts).

Consistency is essential in the definition, communication, distribution and implementation of prompt payment and/or third-party discounts among all MBOs, and within functional areas of MBOs (e.g., patient access, patient accounting, collection agents, satellite clinics, outpatient diagnostic, therapeutic and surgical centers). There must be integrity and equity in existing MBO payor contract arrangements.

Legal requirements are important. Discounts at MBOs must not be intended to provide inducements to patients, physicians, third-party payors or others to refer patients to MBO facilities. Discounts must not be of a nature likely to influence a potential patient to select a MBO facility.

Catholic Health Initiatives
Financial Reporting Manual
Standards and Guidelines: Prompt Pay and Third-Party Discounts
Section 18

The Offering of Discounts

CHI Standard: Prompt payment discounts will be offered only to (a) patients with accounts that are 100% self pay and who fail to qualify for any federal, state, county or local assistance programs, or (b) patients who have 100% non-covered services and, in both cases, fail to meet charitable financial assistance guidelines defined by the MBO. Third-party discounts for accounts in which there is no contract between the insurer and the MBO are permitted only under certain circumstances.

The following is the application of the CHI Standard:

1. Consistent communication, distribution and application the CHI standard for prompt pay and third-party discounts will occur at each MBO and in related entities that are wholly-owned and operated by the MBO. Proactive internal communication of the CHI Standards is necessary to ensure consistency and adherence to standards. External communication of the CHI Standard will facilitate a consistent message to third-party payors.

2. Prompt payment and/or third party discounts must not be used, in any manner whatsoever, as a means of inducing patient referrals or influencing patients to select an MBO or related MBO entity for health care needs.

Prompt Pay Discounts

1. Prompt payment discounts will be offered to **all** patients who (a) are considered 100% self-pay and fail to qualify for any federal, state, county or local assistance programs or (b) have 100% non-covered services. In both cases, patients must fail to meet the charitable assistance guidelines defined by the MBO.

2. Discounts to self-pay patients will be available only if the total balance is paid prior to service, at discharge, or within 30 days of the initial self-pay billing date.

3. Discounts applied to payments received within the applicable timeframe will be up to 20% of the total balance due. The discount policy must include appropriate documentation to support the percentage used and must be approved by the MBO Finance Committee on an annual basis.

4. Prompt self-pay discounts will not be recorded in the books and records until full payment is posted (see the *Accounting and Recording for Discounts* section of this document).

5. Discounts of self-pay balances, for which all payments are not received within the specified timeframe (see Item No. 2 above), are not permitted.

6. Discounts to members of CHI participating congregations are covered by separate guidance, attached as *Exhibit I.*

Third Party Discounts

1. Third-party discounts are permitted under certain circumstances to non-contracted primary payors.

2. Third-party discounts to non-contracted secondary insurance balances (e.g., Medigap) are not permitted.

3. Discounts to non-contracted payors are available only if the balance is paid in full within 30 days of the initial billing date.

4. Discounts applied to payments received within the applicable time frame will be *up to* 3% of the total balance due.

5. Each state, with the current (June 1, 2002) exceptions of Nebraska, North Dakota, Idaho and South Carolina, has a *clean claim* statute that requires payment within 45 days of receipt by the payor of the clean claim. These state statutes mitigate the need to discount billed charges for non-contracted payors. An MBO in a state with a clean claim statute may offer third-party discounts to non-contracted payors, if deemed necessary and sufficient documentation is maintained (i.e., the average payment period for these payors consistently exceeds the payment period identified in the *"clean claim"* statute).

6. Cases in litigation are considered settlements and are not defined as discounts in accordance with the standards and guidelines included in this document.

7. Proactive internal communication (e.g., through utilization of the CHI Standard) will ensure consistency and adherence to the CHI Standard. External communication of the CHI Standard will facilitate a consistent message to third-party payors.

Package Programs

1. Hospital services, procedures and programs are not considered discounts within the context of this policy if (a) there is no third-party coverage (e.g., cosmetic surgery, clinical research trials, etc.) and (b) a separate hospital policy exists that outlines appropriate payment terms and conditions. Please note that any package offer must be provided to **all** patients who receive the service.

Recording and Accounting for Discounts

CHI Standard: Prompt pay discounts will be recorded as follows within the MBO patient accounting system:

1. Prompt pay discounts will be posted to patient accounts only when payment is received in full, satisfying the entire patient financial obligation. If a patient makes interim payments, such payments are posted to patient accounts as they are received; however, the discount is posted to the account only if the final interim payment is received within the stated discount period.

2. MBOs will develop and maintain a tracking mechanism in the patient accounting system to quantify the number of accounts and associated dollars related to prompt pay discounts. This tracking mechanism/code should be called *prompt pay discounts* and should measure only prompt pay discounts. This code should be unique to prompt pay discounts and therefore should not be used for any other type of adjustment posted to a patient account.

3. A periodic report of prompt pay discounts will be generated, preferably daily but no less than weekly, and reviewed for compliance by the MBO Director of Patient Financial Services or equivalent. This report includes patient name, patient number, date of service, self pay balance, date(s) of self-pay payment(s) and the prompt pay discount. The same report is generated on a monthly basis and provided to the MBO Chief Financial Officer for review.

4. Prompt pay discounts will be mapped to a revenues deduction account in the general ledger and recorded as a revenues deduction item in the financial statements in the same period the discount is earned.

CHI Standard: Third-party discounts to non-contracted payors will be recorded as follows within the patient accounting system:

1. Third-party discounts are posted to patient accounts only when payment is received in full to satisfy the entire payor financial obligation. If interim payments are made, these payments are posted to the patient account as received; however, the discount is posted to the account only if final interim payment is received and within the stated discount period.

2. It is necessary to develop and maintain a tracking mechanism in the MBO patient accounting system to quantify the number of accounts and associated dollars related to third-party discounts. This tracking mechanism/code should be called *third party discounts* and should measure only third-party discounts. This code

should be unique to third-arty prompt pay discounts and not used for any other type of adjustment posted to a patient account.

3. A periodic report of third-party discounts will be generated, preferably daily but no less than weekly, and reviewed for compliance by the MBO Director of Patient Financial Services or equivalent. This report includes patient name, patient number, date of service, insurance balance, date(s) of insurance payment(s) and the third-arty discount. The same report will be generated on a monthly basis and provided to the MBO Chief Financial Officer for review.

4. Third-party discounts will be mapped to a revenues deduction account in the MBO general ledger and recorded as a revenues deduction item in the financial statements in the same period the discount is earned.

EXHIBIT I

CATHOLIC HEALTH INITIATIVES
A spirit of innovation, a legacy of care.

Governance Policy No. 3

POLICY SUBJECT:
Relationship Between CHI and its Participating Congregations

EFFECTIVE DATE: 05/24/96
To be reviewed every three years by the Board of Stewardship Trustees

REVIEW BY: 07/01/04

POLICY

It is the policy of Catholic Health Initiatives ("CHI") to assure that the relationship between CHI and its Participating Congregations is clearly articulated and well understood by each religious institute that becomes and serves as a Participating Congregation.

This Policy sets forth the rights and responsibilities of Participating Congregations as established in the Bylaws of CHI. This Policy may be amended only to reflect changes made in the Bylaws, and this Policy must be amended to reflect any such changes. Nothing in this Policy is intended to change the rights and responsibilities of Participating Congregations set forth in the Bylaws of CHI. In the event of any inconsistency between this Policy and the Bylaws of CHI, the rights and responsibilities established in the Bylaws shall govern.

DEFINITIONS

"**Associate**" means a health care entity managed by CHI pursuant to a management agreement or similar arrangement.

"**Contributed Property**" means the assets of those entities, including real or personal property, and other assets that constitute the temporal goods belonging, by operation of Canon Law, to a religious institute and that are contributed by a specific Participating Congregation to CHI.

"**Contributing Congregation**" means the specific Participating Congregation that contributes specified Contributed Property to CHI.

"**Direct Affiliate**" means a corporation of which CHI is the sole corporate member or sole shareholder.

"**Members**" means those individuals selected by the Active Participating Congregations to serve as the corporate members of CHI.

"Participating Congregation" means a religious institute that has executed a consolidation agreement with CHI and agrees to accept the healing ministry and vision of CHI.

PRINCIPLES

1. Active and Honorary Participating Congregations

Each religious institute that becomes a Participating Congregation shall simultaneously elect to serve as either an "Active Participating Congregation" or an "Honorary Participating Congregation." No religious institute that elects to serve as an Honorary Participating Congregation may thereafter become an Active Participating Congregation, although an Active Participating Congregation may at any time thereafter elect to become an Honorary Participating Congregation.

Active and Honorary Participating Congregations have different rights and responsibilities, as provided in the Bylaws of CHI. These rights and responsibilities are as follows:

a. Active Participating Congregations

Each Active Participating Congregations shall have the right and responsibility to:

(1) Select and remove, without cause, a member of the Active Participating Congregation to serve as a Member of CHI;

(2) Approve any alienation, within the meaning of Canon Law, of property considered to be stable patrimony, if the Participating Congregation is the Contributing Congregation of such property;

(3) Participate in the distribution of assets upon dissolution of CHI, in accordance with the Bylaws of CHI;

(4) Attend annual meetings for Stewardship Accountability;

(5) Participate in organizational advocacy efforts; and

(6) Encourage members of the Participating Congregations to participate in the ministries sponsored by CHI.

b. Honorary Participating Congregations

Each Honorary Participating Congregation shall have the right and responsibility to:

(1) Approve alienation, within the meaning of Canon Law, of property considered stable patrimony, if the Participating Congregation is the Contributing Congregation of such property;

(2) Participate in the distribution of assets upon dissolution of CHI, in accordance with the Bylaws of CHI; and

(3) Encourage members of the Participating Congregations to participate in the ministries sponsored by CHI.

2. Alienation of Contributed Property

Under Canon Law, and in accordance with the terms of the CHI Bylaws, each Participating Congregation shall retain its canonical stewardship with respect to its Contributed Property. Alienation of such Contributed Property shall not occur without the approval of the Participating Congregation that is the Contributing Congregation of such property to CHI. At such time as alienation may be requested, each of the Participating Congregations will respond in accordance with the canonical process and such consent will not be unreasonably withheld.

3. Sponsorship Fees

There shall be no sponsorship fees paid to any Participating Congregation for its continuing participation in CHI.

4. Benefits Accruing to Participating Congregations

Benefits accruing to Participating Congregations (see *Benefits Accruing to Participating Congregation* attached hereto) as a result of financial and service relationships between CHI, its Direct Affiliates, its Subsidiaries, and its Associates and each of the Participating Congregations shall be as from time to time determined by the CHI Board of Stewardship Trustees. Such benefits shall be uniform and consistent among the Participating Congregations to the maximum extent possible.

ATTACHMENTS

- Benefits Accruing to Participating Congregation (Attachment A)
- Explanation of Health Services for Members of Our Participating Congregations (Attachment B)

APPROVED AND AMENDED BY BOARD

- 01/09/97
- 07/01/98

12/05/01

BENEFITS ACCRUING TO PARTICIPATING CONGREGATION

There will be benefits provided to participating congregations of CHI. These benefits will be uniform and offered to all active and honorary participating congregations. Timing of the benefits and procedures for implementation will be determined and communicated by CHI. Benefits are defined as follows:

- Accounting and Auditing Services: If CHI and a participating congregation agree, accounting and auditing services will be provided by CHI with the congregation being charged the cost.

- Administrative Services: if CHI and the participating congregation agree, CHI will perform certain administrative services for a congregation. The congregation will be charged the cost of CHI performing the services.

- Health Care Service Payments: A sister from any participating congregation will be able to receive services at any CHI health care facility and the participating congregation will be charged at the Medicare rates for acute care and outpatient services, and at the Medicaid rate applicable in the state in which the facility is located for long term care services. The latter will be subject to a limit on the number of sisters that can be cared for in one long term care facility at a time. Any CHI health care facility that is negatively impacted by this policy will be dealt with on a case-by-case basis by CHI management.

- Insurance (other than health insurance): Any participating congregation can purchase its insurance needs through CHI insurance programs provided that it is willing to pay the usual and customary premiums for the coverage. The full array of coverages will be made available to the participating congregations. In addition, other activities or institutions sponsored by a congregation but not part of the CHI organization will be eligible to purchase their insurance needs through CHI provided they are willing to pay the usual and customary premiums for the coverage.

- Investment Funds and Investment Management: Any participating congregation may invest its funds in the pooled CHI Investment Funds. In addition, other activities or institutions sponsored by a congregation but not part of CHI will be eligible to invest their funds into the pooled CHI Investment Funds at their option.

- Legal and Other Consultative Services: If CHI and the participating congregation agree, CHI will perform legal and other consultative services. The congregation will be charged the cost of CHI performing these services.

- Operational Subsidies: If CHI and a participating congregation agree, CHI will perform services to the congregation to facilitate the congregation's operations. The congregation will be charged the CHI cost for performing these services.

- Rental Income: All existing leases between participating congregations and their related systems continue into CHI until expiration of the current terms of the leases, after which it will be a matter of negotiations between CHI and the participating congregation as to whether to continue a lease, and, if so, at what rental rate.

- Retirement Plans: Any participating congregation may participate in the CHI retirement plans for employees of the participating congregations. In addition, other activities or institutions sponsored by a congregation but not part of the CHI organization can participate in the CHI retirement plans at their option.

- Salaries and Benefits: Members of the participating congregations who perform services for CHI and its related subsidiaries will be paid the equivalent amount of salary and benefits that a lay person would be paid for performing the same services, and a uniform Sister Services Agreement will be used for all employment situations between CHI and its participating congregations.

- Scholarships and Corporate Contributions: All future corporate contributions or scholarships will be within the complete discretion of CHI or one of its subsidiary entities as provided for in the budgeting process.

- Sponsorship Fees: No sponsorship fees will be paid to any participating congregation.

- Debt Financing: there will be no debt financing in the future through the MTI for activities that are sponsored by a congregation, but are not part of the CHI organization.

ATTACHMENT B

EXPLANATION OF HEALTH SERVICES FOR MEMBERS
A. OF OUR PARTICIPATING CONGREGATIONS

Catholic Health Initiatives is committed to providing medical and health services to all members of our Participating Congregations. A Sister from any Participating Congregation will be able to receive services at any Catholic Health Initiatives facility or community service organization, and the Participating Congregation will be charged at the Medicare rates for acute care and outpatient services (if the Sister has no health insurance coverage), and at the Medicaid rate applicable in the state in which the facility is located for long-term services. The latter will be subject to a limit on the number of Sisters that can be cared for in one long-term facility at a time. Any Catholic Health Initiatives healthcare facility which may be significantly impacted financially through compliance with this policy will be dealt with on a case-by-case basis by CHI National and Regional Leadership.

If the member of the Participating Congregation has health insurance coverage, the insurance carrier can be billed at the normal charge rate even if this rate is in excess of the Medicare rate for services provided. The insurance payment, if greater than or equal to the Medicare rate will be considered full payment.

If a member of the Participating Congregation has Medicare supplemental policies, charges normally covered by these policies should be billed and collected by the facility.

Account balances after insurance billings and reimbursements should be written off by the CHI controlled affiliate should they exceed the Medicare charges for these services.

Services not covered by Medicare should be charge in full to the Congregation or their designated insurance carrier should one exist.

The CHI controlled affiliate that is a partner in a joint operating agreement (JOA) is expected to comply with this policy, while compliance of the JOA partner is an issue to be decided locally.

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Question 3

Attachment 3 – 1

MBO and Third Party Collection Agent and Self-Pay Protocols
Frequently Asked Questions

Prepared after March 26, 2004 Conference Call

MBO and Third Party Collection Agent and Self-Pay Protocols
Frequently Asked Questions.

1. The 150-day limit for placement with the third party collection agency seems too short. Does this mean we can't place with secondary agencies?

   The primary intent of the "150-day limit" is to prevent accounts that have had no response activity and therefore have been determined to have no expectation of payment or resolution from remaining open on collection agencies' systems. If an agency has held the account for 150-days and there has been no activity the agency is to return the account to the MBO and cease all work on its collection. Thus any payment received after that time would not be governed by the contract.

   An MBO should be able to reconcile the accounts held in the agency inventories at any point in time. Limiting the time an agency has unproductive accounts facilitates the reconciliation process. In addition, MBOs and agencies should have process workflows which clearly define the collection cycle, thus contributing to an efficient and manageable process.

   Nothing in this guidance prohibits secondary placements, if the MBO feels recoveries are still possible. The same limitation of 150-days applies to secondary placement, as does the requirement that accounts held be reconciled on a periodic basis.

2. Many cases in litigation will not be resolved in this time frame, do we need to close accounts in litigation over 150-days?

   Accounts in litigation can remain open beyond the 150-day period, with appropriate MBO oversight, since the litigation process is seeking to resolve the account.

   Please note: the 150-day period begins on the day the account is placed with the agency for debt collection. Most CHI MBOs have "pre-collect" cycles which last for 90-120 days. This allows approximately 270-days (9 months), from service date for resolution of self-pay balances.

3. Our collection agency reports to Credit Bureaus for us, is this still an acceptable practice?

   Credit Bureau reporting is an acceptable practice.

4. If Credit Bureau reporting is still acceptable, the agency will need to keep the account open well beyond 150-days to identify debtors who apply for loans or additional credit. Do we discontinue this practice?

   MBOs are to maintain reconciling inventories with collection agencies. While this guidance does not prohibit credit bureau reporting, it does not allow the

account (w/ no payment or resolution expected) to remain with any agency for more than 150-days after placement. CHI is exploring the possibility of developing a relationship with a Credit Bureau in order to directly report debtors. Since the MBO is the entity with whom the debt is held (not the agency), it may be possible to directly report to the Credit Bureau.

5. What would be considered "reasonable" payment terms?

   The current CHI Prompt Pay guidance states payments on balances can be divided over several months, but not to exceed 12-18 months. In some cases this is appropriate, in some cases it is not (i.e., periodic payments are too large or too small). MBOs are encouraged to use experiences specific to their communities in order to define, and consistently apply, the MBO definition of "reasonable" (i.e., setting minimum/maximum thresholds on amounts and duration of terms). Payment terms should not be extended beyond 18 months.

6. Could you define what would be considered "cooperative efforts?"

   MBOs are encouraged to utilize the experiences of their own patient access and patient accounting staffs to define "cooperative." This is a very subjective area and the collective experiences of patient finance personnel at each MBO should be utilized when defining what might be the elements of MBO specific cooperation.

   CHI will issue additional self-pay management guidance to help clarify this question, however, the frequency and quality of communication from patients/guarantors should be assessed when determining cooperation.

7. We have many "unemployed" patients/guarantors who have significant assets. Should we avoid debt collections due to their unemployment status?

   No. Nothing in this guidance prohibits using debt collection tactics on patients/guarantors who are unemployed, <u>with</u> significant income and/or assets.

   However, the guidance <u>does</u> prohibit aggressive debt collection tactics on patients/guarantors who are unemployed <u>and</u> have no income or assets. The MBO should always review its charity policy to assure that the patient/guarantor has been appropriately considered for charity services.

8. The guidance states recourse loan programs should not be used. These programs have been very successful for us, and our agencies. Why do we have to discontinue?

   CHI needs to obtain more information surrounding these programs (e.g., criteria used to determine loan approval, fees to patients, tactics used by bank, cost to the MBO, etc.). There are differences of opinion on both the effectiveness and risk of these programs. Additional information is needed and discussions will be held with MBOs before CHI resolution on the use of recourse loan programs is reached.

In the interim MBOs should not develop any new programs which involve recourse loans. Existing loans are to be considered "grandfathered."

9. If I read the guidance correctly, it seems advisable not to pursue any legal tactics. Would this be an accurate statement?

   No. Patients who have been determined by patient financial services or debt collection agency staff to be unwilling versus unable to pay should be pursued for payment. Legal proceedings, other than those prohibited in Section IV.C or Addendum A. I can be used but there must be MBO policies and procedures in place to assure that there is consistency in the use of such tactics. The additional CHI self pay guidance will address the use of authorized legal tactics.

10. Does this policy apply to our physicians and clinics?

    If the physician practice or clinic is part of the MBO, the guidance outlined here is applicable.

11. Does this mean we can now offer discounts to "straight" self-pay patients?

    No. Any discount to "straight" self-pay patients/guarantors must be directly related to the financial need of that patient/guarantor. The CHI charity guidance is to be followed.

Question 3

Attachment 3 – 2

Catholic Health Initiatives
Charity Care Standards and Guidelines
Conference Call
June 24, 2004

Slides (40)

Catholic Health Initiatives

Charity Care Standards and Guidelines

Conference Call
June 24, 2004

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Agenda

- Introduction and Welcome – Geraldine M. Hoyler, CSC
- Opening Prayer – Geraldine M. Hoyler, CSC
- Presentation/Slides –
  - Geraldine M. Hoyler, CSC, Senior Vice President, Finance & Treasury
  - Susan G. Crawford, Vice President, Financial Services
  - J. Peter Savini, Vice President, Patient Financial Services
- Questions & Answers – Geraldine M. Hoyler, CSC

High Priority Issue:

- Media coverage
- Governmental investigations
- Scruggs Lawsuits

High Priority Issue (continued)

- House - Oversight and Investigation
- House - Ways and Means
- Senate – Finance Committee
- State actions

Timeline – Spotlight on Hospital Billing & Collection Practices

- July 16, 2003 – Investigation of hospital charges to the uninsured by the U.S. House of Representatives Energy and Commerce Committee announced requiring detailed information from 20 healthcare systems, both for-profit and not-for-profit

- November 2003 – AHA's Board of Trustees approves principles and guidelines for use by its members in assessing charity care, billing and collection practices.

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- December 16, 2003 – AHA letter to Secretary Thompson requesting clarification on discounts to uninsured patients
- December 17, 2003 – CHI completed and submitted documentation and data in response to the Oversight and Investigations Committee (O&I)
- January 13, 2004 – CHI representatives meet with Subcommittee staff to answer questions concerning documentation submitted

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- January 22, 2004 – O&I Subcommittee of the House Committee on Energy and Commerce requests information from HHS Secretary Thompson

- February 6, 2004 – CHI conference call with MBOs to discuss CHI testimony before O&I Subcommittee

- February 13, 2004 – Illinois revokes tax-exempt status of Provena Covenant Medical Center, Champaign-Urbana resulting in assessment of $1 million in property taxes

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- February 17, 2004 – HHS responds to frequently asked questions about discounts for indigent or uninsured patients, patients with large medical bills
- February 19, 2004 – OIG posts guidelines on hospital discounts for the uninsured
- February 19, 2004 – Consejo de Latinos Unidos places two contentious print ads in the Washington Times taking Catholic hospitals to task

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- March 2, 2004 – Letter to K.B. Forbes from Dick Davidson, President of AHA
- March 9, 2004 – CHI issues Financial Standard No. 5: MBO and Third-Party Collection Agents and Self-Pay Protocols
- March 15, 2004 – Letter to K.B. Forbes from Rev. Michael D. Place, STD, President and CEO of The Catholic Health Association of the United States

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- March 16, 2004 – Draft Revised Standards mailed to selected CFOs and PFS directors
- March 22, 2004 – Second Revised Draft mailed to selected CFOs and PFS directors
- May 6, 2004 – Final update on Revised Draft mailed to CFOs and PFS directors

Timeline – Spotlight on Hospital Billing & Collection Practices (continued)

- June 8, 2004 – CHI issues Revised Standards and Guidelines for Charity Care

- June 10, 2004 – CHI testimony along with four other systems scheduled and then cancelled due to President Reagan's funeral.

Application of Guidance

- CHI Financial Standards & Guidelines Manual
  Section 4 – Uninsured/Underinsured Patient discounts (Charity Care)

- CHI Financial Reporting Manual (FRM) Section 18: Prompt Pay and Third Party Discounts

- CHI Policy 3B – Explanation of Health Services for Members of Participating Congregations

Application of Guidance (continue)

- Guidance is applicable to all medically necessary services offered by CHI facilities (not for profit, controlled) – see specific sections
- Requires periodic reporting to MBO Finance Committee and/or Board

MBO Actions

- Review Standards & Guidelines
- Develop Policy for MBO Board approval
- Review procedures, manuals and forms
- Educate staff
- Implement changes
- Evaluate compliance

Discount

- A reduction of gross charges on a particular patient account for one of the following reasons:
  - Documented support of charity, either 100% or sliding scale
  - Presumptive charity eligibility – 100% only
  - Medical indigency – up to 100%
  - Prompt pay – per MBO policy, not to exceed 20% only if:
    - 100% self pay
    - Paid in full within 30 days
  - Prompt pay – for insurance plans without contract
  - Members of participating congregations without insurance or Medicare

Contracted Arrangements

- Reduction of charges provided under a contract or like agreement:
  - Medicare
  - Medicaid
  - Managed Care
  - Indemnity Coverage
  - Workers' Comp

Legal Arrangements

- Reduction of charges under a legal action/resolution/ settlement

Administrative Adjustments

- Reduction of charges based on an internal administrative procedure, e.g., disputed services
- Packaged programs
- Discounts to physicians <u>are not permitted</u>

Expansion of PM Guidance

- Medicare allowability of charity discount as bad debt expense – uniform application of policy to all patients.

New Guidance Replaces Prior Charity Guidance

- Effective July 1, 2004 for most parts
- Effective July 1, 2005 – required reserve for charity care, accrual method of accounting

Changes:

A. Defines medical necessity –
   - Charity is applicable only in cases of medical necessity
   - Medical necessity must be determined consistently within the MBO
   - MBO to establish a single method to determine (support and document) medical necessity

What MBO needs to do:

- Establish MBO method of scheduling services for all inpatients and non-emergent outpatients
- Assure orders for services are complete including diagnosis and specific documented service requests
- Screen orders against LMRP or other relevant screen to document medical need
- Assure documentation of services and results is complete

Changes:

B. Defines when an emergency patient should be provided with information about charity care availability

What MBO needs to do:

- Review Emergency Department procedures
- Revise as necessary to provide charity information
- Assure patients are made aware of the availability of charity

Changes:

C. Requires use of standard CHI charity care/financial assistance application form (as minimum data gathering tool)

What MBO needs to do:

- Review standard CHI form and expand, if needed
- Place MBO name on form
- Destroy previous forms
- Revise instructions for staff
- Provide new charity application form
- Train staff
- Install appropriate signage

Changes:

D. Requires use of CHI Charity Care Documentation Checklist

What MBO needs to do:

- Revise charity care procedures to include use of Checklist
- Add Checklist to standard forms
- Train staff

Changes:

E. Defines broader application of presumptive eligibility for charity care

- Based on known or "represented" information about patient
- Requires 100% discount

What MBO needs to do:

- Implement use of required CHI Patient Charity Care Discount Application form – Presumptive Eligibility

Changes:

F. Establishes MBO Charity Care Review Committee

- To "oversee" presumptive eligibility
- To "resolve" medical indigency questions

What MBO needs to do:

- Appoint Committee
- Develop operating procedures
- Meet and carry out obligations
- Document meetings

Changes:

G. Defines medical indigency – a new category of eligibility for charity discounts

- Income above scale
- Catastrophic medical costs

What MBO needs to do:

- Develop guidelines for medical indigency levels
- Review by MBO Charity Care Review Committee

Changes:

H. Increases minimum income level <u>application of 100%</u> charity discount to uninsured patients to

130% of HUD very low income adjusted for family size – MSA/ county of residence

Changes:

I. Increase minimum income level for <u>top of sliding</u> scale for charity to

150% of the base charity level

HUD Income Levels

- HUD income levels chosen because:
  - More sensitive to family size
  - Variation of income by geographic location

Also consider:

- Pre-registration
- Admitting processes
- Documentation processes
- Upfront cash collections
- Acceptance of credit cards
- Billing messages
- Patient information material & signage
- Facility Web Site

Sample Policies Reviewed

- January 2004 – Tenet's website – Tenet's Compact with the Uninsured
- February 2004 – HANYS – New York Hospitals issue guidance
- February 2004 – Alliance of Catholic Health Care, California – Standard Business Practices Governing the Billing of And Payment for Services Provided to Low-Income Uninsured Patients

Sample Policies Reviewed (continued)

- March 2004 – HCA – Charity Policy and Discount Policy for Uninsured
- May 2004 – Greater Cincinnati Health Council – Billing & Collections
- May 2004 – Catholic Healthcare Partners – Uninsured/ Underinsured Billing and Collection Program

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Question 3

Attachment 3 – 3

Questions/Answers: Charity Care Conference Call June 24, 2004

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1. Many "for-profit" providers are offering discounts to self-pay patients in excess of twenty percent (20%), can we follow?

   No. At the advice of counsel, CHI is remaining firm with 20% being the maximum allowable self-pay discount. CHI is in the process of seeking clarification from the Department of HHS and the OIG, which would allow providers to discount relative to our managed care contracts.

   Medical Indigency Guidelines should also be considered when determining the level of discount provided to a self-pay patient.

2. Do the standards and guidelines for the uninsured/underinsured patient discounts (charity care) apply to Joint Ventures (JVs), and those JVs which exist with "out of state" entities?

   It depends on how the Joint Venture, and the relationship with the CHI MBO, is structured (e.g. is the JV a taxable entity?). Each JV is designed differently, MBOs are encouraged to consult with their Legal and Finance Group representatives.

3. Currently, the CHI Prompt Pay Guidance states "discounts may not exceed 20%." Do the MBOs have to offer 20% discounts, or could it be less?

   MBOs may offer discounts to self-pay patients. These discounts cannot exceed 20% (it can be less). Prompt pay discounts must be consistently applied.

4. If a patient account qualifies for an administrative adjustment, per the definition provided, can we still bill and collect from the patient's insurance, then write-off the patient liability to an administrative adjustment?

   It depends on the nature and reasons for the administrative adjustment. There will be situations where it would not be appropriate to submit a claim for reimbursement to a patient's insurance, and other situations where the MBO would be justified in submitting the claim. If there is uncertainty, the MBO should consult with their Legal and/or Finance Group representative.

5. Specific to record retention, how long is a completed charity application good for?

   Charity applications should be consistent with a patient's "spell or illness" or "course of treatment." It should be reevaluated every ninety (90) days.

   Refer to III. A. 4. (b) on Page 4-12 of the Charity Guidance.

6. Do follow-up visits or treatment, as a result of an emergency room visit, qualify for charity under the guidelines?

   Yes.

   There may also be opportunities for your MBO to work with other providers in your area that receive specific funding to provide services to low income persons.

7. Under section 4-13, Reserves for Charity Care, could you expand on what is meant by "normal living expenses"?

   Please refer to 4-13. III. A. 6.: "The assessment of normal living expenses is subjective and based on many variables including, but not limited to, the patient's/guarantor's physical and ongoing medical needs, family size, number of wage earners in the household, etc..."

8. Our MBO has a retail pharmacy (which also serves as the MBO's in-house pharmacy), would the supplies and medications dispensed by the retail pharmacy be covered by this policy?

   This question requires more review by CHI legal staff to examine all of the related issues. If you have a similar situation at your MBO, please contact either your assigned V.P. Financial Services or your assigned Legal Services Group member.