UC Health

X	UCH/ENTERPRISE
	UCMC
	WCH
	DRAKE – LTCH
	DRAKE – BWP
	DRAKE – SNF
	DRAKE – OUTPATIENT
	AMBULATORY/UCPC
	LEGAL/COMPLIANCE
	MEDICAL STAFF
	MEDICATION MGMT
	OTHER

POLICY

POLICY #	**UCH-PA-ADMIN-005-05**		
POLICY NAME	**CHARITY CARE AND FINANCIAL ASSISTANCE**		
ORIGINATION DATE	**01/01/2009**		
SPONSORED BY	**Signature on File** **Craig Cain, VP- Revenue Cycle**	**DATE**	**05/16/2017**
ADMINISTRATIVE APPROVAL	**Signature on File** **Rick Hinds, CFO**	**DATE**	**05/16/2017**
LAST REVIEW / REVISION DATE	**04/01/2017**	**NEXT REVIEW DATE**	**04/01/2020**

I. POLICY

[X] Administrative [ ] Interdepartmental [ ] Departmental [ ] Unit Specific

This document details the policies and procedures for providing charity care to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation at all UC Health locations, including, University of Cincinnati Medical Center, LLC, Daniel Drake Center for Post-Acute Care, LLC, West Chester Hospital, LLC, and University of Cincinnati Physicians Company, LLC and all UC Health associates (collectively, "UC Health").

II. PURPOSE

Consistent with UC Health's mission, UC Health strives to ensure that the financial capacity of any person in need of health care services does not prevent the person from seeking or receiving care. UC Health will provide, without

discrimination, care of emergency medical conditions to individuals regardless of their race, creed, ability to pay, or eligibility for financial assistance or government assistance.

This policy serves to establish and ensure procedures for the review and completion of requests for charity medical care including (i) eligibility criteria for financial assistance – both free and discounted care; (ii) the basis for calculating amounts charged to patients eligible for financial assistance under this policy; and (iii) the financial assistance application process.

III. DEFINITIONS

A. **Medically Necessary Care –** Those services reasonable and necessary to diagnose and provide preventative, palliative, curative or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care, generally accepted at the time services are provided and are considered medically necessary by the Medicare and Medicaid services.

B. **Uninsured Patients –** Individuals who do not have governmental or private health insurance or whose benefits have been exhausted.

C. **Federal Poverty Guidelines (FPG) –** Published each year by the Department of Health and Human Services and in affect at the date of service for awards of financial assistance under this Policy.

D. **Patient Friendly Billing –** Guidelines outlined by the Healthcare Financial Management Association (HFMA) that promotes clear, concise and correct patient-friendly financial communication.

E. **Program Administration –** Department within UC Health's Patient Financial Services area that processes financial assistance applications and makes determinations based upon individual program guidelines.

F. **Amounts Generally Billed (AGB) –** UC Health will apply the "look-back method" for determining Amounts Generally Billed. In particular, UC Health will determine the Amounts Generally Billed for emergency or other medically necessary care by multiplying the Gross Charges for that care by the AGB Percentage.

G. **AGB Percentage –** UC Health will calculate the AGB Percentage at least annually by dividing the sum of all claims that have been paid in full for emergency and other medically necessary care by look-back together as the primary payer(s) of these claims during a prior twelve (12)-month period by the sum of the associated Gross Charges for those claims. For these purposes, UC Health will include in ''all claims that have been paid in full'' both the portions of the claims paid by

Medicare or the private insurer and the associated portions of the claims paid by insured individuals in the form of co-insurance, copayments or deductibles.

IV. PROCEDURE

A. ELIGIBILITY AND APPLICATION PROCESS

1. Eligibility for charity care will be based on a patient's financial need. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need, and may:
    a. Include an application process in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
    b. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
    c. Include reasonable efforts by UC Health or each hospital within the UC Health system to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients in applying for such programs;
    d. Take into account the patient's available income and/or assets and all other financial resources available to the patient; and
    e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
2. UC Health disallows actions that discourage individuals from seeking emergency medical care and complies with the Emergency Medical Treatment and Labor Act ("EMTALA) as further detailed in UC Health's EMTALA policy. While it is preferred but not required that a request for charity care and a determination of financial need be made prior to rendering of non-emergent medically necessary services, the determination may be made at any point in the collection process. The need for financial assistance shall be re-evaluated at each occurrence of inpatient services and each subsequent time of outpatient services if the last financial evaluation was completed more than ninety (90) days from the last outpatient service, or at any time that additional information relevant to the eligibility of the patient for charity care becomes known. UC Health has adopted the guidelines set forth in Ohio Administrative Code 5160-2-07.17 in defining re-evaluation for financial assistance.

B. DETERMINING THE FINANCIAL ASSISTANCE ADJUSTMENT

Individuals eligible for financial assistance under this policy shall not be charged more than the amounts generally billed (AGB) to individuals who have insurance. This value shall be calculated using the "look-back" method based on actual paid claims from March through February. The current AGB is 25% and is updated annually.

C. IDENTIFICATION OF PATIENTS WHO MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE

1. UC Health maintains an interdisciplinary team of associates that consists of patient site and Patient Financial Services resources that are trained to help patients and their families with billing, eligibility and payment plans.
2. Staffed in the Admitting department of each UC Health hospital facility are:
   a. Registration associates who focus on capturing accurate and up to date demographic information (e.g. home address, telephone contact numbers, place of employment) so that telephone assistance with the collections or financial assistance process (after patient discharge) is made easy. Each Registrar is knowledgeable of financial assistance programs and can refer interested patients to an in-house Financial Counselor. Registrars will request photo ID for proof of identity to protect against identity theft and ensure the application is accurate.
   b. Financial Counselors who may visit patients and their families on the floors as early in the medical visit as appropriate. By visiting patients while they are in-house, a Financial Counselor can help the patient identify which assistance programs he/she may be eligible for and help start the application process where appropriate. In some cases, the application process can be completed during the patient's stay.
3. Staffed at the Patient Financial Services office located at 3200 Burnet are:
   a. Access Unit - who provide pre-registration, insurance verification and pre-service collection of deductibles, copays, and uninsured services.
   b. Customer Service – who are available to receive patient telephone calls Monday through Thursday from 8:00 AM to 9:00 PM, Friday from 8:00 AM to 4:30 PM. Representatives can answer questions about a patient's bill, accept credit card payments, assist patient in completing a financial assistance application, and set up payment arrangements. Representatives are also available to assist patients in person during normal business hours.
   c. Program Administration – who, working closely with the Financial Counselor, start the application process and process applications for the state and local financial assistance programs (see Section VII. below).
4. For general questions, assistance with completing the financial assistance application or to request a free copy of the plain language summary and financial assistance policy, patients may call (513) 585-6200 or (800) 277-0781 during the hours noted above in section 2.b).

D. ASSISTANCE IN DETERMINING ELIGIBILITY AND APPLYING FOR MEDICAID AND MEDICARE

1. UC Health maintains interdisciplinary teams to assist underinsured and uninsured patients navigate federal and state health insurance programs and help enroll those patients in the programs for which they are eligible.
2. Included on this team are financial counselors who, in part, assist patients to determine their eligibility and complete the application process.

E. BASIC, MEDICALLY NECESSARY HOSPITAL- LEVEL SERVICES

1. UC Health provides, without charge "basic, medically necessary hospital-level services" to certain, eligible individuals who are residents of Ohio, are not recipients of the Medicaid program and whose incomes are at or below the federal poverty line, in a manner consistent with OAC Ann. 5101:3-2-07.17.
2. Such services will be provided consistent with Ohio's Medicaid hospital benefit coverage, with the exception of transplantation and related services.
3. A complete application is required prior to determination of eligibility to receive a discount on services. UC Health may require that an individual apply for Medicaid benefits before UC Health will process an application for such services.

F. DISCOUNT AVAILABLE FOR CERTAIN UNINSURED PATIENTS WHO ARE INELIGIBLE FOR MEDICAID

1. To be eligible for this discount, UC Health must have determined that:
   a. the patient satisfies all residency requirements per the state of Ohio Hospital Care Assurance Program (HCAP) guidelines,
   b. the patient cooperated in supplying all requested information, the patient is uninsured, and
   c. the patient does not have other assets that could be used to pay the hospital bill.
   d. In these circumstances, the amount of the discount from the charges will vary depending upon the Federal Poverty Guidelines ("FPG") published yearly by the United States Department of Health and Human Services, in the following manner:

Income	Amount of Charges Discounted
Income less than or equal to 150% of FPG	100%
Income greater than 151% of FPG but less than or equal to 200% of FPG	75%

G. CATASTROPHIC MEDICAL CIRCUMSTANCES

1. UC Health provides a charity care discount for patients who have experienced catastrophic medical circumstances and whose medical bills far-exceed their ability to pay ("Catastrophic Circumstances").
    a. This discount is determined by UC Health on a case-by-case basis, without giving exclusive consideration to a patient's income after UC Health obtains and/or develops documentation concerning the Catastrophic Circumstances. The following are examples of circumstances that might justify, depending on other circumstances, such a discount after appropriate documentation is provided:
        1) the patient is not eligible for any state or federal health insurance program that provides assistance to uninsured or underinsured patients; the patient has no identifiable assets; and the balance on the account exceeds $20,000 after all third-party insurance has been paid on the account;
        2) the patient has medical bills and hospital bills, after third party insurance has paid, that exceed 30% of the patient's gross annual income; or
        3) the patient's payment of his hospital bill would require liquidation of assets critical to living or would cause undue financial hardship, as determined by UC Health, to the patient's family-support system.

H. PRESUMPTIVE ELIGIBILITY FOR DISCOUNT

1. Certain circumstances indicate that an uninsured patient should be eligible for a charity care discount even in the absence of complete documentation.
    a. The following are examples of such circumstances:
        1) the patient is homeless and/or has received care for the homeless
        2) the patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down). When UC Health determines that such circumstances justifying presumptive eligibility exist, UC Health provides a 100% discount.

I. OTHER UNINSURED DISCOUNT PROGRAMS

1. Being sensitive to the high cost of medical care, UC Health offers uninsured patients whose medically necessary care is not eligible for any discount under the terms of this policy an uninsured discount of a percentage off billed charges to help ease the burden of medical expenses.

2. No patient who is eligible for financial assistance under the terms of this policy shall be charged an amount equal to the gross charge for the services provided to the patient.

J. UNEXPECTED CHANGES

1. When unforeseen changes occur that impact a patient's ability to pay, UC Health may take these circumstances into account in determining the applicability of a charity care discount. For example, if, as a result in a change of circumstance, a patient would now be eligible for a charity care discount (but had previously not been eligible), UC Health may retroactively apply the discount up to 180 days from the new date of determination.
2. Also, if information is obtained of a positive change in a patient's financial situation, UC Health reserves the rights to withdraw a previously approved charity discount and pursue the outstanding balances on the account.

K. RELATIONSHIP TO BILLING AND COLLECTION POLICIES

1. UC Health subscribes to the principles of PATIENT FRIENDLY BILLING and works to ensure the financial communications and counseling are clear, concise, correct, and considerate of the needs of patients and family members.
2. UC Health's financial counseling team's goal is to work closely with a patient to identify the appropriate payment plan (if one is required), to resolve the patient's hospital bill.
3. UC Health will not engage in extraordinary collection actions before it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this policy.
4. Collection activity will proceed based on a separate Collection Policy. The UC Health Billing & Collection Policy can be viewed and printed free of charge online at http://uchealth.com/financial/financial-assistance/.

L. COMMUNICATION OF THE CHARITY CARE AND FINANCIAL ASSISTANCE POLICY TO PATIENTS AND THE COMMUNITY

1. UC Health is committed to publicizing this policy and the financial assistance programs available within the communities it serves by taking the following steps:
   a. Posting a copy of this policy along with a downloadable copy of the plain language summary and financial assistance application on the UC Health internet website: http://uchealth.com/financial/financial-assistance/.
      1) There is no fee or special hardware or software required for downloading a copy the Policy or Financial Assistance Application.
      2) Financial Assistance Policy, Plain Language Summary, and Financial Assistance applications are available in English

and any other languages spoken by the lesser of 1,000 individuals or 5% of the community served.

b. Financial Counselors will make a copy of this policy available to all patients whom they meet and will provide a copy to any other person who requests it.

c. Signs are posted throughout the Emergency Room and admission areas within each hospital facility providing details of financial assistance available.

d. Pamphlets are available in facility admitting and registration areas outlining those financial programs available to the uninsured.

e. Patient statements will include a request that the patient is responsible to inform UC Health of any available health insurance coverage; and will include a notice of UC Health's Financial Assistance policy, a telephone number to request Financial Assistance, and the website address where Financial Assistance documents can be obtained.

f. UC Health will make information regarding its Policy available to appropriate governmental agencies and nonprofit organizations dealing with public health in UC Health's service areas.

M. PHYSICIANS COVERED AND NON COVERED UNDER THE CHARITY CARE AND FINANCIAL ASSISTANCE POLICY

1. Most services provided by physicians at a UC Health facilities are covered by the UC Health Financial Assistance Policy, as described above. Physicians working at a UC Health facility who are not covered under the FAP are identified in a separate document online at http://uchealth.com/financial/financial-assistance/.

V. RESPONSIBILITY

Patient Financial Services/Program Administration

VI. KEY WORDS

Charity Care or Financial Assistance

VII. APPENDIX

A. Financial Assistance Application Form

VIII. RELATED FORMS

A. Financial Assistance Application Form

IX. REFERENCES / CITATIONS

A. Billing & Collection Policy

B. EMTALA Policy

C. Financial Assistance Plain Language Summary

D. Covered & Non Covered Physician Lists

1. Due to the length of these exhibits, the lists will be made available as a separate document online at http://uchealth.com/financial/financial-assistance/.
2. Free paper copies of these Exhibits are also available upon request (513) 585-6200 or (800) 277-0781 for all UC Health entities.

E. Amounts Generally Billed Percentages by Entity

1. Patients who qualify for Financial Assistance will not be charged more for medical necessary care than the amounts generally billed (AGB) to patients who have insurance.
2. The hospital AGB percentages are calculated using the "look-back" method, which is the total of Medicare fee-for-service and private health insurer allowed claims divided by the total gross charges for those claims for a 12-month period. The AGB percentage for physician services is calculated using the "look-back" method, using the total of *[insert]* allowed claims for the physician medical group divided by the total gross charges for those claims for a 12-month period. Discounts provided to patients who qualify for Financial Assistance will be reviewed against the AGB percentage limits to ensure patients are not charged more than AGB.

Entity	AGB %
University of Cincinnati Medical Center	25%
West Chester Hospital	25%
Daniel Drake Center	25%
University of Cincinnati Physician Company	25%

For use in this policy, the AGB percentages for each facility are to be calculated annually and applied by the 120th day after the start of the year.

F. Federal Poverty Guidelines

The poverty guidelines referenced in this policy are those issued each year by the U.S. Department of Health and Human Services as published in the Federal Register. The income thresholds in the current poverty guidelines were published on January 24, 2018.

Family Size	Federal Poverty Guidelines	Max Income for 100%	Max Income for 75%
1	$12,490	$18,735	$24,980
2	$16,910	$25,365	$33,820
3	$21,330	$31,995	$42,660
4	$25,750	$38,625	$51,500
5	$30,170	$45,255	$60,340
6	$34,590	$51,885	$69,180
7	$39,010	$58,515	$78,020
8	$43,430	$65,145	$86,860

For family units of more than 8 persons, add $4,420 for each additional person to determine Federal Poverty Guideline.

For purposes of this policy, the income levels specified above are understood to be at gross income, although certain provisions allow for adjustments to income for extraordinary medical expenses. For use in this policy, the federal poverty income levels are to be updated annually after their revision and publication by the federal government in the Federal Register.

Appendix A: Financial Assistance Application Form

Dear Patient:

We provide full or partial financial assistance to persons whose family income is at or under the income guidelines listed below.

Eligibility depends upon meeting:

- Cooperation with applying for Medicaid
- Being deemed ineligible for Medicaid
- Income qualifications as outlined below
- Residency

To determine if you may be eligible for available financial assistance programs, you must provide a completed Financial Assistance Application, along with a copy of 1 of the documents from each category listed on the back of this letter. Upon receipt, we will process your application and notify you of our determination.

INCOME GUIDELINES

Family Size	Income Per Year
1	$24,280
2	$32,920
3	$41,560
4	$50,200
5	$58,840
6	$67,480

* For families greater than 6, add an additional $8,640 for each member.

Financial assistance is not health insurance and does not meet the criteria for health insurance as defined by the Affordable Care Act. Financial assistance approvals are valid only for balances not covered by a third party. Financial assistance does not cover balances resulting from your failure to follow through with requests for information from your insurance company or failure to cooperate with the Medicaid application process.

Medicaid recipients are not eligible for financial assistance. Financial assistance cannot be used to cover services if you receive Medicaid coverage through an insurance company that is not in network for UC Health.

If you have any questions, please call (513) 585-6200 or (800) 277-0781. If you believe you are not eligible for financial assistance under the above programs, Customer Service can discuss other program qualifications or payment arrangements with you at that time.

Thank you for choosing UC Health for your medical care.

Please complete and sign the Financial Assistance Application and provide a copy of 1 of the following documents from each category:

Category 1 – Proof of Income:

- If you are claiming that you have no income, a sworn statement from the person providing you with basic financial support, validating your lack of income must be completed.
- Check stubs for three months prior to the date of service (including payroll, Social Security, Worker's Compensation, unemployment compensation, etc.) or comparable payment record. If you are self-employed, please send a notarized statement of income and expenses for the three-month period prior to the date of service.
- A letter from your employer setting forth compensation details on official employer letterhead with contact information.
- Court support order.
- Copy of benefit letter / check (ex. Social Security Benefit Letter).
- Letter from tenant setting forth rental income.
- Strike pay.

Note: We do NOT accept tax returns, bank statements, Forms 1099, Forms W-2, etc. as proof of income.

Category 2 – Proof of Residency:

- Driver's license or vehicle registration - matching your current address.
- Voter registration.
- Rent receipts for rent paid within 60 days of when the services are rendered.

- Mortgage statement.
- Utility bill, credit card bill or bank statement postmarked or dated by the issuer within 60 days of when the services are rendered.
- Confirmation of address if a home visit is made by hospital staff.
- Copy of most recent Hamilton County property tax bill.
- Address confirmation by collection agency.
- Letter from lease management, mortgage company, or person providing the patient with shelter, including homeless shelters.
- Credit report.

UC Health

APPLICATION FOR FINANCIAL ASSISTANCE

University of Cincinnati Medical Center | **West Chester Hospital** | **Daniel Drake Center** | **University of Cincinnati Physicians**

PLEASE PRINT:

Today's Date: ____ / ____ / ____ ____ ____
Month / Day / Year / Med Rec # / Account #

Patient Name: ____ ____ ____
Last / First / M.I.

Responsible Party, if not Patient: ____ ____ ____
Last / First / M.I.

Patient Address: ____ ____
Street / Apt. #

____ ____ ____ ____
City / County / State / Zip

Home Phone: ___ - ___ - ____ Area Code
Work Phone: ___ - ___ - ____ Area Code

Email Address: ____

Patient Social Security Number: ___ - __ - ____

Patient Date of Birth: __ / __ / __
Month / Day / Year

Date of Service: __ / __ / __
Month / Day / Year

Please list all family members (including you). Family members include the applicant, their spouse* and children (natural or adoptive) under the age of 18 living in the home along with the applicant. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service

1.					
2.					
3.					
4.					
5.					
6.					

*The State of Ohio does not have a legal distinction of "legally separated" for married couples. Until a final decree of divorce, annulment, dissolution, etc. is granted a separated couple is the same as a married couple and the spouse must be included as a family member.

UC HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

Were you an Ohio resident at the time of your hospital service?	**Yes**		**No**	
Were you a United States citizen at the time of your hospital service?	**Yes**		**No**	
Did you have health insurance at the time of your hospital service?	**Yes***		**No**	
Were you an active recipient of Disability Assistance or Medicaid at the time of your hospital service?	**Yes***		**No**	

** If you answered "Yes" to either of the above two insurance questions, please attach a copy of your insurance card (front and back), Medicaid or Disability Assistance card to this application and complete the following:*

Name of Insurance Company:

If you reported $0.00 income above, please have the Support Statement below completed by the person(s) helping to support you and/or your family.

Policy Number: **Group Number:**

Insurance Phone Number: **Medicaid or Disability Assistance Number:**

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing this support.

_____

_____

_____

_____

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

_____ _____

Signature of person providing financial support to applicant **Address**

_____

City, State Zip

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Patient/Guarantor Signature: _____ **Date Completed:** _____

If you have questions or need assistance with this application, please call 513-585-6200 or 1-800-277-0781.