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Title: Financial Assistance (Charity Care-Uncompensated Care)

Document Owner: Michael Borge (EXECUTIVE DIRECTOR REVENUE CYCLE OPERATIONS) (EXECUTIVE DIRECTOR REVENUE CYCLE OPERATIONS)

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Policy:
Kootenai Health provides medically necessary care regardless of ability to pay or insurance coverage status. Kootenai Health believes that medically necessary health care services should be accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility or ability to pay. Kootenai Health is committed to excellence in providing high quality health care services, while serving the diverse needs of those living within its service area.

This policy describes the Kootenai Health Financial Assistance eligibility requirements and approval process. Generally, eligibility for Financial Assistance is determined by comparing the patient's income to the current year Federal Poverty Level Income Guidelines (FPG) as established by the Department of Health and Human Services, and eligible living and medical expenses to qualifying criteria.

Purpose:
The purpose of this policy is to establish and describe Kootenai Health's Financial Assistance Policy and eligibility requirements, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care.

Scope:
These programs apply solely to emergency and other medically necessary healthcare services provided *at Kootenai Health locations,* and when there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service.

Definitions:

Kootenai Health - Includes all entities, hospital, clinics, and other care facilities that currently bill under the Kootenai Health Tax ID number.

Financial Assistance – For the purposes of this policy, "financial assistance" includes indigent care and other financial assistance programs offered by Kootenai Health for appropriate services for which Kootenai health does not expect to be reimbursed due to a patient's inability to pay, and ineligibility to qualify for government or other available financial assistance programs.

Bad Debt – Accounts are considered bad debt when the patient has demonstrated an unwillingness to pay his/her portion of the Kootenai Health hospital or professional services bill(s), and has not provided documentation required to support the Financial Assistance application process. This applies to uncollectable billed amounts, excluding contractual adjustments, arising from failure to pay by patients or guarantors whose care has not been classified as Financial Assistance eligible.

Discretionary Expenses – A discretionary expense is a patient's or guarantor's cost that is not determined to be essential for the operation of the household. This includes expenses that can be reduced or eliminated without having an immediate impact on the patient. Payment plans may be set up based on applicants' discretionary income.

Eligible living and medical expenses – Patient or guarantor expenses not classified as discretionary.

Eligibility – A determination made by Kootenai Health based upon required financial documentation to verify the patient's inability to pay for medically necessary services provided to the patient.

Federal Poverty Guidelines – (defined through Federal DHS, updated annually on the KH website, following government published updates.)

Catastrophic Care – A circumstance of extraordinary medical expense from which a patient or guarantor would not have the ability to pay off the bill in their lifetime, given the patient or guarantor's validated income and available resources, without it resulting in a severe financial hardship.

Presumptive Eligibility – Established and defined criteria through which Kootenai Health may determine a patient's eligibility for Financial Assistance in the absence of supporting documentation. In this event, Kootenai Health may use outside agency information to complete the eligibility determination and level of financial assistance awarded. Examples:

- Homelessness or Transient
- Deceased with no Estate
- Severe mental illness
- Social/Family abandonment

Family – A group of two or more persons related by *birth, marriage, or adoption,* who live together; all such related persons are considered as members of one family. This may include individuals residing together who have consented to an arrangement similar to ties of blood or marriage. An unmarried person living alone will be considered a family for purposes of this policy.

Income – Personal Income: Total cash receipts and gross wages before taxes, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, or alimony, and investment activities paid to the individual and/or family members. Business Income, EBIDA: Profit or Loss (from Line 29, Schedule C), excluding Depreciation, Interest, and Amortization. Requires detail from Line 48, to have 'Other Expenses' considered.

Assets – Any item of economic value owned by an individual or corporation, especially that which could be converted to cash. Examples include checking and savings accounts, securities, real estate, car, boat, life insurance, IRA, trust accounts, and other property.

Indigent Persons – Patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or *below 250%* of the federal poverty standards adjusted for family size, or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third party payer.

Uninsured – No third party insurance coverage. Health savings accounts, for the purpose of this policy, are considered insurance. Depending on other available resources, an uninsured patient is not necessarily assumed to also be indigent or otherwise eligible for financial assistance.

Eligibility requirements:

Information regarding eligibility and the Financial Assistance application process is available and can be obtained at all points of patient registration at Kootenai Health Hospital and clinic locations, from Financial Counselors, Customer Service, and Social Services Departments, and is located through the Kootenai Health website.

1. A Financial Assistance request should be initiated by the patient, guarantor, or appropriate agent representing the patient. Patients demonstrating and/or communicating a need for assistance will be evaluated according to this policy.

2. Patients who may be eligible for Financial Assistance shall be identified as early as possible in the patient care cycle. However, determination of eligibility can take place after discharge at any point in the billing cycle.

3. After a request has been initiated, a Financial Counselor will screen the patient. This screening process will give the patient a preliminary determination if sufficient eligibility is indicated to allow the application process to move forward.
    a. If preliminary eligibility is indicated, the patient will receive a Financial Assistance application.

    b. The Financial Counselor will instruct the patient or responsible party that the application must be completed, signed and submitted to an authorized Kootenai Health representative within **30** days of the screening date, or such time that is medically and reasonably feasible to submit the required documentation. Collection efforts will not be initiated during the financial assistance determination process provided the responsible party is cooperative with the hospital's efforts to reach an initial determination of sponsorship status.

4. In order to be evaluated for Financial Assistance, it is the responsibility of the patient/guarantor to submit verification of annual income and assets through the completion and timely submission of a Financial Assistance Application.
    a. During the screening and application process, the patient's account(s) will maintain in a "Self Pay" status, which will allow the billing and collection process to continue. This billing classification will not change until a final approval decision has been recorded.

5. Determination of Eligibility:

A valid completed Financial Assistance Application will include the following documented information:

- a. Current, valid Picture I.D.
- b. Proof of income, to include:
    - i. The patient's most recent filed Federal Tax Return with **all** schedules. If unable to provide the tax return, alternate documents may be substituted: Supporting W-2's **and/or** or 1099 statements and a broker's statement from the IRS.
    - ii. Current three months of employer pay stubs
    - iii. Copies of **all** checking, savings and other bank statements for last **three** months
    - iv. Social security, Pension, Veterans, or equivalent benefits documentation
    - v. Disability and/or Unemployment benefits received
    - vi. Current food stamps award letter from patient's state of residence
    - vii. Written documentation from other income sources. to include assistance received from an individual or organization
    - viii. A copy of a most recent application denial from Medicaid
    - ix. Proof of mortgage, rent and utilities payment
- c. Proof of income excludes non-cash benefits (such as housing subsidies), capital gains or losses, and household income from non-family persons. However, non-family persons, such as roommates, may be considered if expenses are shared.
- d. Proof of Assets, to include supporting documentation of:
    - i. Value of home (if owned)
    - ii. Vehicles
    - iii. Assets available through a family or other Trust
- e. In the event that the responsible party is not able to provide any of the documentation described above, Kootenai Health may rely upon written and signed statements from the responsible party in the verification process. This circumstance should be a rare occurrence, with a final determination of financial assistance eligibility or classification as "indigent" authorized by the Financial Counseling leadership.
    - i. Based on the information provided and the verification process, after review of the Application, the Financial Counseling leadership or designee, may waive documentation requirements, when it is apparent that the patient or responsible party clearly meets the Financial Assistance guidelines.

6. Kootenai Health will complete all Financial Assistance applications 14 days of Kootenai Health receiving a completed and signed application. Patients eligible for Financial Assistance will be informed in writing of the approval determination.

7. Kootenai Health will approve Financial Assistance only after all other means of financial support are exhausted from available payment sources, including but not limited to Medicaid Programs.

8. Once the patient meets eligibility requirements, any outstanding balances from prior services that are owed by the patient as of the date of application, for deductible, coinsurance or where the insurance benefits have been exhausted, and which have not previously been assigned to bad debt, may qualify for Financial Assistance. In such cases, the determination of the benefit will be based upon the patient balance due at time of application, and not the original billed amount.

9. Financial Assistance eligibility and benefit determination is based on the patient's medical expenses, financial status at the time of application, and may also be impacted by the household's discretionary expenses. In certain circumstances, in the absence of qualifying documentation, the patient may meet presumptive eligibility criteria.

10. Patients eligible for Financial Assistance will be informed in writing of the determination (approval, partial approval, or denial) within 14 days of Kootenai Health receiving a completed and signed application. For patients awarded less than 100% Financial Assistance, this notification letter will include instructions to contact the Financial Counselor to arrange payment (which may include terms of a payment plan) of outstanding amounts due.

11. Patients not eligible for Financial Assistance will be informed in writing of the denial with in within 14 days of Kootenai Health receiving a completed and signed application, this notification letter will include instructions to contact the Financial Counselor to arrange payment (which may include terms of a payment plan) of outstanding amounts due.

12. Patients whose application has been denied have an option to appeal the decision. The Financial Counseling Committee, or designee, will make final determination on appealed decisions. The Responsible Party may appeal the determination once by providing additional verification of income or family size within forty (30) calendar days from the date of the first determination letter.

13. Approval of Financial Assistance is granted on basis of all current hospital or professional services accounts and/or outstanding balances included for consideration in the application process.

14. Financial Assistance applications may be considered for up to six (6) months forward from current service date(s) covered through the application process, unless the patient or guarantor's ability to pay has changed during the eligible time period. Should future care, within the six-month application period, be considered for eligibility, it is the patient's responsibility to inform Kootenai Health of any change in financial status, and it is the Kootenai Health representative's responsibility to validate the information provided.

Pending Medicaid - Effect on Financial Assistance Eligibility

The pending Medicaid and Financial Assistance application processes are not concurrent events. Determination of Medicaid benefit must be finalized prior to evaluating an application for Financial Assistance. If a Financial Assistance application is completed, it will pend until a decision from the State Medicaid agency is returned. Otherwise, it is the patient's responsibility to contact Kootenai Health Financial Counseling after receiving a State denial, should the patient wish to pursue Financial Assistance.

Level of Financial Assistance	Qualifying Federal Poverty Level
100% Assistance Award	0-250% of FPL

Special Circumstances and Presumptive Eligibility

A patient who is unable to provide documentation or who is unable to follow the application procedures may receive full or partial financial assistance, with the approval of the Chief Financial Officer or Manager of Patient Access and Financial Clearance. The Kootenai Health authorized representative must document the decision, including the reasons why the patient did not meet criteria outlined in the policy. Circumstances may include, but are not limited to, deceased with no estate, homeless, transient, severe mental illness, and social/family abandonment.

Out of State Medicaid – No Provider Number

Patients who are a current approved member of a non-participating Out of State Medicaid program (for which Kootenai Health is not enrolled), where a provider number is not available, and whose prorated charges are less than twenty-five hundred dollars ($2,500), may also satisfy the Special Circumstances or Presumptive Eligibility criteria. In such circumstance, the account will be forwarded to the Billing Department Supervisor for review and approval. If charges are over twenty-five hundred dollars ($2,500) to twenty-five thousand ($25,000), the account will be escalated to the Financial Counseling Manager or designee to review and approve. Amounts greater than $25,000, require approval from the Executive Director, Revenue Cycle Operations. In such cases, the patient must provide documented proof of current Medicaid eligibility in their state of residence. For these patients, the Out of State Medicaid plan will be replaced with the Financial Assistance classification. At the discretion of the Financial Counseling Manager, retroactive enrollment in an Out of State Medicaid program may be pursued.

Catastrophic Financial Assistance

If a patient meets the conditions through which catastrophic financial assistance may apply, the financial counselor will submit the application for consideration to the department manager or to the Director of Patient Access and Financial Clearance for final determination. The patient will be notified of approval or denial, within thirty business days of receipt of required documents, as per policy.

Non-Medically Necessary or Cosmetic Care:

- Financial Assistance is not applicable to non-emergent services, such as elective services or procedures that do not meet criteria for medical necessity, as determined by a physician or care manager. Examples of not medically necessary services: Department of Transportation Physicals and Sports Physicals.
- Financial Assistance will not be granted for services not covered by Medicaid per the patient's state-specific guidelines of medically necessary care. Such non-covered, not medically necessary services will be identified through the pre- authorization process and may result in a delayed decision. The referring physician's office staff, the financial counselor or the Financial Clearance Specialist will notify the patient if there is a possibility that services may be deemed non-medically necessary. Examples of services not covered by Medicaid: circumcisions and reversal of voluntary sterilization procedures.
- Financial Assistance will not be granted for Medicaid accounts where Emergency room visits or Rehab/Therapy services have exceeded the maximum allowable visits for the patient.

Patient Cooperation Standards

A patient must exhaust all other possible payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties, prior to being considered for any level of Kootenai Health Financial Assistance. Failure on the part of the responsible party to cooperate with Kootenai Health in the eligibility process shall be grounds for denial of any benefit covered by this policy. If at any point during the Financial Assistance review process, it becomes apparent that Patient is eligible for Insurance coverages through a Family Member or is eligible for an APTC tax credit and is not utilizing this credit, the account may be ineligible for Financial Assistance.

Continuing Eligibility

For a patient to remain eligible for Kootenai Health Financial Assistance, the patient/guarantor must apply for and continue to pursue all other benefits for which they are entitled, or may become entitled, including Medicare, Medicaid, Social Security Disability, or any other state or federal programs. This responsibility continues until the patient or guarantor receives documented approval or denial from the applicable benefit program. If the patient is denied benefits due to lack of cooperation, Kootenai Health Financial Assistance may not be granted or may be revoked, and any benefits may be subject to review and may be reversed. Should this occur, any current or outstanding balances might revert to the financial responsibility of the patient or guarantor.

The patient or responsible party is required to reapply for Financial Assistance, should any change in the patient's household size, status, or income level occur. This requirement is applicable at any time following the original decision

Approval authority for Financial Assistance

- The department manager may approve up to $25,000, based on the application meeting policy criteria.
- Manager or Director of Patient Access and Financial Clearance may approve financial assistance up to $50,000, based on Financial Counseling recommendation and the application meeting policy criteria.
- Amounts greater than $50,000, require approval from the Chief Financial Officer.
- Catastrophic financial assistance or other extenuating circumstance decisions, requires approval from either the Manager of Patient Access and Financial Clearance or the Chief Financial Officer.

All personal and financial documentation submitted by the patient or guarantor to support the Financial Assistance application process, will be maintained as part of the patient's confidential record and protected in accordance with the Health Information Portability and Accountability Act (HIPAA) and the Kootenai Health retention policy.