Chan Soon-Shiong Medical Center at Windber

BUSINESS OFFICE POLICIES AND PROCEDURES

Subject:	Financial Assistance Policy (Charity Care)
Effective Date:	03/2002
Revised:	08/2010; 03/2019; 01/2022; 09/2024 Reviewed: 01/22, 09/24

Policy: As a benefit and obligation to the community, the hospital recognizes its responsibility to provide medically necessary services and to provide financial assistance to patients paying for those services. As important, is the hospital's financial ability to provide future community benefits which necessitates that those with the ability to pay are required to do so and may be pursued to the fullest extent available within the laws of the Commonwealth of Pennsylvania governing debt collection. This policy will comply with all requirements of the IRS of a non-profit organization, and all other regulations, such as EMTALA, that relate to the provision of service

Purpose: To provide a continuum of financial assistance/requirements across the entire patient experience at all service entry/delivery points that define the patient's financial obligations, provides the methodology for assistance, the available forms of assistance, and the processes to assist in the communication and understanding of the same by all involved.

Definitions:

Financial Assistance – Includes all forms of financial help for payment/resolution of patient liable balances including full or graduated reductions in liable balance or all payment arrangements.

Financial Liability - the amount calculated to reflect liability assigned to the patient. This may include full charges, discounted services after appropriate approved self pay discount is applied, or balance after patient's insurance has processed a claim. This may include unmet deductible, coinsurance, and copay assigned by the insurance carrier and is the patient's or guarantor's responsibility.

Pre-collect Amount – the amount of the patient liability that a hospital may require a patient to pay in advance of elective, non-emergent services.

Medically Necessary Services – Services provided that are supported by patient diagnoses that meet the current definitions as defined by Medicare and other accepted

criteria used by the hospital. Services not meeting this definition include personal cosmetic and other services not required to treat a medical condition.

Emergency Care – Care provided in the section of the hospital designated as Emergency Room and/or those areas subject to EMTALA.

Guarantor – The person who is financially obligated to pay for out of pocket expense for services to the patient.

Financial Assistance Policy (FAP) – Term used by the IRS for the policy of providing assistance for those in need.

AGB – Amounts Generally Billed to those covered by insurance.

ECA – Extraordinary Collection Actions that cannot be taken before expiration of 240 days or when there is an open/unprocessed FAP application.

Surgical Services - All services that are defined in the HCPCS code range of 10000 – 69999 with the exclusion of venipuncture.

Writ of Body Attachment -It is the civil equivalent of a bench warrant issued by a court. Typically, it is used where someone has failed to obey a civil court order, such as not paying child support, refusing to turn over property or ignoring a subpoena. The Sheriff will arrest the miscreant and bring him before the judge to explain why he shouldn't be committed to jail for civil contempt.

I Requirements – General:

1) Patient obligations and related financial assistance levels is a continuum that is segmented enough to provide consistency as a guarantor's financial position moves from 100% debt forgiveness through relaxed payment arrangements to requiring the guarantor to seek alternative external financing.

2) The framework for the determination of 1) above is found in Appendix A. The hospital will determine the percentages of the poverty used for the graduated benefit/requirements as needed to meet their FAP and financial goals of the organization.

3) The hospital will also identify the calculations used for determining the ABG, identify an effective date, record this information on Appendix A, and update the information each time there is a change. This calculation can be adjusted as needed but should be reviewed at least annually.

4) Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance.

5) Patients must apply for Medical Assistance and be denied eligibility for Medical Assistance based on current Income Eligibility guidelines.

6) The amount billed to a patient with no insurance represents each hospital's respective AGB – Amounts Generally Billed to those covered by insurance. See Appendix A for calculation method.
7) For patients that have insurance coverage, the financial assistance is limited to defined patient liabilities (deductible, coinsurance, co-pay) and non-covered services.

8) Valid health insurance coverage will be accepted in lieu of immediate payment and a claim will be sent on behalf of the patient provided that the patient fully cooperates with any and all requirements needed to process the claim including but not limited to:
    a. Steps necessary to obtain required notifications, authorizations, or approvals.
    b. Provide accurate and comprehensive demographic and insurance information.
    c. Assignment of insurance benefits.
    d. All necessary information releases.
    e. Prompt responses to insurance and/or hospital correspondence or communication necessary to adjudicate the claim such as COB questionnaires, etc.

    Failure to adequately or promptly respond to these requirements may require a demand of immediate and full payment of the account balance. No self-pay discounts would apply as the insurance should remain on the account and the balance moved to the patient responsibility. In addition, acceptance of the insurance does not lessen the financial obligation of the debtor.

9) Patients have the right to refuse insurance coverage for specific services. Due to the various legal requirements of this option, adherence to the following is required:
    a. This is only an option for elective services. No emergency related services may use this option
    b. This option is not available when a government insurance is on the account regardless of payer priority,
    c. This option must be elected individually for each account.
    d. An insurance named "Self Pay by Request" (do not update Demo recall) will be added to the account so that: i. An insurance is never added to the affected account after this option is elected. ii. All other parties that process the account can easily identify that this option was elected.
    e. Medical records for these services cannot be sent to the patient's insurance carrier. Releasing medical records to their insurance for a patient selecting this option may create a HIPAA disclosure violation.
    f. The option must be elected prior to the service and prior to providing insurance information that has been eligibility verified and/or used to obtain authorization.
    g. Payment in the amount of 100% of the AGB calculated amount must be provided at the time of election as a deposit toward the financial settlement of

the account. Any difference in actual AGB amount post service will be due and payable.

10) Balances after an insurance claim has processed will be billed to the patient based on the type of coverage or denial classification.
    a. **NON-COVERED** Services denied as non-covered (No benefit type denial) will be considered as no benefit coverage was available for that type of service. Non-covered denials will not be considered provider liable regardless of contractual language or misclassification of the denial by the insurance coverage entity.

    b. **EXPERIMENTAL** Services classified by an insurance company as experimental will be patient liable provided that the service is a medically acceptable practice. However, the insurance coverage entity should use a denial that is classified as Medically Appropriate. All other cases will be the considered a non-covered service and therefore a patient liability as the insurance has deemed the service to be non-covered based on their benefit determination.
11) An AGB adjustment is applied regardless of the guarantor's ability to pay and will be reversed if insurance coverage payment becomes available on the account. This adjustment does not apply to patient liabilities identified through a claim adjudication process or for when the patient elects not to use insurance coverage that is valid at the time of service.

12) Financial assistance applicants that make any material misrepresentations will result in the reversal of approval and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.

13) Prompt pay discounts are not available and are not to be offered.

14) Settlement campaigns of payment arrangement accounts exceeding 6 months in duration may be occasionally offered. However, this approach should not be routine or be on a fixed schedule to avoid payment delays (awaiting a scheduled campaign).

15) Catastrophic circumstances may justify financial assistance to an individual that falls outside the score and/or income levels established in this policy. For these extenuating situations, patient financial assistance adjustments may be given upon documented recommendation of revenue cycle leadership and approval by the CEO or CFO. Criteria for determining such catastrophic circumstances is based on the judgement of the executive for the situation but should be a rare occurrence.

16) Agreements with the Amish or other groups that self-fund their health insurance expenses are processed like other contracts and are excluded from this process when a financial agreement exists with the family clan or governing body.

17) No information obtained from this process may be disclosed to any party that is not a part of their position responsibilities. Inappropriate discloser will result in disciplinary action and/or dismissal.

II Patient Financial Assistance Application Approval Process:

1) Financial Assistance provided to the patient in the form of balance forgiveness (charity) will be determined by application that indicates the patient's ability to pay.

2) The Financial Assistance application process includes the following:
   a. A completed application is presented to a Financial Counselor. The application form must be completed in its entirety.
   b. All supporting documentation is required with the application form, including proof of income and proof of assets
   c. Financial Counselor will review and verify the completed application and supporting documentation, using the Financial Assistance application checklist and guidelines.
   d. Determination will be made as to the patient's eligibility and level of balance forgiveness for which the patient qualifies.
   e. Copies of application and supporting documentation will be retained by the facility for as long as record retention policies dictate.
   f. Open balance accounts will be reviewed for qualification of balance forgiveness and appropriate adjustments will be made.
   g. Patient will be notified in writing of the determination whether approved or denied for Financial Assistance.

III Requirements – Communication:

1) The hospital will widely publicize the Patient Financial Assistance policy by completing the following:
   a. Make available paper copies of the application when requested and provide the Patient Financial Obligation Policy without charge to distribute by mail, in person and at locations in the hospital.
   b. Notification by way of postings.
   c. Document the activities used to inform the community served about the program on a minimum of an annual basis. Information provided on the hospital web site and other electronic media on the policy and how to obtain additional information.

IV Requirements – Emergency Care:

1) No financial interactions will occur before patient is medically screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, conversations regarding patient liability payments will only occur during the discharge process.
2) Patients will be registered as soon as possible without interfering with the provision of care.
3) Financial counseling: Patient is offered information regarding the provider's financial counseling services and assistance policies upon request.
4) Prior balance and patient share discussions will only occur upon discharge. All hospital employees will provide the support necessary to ensure that the patient returns to the discharge area. The provider representative will provide as much information as possible about the patient's likely financial obligations. Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have.

V Payment Requirements – Advance of Care (Large Dollar Cases):

1) The scope of services for this section of the process includes scheduled high dollar services including but not limited to:
    a. Inpatient elective
    b. Outpatient Surgery included under the definition of surgery
    c. MRI/CT/PET and any other hospital defined procedures
    d. Nuclear stress testing
1) e Infusions involving high dollar drug therapies.
    e. Any other hospital specific identified tests.
2) Services considered to be personal cosmetic and personal services require 100% of the estimated charges be paid prior to receiving the service.
3) Non Emergency Room services will be considered elective and are subject to the requirements contained in this Advance of Care section.
4) Services are to be scheduled in advance as much as possible but a minimum of 7 days is preferred in order to ensure ample time to provide the patient with complete financial counseling and assistance.
5) The following process will be used when advance payment requirements are not met;
    a. Advise the ordering/scheduling physician that the service may be re-scheduled due to advance payment requirements.
    b. If the ordering/scheduling physician is in disagreement with re-scheduling the patient, they will contact the hospital's chief clinical representative which would include the Medical Director, or clinical coverage person (VP Nursing or similar position) and discuss the medical needs of the patient. Should the re-scheduling delay be unacceptable, the clinical justification should be communicated to the Patient Financial Counseling

representative to approve the elective service without meeting the minimum pre-service payment requirement. All referred cases that are approved in this manner will be tracked and submitted at least on a monthly basis to the hospital CFO. Review of these cases by the hospital's executive team is recommended to ensure an acceptable level of application of the intent and requirements of this process.

6) Patient Financial Interactions in Advance of Service:
    a. Appropriately trained provider representatives will have these discussions with the guarantor. Guarantor should be given the opportunity to request a patient advocate or family member to assist them in these conversations.
    b. Discussions will occur using the most appropriate means of communication for the patient.
7) All discussions with patients will occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient's ability to pay.
8) The representative will first gather basic registration information including, insurance coverage, as well as determining the potential need for financial assistance.
9) The representative will review insurance benefit details with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.
10) Guarantor is offered information regarding the provider's financial counseling services and assistance policies.
11) Financial counseling: Patient is offered information regarding the provider's financial counseling services and assistance policies.
12) Prior balance and patient share discussions: These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care and will focus on patient education. During patient share and prior balance interactions, the provider representative will:
    a. Provide as much information as possible about patient's likely financial obligations, including a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
    b. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.
    c. Ask the patient if they are interested in receiving information regarding payment options.
    d. Ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.
13) Balance resolution: Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would

like to resolve the balance for the current service and any prior balance the patient may have.

14) Upon request, the patient will receive in writing, information regarding the provider's supportive financial assistance programs, and a summary of the financial implications for the services rendered, including a phone number to call with questions.

VI Requirements – At Time of Service (Non-Emergency Care):

1) All co-pays are due at the time of service and are to be requested prior to completing the service.
2) Patient will be expected to provide any and all information required for a complete and accurate claim, including active insurance information, to Patient Access staff during the registration process.
3) Refusal to provide insurance information or to allow billing to available active insurance will result in implementation of the Self Pay By Request process.

VII Requirements – Collection Process:

1) Patients will receive a minimum of 4 statements over a period of 120 days prior to consideration for placement as bad debt with a third-party agency.
2) Accounts associated with the same guarantor may be tied or grouped for the purpose of consolidated statement processing and for attempting to contact the guarantor. Other than the first notice of payment from the patient, new accounts entering the self-pay collection cycle will be moved to the progressive step of existing accounts in the active collection flow. The hospital reserves the right to move active self-pay account balances directly to bad debt when repetitive and current account history indicates defiant and consistent avoidance in the resolution of account balances.
3) The hospital reserves the right to record telephone conversations provided the notice requirements have been fulfilled.
4) Partial payments on an account that are not part of an existing approved payment arrangement will be considered as payment on account and are not to be construed as an acceptance to a payment arrangement or the prepayment of future payment arrangement requirements. Subsequent statements will so advise the guarantor to avoid any misunderstanding of an offer and acceptance.
5) Partial payments will be applied to the oldest account in the self-pay flow so to ensure appropriate statement messaging and support character recognition and payment allocation technology. Exceptions to this requirement would be web and IVR payments that are account specific. However, the statement messages are not to be reset unless the minimum payment requirements of an agreed upon payment arrangement are satisfied.
6) ECAs or extra collection actions are not permitted when a FAP (charity) application has been received during the first 240 days of a collection cycle. The

collection cycle includes both active and bad debt periods. ECAs include, but may not be limited to:

a. Place a lien on an individual's property
b. Commence a civil action against an individual
c. Reporting to credit agencies

7) The self-pay collection flow will be as follows to ensure compliance to Medicare and 990 requirements:
    a. Medicare patients should receive a patient balance statement within 90 days of Medicare payment or 60 days of a secondary/tertiary claim payment when such insurance exists.
    b. Active self-pay collection flow will be a minimum of 120 days. A minimum of 4 statements will be sent with the third as a Final Notice and the fourth as a Third Party Collection attempt. Outbound phone attempts may occur at any time after 10 days from the initial statement. FAP applications will be accepted during this entire period.
    c. Accounts not paid or in an acceptable payment arrangement will be referred to a primary collection agency (bad debt) for a period of 6 months. No ECAs are permitted during this period. FAP applications not completed during an above period will be continued through this period. New FAP applications will be accepted during this period through the first 120 days of placement. All incomplete and open FAP applications at 150 days old will be sent a letter to request the application be finished or it will automatically be denied at the end of the 6 month placement cycle.
    d. All balances returned in step c above will be placed with a second agency (bad debt). No FAP applications will be accepted or processed during this period. All ECAs that are approved by the hospital will be utilized during this period. All secondary placements will be immediately reported to the credit reporting agencies.

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FINANCIAL ASSISTANCE POLICY – APPENIDX A

501r AGB Discount Calculation for Balances after Insurance

		Calculation		
a	Total Account Charges			
b	AGB Payment Rate			
c	AGB Discount Amount	= (1-b)*a	$	
d	Maximum Amount Billed to Patient	= a-c		$
e	Account Balance Due From Patient			
f	Percent Charity Discount			
g	Charity Discount Amount	= e*f	$	
h	Balance of Patient Liability	= e-g		$
i	Amount of AGB Discount (calculate only when line h exceeds line d)	= h-d		$
j	Max Billable to Patient	= h-i		$

AGB Calculation

FY	Inpatient	Outpatient
2024	34%	24%
2023	34%	23%
2022	34%	25%
2021	33%	24%

Calculation Method: annually updated based on look back method which includes claims allowed during the prior 12 month period using Medicare fee for service and all private health insurers that pay claims to the hospital facility.