



MOUNT CARMEL

Stewardship (Finance)

Procedure No.:

PROCEDURE TITLE:

Mount Carmel Health System Financial Assistance to Patients

EFFECTIVE DATE:

August 1, 2019

To be reviewed annually by MCHS Revenue Cycle

SPONSORING DEPARTMENT:

Revenue Cycle

DATE TO BE REVIEWED:

July 1, 2024

Department Contact:

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PURPOSE:

Mount Carmel Health System is a community of persons serving together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Aligned with our Core Values, in particular that of Commitment To Those Who Are Poor, we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the health care expenses incurred. Mount Carmel Health System is committed to:

- Providing access to quality health care services with compassion, dignity and respect for those we serve, particularly the poor and the underserved in our communities;
- Caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

This Procedure balances financial assistance with broader fiscal responsibilities and supports the Trinity Health requirements for financial assistance for physician, acute care and post-acute care health care services.

DEFINITIONS:

Application Period - Begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either --

- i. the end of the 30-day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.
- ii. the deadline provided in a written notice after which ECAs may be initiated.

Amounts Generally Billed ("AGB") - The amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, Mount Carmel Health System's acute and physician AGB will be calculated utilizing the look back methodology of calculating the sum of paid Medicare claims divided by the total or "gross" charges for those claims by the System Office or Mount Carmel Health System annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

Discounted care – A partial discount off the amount owed for patients that qualify under the FAP.

Emergent (service level) - Medical services needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by Emergency Medical Treatment and Active Labor Act (EMTALA).

Executive Leadership Team ("ELT") - The group that is composed of the highest level of management at Trinity Health.

Extraordinary Collection Actions ("ECA") - Include the following actions taken by Mount Carmel Health System (or a collection agent on their behalf):

- Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP. If Mount Carmel Health System requires payment before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual's nonpayment of the outstanding bill(s) unless Mount Carmel Health System can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.
- Reporting outstanding debts to Credit Bureaus.
- Pursuing legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).
- Placing liens on property of individuals.

Family - As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue

Service rules, they may be considered a dependent for the purpose of determining eligibility under the Mount Carmel Health System's financial assistance policy.

Family Income - A person's family income includes the income of all adult family members in the household. For patients under 18 years of age, family income includes that of the parents and/or stepparents, or caretaker relatives. Annual income from the prior 12-month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate.

Financial assistance policy (FAP) - A written policy and procedure that meets the requirements described in §1.501(r)-4(b).

Financial Assistance Policy ("FAP") application - The information and accompanying documentation that a patient submits to apply for financial assistance under Mount Carmel Health System's FAP. Mount Carmel Health System may obtain information from an individual in writing or orally (or a combination of both).

Financial Support - Support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by Mount Carmel Health System who meet the eligibility criteria for such assistance.

Free Care - A full discount off the amount owed for patients that qualify under the FAP.

HCAP - A state and federal program maintained by the Ohio Department of Job and Family Services to comply with a federal requirement to implement additional payments through the disproportionate share (DSH) program to hospitals that provide a disproportionate share of uncompensated services to indigent and uninsured Ohioans who are at or below 100% of the current Federal Poverty Guideline Level and who are ineligible for Medicaid.

Income - Income includes wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, child support, alimony, educational assistance, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity - Is defined as documented in the State of Ohio's Medicaid Provider Manual.

Policy - A statement of high-level direction on matters of strategic importance to Trinity Health or a statement that further interprets Trinity Health's governing documents. System Policies may be either stand alone or Mirror Policies designated by the approving body.

Plain language summary of the FAP - A written statement that notifies a patient that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

- A brief description of the eligibility requirements and assistance offered under the FAP.
- A brief summary of how to apply for assistance under the FAP.
- The direct Web site address (or URL) and physical locations where the patient can obtain copies of the FAP and FAP application form.
- Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail
- The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and provide assistance with the FAP application process
- A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.
- A statement that a FAP-eligible patient may not be charged more than AGB for emergency or other medically necessary care

Procedure - A document designed to implement a Policy or a description of specific required actions or processes.

QHP - An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act, starting in 2014. A qualified health plan will have a certification by each Marketplace in which it is sold.

Regional Health Ministry (“RHM”) – A first tier (direct) subsidiary, affiliate or operating division of Trinity Health that maintains a governing body that has day-to-day management oversight of a designated portion of Trinity Health System operations. RHMs may be based on a geographic market or dedication to a service line or business.

Service Area –The list of zip codes comprising Mount Carmel Health System’s market area constituting a “community of need” for primary health care services. (See attachment “A”)

Standards or Guidelines - Additional instructions and guidance which assist in implementing Procedures, including those developed by accreditation or professional organizations.

Subsidiary - A legal entity in which Mount Carmel Health System is the sole corporate member or sole shareholder.

Uninsured Patient - An individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which Mount Carmel Health System is subrogated, but only if payment is actually made by such insurance company.

Urgent (service level) - Medical services for a condition not life threatening but requiring timely medical services.

PROCEDURE:

I. Qualifying Criteria for Financial Assistance Mount Carmel Health System's Financial Assistance Policy (FAP) is designed to address the need for financial assistance and support to patients for all eligible services regardless of race, creed, sex, or age. Eligibility for financial assistance and support is determined on an individual basis using specific criteria and evaluated on an assessment of the patient's and/or family's health care needs, financial resources and obligations.

- a. Services eligible for financial support:
 - i. All medically necessary services, including medical and support services provided by the Mount Carmel Health System are eligible for financial support.
 - ii. Emergency medical care services will be provided to all patients who present to the emergency department, regardless of the patient's ability to pay. Such medical care will continue until the patient's condition has been stabilized prior to any determination of payment arrangements.
- b. Services not eligible for financial support:
 - i. Cosmetic services and other elective procedures and services that are not medically necessary.
 - ii. Services not provided and billed by Mount Carmel Health System (e.g. independent physician services, private duty nursing, ambulance transport, etc.).
 - iii. Mount Carmel Health System will make affirmative efforts to help patients apply for public and private programs. Mount Carmel Health System may deny financial support to those individuals who do not cooperate in applying for programs that may pay for their health care services.
 - iv. Services that are covered by an insurance program at another provider location but are not covered at Mount Carmel Health System after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.
- c. Residency requirements

- i. Mount Carmel Health System will provide financial support to patients who reside within the service areas (see Attachment "A") and qualify under the FAP guidelines.
 - ii. Eligibility for Financial Assistance will be determined by using the zip code of the patient's primary residence.
 - iii. Financial Assistance will be provided to patients from outside the defined service areas who qualify under the FAP and who present with an urgent, emergent or life-threatening condition.
 - iv. Mount Carmel Health System will provide financial support to patients identified as needing service by physician foreign mission programs conducted by active medical staff for which prior approval has been obtained from the Mount Carmel Health System's President or designee.
- d. Documentation for Establishing Income
 - i. Information provided by the patient and/or family for Mount Carmel Health System Financial Assistance should include earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and income from any other source; number of dependents in household; and other information requested on the FAP application to determine the patient's financial resources.
 - ii. Supporting documents such as payroll stubs, tax returns, and credit history may be requested to support information reported and will be maintained with the completed application and assessment. Mount Carmel Health System may not deny Financial Support based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.
 - iii. Mount Carmel Health System will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. Mount Carmel Health System may initiate ECAs if the patient does not submit the missing information and/or documentation within the 30-day resubmission period and it is at least 120 days from the date Mount Carmel Health System provided the first post-discharge billing statement for the care. Mount Carmel Health System must process the FAP application if the patient provides the missing information/or documentation during the 240-day application period (or, if later, within the 30-day resubmission period).
 - iv. Information provided by the patient and/or family for HCAP assistance will follow the State of Ohio HCAP requirements.
- e. Consideration for Patient Assets
 - i. Protection of certain types of assets and protection of certain levels of assets include the following:

Protected Assets:

- Equity in primary residence: up to 50% of the equity up to \$50,000,
- Business use vehicles,
- Tools or equipment used for business; reasonable equipment required to remain in business.
- Personal use property (clothing, household items, furniture),
- IRAs, 401K, cash value retirement plans withdrawn
- Financial awards received from non-medical catastrophic emergencies,
- Irrevocable trusts for burial purposes, prepaid funeral plans, and/or
- Federal/State administered college savings plans

All other assets will be considered available for payment of medical expenses. Available assets above a certain threshold can either be used to pay for medical expenses (or alternatively count excess available assets as current year income in establishing the level of discount to be offered to the patient). A minimum amount of available assets should be protected. The minimum amount is currently set at \$5,000.

f. Presumptive Support

- i. Mount Carmel Health System recognizes that not all patients are able to provide complete financial information. Therefore, approval for financial support may be determined based on limited available information. When such approval is granted it is classified as "Presumptive Support".
- ii. The predictive model is one of the reasonable efforts that will be utilized to identify patients who may qualify for financial assistance prior to initiating collection actions, i.e. write-off to bad debt and referral to collection agency, for the patient account. This predictive model enables Mount Carmel Health System to systematically identify financially needy patients.
- iii. Examples of presumptive cases include:
 - deceased patients with no known estate
 - homeless
 - unemployed patients
 - non-covered medically necessary services provided to patients qualifying for public assistance programs
 - patient bankruptcies, and
 - members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.
- iv. For patients who are non-responsive to the application process, other sources of information, if available, should be used to make an individual assessment of financial need.
- v. For the purpose of helping financially needy patients, Mount Carmel Health System may use a third-party to conduct a review of patient information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record

databases. This process enables Mount Carmel Health System to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

- vi. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within established timelines and be considered under the traditional financial assistance application process.
 - vii. Patient accounts granted presumptive support status will be adjusted using *Presumptive Financial Support* transaction codes at such time the account is deemed uncollectable and prior to referral to collection or writeoff to bad debt. The discount granted will be classified as financial support; the patient's account will not be sent to collection and will not be included in bad debt expense.
 - viii. Mount Carmel Health System will notify patients determined to be eligible for less than the most generous assistance available under the FAP that he or she may apply for more generous assistance available under the FAP within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, Mount Carmel Health System may initiate or resume ECAs if the patient does not apply for more generous assistance within 30 days of notification if it is at least 120 days from the date Mount Carmel Health System provided the first post-discharge billing statement for the care. Mount Carmel Health System will process any new FAP application that the patient submits by the end of the 240-day application period or, if later, by the end of the 30-day period given to apply for more generous assistance.
- g. Timeline for Establishing Financial Eligibility
- i. Every effort should be made to determine a patient's eligibility for financial support prior to or at the time of admission or service. FAP Applications must be accepted any time during the application period. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or either:
 - i. the end of the period of time that a patient that is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or
 - ii. the deadline provided in a written notice after which ECAs may be initiated.

Mount Carmel Health System may accept and process an individual's FAP application submitted outside of the application period on a case-by-case basis as

authorized by Mount Carmel Health System's established approval levels. ii. Mount Carmel Health System (or other authorized party) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refunds of payments is only required for the episodes of care to which the FAP application applies. iii. Determination for financial support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted.

- iv. Mount Carmel Health System will make every effort to make a financial support determination in a timely fashion. If other avenues of financial support are being pursued, Mount Carmel Health System will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.
- v. Once qualification for financial support has been determined, subsequent reviews for continued eligibility for subsequent services will continue for a reasonable time period. Mount Carmel Health System Financial Assistance Applications are valid for a period not to exceed six (6) months and apply to both I/P and O/P services. HCAP I/P applications are valid for 45 days from discharge and HCAP O/P applications are valid for 90 days from admission date. Separate applications must be completed for I/P and O/P services.
- h. Level of Financial Support
 - i. A percentage of the Federal Poverty Guidelines (FAP), (Attachment B) which is updated on an annual basis, is used for determining a patient's eligibility for financial support. However, other factors, as identified above, may also be considered such as the patient's financial status and/or ability to pay as determined through the assessment process.
 - ii. **Family Income at or below 200% of Federal Poverty Income Guidelines:**
 - A full discount off total charges will be provided for uninsured patients whose family's income is at or below 200% of the most recent Federal Poverty Income Guidelines.
 - iii. **Family Income between 201% and 400% of Federal Poverty Income Guidelines:**
 - A discount off of total charges of 85%, which is equal to Mount Carmel Health System's average acute care contractual adjustment for Medicare will be provided for uninsured acute care patients whose Family Income is between 201% and 400% of the Federal Poverty Level Guidelines. The largest discount rate at an individual facility will be used across the system. Medicare discount rates by facility:

Zero Balance Claims as of 5/31/23

Discharge Date Range 06/01/22 - 05/31/23

Facility Names	Total Medicare Charges (A)	Total Medicare Contractual (B)	Medicare Discount Rate (B/A)
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Mount Carmel East	\$232,894,354	\$180,179,754	77.4%
Mount Carmel Grove City/West	\$120,784,243	\$92,400,637	76.5%
Mount Carmel St. Ann's	\$190,052,486	\$148,521,809	78.1%
Mount Carmel New Albany	\$89,368,333	\$70,167,944	78.5%
Diley Ridge Medical Center	\$8,389,000	\$6,706,161	79.9%

- A discount off of total charges of 51%, which is equal to Mount Carmel Health System's physician contractual adjustment for Medicare will be provided for uninsured ambulatory location patients whose Family Income is between 201% and 400% of Federal Poverty Level Guidelines.
 - Mount Carmel Health System's acute and physician contractual adjustment amounts for Medicare will be calculated utilizing the look back methodology of calculating the sum of paid claims divided by the total or "gross" charges for those claims by the System Office or Mount Carmel Health System annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.
- iv. Insured patients with Family Income up to and including 200% of the Federal Poverty Income Guidelines will be eligible for Financial Support for co-pay, deductible, and co-insurance amounts provided that there is no conflict with contractual arrangements with the patient's insurer and that they apply for financial assistance.
- v. **Medically Indigent Support / Catastrophic:** Financial support is also provided for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their family or household income (for example, due to catastrophic costs or conditions), regardless of whether they have income or assets that otherwise exceed the financial eligibility requirements for free or discounted care under Mount Carmel Health System's FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence / catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's income, expenses and assets. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of income will permit co-pays and deductibles to qualify as catastrophic charity care. Discounts for medically indigent care for the uninsured will not be less than 85%, which equals the Mount Carmel Health System's average contractual adjustment amount for Medicare for the services provided or an amount to bring the patients catastrophic medical expense to income ratio back to 20%. Medical indigent

and catastrophic financial assistance will be approved by the Mount Carmel Health System CFO or his designee and reported to the System Office Chief Financial Officer.

- vi. It is recognized that occasionally there will be a need for granting additional financial support to patients based upon individual considerations. Such individual considerations will be approved by the Mount Carmel Health System CFO or his designee.
- i. Accounting and Reporting for Financial Support
 - i. In accordance with the Generally Accepted Accounting Principles, financial support provided by Mount Carmel Health System is recorded systematically and accurately in the financial statements as a deduction from revenue in the category “Charity Care”. For the purposes of Community Benefit reporting, charity care is reported at estimated cost associated with the provision of “Charity Care” services in accordance with the Catholic Health Association.
 - ii. The following guidelines are provided for the financial statement recording of financial support:
 - Financial support provided to patients under the provisions of “Financial Assistance Program”, including the adjustment for amounts generally accepted as payment for patients with insurance, will be recorded under “Charity Care Allowance.”
 - Write-off of charges for patients who have not qualified for financial support under this procedure and who do not pay will be recorded as “Bad Debt.”
 - Pre-pay discounts will be recorded under “Contractual Allowance.”
 - Accounts initially written-off to bad debt and subsequently returned from collection agencies where the patient was determined to have met the financial support criteria based on information obtained by the collection agency will be reclassified from “Bad Debt” to “Charity Care Allowance”.

II. Assisting Patients Who May Qualify for Coverage

- a. Mount Carmel Health System makes affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Premium assistance may also be granted on a discretionary basis according to Trinity Health’s “Payment of QHP Premiums and Patient Payables Procedure.”
- b. Mount Carmel Health System has understandable, written procedures to help patients determine if they qualify for public assistance programs or Financial Assistance. Patient Registration, Customer Service and Collections staff have received training on how to assist patients and answer questions.

III. Effective Communications

- a. Mount Carmel Health System provides financial counseling to patients about their health care bills related to the services they receive and makes the availability of such counseling known.
- b. Mount Carmel Health System responds promptly and courteously to patients' questions about their bills and requests for financial assistance.
- c. Mount Carmel Health System has a billing process that is clear, concise, correct and patient friendly.
- d. Mount Carmel Health System makes available for review by the public specific information in an understandable format about what they charge for services as required under Ohio law.
- e. Mount Carmel Health System has signs and displays brochures that provide basic information about HCAP and Mount Carmel Financial Assistance in public locations as required by Ohio law (see Attachment C). A copy of the Financial Assistance Policy is provided at the time of service (if requested) and is included with all patient statements that are mailed to patients by Mount Carmel Health System.
- f. Mount Carmel Health System makes available a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process. Mount Carmel Health System will not have failed to widely publicize its FAP because an individual declines a plain language summary that was offered on intake or before discharge or indicates that he or she would prefer to receive a plain language summary electronically.
- g. Mount Carmel Health System makes the FAP, a plain language summary of the FAP and the FAP application form available to patients upon request, in public places (at a minimum, the emergency room (if any) and admission areas) within Mount Carmel Health System, by mail and on Mount Carmel Health System's website. Any individual with access to the Internet is able to view, download and print a hard copy of these documents. Mount Carmel Health System will provide any individual who asks how to access a copy of the FAP, FAP application form, or plain language summary of the FAP online with the direct website address, or URL, where these documents are posted.
- h. Mount Carmel Health System lists the names of individual doctors, practice groups, or any other entities that are providing emergency or medically necessary care in the Mount Carmel Health System's facility by the name used either to contract with the hospital or to bill patients for care provided. Alternately, Mount Carmel Health System may specify providers by reference to a department or a type of service if the reference makes clear which services and providers are covered under the Mount Carmel Health System's FAP. Mount Carmel Health System also makes available a list of providers who are not covered under the FAP.
 - h.1. Covered link: [mchs-fap-participating-providers-6-24-21.pdf \(mountcarmelhealth.com\)](#)
 - h.2. Non-covered link: [mchs-fap-non-participating-providers-6-24-21.pdf \(mountcarmelhealth.com\)](#)
- i. These documents will be made available in English and in the primary language of any population with limited proficiency in English that constitutes the lesser of the 1,000 individuals or 5 percent of the community served by Mount Carmel Health

System. The Financial Assistance Policy, Application and Plain Language Summary are translated into the following languages: Spanish, Somali, Nepali, Chinese, Arabic, French, Mandarin, Japanese, Russian, Korean, and Vietnamese.

- j. Mount Carmel Health System takes measures to notify members of the community served by Mount Carmel Health System about the FAP. Such measures may include, for example, the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low-income populations.
- k. Mount Carmel Health System includes a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under Mount Carmel Health System's FAP and includes the telephone number of the Mount Carmel Health System's department that can provide information about the FAP, the FAP application process and the direct Web site address (or URL) where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained.
- l. Mount Carmel Health System will refrain from initiating ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient. Mount Carmel Health System will also ensure all vendor contracts for business associates performing collection activity will contain a clause or clauses prohibiting ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient.
- m. Mount Carmel Health System will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECA(s) that Mount Carmel Health System (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided. Mount Carmel Health System will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the Mount Carmel Health System's FAP and about how the patient may obtain assistance with the FAP application process.
- n. In the case of deferring or denying, or requiring a payment for providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under Mount Carmel Health System's FAP, Mount Carmel Health System may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, Mount Carmel Health System must satisfy several conditions. Mount Carmel Health System must:
 - i. Provide the patient with an FAP application form (to ensure the patient may apply immediately, if necessary) and notify the patient in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process an FAP application submitted by the patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge

billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the patient must be afforded at least 30 days after the notice to submit an FAP application for the previously provided care.

- ii. Notify the patient about the FAP by providing a plain-language summary of the FAP and by orally notifying the patient about the hospital facility's FAP and about how the patient may obtain assistance with the FAP application process.
- iii. Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above are not needed in the following cases:

- i. If 120 days have passed since the first post-discharge bill for the previously provided care and Mount Carmel Health System has already notified the patient about intended ECAs.
- ii. If Mount Carmel Health System had already determined whether the patient was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the patient was FAP-eligible for the previously provided care.
- o. Mount Carmel Health System will provide written notification that nothing is owed if a patient is determined to be eligible for Free Care.
- p. Mount Carmel Health System will provide patients that are determined to be eligible for assistance other than Free Care, with a billing statement that indicates the amount the patient owes for care as a FAP-eligible patient. The statement will also describe how that amount was determined or how the patient can get information regarding how the amount was determined.

V. Fair Billing and Collection Practices

- a. Mount Carmel Health System has billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations.
- b. Mount Carmel Health System has a short-term interest free payment plan with defined payment time frames based on the outstanding account balance that is available to all patients that qualify. Mount Carmel Health System also offers a loan program for patients who qualify.
- c. Mount Carmel Health System has written procedures outlining when and under whose authority a patient debt is advanced for external collection activities that are consistent with this procedure.
- d. The following collection activities may be pursued by Mount Carmel Health System and/or by a collection agent or attorney on its behalf:
 - i. Communicate with patients (call, written, fax, text, email, etc.) and their representatives in compliance with the Fair Debt Collections Act, clearly identifying Mount Carmel Health System. The patient communications will also comply with HIPAA privacy regulations.

- ii. Solicit payment of the estimated patient payment obligation portion at the time of service in compliance with EMTALA regulations and state laws.
 - iii. Provide low-interest loan program for payment of outstanding debts for patients who have the ability to pay but cannot meet the short-term payment requirements.
 - iv. Report outstanding debts to Credit Bureaus only after all aspects of this procedure have been applied and after reasonable collection efforts have been made in conformance with the Mount Carmel Health System FAP.
 - v. Pursue legal action for individuals who have the means to pay but do not pay or who are unwilling to pay. Legal action also may be pursued for the portion of the unpaid amount after application of Mount Carmel Health System's Financial Assistance Policy. An approval by the Mount Carmel Health System CFO or his designee must be obtained prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).
 - vi. Place liens on property of individuals who have the means to pay but do not or who are unwilling to pay. Liens may be placed for the portion of the unpaid amount after application of the Mount Carmel Health System Financial Assistance Policy. Placement of lien requires approval by the Mount Carmel Health System CFO or his designee. Liens on primary residence can only be exercised upon the sale of property and will protect certain asset value in the property as documented in Mount Carmel Health System's FAP.
- e. Mount Carmel Health System (or a collection agent on its behalf) shall not pursue action against the debtor's person, such as arrest warrants or "body attachments." While in extreme cases of willful avoidance and failure to pay a justly due amount when adequate resources are available to do so a court order may be issued; in general, Mount Carmel Health System will first use its efforts to convince the public authorities not to take such an action, and, if not successful, consider the appropriateness of ceasing the collection effort to avoid an action against the person of the debtor.
- f. Mount Carmel Health System (or a collection agent on their behalf) will take all reasonably available measures to reverse ECAs related to amounts no longer owed by FAP-eligible patients.
- g. Mount Carmel Health System has approved arrangements with collection agencies and/or attorneys that meet the following criteria:
- i. The agreement with a collection agency is in writing;
 - ii. Neither Mount Carmel Health System nor the collection agency may at any time pursue action against the debtor's person, such as arrest warrants or "body attachments"
 - iii. The agreement defines the standards and scope of practices to be used by outside collection agents acting on behalf of Mount Carmel Health System, all of which must be in compliance with this procedure;
 - iv. No legal action may be undertaken by the collection agency without the prior written permission of Mount Carmel Health System;

- v. Trinity Health Legal Services has approved all terms and conditions of the engagement of attorneys to represent Mount Carmel Health System in collection of patient accounts;
- vi. All decisions as to the manner in which the claim is to be handled by the attorney, whether suit is to be brought, whether the claim is to be compromised or settled, whether the claim is to be returned to Mount Carmel Health System, and any other matters related to resolution of the claim by the attorney shall be made by Mount Carmel Health System in consultation with Mount Carmel Health System and CHE Trinity Health Legal Services;
- vii. Any request for legal action to collect a judgment (i.e., lien, garnishment, debtor's exam) must be approved in writing and in advance with respect to each account by the appropriate authorized Mount Carmel Health System representative as detailed in section V.
- viii. Mount Carmel Health System reserves the right to discontinue collection actions at any time with respect to any specific account;
- ix. The collection agency agrees to indemnify Mount Carmel Health System for any violation of the terms of its written agreement with Mount Carmel Health System.

IV. Implementation of Accurate and Consistent Policies

- a. Mount Carmel Health System educates staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections, physician offices) about billing, financial assistance, collection policies and practices, and treatment of all patients with dignity and respect regardless of their insurance status or their ability to pay for services.
- b. Mount Carmel Health System will honor financial support commitments that were approved under previous financial assistance guidelines. At the end of that eligibility period the patient may be re-evaluated for financial support using the guidelines established in this procedure.

VI. Other Discounts

- a. **Pre-Pay Discounts:** Mount Carmel Health System has a pre-pay discount program which is limited to balances equal to or greater than \$200.00 and will be no more than 20% of the balance due. The pre-pay discount is to be offered at the time of service and recorded as a contractual adjustment and cannot be recorded as charity care on the financial statements.
- b. **Self-Pay Discounts:** Mount Carmel Health System has a standard self-pay discount of 25% off charges for all registered self-pay acute care patients that do not qualify for financial assistance (e.g., > 400% of FPL) based on the highest commercial rate paid. A standard self-pay discount of 16% will be provided for physician patients.

- c. **Additional Discounts:** Adjustments in excess of the percentage discounts described in this procedure may be made on a case-by-case basis upon an evaluation of the collectability of the account and authorized by Mount Carmel Health System's established approval levels.

Should any provision of this FAP conflict with the requirement of the law of the state of Ohio, Ohio state law shall supersede the conflicting provision and Mount Carmel Health System shall act in conformance with applicable state law.

SCOPE/APPLICABILITY

This procedure applies to all Trinity Health RHMs that operate licensed tax-exempt hospitals. Trinity Health organizations that do not operate tax-exempt licensed hospitals may establish their own financial assistance procedures for other health care services they provide and are encouraged to use the criteria established in this FAP procedure as guidance.

This Procedure is based on a Trinity Health "Mirror Policy." Thus, all Trinity Health RHMs and Subsidiaries that operate licensed tax-exempt hospitals are required to adopt a local Procedure that "mirrors" (*i.e.*, is identical to) the System office Procedure. Questions in this regard should be referred to the Trinity Health Office of General Counsel.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Procedure may be obtained from the VP, Revenue Cycle, in the Revenue Excellence Department.

RELATED PROCEDURES AND OTHER MATERIALS

- Trinity Health Revenue Excellence Policy No. 1: "Financial Assistance to Patients" ("FAP") <http://intranet.trinity-health.org/web/policies-procedures/table-ofcontents#finance>
- Trinity Health Revenue Excellence Policy No. 2: "Payment of QHP Premiums and Patient Payables" <http://intranet.trinity-health.org/web/policies-procedures/table-ofcontents#finance>
- Patient Protection and Affordable Care Act: Statutory Section 501(r)
- Internal Revenue Service Schedule H (Form 990)
- Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Final Rule: Volume 79, No. 250, Part II, 26 CFR, Part 1
- Individual RHM's EMTALA Policies

Attachment A: MCHS Service Area Zip Codes

<W:\AC\Customer Service & Collections\HCAP MCFAMCH Service Area 2014.xlsx>

Attachment B: Federal Poverty Guidelines

[Poverty Guidelines | ASPE \(hhs.gov\)](#)

Attachment C: Financial Assistance Public Locations

Mount Carmel Health System has signs and displays brochures that provide basic information about HCAP and Mount Carmel Financial Assistance in public locations as required by Ohio law. This Addendum provides the locations in which this information is displayed. A copy of the Financial Assistance Policy is provided at the time of service (if requested) and is included with all patient statements that are mailed to patients by Mount Carmel Health System.

MCE Registration Sites:

Main Outpatient	ED	Cashier
Imaging Center	OB/MFM	WHC
Anti-Coagulation	Trauma/Pain Clinic	

Reynoldsburg Registration Sites:

ED

Franklinton Registration Sites:

ED

WHC

Hillard

MCSA Registration Sites:

Main Registration	Diagnostic Center
ED	WHC
OB/MFM	Anti-Coagulation
Columbus Cardiology Consultants	

MCNA Registration Site:

Main Registration

MCGC Registration Site:

Main Registration	Cashier	St Ann's Family Practice
WHC	MFM	HPOD
ED	GME Clinic	Pain Clinic

Diley Ridge Medical Center:

Main Registration

ED

Mount Carmel Lewis Center:

Main Registration

ED

Non-Patient Access Reporting Registration Departments:

OP Lab Locations

Cardiac Rehab

Physical Therapy/Rehab

APPROVALS

Reviewed by: John O'Connell, Jeff Ellerbrock, Dan Powell

Approved:

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