

CC005 - HOSPITAL CARE ASSURANCE & FINANCIAL ASSISTANCE POLICY

ISSUED DATE: 01/01/2003	APPROVED DATE: 03/15/2021
PREPARED BY: Carolyn Byers (Credit/Collections Supervisor)	
APPROVED BY: Carolyn Brant, Tammy Hoke (Director of Patient Accounts)	

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HOSPITAL CARE ASSURANCE & FINANCIAL ASSISTANCE POLICY

NUMBER: CC# 005 (Replaces both 005 and 012)
REFERENCE: Ohio Revised Code / Ohio Administrative Code/Section 501(r) of the Internal Revenue Code of 1986, as amended, in addition to Ohio law references.

I. PURPOSE:

Consistent with its mission to provide quality health care and promote wellness, close to home for the extended community, Wayne HealthCare is committed to providing financial assistance to every person in need of emergency or other medically necessary care even if that person is uninsured, underinsured, or ineligible for other government programs, in accordance with the eligibility criteria and other guidelines set forth in this policy.

II. POLICY:

Under the provisions of section 5168.14 of the Ohio Revised Code, each hospital that receives payment under the provision shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of Ohio, who is not a recipient of the Medicaid Program and whose income is at or below the federal poverty guidelines. Current recipients of the disability assistance or its successor programs as defined in Chapter 5115 of the Ohio Revised Code, qualify for services under the provisions of this rule.

To consistently apply the rules and regulations for the Hospital Care Assurance (HCAP) and Financial Assistance Programs.

III. DEFINITIONS:

AGB: Amounts Generally Billed for emergency or other medically necessary care to individuals who have insurance coverage.

Care Assurance/HCAP: A state-funded program that compensates hospitals that have a disproportionate share of charity patients who are at or below the Federal Poverty Guidelines.

Emergency Care: Immediate care which is necessary to prevent putting the patient’s health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

EMTALA: The federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd.

Financial Assistance: Healthcare services provided which are not expected to result in cash inflows; medically necessary services rendered without expected payment to individuals meeting established criteria. Wayne HealthCare’s Financial Assistance Program considers income and family size to determine a percentage discount off of gross hospital charges up to 200% of the Federal Poverty Guidelines. Income and family size are determined under the Hospital Care Assurance Guidelines.

FPG: Federal Poverty Guidelines as listed by the United States Department of Health and Human Services, available at <http://aspe.hhs.gov/poverty>.

Medically Necessary: Inpatient and outpatient hospital services or care rendered to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.

Residency: The patient must be living in Ohio voluntarily. This includes temporary residents, such as students, migrant workers, or illegal aliens, and persons who are temporarily residing with in-state relatives. Out-of-state patients who are on vacation, or any patient who has come to Ohio solely to receive medical care, are not considered residents.

Third Party Payer: Any private or public entity or program (e.g., Medicare, Medicaid, or Commercial Insurance) that may be liable by law or contract to make payment to or on behalf of an individual for health care services. Third-party payer does not include a hospital or physician that provides services to the patient.

Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.

Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if not treated within 12 hours.

IV. COMMITMENT TO PROVIDE EMERGENCY MEDICAL CARE:

Wayne HealthCare provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. Wayne HealthCare will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all Wayne HealthCare patients in a non-discriminatory manner, pursuant to the Wayne HealthCare's EMTALA policy.

V. SERVICES ELIGIBLE FOR FINANCIAL ASSISTANCE:

Services eligible for financial assistance include emergency or urgent care, services deemed medically necessary by Wayne HealthCare, and, in general, care that is non-elective and needed in order to prevent death or adverse effects to the patient's health.

Radiologists, Anesthesia, and EKG Reading charges are not a part of Wayne HealthCare's Financial Assistance Program. Attached to this policy as **Appendix A** is a complete list of providers, in addition to Wayne HealthCare itself, delivering emergency or other medically necessary care at Wayne HealthCare that specifies which providers are covered by this policy and which are not covered.

VI. AMOUNT OF FINANCIAL ASSISTANCE:

Uninsured Self-Pay Discount: Uninsured patients who do not qualify for free care (e.g., due to their household income) will receive a discount of **25%** off of gross charges for medically necessary services. The discount is based on policy effective date and not date of service. These patients are expected to pay their remaining balance for care, and may work with financial counselors to set up a payment plan based on their financial situation.

Financial Assistance Discount: Free care is provided only when care is deemed medically necessary and after uninsured patients have been found to meet all financial criteria, including household income at or below 100% FPG. If household income is over 100% FPG but at or below 200% FPG, then patients may receive a discount based on the sliding scale attached as **Appendix B**.

Uninsured patients may be assisted with applications for other means of payment or financial assistance (e.g., Medicaid, other local funding programs) before approval for financial assistance.

Uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so in order to ensure healthcare accessibility and overall well-being.

Medically indigent persons who have income or assets above qualifications for any assistance programs but have catastrophic medical costs may be eligible for free or discounted care with the approval of Director of Patient Financial Services. Such individuals must complete a financial assistance application as described in Section VIII below.

Following a determination of eligibility under this policy, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care (AGB). Wayne HealthCare uses the Look-Back Method to determine AGB. Under this method, AGB is calculated by dividing the sum of all of its claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital during a prior 12-month period by the sum of the associated gross charges for those claims. Wayne HealthCare will begin applying the AGB percentage by the 120th day after the end of the 12-month period used in the calculation. The current AGB percentage is 55%.

Wayne HealthCare does not bill or expect payment of gross/total charges from individuals who qualify for financial assistance under this policy.

VII. ELIGIBILITY CRITERIA:

As stated above, patients who are uninsured or underinsured and have a household income within 200% of the Federal Poverty Guidelines (shown in **Appendix B**) may receive free or discounted care.

When determining patient eligibility, Wayne HealthCare does not take into account race, gender, age, sexual orientation, religious affiliation, social status, immigrant status, or any other classification protected by federal, state or local laws.

Family: A “family” is defined by the Medicaid program in Chapter 5101:3-2-07.17. A “family” shall include the patient, the patient’s spouse (regardless of whether they live in the home), and all of the patient’s children natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the “family” shall include the patient, the patient’s natural or adoptive parent(s) (regardless of whether they live in the home), and the parent’s children natural or adoptive under the age of eighteen who live in the home. If the income of the spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information, using the total family size. If the patient is the child of a minor parent who still resides in the home of the patient’s grandparents, the “family” shall include only the parent (s) and any of the parent (s) children, natural or adoptive who reside in the home. In determining appropriate family size, consider the following:

- a. If determining eligibility on a child and both parents are living in the home, whether they are married or not, both incomes are determined.
- b. If the live-in partner is not the child’s parent, his/her income would not be included.
- c. The income of grandparents or elderly parents living in the household is not to be considered.
- d. If determining a mother’s eligibility, child support for a child would not be included as income. Child support would only be included if determining eligibility for the child who is receiving child support and then only if the child support is received on a regular basis.
- e. If determining eligibility for an 18-year-old who lives with his/her parents, the parent’s income is not included (even if the individual is a full time student).
- f. If determining eligibility of an individual who has a child and a live-in partner, the income of the live-in is not considered because the couple is not married.

Income: Income is defined as total salaries, wages and cash receipts before taxes. For self-employed and farm employment individuals, receipts that reflect reasonable business expenses shall be counted.

- a. Other sources of income include, but not limited to, alimony, child support, veteran’s benefits, and unemployment compensation.
 - i. Child support as a form of income is not considered when the mother or the father is the patient. If the child is the patient, child support would be counted as income.
- b. An income tax return does not generally cover the date of service, which Ohio Administrative Code 5101:3-2-07.17 requires to be the basis for determining eligibility, and a tax return defines family and income differently. The tax return must be used as a form of documentation as a last resort and can only be used 1) if the patient’s date of service is in January and can represent the previous 12 month reporting period or 2) as proof of patient’s self-employment income.
 - i. If an income tax return must be used for proof of self-employment income, only the amount from the following lines on the tax return must be taken into consideration for the calculation:
 - a. Business Income or (Loss). Attach Schedule C or C-EZ.
 - b. Farm Income or (Loss). Attach Schedule F.
 - c. Rental real estate ONLY. Attach Schedule E.
 - ii. In the event that the individual is providing proof of household self-employment income and the patient and the spouse filed their tax returns Married Filing Separate, both tax returns should be taken into account for the calculation of income.
- c. A family’s or individual’s income and qualifying information submitted on the application for the date that these services were provided shall be determined one of 2 ways:
 - i. Using the income for every member of the “family” for the twelve months prior to date of service.
 - ii. Using the income for every member of the “family” for the three months prior to the date of service and multiplying by 4.

Revisions and Effective Dates: Internal policy changes cannot be implemented retroactively. A specific date must be chosen (usually the date listed on the revisions column above) on which to change its policy and all actions for dates of service on or after that date must be judged under the revised documentation standards.

VIII. HOW TO APPLY FOR FINANCIAL ASSISTANCE:

Determinations for eligibility for free or discounted care will require patients to submit a complete financial assistance application (including all documentation required by application) and may require appointments or discussion with hospital financial counselors.

1. Hospital Care Assurance Program (HCAP) applications are given at all the registration areas and can be obtained by requesting them from the Patient Financial Services.
2. The hospital will routinely mail applications to patients who do not have insurance. The hospital will post signs in accordance with rules and regulations, and will notify patients of the Hospital Care Assurance and Financial Assistance Programs by adding a message to the effect on every patient statement.
3. The initial bill, and at least the first follow-up bill is accompanied by a written statement that does all of the following:
 - a. Explains that individuals with income at or below the federal poverty guidelines are eligible for services without charge.
 - b. Specifies the federal poverty guidelines for individuals and families of various sizes at the time the bill is sent.
 - c. Describes the post-billing procedures for determining the individual's income and canceling the charges if the individual is found to qualify for services.
 - d. The federal poverty guidelines and Hospital Care Assurance applications are available on the Wayne HealthCare website. (waynehealthcare.org)
4. The information required in the application can be obtained via personal interview, phone conversation, faxed information, and/or mail. A spouse, significant other or member of the immediate family may also provide this information via a personal interview. If unable to obtain the information from the patient due to his/her immediate medical condition, verbal documentation may occur as a last resort via the telephone with the spouse, significant other or a member of the immediate family.
 - a. If the applicant is someone other than the patient, the information on the application must be completed as to the applicant's name. This person should only be the person who is taking financial responsibility for the patient.
5. Verbal documentation of income is acceptable and should be detailed and complete. Applicants must cooperate in supplying information about health insurance, medical benefits, proof of income, or any requirement in order to complete the application. For Financial Assistance, the patient may be asked to supply a form of income documentation.
6. Examples of Household Gross Income per Month:
 - a. Salary (combined)
 - b. Child support/alimony
 - c. Farm or self-employment
 - d. Military Family allotment
 - e. Public assistance
 - f. Pensions or veteran's benefits
 - g. Social Security
 - h. Rental Income
 - i. Unemployment compensation
 - j. Grants
 - k. Workman's compensation
 - l. Investment income
 - m. Other
7. Acceptable forms of documentation may include the following:
 - a. Pay Stub
 - b. Bank Statement
 - c. Social Security Statement
 - d. Tax Return
 - e. Unemployment insurance payment stubs
 - f. Information on how patients are currently supporting themselves
8. All applications should be signed by the patient or by someone who has a legal right to represent. If a patient or applicant is physically unable to complete an application, or does not live in the vicinity of the hospital and is unable to return an application by mail, the hospital may complete the application via the telephone. This should be considered a last resort. The person interviewing the patient should complete

- all the questions on the application, sign and date it, and document why the patient or applicant was not able to complete and sign the application himself/herself.
9. If the application is taken by phone, the original application must be sent to the patient with a cover letter of explanation for their signature with a self-addressed return envelope. The account notes must be documented that the original application and cover letter were sent to the patient to obtain signature. A copy of the application should be maintained and filed until the signed form is returned. If the signed form is not returned within 30 days, the Patient Accounting Clerk must document the failed attempt for the collection of the signature in the account notes. Signature must be obtained before the account can be adjusted for HCAP eligibility.
 10. Attestation of income and qualifying information submitted on the application shall be confirmed by signature.
 11. Providing false or inaccurate information may serve to disqualify an applicant from receiving financial assistance from the hospital.
 12. Patients covered under Medicaid do not qualify for this program; patients covered under the Disability Assistance or its successor program do qualify for this program.
 13. Patients may apply for assistance at any time within three years from the date of the follow up notice/second data mailer. Within this time frame, if the individual qualifies for HCAP/Financial Assistance and the account has been placed with a collection agency, the agency should be notified to adjust the account due to HCAP/Financial Assistance eligibility.
 14. Patients are deemed eligible by Patient Financial Services

The account will follow policy CC001 in regards to sending an account to collections. Patient's failing to respond will be considered delinquent and uncollectable after 240 days from the first statement date.

Claim Adjudication is as follows:

1. An HCAP application should be completed for each patient and is effective for ninety (90) days from initial date of service for **outpatient** services. **Eligibility for inpatients must be determined separately for each admission unless the patient is readmitted within 45 days of discharge for the same condition with the same diagnosis.** *The date of the application determines which Care Assurance/Financial Assistance policy guidelines will be followed.* Eligibility for recipients of the Disability Assistance program or its successor program must be verified on a monthly basis.
2. A completed application is reviewed and matched to the State guidelines for approval. There must be a signature on the application. The account(s) are adjusted to a zero balance by using the appropriate adjustment code. Once eligibility has been determined and charges are written off, self-pay payments that have been made on the account will first be applied to any open accounts that do not qualify for HCAP. HCAP self-pay payments will then be refunded to the patient. Charity self-pay payments will be refunded in accordance with the Billing and Collections Policy. If the charity account has been paid in full, payments will be applied to any outstanding balances.

IX. ACTIONS TAKEN IN THE EVENT OF NONPAYMENT:

The collection actions Wayne HealthCare may take if a financial assistance application and/or payment is not received are described in the Patient Billing and Collections Policy CC015. In brief, Wayne HealthCare will make certain efforts to provide uninsured patients with information about our financial assistance policy, such as including a summary of it with billing statements; before we or our collection vendors take certain actions to collect your bill (these actions include civil actions, garnishing wages, or reporting negative information to credit bureaus). Our collection vendors follow the guidelines of the IRS Rule 501r in regards to ECA (Extraordinary Collection Actions). Members of the public may obtain a free copy of the separate policy from Wayne HealthCare via the contact information listed below.

X. MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE AVAILABILITY:

Wayne HealthCare's financial assistance policy, financial assistance application, and summary of the financial assistance policy are available to patients in English.

A free copy of this policy will be available upon request at the cashier's window at our facility at 835 Sweitzer St., Greenville, OH, and will be available by mail or by calling us at 937-547-5770 or it can be accessed online at www.waynehealthcare.org.

Wayne HealthCare communicates the availability of financial assistance through means which include:

- Posting signs within the facility
- Providing brochures
- Creating a document that summarizes the financial assistance policy in simple, easy to understand terms
- Providing copies of the policy and summary in multiple languages, as needed by members of the community and having interpreter services available to provide translation assistance
- Ensuring free copies of financial assistance policy can be obtained within the facility or by mail
- Posting information about financial assistance on Wayne HealthCare website
- Providing information about the policy and how to apply during verbal communication about the patients' bill
- Ensuring designated staff are knowledgeable of the financial assistance policy and can answer patients' questions

XI. HOSPITAL CONTACT INFORMATION:

Patients concerned about their ability to pay for services or who would like to learn more about financial assistance should be directed to the Patient Financial Services Department as follows:

Phone: 1-800-589-2963 (toll free) OR 937-547-5770

Walk-in and Mailing Address:

Wayne HealthCare (walk-in – ask for cashier’s window)
 Patient Financial Services Department
 835 Sweitzer Street • Greenville, OH 45331

Website: www.waynehealthcare.org

Issue date:	Revision	Issued by::	Approved by:	Department Approved By:
2003		C Brant	P Emrick	Patient Financial Services
	2005	C Brant	P Emrick	Patient Financial Services
	2006	C.Brant	P Emrick	Patient Financial Services
	2011	C Brant	Shannon Everman	Controller
	2012	C Brant	Shannon Everman	Controller
	2013	C Brant	Dennis Lockard	CFO
	2014	P Emrick	Dennis Lockard	CFO
	2015	T Hoke		
	2017	CBRANT		
	09/01/18	CBrant		Patient Financial Services
	01/01/2019	Cbrant		Patient Financial Services
	01/17/2019	CBrant		Patient Financial Services
	02/06/2020	CBrant		Patient Financial Services
	08/01/2020	CBrant		Patient Financial Services
	01/19/2021	CBrant		Patient Financial Services

APPENDIX A

PROVIDER LIST

The provider list is maintained in a separate document. The provider list is a list that includes the names of all providers, other than Wayne HealthCare itself, providing emergency or other medically necessary care in the hospital facility that specifies which providers are covered by this Hospital Care Assurance & Financial Assistance Policy and which are not covered.

In order to obtain a free copy of the list, please contact Wayne HealthCare as follows:

Website: www.waynehealthcare.org

Telephone: 937-547-5770

APPENDIX B

FEDERAL POVERTY GUIDELINES

Patients eligible for a financial assistance discount will receive the most generous discount of the sliding scale or AGB.

If you think you may be eligible for uncompensated care assistance (free or reduced charge), you may contact the Patient Financial Counselors at (937) 547-5770 or you may visit the Financial Counselors office located at the Cashier Office.

2021 - SLIDING FEE SCHEDULE

Family Size	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%		
				Income	Level	as % of	Poverty						
1	< or = 12,760	12,761 to 14,036	14,037 to 15,312	15,313 to 16,588	16,589 to 17,864	17,865 to 19,140	19,141 to 20,416	20,417 to 21,692	21,693 to 22,968	22,969 to 24,244	24,245 to 25,520	INCOME BRACKETS	
2	< or = 17,420	17,421 to 19,162	19,163 to 20,904	20,905 to 22,646	22,647 to 24,388	24,389 to 26,130	26,131 to 27,872	27,873 to 29,614	29,615 to 31,356	31,357 to 33,098	33,099 to 34,840		
3	< or = 21,960	21,961 to 24,156	24,157 to 26,352	26,353 to 28,548	28,549 to 30,744	30,745 to 32,940	32,941 to 35,136	35,137 to 37,332	37,333 to 39,528	39,529 to 41,724	41,725 to 43,920		
4	< or = 26,500	26,501 to 29,150	29,151 to 31,800	31,801 to 34,450	34,451 to 37,100	37,101 to 39,750	39,751 to 42,400	42,401 to 45,050	45,051 to 47,700	47,701 to 50,350	50,351 to 53,000		
5	< or = 31,040	31,041 to 34,144	34,145 to 37,248	37,249 to 40,352	40,353 to 43,456	43,457 to 46,560	46,561 to 49,664	49,665 to 52,768	52,769 to 55,872	55,873 to 58,976	58,977 to 62,080		
6	< or = 35,580	35,581 to 39,138	39,139 to 42,696	42,697 to 46,254	46,255 to 49,812	49,813 to 53,370	53,371 to 56,928	56,929 to 60,486	60,487 to 64,044	64,045 to 67,602	67,603 to 71,160		
7	< or = 40,120	40,121 to 44,132	44,133 to 48,144	48,145 to 52,156	52,157 to 56,168	56,169 to 60,180	60,181 to 64,192	64,193 to 68,204	68,205 to 72,216	72,217 to 76,228	76,229 to 80,240		
8	< or = 44,600	44,601 to 49,060	49,061 to 53,520	53,521 to 57,980	57,981 to 62,440	62,441 to 66,900	66,901 to 71,360	71,361 to 75,820	75,821 to 80,280	80,281 to 84,740	84,741 to 89,200		
9	< or = 49,140	49,141 to 54,054	54,055 to 58,968	58,969 to 63,882	63,883 to 68,796	68,797 to 73,710	73,711 to 78,624	78,625 to 83,538	83,539 to 88,452	88,453 to 93,366	93,367 to 98,280		
10	< or = 53,680	53,681 to 59,048	59,049 to 64,416	64,417 to 69,784	69,785 to 75,152	75,153 to 80,520	80,521 to 85,888	85,889 to 91,256	91,257 to 96,624	96,625 to 101,992	101,993 to 107,360		
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%		
				Patient	out of	Pocket	Expense						
For each additional family member –													
Add	4,540	4,994	5,448	5,902	6,356	6,810	7,264	7,718	8,172	8,626	9,080		

This table is self-calculating, requiring entry of values in RED only.

Effective January 13, 2021