Baptist Health South Florida

POLICY NO.: BHSF-355.14

☑ Administrative
☐ Departmental

POLICY TITLE:
Charity Care

SUMMARY & PURPOSE:
To set forth guidance for providing charity care to patients, including guidance on communicating the availability of the program and on recording and reporting charity care granted.

POLICY:
In furtherance of its charitable purpose and tax exempt mission, Baptist Health South Florida and each of its wholly-owned hospitals and affiliates ("BHSF" or "Baptist Health") will provide charity care to those individuals in need. BHSF will comply with all federal and state laws, regulations and guidelines governing the provision and recording of charity care. In keeping with effective stewardship, provision for charity care will be budgeted annually.

In order to promote the health and well-being of the community served, uninsured individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will primarily be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. The eligibility criteria may be revised upward or downward as necessary. The objective of the eligibility criteria under this policy is to allocate charity care resources based upon a patient's ability to pay.

Financial assistance may be denied if a patient is eligible for other coverage resources such as Medicaid or a subsidized Health Insurance Exchange plan and refuses to apply for these resources.

This policy applies to patient service charges which no health insurance or any other payor source (e.g. third party auto insurance, workers compensation, etc.) covers. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date. The need for charity care/financial assistance is to be re-evaluated at the following times:

1. Subsequent rendering of services,
2. Income change or,
3. Family size change.

This policy does not apply to services rendered by Express Care, Care on Demand, any concierge practice of Baptist Health Medical Group or Bethesda Health (Bethesda) facilities or physicians. Bethesda provides financial assistance under a separate policy. In addition, this policy does not apply to cosmetic surgery or other procedures that are not medically necessary for the diagnosis or treatment of illness or injury. This policy applies only to facility charges and employed physician charges. The policy does not apply to private-practicing physician charges or other independent company billings.

The allocation of BHSF charity care resources will be limited to patients who:

1. Reside:
    a. In Miami-Dade County

   b. In Broward County (limited to services rendered at BHSF facilities located in Broward County) and
   c. North of mile marker 25 in Monroe County OR
2. Received/need to receive emergent or urgent services for an acute event unrelated to a pre-existing condition (e.g., car accident injuries, pneumonia, and appendicitis).

Other applicants with special needs (such as lack of services in their own geography) will be considered on a case by case basis, as budgeted resources permit.

To be considered for charity care, the patient must cooperate to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for charity care. BHSF financial counselors will be available to assist patients with completion of the application.

The necessity for urgent or emergent medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect, kindness, fairness and courtesy in attitude, mannerisms and tone of voice, regardless of their ability to pay.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources Baptist Health can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay.

The following are the levels of charity care under this policy:

Designation	Responsible for administration	Eligibility guidelines[1] (based on federal poverty levels [FPL])	Applicable discount off of gross charges
State or federally qualified[2]	Vice President of Revenue Management	Family income of 200% FPL or less (not to exceed $75,000)	100%
Special needs financial assistance	Vice President of Revenue Management	Family income of 200 to 300% FPL (not to exceed $75,000)	100%

[1] **T**he federal poverty levels are the base eligibility criteria for this policy. Other financial information such as assets and hospital charges may be considered.

[2] Accounts qualifying at this level may be classified as "state or federally qualified" as long as the patient's discharge date is in the same or the preceding two fiscal years as the write-off. If the discharge date is prior to this time, the charity care will be classified as "special needs financial assistance."

Since patients qualifying for charity care under this policy receive a 100% discount (i.e. free care), Baptist Health does not compute amounts generally billed to individuals with health insurance as defined in the Internal Revenue Code section 1.501(r)-5(b)(1).

Baptist Health shall make reasonable efforts to determine whether a patient is eligible for charity before engaging in extraordinary collection action(s). Such reasonable efforts shall apply only to uninsured patients for medically necessary services in accordance with the eligibility criteria of the charity care program.

SCOPE/APPLICABILITY:
This policy applies to all BHSF wholly-owned affiliates providing health care services with the exception of Express Care, Care on Demand, any concierge practice of Baptist Health Medical Group and Bethesda Health facilities and physicians.

PROCEDURES TO ENSURE COMPLIANCE:
1. Definitions:
   a. **Assets:** Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. Assets also include the equity in the primary residence and other real estate.
   b. **Charity Care:** Health care services that were never expected to result in cash inflows. Charity care results from providing health care services free or at a discount to individuals who meet the established criteria.
   c. **Charity Care Committee:** A committee consisting of the Chief Financial Officer, Vice President of Finance, Vice President of Marketing and Public Relations, Vice President of Revenue Management, Vice President of Managed Care, Assistant Vice President of Patient Financial Services, Assistant Vice President of Patient Access and the Assistant Vice President of Pastoral Care.

d. **Disposable Income:** Annual family income divided by 12 months, less monthly expenses as requested on the application.
e. **Emergent and Urgent Patients:** Patients who present to and are treated in a BHSF hospital emergency department (including inpatients and observation patients admitted through the emergency department) or urgent care center and inpatients pending discharge with need for follow-up outpatient services.
f. **Extraordinary Collection Action:** Any action taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital's charity care program that require legal or judicial process including but not limited to: placement of a lien on an individual's property, foreclosure on an individual's real property, attachment or seizure of an individual's bank account or other personal property, commencement of a civil action against an individual, causing an individual's arrest or writ of body attachment, garnishment of wages, reporting adverse information about individual to a consumer credit reporting agency and sale of an individual's debt to another party.
g. **Family:** The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of charity care.
h. **Family Income:** Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.
i. **Medically Indigent:** A patient whose medical or hospital bills exceed a specified percentage of the person's annual gross income determined in accordance with the healthcare entity's eligibility system, and who is financially unable to pay the remaining bill. The patient who incurs catastrophic medical expenses is classified as medically indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.
j. **Medically Necessary:** In most cases, medically necessary will be defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury). Other services, not considered medically necessary under Medicare guidelines, will be considered by Baptist Health on a case-by-case basis in consultation with Baptist Health physician leadership.
k. **Notification Period:** The notification period begins on the date the patient receives services and ends on the 120th day after Baptist Health provides the patient with the first billing statement.
l. **Uninsured:** A patient with no health insurance or any other payor source (e.g. third party auto insurance, workers compensation, etc.) to cover the care requested or rendered. In addition, charges remaining after insurance payment due to exhaustion of benefits or dollar specified coverage limitations (e.g. inpatient benefits of $100/day) are uninsured charges. Charity care for elective patients with exhausted benefits or coverage limits requires approval by the Vice President, Revenue Management. The designation of uninsured does not extend to a patient for the patient's out-of-pocket obligation for co-pays, deductibles or co-insurance.

2. Charity Care Guidelines:
   a. Accounts of medically indigent patients will be considered on a case by case basis by the Assistant Vice President of Patient Financial Services or the Vice President of Revenue Management or their designee.

b. Charity care applications will be considered current for six months or until a change in patient financial status is determined.

3. Program Communication:
   a. This policy, the related financial assistance application and application instructions and a plain language summary of this policy shall be available as follows:
      i. Upon request, a paper copy by mail without charge to the requesting party
      ii. On the Baptist Health website (www.baptisthealth.net)
      iii. At each hospital's admitting department and at each urgent care center operated under a hospital license
   b. The plain language summary shall address the following:
      i. A brief overview of the financial assistance program and eligibility requirements
      ii. How an individual may obtain more information and a copy of the application
      iii. Contact information of hospital resources who can answer questions about program and the application
      iv. A statement that no charity-qualified individual will be charged more than amounts generally billed to individuals with health insurance
   c. Signage with basic information about the hospital's financial assistance policy shall be posted in hospital registration areas.
   d. Baptist Health will identify local public agencies and not-for-profit organizations that address the health needs of the community's low income population and provide such organizations with basic information about the financial assistance program.
   e. All letters and statements to uninsured patients, including those sent by third-party collection agencies and any other written communication regarding the patient's bill during the Notification Period, will include a copy of the plain language summary of the charity care program.
   f. All oral communications with uninsured patients regarding the amount due for services during the Notification Period will include information about the charity care program.
   g. All public information and/or forms regarding the provision of charity care will use languages that are appropriate for the Baptist Health service area.

4. Identification of Potentially Eligible Patients:
   a. Where possible, prior to the registration of the patient, a financial counselor will conduct a pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-registration interview is not possible, this interview should be conducted upon registration/admission or as soon as possible thereafter. In the case of an emergency admission, the evaluation of payment alternatives should not take place until the medical care required to stabilize the patient has been provided.
   b. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
   c. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for charity care.

5. Determination of Eligibility:
   a. All uninsured patients identified prior to service and/or discharge as potential charity care recipients should be offered the opportunity to apply for charity care.
      i. Pre-service applications for charity care may be obtained from and returned to the Financial Assistance Department.
      ii. Post-service applications for charity care may be obtained from and returned to Patient Financial Services.
      iii. In all cases, a communication with basic instructions shall accompany the application sent to the patient and will indicate that a financial counselor is available to assist the patient with the application.

b. The patient should receive and complete a written application and provide all supporting data required to verify eligibility. The determination of eligibility must be a verifiable process and must include at least one of the following pieces of documentation:
   i. W-2 withholding forms.
   ii. Paycheck stubs.
   iii. Income tax returns.
   iv. Forms approving or denying unemployment compensation or workers compensation.
   v. A written verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the past twelve months.
   vi. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.
   vii. A witnessed statement signed by the patient or responsible party. The statement shall include an acknowledgment that, in accordance with state law, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

   For all non-emergent/urgent patients, the documentation provided must be one of items i through vi above.

c. In the event that the patient does not provide sufficient information to make a determination of eligibility for charity care, a financial counselor will provide written notice to the patient to let them know what information is missing. A copy of the plain language summary of the program shall be sent with such notice. If a financial counselor identifies a meritorious application that is supported by documentation (e.g., a credit bureau report) but is missing an element set forth in b. above (e.g., an application missing the signature of a witness), the Corporate Vice President, Revenue Management or the Assistant Vice President, Patient Financial Services may approve the charity as Special Needs Financial Assistance.

d. A Medicaid remittance voucher reflecting that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted may be used without a written application to approve charity eligibility.

e. A unique situation exists in the event of a hospital admission of a patient with both Medicare and Medicaid where:
   i. Patient's Medicare Part A benefits are exhausted at or near the beginning of a Medicaid fiscal year (July 1st) and
   ii. Patient's inpatient Medicaid benefits are exhausted.

   In this scenario, Medicaid does not issue a remittance voucher to indicate that the coverage is exhausted. For this specific scenario, charity may be approved without a written charity application and without a Medicaid remittance voucher reflecting that the patient's Medicaid benefits are exhausted if the following documents are maintained:
   i. Copy of the Medicare remittance voucher demonstrating that the benefits are exhausted.
   ii. A screen-print demonstrating Medicaid eligibility for the entire admission.
   iii. Copy of the page from the *Florida Medicaid Provider General Handbook* specifying the policy for Inpatient Hospital and Medicare Part A Benefit Exhaustion.
   iv. Copies of split bills for the admission, segregating the charges for 1) Medicare Part A coverage, 2) Medicaid coverage and 3) the period following exhaustion of Medicare and Medicaid benefits.

   Note: This provision may be applied retroactively for dates of service in fiscal year 2011 and forward.

f. If a Medicaid beneficiary applies for charity care for medically necessary services from a Baptist Health facility or provider that is not a Medicaid provider, the Medicaid beneficiary will be considered uninsured for such services and eligible to apply for charity care. In

these cases, the validation of the patient's Medicaid eligibility along with a Medicaid remittance voucher denying Medicaid benefits may be used without a written application to approve charity eligibility. If a denial from Medicaid is not forthcoming within 60 days of billing, a screen print of the patient's Medicaid eligibility will be placed in the document imaging system and the account may be approved for charity without a written application and without a remittance voucher denying Medicaid benefits.

g. A credit report will be generated for applicants as considered necessary to validate the information provided in the application.
h. A record, paper or electronic, should be maintained documenting the identification of the individual who reviewed and approved or denied application and the date of such decision.
i. Upon completion of the application and submission of appropriate documentation, a financial counselor will document either on the application or on an attached summary: 1) approval or denial; 2) financial counselor name; 3) date of approval/denial and 4) any special comments/instructions.
j. Baptist Health facilitates hospital care for the patients of certain local charitable clinics. These local charitable clinics will provide annual confirmation of their charity eligibility requirements to Baptist Health. In addition, documentation supporting the eligibility of patients approved by these local charitable clinics will be subject to periodic audit by Baptist Health. These local charitable clinics are provided with clinic-specific insurance plan codes to use when referring patients to Baptist Health. Patients approved for charity by these local charitable clinics are automatically approved for Baptist Health charity care. In addition, the charity eligibility determinations by these local charitable clinics will be considered current for a period of one year.
k. If a patient's ability to meet the residency requirements set forth in this policy is in question, the patient shall produce documentation demonstrating that he/she resides at an eligible address. An example of acceptable documentation is a utility bill with the patient's name and service location. Other documentation substantiating a patient's residency may be accepted with the approval of the Corporate Vice President, Revenue Management. If a patient does not meet the residency requirements, Patient Financial Services will send an email inquiry to Care Management to obtain a decision on whether the patient had an acute event unrelated to a pre-existing condition.

6. <u>Billing & Collection</u>

a. Baptist Health shall take the following steps to demonstrate reasonable efforts to determine whether a patient is eligible for charity care:
    1. Notify the patient about the charity care program during the Notification Period. (See procedure 3 above).
    2. Provide written notice relevant to completing a charity application to a patient who submits an incomplete charity application (See procedure 5c above)
    3. Make and document a determination of whether the patient is eligible for charity care for a patient who submits a complete charity application, (See procedures 5h and 5i above)
    4. Provide the patient with at least one written notice that informs the patient about extraordinary collection action Baptist Health may take if the patient does not pay the amount due or submit a financial assistance application. Such notice shall be provided to the patient at least 30 days prior to the deadline stated in the notice.
    5. Maintain and enforce legally binding agreements with third parties to which a patient's debt is referred or sold during the first 240 days after the patient receives his/her first billing statement to abide by certain requirements as follows:
        i. During the Notification Period, the third party shall refrain from engaging in Extraordinary Collection Actions until the hospital has made reasonable efforts to determine whether the patient is eligible for charity care.

ii. If a patient submits a charity application, the third party shall suspend any Extraordinary Collection Actions until the hospital has made a reasonable effort to determine if the patient qualifies for charity care.

iii. If a patient is determined to qualify for charity care, the third party shall cease all efforts to collect any amount in excess of the amount due under the charity care program and reverse any Extraordinary Collection Action taken against the patient.

b. Upon determination that a patient is eligible for charity care, Baptist Health shall:
   1. Notify the patient of the decision in writing.
   2. Refund any payments received for the service covered by the charity approval.
   3. Reverse any collection action taken against the patient.

c. Prior to an account being authorized for Extraordinary Collection Action(s),a final review of the account shall be conducted and approved by the Assistant Vice President of Patient Financial Services to ensure that the reasonable efforts to determine if the patient is eligible for charity care are complete.

7. Notification of Eligibility Determination:
   a. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason for denial will be provided, generally within 30 days of receipt of a completed application.
   b. If a credit bureau report was used in the determination that a patient is not eligible for charity care, the use of the credit bureau report is to be reported to the patient in accordance with the requirements of the Fair Credit Reporting Act.
   c. Charity applications for patient accounts which are pending Medicaid approval will not be processed until Patient Financial Services has received final notification from the Medicaid program or a third party eligibility consultant. If notification is not received within 120 days from the discharge date, the charity application will be processed, with notification to the patient, generally within the following 30 days (unless there is notification of Medicaid approval during this time).

8. Monitoring and Reporting:
   a. Charity care will be reported annually in the Community Benefit Report and quarterly to the Community Benefit Committee.
   b. Charity care reported to the State of Florida must meet the state's charity care reporting guidelines. These guidelines are amended periodically. The current eligibility criteria are family income at or below 200% of the federal poverty guidelines or the amount of hospital charges due from the patient must exceed 25% of the patient's annual family income. However, in no case, shall the hospital charges for a patient whose family income exceeds four times the federal guidelines for a family of four be considered charity care for state purposes.

SUPPORTING/REFERENCE DOCUMENTATION:

- Florida Statute 395.301 (8) *Itemized Patient Bill*
- Florida Statute 381.026 (4)(c)3 *Florida's Patient Bill of Rights and Responsibilities, Rights of Patients, Individual Dignity*
- Florida Statute 409.11 (1)(c) *Disproportionate Share Program, Definition of Charity Care*
- Internal Revenue Code section 1.501(r)

RELATED POLICIES, PROCEDURES, AND ASSOCIATED FORMS:

- Attachment: Eligibility Criteria for the Baptist Health South Florida Charity Care Program

- Financial Evaluation and Request for Financial Assistance Form

ENFORCEMENT & SANCTIONS:
This policy will be enforced by the Corporate Vice President, Revenue Management and the Assistant Vice President, Pastoral Care. Violation of this policy may lead to disciplinary action, up to and including termination.

ELIGIBILITY CRITERIA FOR THE BAPTIST HEALTH SOUTH FLORIDA CHARITY CARE PROGRAM Based upon Federal Poverty Guidelines, Gross income levels, 2020.

Family Size	200% FPL (100% discount)	200 to 300% FPL (100% discount)
1	$25,520	$25,521 to $38,280
2	$34,480	$34,481 to $51,720
3	$43,440	$43,441 to $65,160
4	$52,500	$52,501 to $75,000
5	$61,360	$61,361 to $75,000
6	$70,320	$70,321 to $75,000
7	$75,000	$75,000
8	$75,000	$75,000
More than 8, add indicated amount for each additional member (not to exceed $75,000)	Not applicable – would exceed $75,000	Not applicable – would exceed $75,000