

Financial Reporting Policy

Policy Title: Charity Care, Uninsured/Underinsured Patient Discounts

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Introduction

The purpose of this document is to establish CHI standards for identifying and recording charity care services provided in CHI entities. This policy provides guidance for Market Based Organizations (MBOs) to use in establishing detailed policies at their organizations consistent with CHI's philosophy and practice.

Definition of Key Terms

Charity Care

Charity care is defined as care provided to patients without expectation of payment for services as a result of a patient's financial inability to pay. The terms charity care and financial assistance are used interchangeably throughout this document.

Medically Indigent Patients

Those patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses, in relationship to their income, [and] would make them indigent if they were forced to pay full charges for their medical expenses.

Medical Necessity

Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

Applicable Accounting Literature

AICPA Audit and Accounting Guide for Health Care Organizations. Included in Accounting Standards Codification [AAG-HCO]

Background, Overview and Definitions

As Catholic health care providers and tax-exempt organizations, Market Based Organizations (MBOs) are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

Charity care traditionally has been defined as care provided to patients without expectation of payment for services as a result of a patient's financial inability to pay.

Charity care may be provided to patients who are uninsured, underinsured or determined to be medically indigent. Medically indigent patients are those patients:

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...whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses, in relationship to their income, [and] would make them indigent if they were forced to pay full charges for their medical expenses.”

Source: *FAQs AI HHS (U.S. Department of Health and Human Services) 2/17/04*

The complete set of the HHS FAQs and answers, published on February 17, 2004, is included with this document as an attachment (Exhibit 1).

Charity care does not include services for which an MBO has agreed to accept a reduced payment pursuant to a managed care arrangement.

There may be a requirement within a managed care agreement to pursue patients for their portion of the payment amount. Such patients are eligible for charity if they qualify as underinsured. Each MBO is responsible for developing a policy statement, approved by the MBO board of directors, and applicable procedures to identify patients who are eligible for charity care.

Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service to enable the MBO to properly record the related revenues, net of charity care allowances. The objective is to provide financial relief for those people who are truly in need.

As identified in The Catholic Health Association (CHA) publication, *Community Benefit Program, A Revised Resource for Social Accountability*:

Jesus had a special affection for those on the margins of society because they are so often excluded from participation in the community and from its benefit. Today, a preferential option for the poor, of which charity care is an expression, is a prime impetus of community benefit initiatives in Catholic health care.

Most MBOs are designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Providing care to the poor, without regard to a patient's ability to pay, is considered a significant indicator in determining whether an MBO meets the IRC community benefit requirement applicable to tax-exempt health care providers. By virtue of IRC Section 501(c)(3), MBOs receive special tax status exempting them from federal and state income taxes. This charitable nonprofit tax status also exempts MBOs from many state and local sales, use and property taxes.

MBOs, including all CHI direct affiliates, wholly-owned and controlled subsidiaries, are required to establish annual budgeted levels for both charity care discounts and community benefit (i.e., benefit provided to the poor and the broader community). MBOs are required to review actual experience for both charity care discounts and community benefit, in comparison to budgeted expectations, on at least a quarterly basis. Charity care discounts and community benefit provided by joint operating agreements between a CHI affiliate and another party or parties is subject to the language contained

in governing documents at the time of formation or as subsequently modified and approved in writing.

The terms charity care and financial assistance are used interchangeably throughout this document. MBOs are encouraged to develop policies and procedures that contain terminology which reduces any stigma attached to the term “charity” and, thereby, reach those individual patients who meet the MBO’s eligibility criteria for free or reduced-fee services.

For services provided to Medicare beneficiaries, Medicare historically has reimbursed hospitals for a portion of bad debts (including co-payment amounts deemed uncollectible) if a patient was reasonably determined to be indigent. The establishment of consistent collection and bad debt processes is essential for all patient categories. MBOs shall submit information in Medicare cost reports about both charity care discounts and uncollectible bad debts. Additional clarification was provided by HHS, as follows:

... if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent, the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts. Source: *FAQs A9 HHS 2/17/04*

Policy for Identifying Patients Unable to Pay for Needed Services

MBO Requirements

Each MBO shall establish a charity care policy consistent with CHI Policy. In accordance with the policy, the MBO shall provide charity care to patients for all medically necessary or otherwise necessary services including, but not limited to, the following full range of services: patients treated at a hospital; residents in a long-term care center; residents in housing for the elderly; patients receiving home care; and other instances. The policies and procedures shall relate to the variety of services provided by the MBO to patients ranging from, for example, emergency and ambulance services to inpatient and outpatient elective surgery, diagnostic testing, and educational programs. .

Hospitals, Outpatient Surgical Services and Clinics

Consistent with the principles of Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care at a CHI hospital shall be treated without regard to a patient’s ability to pay for care. CHI hospitals shall operate in accordance with all federal and state requirements for the provision of health care services, including screening, treatment and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). MBOs should consult and be guided by their emergency services policy, EMTALA regulations and applicable

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Medicare/Medicaid Conditions of Participation in determining what constitutes an urgent or emergent condition and the processes to be followed with respect to each.

Patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition (refer to #6 below). If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be made as soon as possible.

Medical Necessity and related documentation: MBOs shall maintain clinical documentation in the patient's medical record that includes an attestation from the patient's physician indicating appropriate medical necessity for all patients who are granted charity care:

- a) Medical necessity is defined as any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available. (Note that this definition may be modified to be in accordance with the MBO's applicable state law.)
- b) MBOs shall establish a procedure to assure that all medical necessity determinations are administered in a consistent manner.

MBOs shall clearly post signage in English to advise patients of the availability of financial assistance. Signs shall be posted in other languages in instances where 10% or more of the local population speaks a foreign language. Every effort will be made for patients speaking languages other than those for which the charity guidelines are printed to ensure the policies are clearly communicated.

Emergency patient vs. non-emergency patient: Sharing information about charity care is differentiated into two scenarios – one for an emergency patient and another for a non-emergency patient scheduling an admission or other procedure.

- 1) Scenario – emergency patient:
 - a) Patients receiving emergency services shall be treated in accordance with the CHI hospital's emergency services policy, developed in accordance with EMTALA and other requirements.
 - b) Consistent with CHI guidance (i.e., reasonable registration processes for the emergency department) and EMTALA requirements, CHI hospitals shall engage in reasonable registration processes for individuals requiring examination or treatment:

- i) Reasonable registration processes shall include asking whether an individual is insured and, if so, the name of the insurance program utilized, if such inquiry does not delay screening or treatment.
 - ii) Reasonable registration processes shall not unduly discourage patients from remaining for further evaluation. Note: In light of the foregoing, caution recommends (but does not require) deferring discussions regarding financial issues until after the emergency patient has been screened and necessary stabilizing treatment has been initiated. Key to compliance with applicable policies, laws and regulations is ensuring that such inquiries do not delay screening or treatment and do not discourage patients with potentially emergent conditions from seeking care.
 - iii) Once EMTALA requirements are met, patients identified through the registration process as being without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance on request.
- 2) Scenario – non-emergency patient scheduling an admission or other procedure:
 - a) Upon registration, patients without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall receive either (1) a packet of information that addresses the financial assistance policy and procedures or (2) immediate financial counseling assistance from staff, including the presentation of the application for financial assistance on request.

MBOs may consider other processes to manage non-emergent/elective patients and outline such processes via separate policy.
- 3) Under either scenario, the packet of information shall clearly indicate that the MBO provides care, without regard to ability to pay, to individuals with limited financial resources, and shall explain how patients can apply for financial assistance.
 - a) For instances in which there are a significant number of patients not proficient in reading, writing or speaking English, additional information shall be provided (or assistance shall be made available) to complete necessary forms.
 - b) MBOs with 10% or more non-English speaking populations shall prepare informational notices in each of the languages that account for 10% or more of the total population.
 - c) To allow the MBO to properly determine charity care eligibility, documents provided by patients to the MBO shall be written in English.

- d) Records maintained by the MBO to substantiate eligibility for charity care shall be completed in English.
- e) MBOs shall identify the availability of financial assistance in information booklets provided to patients and in general information provided on the MBO website.
- f) MBOs shall begin the process of assessing financial ability as soon as patients contact the hospital to schedule a procedure or when they register as an emergency patient (subject to the EMTALA requirements discussed above).

Long-Term Care Residential Services

Once admitted, patients shall not be denied service or residency due to a financial inability to pay. To be considered tax-exempt, MBOs shall operate in a manner designed to satisfy three primary needs of the elderly: housing, healthcare and financial security.

MBOs with long-term care residential services shall accept patients covered by Medicare and/or Medicaid. Prior to admission, potential patients shall complete application forms that include detailed financial information. Patients not covered by Medicare or Medicaid shall be responsible for making advance payments on a monthly basis for estimated services to be received.

If a resident's resources become depleted, the MBO shall provide assistance so the patient can apply for Medicaid coverage or other local financial assistance.

MBOs with long-term residential services shall develop a charity care policy which adheres to its faith-based tax-exempt designation and sets financial guidelines for its provision in such a manner that it maintains financial stability.

Homes/Apartments for the Aged and Disabled

The CHI charity care policy shall apply to services provided by MBOs that operate homes/apartments for the aged and disabled. Facilities sponsored by the U.S. Housing and Urban Development (HUD) accept residents in accordance with HUD guidelines, which consider income levels. MBOs that operate homes/apartments for the aged shall have stewardship obligations to assure the generation of sufficient resources to meet routine operating expenses, building upkeep and routinely set aside funds for capital needs and improvements.

MBOs with homes/apartments for the aged and disabled shall develop a charity care policy which adheres to its faith-based tax-exempt designation and sets financial guidelines for its provision in such a manner that it maintains its financial stability.

MBOs shall identify, as part of the annual budget, the amount of charity care discounts provided to current residents who are no longer able to meet monthly rental

payments. Tax exemption under IRC Revenue Ruling 72-124, however, requires that no resident shall be discharged due to a financial inability to pay.

MBOs that risk exceeding annual budgeted charity care discount reserves shall be responsible for raising additional funds from philanthropic sources, assisting residents in obtaining additional financial assistance or relocating them to alternate facilities within a reasonable amount of time.

Physician Services

Physician practices or clinics that include employed physicians as part of an MBO or its nonprofit subsidiaries that have not received a separate 501(c)(3) tax-exempt ruling from the I.R.S. shall adopt the CHI charity care policy. These organizations shall comply with the same charity care policy and procedures adopted by the MBO board of trustees for the tax-exempt healthcare provider.

If the physician clinic has received a separate 501(c)(3) tax-exempt ruling from the I.R.S. the following applies:

1. The charity care policy currently in place should be consistent with representations made to the I.R.S. at the time of filing for tax-exempt status.
2. Review the application form (I.R.S. form 1023) to assure compliance with the representations.
3. There should be defined income levels for determining eligibility for charity write-off.
4. There should be a sliding scale at varying income levels for write-offs.
5. Separate reporting of charity discounts by the clinic organizations in the financial statements.

In addition, CHI's tax department advises that if the clinic has been classified as a 501(c)(3) organization both pursuant to the Official Catholic Directory (OCD) and via a separate 501(c)(3) tax exemption ruling, the organization should use the charity care policy described / included with the Form 1023.

Each MBO shall identify and develop a listing of those physician services that will be included in the charity discount policy. This listing will be shared with patients receiving the charity discount; outlining the applicability of the additional charity write-off distinguishing between employed physicians, contracted physicians or general medical staff with admitting privileges.

Joint Operating and Joint Venture Agreements

A CHI-sponsored MBO under a joint operating agreement (JOA) shall adopt the CHI charity care policy unless adoption is not permitted by language contained in the applicable JOA.

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The CHI charity care policy shall apply to both minority and majority-owned joint venture agreements (e.g., joint-venture ambulatory care centers) in accordance with the respective governing documents.

MBOs shall consider charity care obligations in agreeing upon the terms and conditions in JOAs and joint ventures.

Providing Financial Assistance to Patients

Authorization and Methodology

The authorization of charity care discounts shall be restricted to patient financial services directors and/or other MBO management resources above the director level. Approval limits for charity care discounts shall be established by each MBO in accordance with the policy approved by the MBO board of trustees. Each MBO shall develop criteria to determine whether a patient is eligible for a charity care discount and the amount eligible for write-off or discount. An established assessment methodology, applied consistently, shall be adopted by each MBO. The methodology shall consider income, family size, available resources and the likelihood of future earnings (net of living expenses) sufficient to pay for the health care services provided.

1. Each MBO shall utilize the *CHI Standardized Patient Charity Care Discount Application Form*, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.
 - See attached Exhibit 2: CHI Standardized Patient Charity Care Discount Application Form (3 pages, *Word* document).
2. Each MBO shall utilize *CHI Standardized Charity Care Determination Checklist*, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.
 - See attached Exhibit 3: CHI Charity Care Determination Checklist (2 pages, *Word* document).
3. All available financial resources shall be evaluated before determining financial assistance eligibility. MBOs shall consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g., the parent of a minor child or a patient's spouse). The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs. Patients with health spending accounts (HSAs) are considered to have insurance; the amount that the patient has on deposit in the HSA is to be considered insurance and not eligible for any discount. The MBO may discuss with the patient whether other financial resources are available; based on information obtained, MBO may make the determination as to whether the patient is eligible for

charity. All determinations will be documented. Charity discounts shall be the last on the list of available methods to resolve open accounts. (See attached Decision Tree.)

- **Note:** The term “patient/guarantor” sometimes is used subsequently in this document to refer collectively to the patient as well as any such other person(s) having legal responsibility for the patient. Persons who have a legal responsibility for the patient may include a parent or parents for a minor child, an executor of the estate for a deceased patient, a person holding a valid financial power of attorney for a patient, and a court-appointed guardian for a patient (usually incompetent) when the court order grants financial powers to the guardian. Some powers of attorney and guardianship orders are limited to healthcare decision-making only, so it is important to check the scope of the powers granted before pursuing payment from someone who is assumed to be legally responsible for a patient.
4. In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor’s legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor’s most recently-filed federal income tax form shall be relied upon to determine whether an individual should be considered a dependent. The patient/guarantor shall provide employment information for the patient/guarantor, as well as any others for whom the guarantor is legally obligated in regard to the well-being of the patient. Such information shall identify the length of service with the current employer, contact information to verify employment and the individual’s job title.
 5. Eligibility for charity care discounts shall be determined based on 130% of the annually updated *HUD Geographic Very-Low Income Guidelines*, referenced later in this document, available assets and any extenuating circumstances. Thus, the standards of eligibility for the application of charity discounts must consider assets, as well as income (see glossary for definitions). MBOs shall utilize 130% of the *HUD Geographic Very-Low Income* guidelines as a minimum (i.e., establishing a new base). MBOs shall not lower the income levels below the CHI-defined standard of 130% of the *HUD Geographic Very-Low Income* guidelines (i.e., the new base).
 - a) The need for future services requiring financial assistance shall be assessed.
 - b) Separate determinations of eligibility for charity care discounts shall be made for each date of service for all medically necessary services.
 - c) Confirmation of continued eligibility shall be updated every 90 days for patients who require ongoing health care services. i.e.; therapeutic services or repeated laboratory work.

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- d) If the patient has received charity within the past 90-days, MBOs shall revalidate the patient's financial condition, before charity is granted.

In accordance with the preceding, MBOs shall utilize 130% of the *HUD Geographic Very-Low Income* guidelines as a minimum (i.e., the new base). However, MBOs may determine, on a market-specific basis, that higher income levels for 100% charity write-off are more appropriate.

6. Information provided in the financial assistance application may indicate that a patient is eligible for financial assistance or insurance coverage not only for health care services but also other benefits. Financial counseling staff shall assist patients in applying for available coverage. First, the patient's financial position will be evaluated to distinguish between "unwilling" to pay rather than "unable" to pay, based on all publicly available data. Utilizing reputable external resources who have experience in gathering and assimilating such data is encouraged. This information may provide additional data beyond which the patient provides.

MBOs that contract with organizations to assist patients in applying for federal, state or other assistance shall assure that such agreements are in writing and contain provisions requiring compliance with CHI Standards of Conduct, maintain patient confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and delineate compliance with all applicable laws and regulations including the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

- a) All information obtained from patients, family members, and external resources, shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and oral communications. Assessment forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including the following evidence of:
- Income from wages
 - Income from self-employment
 - Alimony
 - Child support
 - Military family-allotments
 - Public assistance
 - Pension
 - Social Security
 - Strike benefits
 - Unemployment compensation
 - Workers' compensation
 - Veterans' benefits
 - Other sources, such as income from dividends, interest or rental property

- b) Copies of documents to substantiate income levels shall be obtained (e.g., pay check stubs, alimony and child-support documents).
- c) Assessment forms may provide for a recap of average monthly expenses including:
- Rental or mortgage payments
 - Utilities
 - Car payments
 - Food
 - Medical bills
7. For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year; these assets shall be evaluated as cash available to meet essential living expenses. Assets that shall not be considered as available to meet living expenses include: a patient's primary place of residence; adequate transportation; adequate life insurance; and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents:
- Savings, certificates of deposit, money-market or credit union accounts
 - Descriptions of owned property
8. The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about family members and/or dependents residing with the patient/guarantor, including the following information for all:
- Name, address, phone number (both work and home)
 - Age
 - Relationship
9. Copies of rent receipts, utility receipts or monthly bank statements may be requested.
10. Each MBO shall develop a sliding scale to provide up to a full discount of charges for patients with no third-party insurance and up to a full waiver of co-payments after third-party insurance proceeds, based on indigence. The following points shall be taken into consideration:
- a) The standards of eligibility for the application of charity discounts must consider assets, as well as income. Eligibility shall be based on 130% of the annually updated *HUD Very-Low Income Guidelines*. These HUD guidelines take into consideration family incomes that do not exceed 50% of the median family income for a geographic area and shall utilize a sliding scale approach based on income and family size. The guidelines are available at the HUD Office of Policy Development and Research website at <http://www.huduser.org/datasets/il.html>. Data may be downloaded in PDF, Word or Excel file formats.

- See attached Exhibit 4: 130% of the annually updated HUD Very-Low Income Guidelines as the new base (Updated January 28, 2010), including Instructions and Application Example: Little Rock AR (8 pages, Excel document).

b) When circumstances indicate the presence of severe financial hardship or personal loss, those patients with few resources and a high number of dependents shall receive higher levels of financial assistance. This shall be determined by the use of a sliding scale based on income and family size (as noted at Exhibit II).

11. Regarding medical bills from other hospitals or non-employed physicians.

- a) The guarantor/patient will be required to provide disclosure of any charity provided by other providers. If charity has been provided by other providers, then those amounts will be excluded from the evaluation of the patient's eligibility for a charity discount from the MBO.
- b) A good faith determination of charity eligibility is acceptable in those situations where individuals have provided documentation whereby it appears that the individuals involved had made questionable financial decisions which might qualify the individual for charity. For example patients who appear to have excessive discretionary spending, such as payments for tanning salon services, expensive accessories for their vehicle, vacations, electronic equipment, etc. Situations such as these are rare. However, if evident they will be reviewed by the charity committee of the MBO.
- c) Any questionable situation will be referred to the MBO's charity review committee. The charity committee will have the discretion to utilize the MBO's charity policy to authorize a partial or total charity discount based on a good-faith determination of eligibility. Any amounts written off as charity will require the signature of the CFO. If the determination is made that the patient is not eligible for a charity discount, then the patient would be eligible for the MBO's self-pay discount. The reason for charity care denials will be retained in a confidential file but the charity committee should feel comfortable with supporting their decision should it become public knowledge.

12. Approved Charity - Patients/guarantors shall be notified when the MBO determines the amount of charity care discount eligibility related to services provided by the MBO. Patients/guarantors shall be advised that such eligibility does not include services provided by non-MBO employees or other independent contractors (e.g., private physicians, physician practices, anesthesiologists, radiologists, pathologists, etc., depending on the circumstances.) The patient/guarantor shall be informed that

periodic verification of financial status shall be required in the event of future services.

13. Denied Charity - Patients/guarantors shall be informed in writing if financial assistance is denied and a brief explanation shall be given for the determination provided. MBO financial counselor will provide a generic explanation, all denials must be credible and done with the highest integrity, the MBOs need to be comfortable with their reasons for determining that the patient is not eligible for charity. A copy of the letter shall be retained in the confidential central file, along with the patient/guarantor's application.
14. Each MBO shall delineate, in accordance with the charity care policy approved by the MBO board, the management-level positions authorized to approve discounts for charity care/financial assistance. Varying levels of approval authority shall be established for each management-level position. On a quarterly basis, the MBO shall report each account with a charity care discount threshold of \$100,000 or more to the finance committee of the MBO board.
 - a) Each account with a charity care threshold of \$100,000 or more shall be reported to the finance committee of the MBO board. However, an MBO may reduce the threshold amount to a lower amount if it is deemed appropriate to do so.
15. Determining eligibility for charity care discounts shall be a continuing process. An ongoing review of accounts referred to the internal and external self pay management resources by the MBO shall determine if any accounts would have been more properly recorded as charity care and, if so, the MBO shall recall such accounts and reclassify them to charity, in accordance with generally accepted accounting principles.
16. MBOs shall retain a central file by each patient/guarantor containing financial assistance applications. A listing of all charity care discounts shall be maintained by the accounting department, documenting patient names, patient account numbers, dates of service, brief descriptions of services provided, total charges, amounts written-off to charity, dates of write-offs and the names of the authorizing individuals. Copies of written approval and denial letters for charity care including denial reasons, shall be retained in a confidential central file. Such documentation may include the patient's application and other supporting materials.

Medical Indigency

The decision about a patient's medical indigency is fundamentally determined by an MBO without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients are patients who do not have appropriate insurance coverage that applies to services related to the following examples: neonatal care, organ transplants, cancer, burn care, long stays and/or

intensive care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets and the payment of their medical bills would be detrimental to their basic financial well-being.

The MBO charity care committee shall make the decision about a patient/guarantor's medically indigent status by reviewing formal documentation as noted below.

1. The patient shall apply for a charity care discount in accordance with the MBO policy in effect.
2. The MBO shall obtain and/or develop documentation to support the medical indigency of the patient. The following are examples of documentation that shall be reviewed:
 - Letter from attending physician confirming medical necessity for services provided
 - Copies of all unpaid patient/guarantor medical bills.
 - Information related to patient/guarantor drug costs.
 - Multiple instances of high-dollar patient/guarantor co-pays, deductibles, etc.
 - Other evidence of high-dollar amounts related to healthcare costs, such as the existence of an HSA that has been fully expended.
3. The MBO shall grant a charity care discount either through the use of the sliding scale approach referenced in Exhibit II or up to 100% if the patient has the following:
 - No material applicable insurance.
 - No material usable liquid assets.
 - Significant and/or catastrophic medical bills.
4. In the case of medical indigency, the patient shall be expected to pay some amount of the medical bill, but the MBO charity care committee shall determine the amount for which the patient shall be responsible based solely on the income level of the patient.

Presumptive Charity Care Eligibility

There are occasions when a patient may appear eligible for a charity care discount, but there is no financial assistance form on file because documentation was lacking that would support the provision of financial aid. Such instances have resulted in a patient's bill being assigned to a collection agency and ultimately recognized in the accounting records as a bad debt expense, due to a lack of payment. This approach, however, results neither in a fair solution for the patient nor in an appropriate accounting of the transaction. This presumptive eligibility, when properly documented internally by MBO staff, is sufficient to provide a charity care discount to patients who qualify. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted to the patient by the MBO is a 100% write-off of the account balance.

Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g., homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.). MBOs shall grant only 100% charity care discounts to patients determined to have presumptive charity care eligibility. MBOs shall internally document any and all recommendations to provide presumptive charity care discounts from patients and other sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel.

1. For instances in which a patient is not able to complete an application for financial assistance, the MBO may grant a 100% charity care discount without a formal request, based on presumptive circumstances, approved by the MBO charity care committee in accordance with MBO policy.
2. Each MBO shall utilize the CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility, adapting it by adding any additional requirements necessary to accommodate local programs and circumstances.
 - See attached Exhibit 5: CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility (1 page, *Word* document).
3. The determination of presumptive eligibility for a 100% charity care discount shall be made by an MBO charity care committee on the basis of patient/guarantor income, not solely based on the income of the affected patient services provided to such individuals shall be considered charity care and shall be considered as qualifying such patients on the basis of presumptive eligibility. The following are examples of patient situations that reasonably assist in the determination of presumptive eligibility :
 - Patient is deceased, with no known estate.
 - Patient is homeless.
 - Patient qualifies for other state or local assistance programs that are unfunded or the patient’s eligibility has been dismissed due to a technicality. (Note this only applies to patients who are cooperative. Uncooperative patients are not eligible for presumptive charity care.).

Charity Care Review Committee

Each MBO shall establish a Charity Care Review Committee to assist in the evaluation of information related to patient accounts that do not clearly qualify under basic charity care discount eligibility criteria.

1. The types of patient accounts to be reviewed by the Committee shall include, but not be limited to, the following:

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- Patients with extenuating circumstances (e.g., patients who may be medically indigent, patients who may have presumptive eligibility for a charity care discount, etc.).
 - Patients who have significant non-liquid assets
 - Patients whose eligibility exceeds 180% of the HUD Very Low Income Guidelines and thus are not eligible for charity care discounts on the sliding scale, but whose medical bills are so large that they are unable to pay.
2. The Committee shall be comprised of hospital employees and chaired by a senior management representative. At a minimum, membership shall include a social worker and staff from mission/ministry, general accounting and patient financial services. Other members may be appointed to the Committee as deemed appropriate by the MBO.
 3. The Committee shall meet as needed, depending on MBO size, nature of patient population and frequency and types of charity care discounts provided. For large MBOs, meetings will be required on at least a monthly basis and at times more often. For small MBOs, meetings may be required only once every one to three months.
 4. The agenda for each meeting shall be comprised of patient cases requiring additional review and input by the Committee prior to the determination of charity care discount eligibility. For each patient case, the agenda will include a summary of the case, the financial situation of the patient and other pertinent information as necessary.
 5. Documentation of the Committee's meetings shall be recorded. Actions related to specific patients shall be included in the central file as discussed at Item No. 12 (verify reference) in Section II-A of this document.

Recording Charity Care

Each MBO shall properly distinguish write-offs of patient accounts between charity care and bad debt expenses. Such amounts shall be recorded in accordance with generally accepted accounting principles and properly disclosed in financial statements and other reports.

Generally Accepted Accounting Principles

The AICPA Audit and *Accounting Guide for Health Care Organizations* [AAG-HCO] is the current guidance for reporting charity care and bad debt expense in an entity's financial statements.

1. Section 10.03 of the AAG-HCO states the following, with regard to distinguishing bad debt expense from charity care:

Distinguishing bad-debt expense from charity care requires judgment. Only the portion of a patient's account that meets the entity's charity care criteria should be recognized as charity. FASB ASC 954-605-25-11 states that although it is not necessary for the entity to make this determination on admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care. Charity care represents health care services that were provided but were never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.

2. Each MBO shall write off patient accounts in one of the following two categories:
 - Charity care – consisting of:
 - Patients with no third-party payment source and for whom there is no expectation of payment
 - ... *Or* ...
 - Medicare (and Medicaid if applicable in the particular state) patients who are determined to be financially unable to pay applicable co-payment obligations, in which case the unpaid co-payment qualifies as charity care for the MBO and can be claimed on any filing for reimbursement as a Medicare (Medicaid) bad debt.
 - Bad debts – consisting of patients who have the ability to pay for health care services (including those with private insurance), where the patient or insurer does not pay the applicable obligation.

Financial Statement Disclosures

Each MBO shall provide charity care information as requested by the National Financial Reporting department via the audit template so information about the amount of charity care will be included in the consolidated year-end CHI community benefit disclosure. *Note A to the CHI Audited Consolidated Financial Statements* states the following regarding CHI's charity care policy:

As an integral part of its mission, CHI accepts and treats all patients without regard of the ability to pay. A patient is classified as a charity patient in accordance with these Policies established across all entities. Charity care represents services rendered for which no payment is expected. Charity care is not included as revenues in the statements of operations and changes in net assets. The amounts of charity care provided, determined on the basis of charges, were \$XXX million and \$XXX million in 201X and 201X, respectively.

IRS Reporting

Each MBO shall include the information noted in the preceding Section IV-C of this document in the IRS Form 990 federal reporting and required state reporting. MBOs are encouraged to publicize this information in notices to the local community.

Charity Care Write-offs

Charity care is netted against gross revenues and, therefore, does not appear in the MBO statements of operations as a separate line item. As a practical matter, this essentially meets the accounting requirement that charity care revenue not be recorded since it is immediately written off or allowed for in the allowance calculation described below. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care and prior-period charity care. The cost of providing charity care to patients is comingled with the expense in the MBO statements of operations.

Where scholarships are provided for community health education programs, the waived tuition or fee amounts should be tracked and reported as part of the community benefit reporting process.

Allowance for Charity Care

There may be a lag between the time services are provided to patients and when the determination is made about the eligibility for charity care or financial assistance. As a result, MBOs are required to establish an allowance methodology for estimating charity care.

The following are the journal entries required to record the allowance for charity care. MBOs shall apply these accounting standards for all entities. These entries assume the MBO is using the *indirect method* of recording charity care write-offs, whereby charity care write-offs are recorded against the allowance for charity care on the balance sheet.

1. To record monthly allowance for charity care:

<u>Journal Entry</u>	<u>Dr</u>	<u>Cr</u>	<u>Description of Account</u>
Charity care write-offs	X		Contra revenues account (statement of operations)
Allowance for charity care		X X	Contra gross accounts receivable (balance sheet)

- Monthly journal entries should be established for estimated charity care.
- The amount recorded will be the difference (debit or credit) between the allowance for charity care and the calculation of the required reserve performed by the MBO on a monthly basis.

2. To record charity care write-offs:

<u>Journal Entry</u>	<u>Dr</u>	<u>Cr</u>	<u>Description of Account</u>
Allowance for charity care	X X		Contra gross accounts receivable account (balance sheet)

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Accounts receivable	X	Accounts Receivable
	X	(Balance sheet account)

- This transaction should be recorded in the patient billing system as accounts are processed and will be posted to the general ledger through the billing system interfaces.
- If the MBO uses the *direct method* of writing off charity care accounts, the write-off will be made directly to the statement of operations rather than flow through the allowance for charity care on the balance sheet. The MBO is still required to review accounts receivable at monthend to determine if an allowance on remaining account balance is required for anticipated/estimated charity care services. This methodology is generally permitted for physician clinics only.

3. To change the status of accounts receivable from bad debts to charity care discounts:

<u>Journal Entry</u>	<u>Dr</u>	<u>Cr</u>	<u>Description of Account</u>
Allowance for charity care	X		Contra gross accounts receivable (balance sheet)
Reserve for bad debts		X	Contra gross accounts receivable account (balance sheet)

- This transaction occurs when an account that was written off as a bad debt expense is subsequently determined to be a charity care patient account.

Recording Community Benefit

See the CHI Community Benefit Handbook in the CHI (General) section of the CHI Public Folders.

CHA highlights the need for organizations to ensure that MBO charity policies are being implemented consistently and fairly. The following are suggested methods to assure that policies and procedures are implemented:

- Develop and periodically distribute questionnaires to gauge staff perceptions of charity policies, utilize the results to hold staff discussion groups or training sessions.
- Encourage discussion groups that allow staff to describe their perceptions of charity care discounts and to identify possible conflicting practices.
- Monitor staff adherence to MBO charity care policy and procedures.
- Include questions in patient satisfaction surveys to determine whether patients were made aware of MBO financial assistance policies and how patients perceived that offer of assistance.

Please refer to the sample community benefit disclosure included in the Notes to the CHI Consolidated Financial Statements, prepared annually.

See attached Exhibit 7: Sample Community Benefit Disclosure in the Notes to the Financial Statements (2 pages, Word document).

Resources for Community Benefit Reporting

The Healthcare Financial Management Association (HFMA) Principles & Practices Board (P&P Board) Statement No. 15, *Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers*, is available at <http://www.hfma.org/kn/statement15.htm>.

Internal Revenue Service (IRS) Field Service Advice (FSA) 200110030, issued March 9, 2001, contains a listing of 14 factors that IRS agents can weigh when considering the charitable care policies and activities of a hospital. (Please note that the IRS has publicly disavowed any implication in FSA 200110030 that tax-exempt hospitals are obligated to provide any level of charity care.)

See attached Exhibit 8: IRS Field Service Advisory – Issue: March 9, 2001 (8 pages, *Word* document).

Self-Pay, Prompt Pay and Third-Party Discounts

Introduction

The purpose of this document is to establish CHI standards for application of self-pay discounts for uninsured patients with the ability to pay, prompt pay discounts and third-party discounts for non-contracted payors. In addition to the standards provided herein, some guidelines apply within those standards, and these are noted in several places throughout the document.

Definition of Key Terms

Self-pay Discounts for Uninsured Patients with the Ability to Pay

Patients considered to be “uninsured with the ability to pay” shall be patients who meet the following criteria:

1. The patient/guarantor provides evidence that no health insurance coverage exists either through an employer-provided program or a governmental program such as Medicare, Medicaid or other state and local program to pay for health care services rendered to the patient.
2. The patient/guarantor does not qualify for other charity or medically indigent programs or the MBO has documentation indicating that the patient has clearly stated he/she does not want to be considered for charity. Patients who do qualify (for other charity or medical indigent programs) are entitled to discounted or free care under those applicable programs, rather than this discount program.
3. Patients with income or personal property, which indicates that they are able to pay for the care rendered.

Prompt Pay Discount

If prompt-pay discounts are offered by MBOs in connection with both inpatient and outpatient services, they shall be offered on coinsurance and deductible amounts to insured patients, regardless of financial status or ability to pay. Patients benefit from the prompt-pay discount in the following two circumstances:

1. When payments are made on a hospital bill prior to the discharge of the patient.
2. When payments are made after discharge, but within thirty (30) days of the patient being informed of the discount offer.

Third-party discounts

Third-party discounts shall be offered to third-party payors who do not have an existing contract in effect with the MBO, for the purpose of expediting payments (i.e., payment within a specified number of days following the date of the initial bill) and/or avoiding a retrospective claim audit.

Background and Overview

MBOs shall not offer patient discounts in a manner prohibited by law (e.g., discounts used in connection with marketing healthcare services to potential patients or discounts that may influence patients to select an MBO or related entity) or by contractual limitations (e.g., prohibitions contained in managed care organization [MCO] contracts).

Consistency shall be essential in the definition, communication, distribution and implementation of self-pay, prompt pay and third-party discounts standards among all MBOs, and within functional areas of MBOs (e.g., patient access, patient accounting, collection agents, satellite clinics, outpatient diagnostic, therapeutic and surgical centers, etc.).

Compliance with legal requirements is required. Discounts at MBOs shall not be intended to provide inducements to patients to self-refer or physicians and others to refer patients to MBO facilities. Discounts shall not be of a nature likely to influence a potential patient to select a MBO facility.

Communication shall comply with the appropriate procedural CHI Standards outlined in this document. Communication is essential to patients, third-party payors and the health care community as a whole regarding the availability and implementation of discounts (subject to limitations on advertising discounts in connection with marketing healthcare services, as noted above).

Self-Pay Discounts

Self-pay discounts shall be offered only to (a) patients with accounts that are 100% self-pay and who meet the definition of uninsured patients with the ability to pay or (b) patients who have 100% non-covered services and, in both cases, fail to meet charitable financial assistance guidelines defined by the MBO or the MBO has documentation indicating that the patient has clearly stated he/she does not want to be considered for charity.

In either case, patients must fail to meet MBO-defined charitable assistance guidelines or the MBO shall have documentation indicating that the patient has clearly stated he/she does not want to be considered for charity. Patients/guarantors shall be screened to determine ability to pay.

Unless otherwise mandated by local law which would require a more specific discount, an average managed care contractual allowances rate shall be developed annually by each MBO and applied to all uninsured patients deemed eligible for this discount. The discount shall be calculated by each separate entity within the MBO by dividing the total amount of managed care contractual allowances, for the most recent fiscal year, by the total gross charges for those managed care plans to determine a discount rate that shall be used for the current fiscal year, as follows:

$$\text{Discount Percentage} = \frac{\text{Total managed care contractual allowances}}{\text{Total managed care gross charges}}$$

Federal, state, local and county entitlement programs shall be excluded from the above calculation (i.e., disregard the discounts and charges from such plans).

The self-pay discount rate shall be based on the average managed care contractual allowances rate at the specific MBO, applied to the total balance due. The MBO discount policy shall include appropriate documentation to support the percentage used and shall be approved by the MBO finance committee on an annual basis.

Self-pay discounts shall be provided to uninsured patients only when the patients pay total balances within 60 days or agree to payment terms (under which the patients pay the balance in full within an 18-month period, in accordance with a written payment schedule). Reserves for this patient receivable should be consistent with current reserve methodology for patient payment arrangements.

Self-pay discounts shall be recorded either when the payment in full is received, within the 60-day timeframe, or recorded when the payment arrangement plan is entered into.

If the payment arrangement plan is entered into but not fulfilled and the patient/guarantor defaults for three consecutive months, without notification to the MBO, the discount shall be reversed and self-pay collection procedures shall be implemented.

Self-pay discounts shall not be reapplied if a new patient payment arrangement is established. The patient shall forfeit his/her right to such discount based on previous experience.

Self-pay discounts (i.e., when patients are paying "in-full") shall not be provided if payments are not received within the specified timeframe. In such cases, the MBO shall use all reasonable efforts to collect full charges.

Discounts to members of CHI participating congregations shall be covered by separate guidance.

- **See attached** *Exhibit I, Relationship between CHI and Its Participating Congregations.*

Prompt-Pay Discounts

Prompt-pay discounts may be offered on coinsurance and deductible amounts when (a) payments are made on a hospital bill prior to the discharge of the patient, or (b) when payments are made after discharge but within thirty (30) days of the patient being informed of the discount offer.

The MBO has the discretion to determine whether the offering of prompt-pay discounts on patient coinsurance and deductible amounts are appropriate for their community and/or market.

MBOs are not required to offer prompt-pay discounts. However, if MBOs determine prompt pay discounts are appropriate, the following standards shall be followed in order to be in compliance with legal requirements:

- a) The MBO shall not claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, or other third party payors, or individuals.
- b) The MBO shall make the waiver without regard to the patient's reasons for admission, length of stay, or diagnostic related group, or ambulatory payment classification.
- c) The waiver shall not be part of a price reduction agreement between the MBO and a third party payor.
- d) MBOs shall notify third party payors of prompt payment policies.
- e) MBOs shall verify that the amounts of fees discounted to patient would bear a reasonable relationship to the amount of avoided collection costs.
- f) The discount shall not be advertised. Instead patients shall be notified of the prompt pay discount at the time of, or post service delivery.

The size of the prompt pay discount shall depend on both the timing of the payment and the size of the remaining balance owed by the patient. Prompt pay discounts shall be reasonably related to the amount of the collection costs that would be avoided.

For example: the prompt pay discount could be provided according to the following:

% of bill discounted on payments made prior to discharge

Balances \$0 - \$999 = 10%

Balances \geq \$1,000 = 15%

% of bill discounted on payments made post-discharge but within 30 days of discount offer

Balances \$0 - \$999 = 5%

Balances \geq \$1,000 = 10%

Any prompt pay discount which does not follow the standards noted above shall require the approval of the MBO CEO and CFO.

Third-Party Discounts

Third-party discounts, for accounts in which there are no contracts between the insurers and the MBOs, shall be permitted *only* under certain circumstances. Consistent communication, distribution and application of this Policy shall be required at each MBO (and in related entities wholly-owned and operated by the MBO). Proactive internal communication of this Policy shall be necessary to ensure consistency and adherence to its requirements. External communication of this Policy shall facilitate a consistent message to third-party payors. Discounts shall not be used, in any manner whatsoever, as a means of inducing patient referrals or influencing patients to select an MBO or related MBO entity for health care needs.

Third-party discounts shall be permitted under certain circumstances to non-contracted primary payors.

Third-party discounts to non-contracted secondary payors (e.g., Medigap, etc.) shall not be permitted.

Discounts to non-contracted payors shall be made available only if the balance is paid in full within 30 days of the initial billing date, and the payor does not dispute the charges and services rendered. If charges are found to be in error, the payer will be allowed 30 days from receipt of a corrected claim to pay.

Discounts applied to payments received within the applicable time frame shall be allowed *up to* a discount rate which does not exceed an existing contract, and shall have a cap of 10%.

Discounts for third parties shall not be recorded in the books and records until full payment is posted (see the *Accounting and Recording for Discounts* section of this document).

Most states have a *clean claim* statute that requires payment within 45 days of receipt by the payor of the clean claim. These state statutes shall mitigate the need to discount billed charges for non-contracted payors.

An MBO in a state with a clean claim statute may offer third-party discounts to *non-contracted* payors, if it is deemed necessary and sufficient documentation is maintained (i.e., the average payment period for these payors consistently exceeds the payment period identified in the *clean claim* statute).

Cases in litigation shall be considered settlements and shall not be defined as third-party payors in accordance with the CHI standards included in this document.

Proactive internal communication (i.e., patient information brochures, financial counseling and self-pay management work flows) shall ensure consistency and adherence to the Policies. External communication of the CHI policies shall facilitate a consistent message to third-party payors.

Package Programs

Hospital services, procedures and programs for which (a) third-party payors in general do not cover the services/procedures (e.g., cosmetic surgery, clinical research trials, etc.) and (b) a separate hospital policy for discounted or free services applies to the particular patient, shall *not* be considered for self pay discounts within the context of this policy, but could at the MBO discretion, be considered for prompt payment.

Any package offer shall be provided to *all* patients who receive the service, irrespective of payor category, subject to the limitations noted above.

Applicability of the Policy to Patient Services Categories

The CHI Policy shall apply to the following types of patient services:

Inpatient hospitalization and outpatient services – whether provided in a hospital or in an MBO-operated ambulatory surgery center, urgent care clinic or other outpatient departments.

Physician services – if the physician is employed by the MBO that provides services in the locations specified above. The MBO may apply the discount outlined in this policy to its owned physician practice corporations.

MBOs shall not be required to adopt the self pay discount policies for home health services, long-term care services, pharmacy services and other services.

Within this CHI Policy, however, at the discretion of the MBO, the prompt-pay discount may be adopted for home health services, long-term care services, pharmacy services and other services, provided that the serving corporations are not operated through the corporate structure that operates the not-for-profit hospital.

Recording and Accounting for Discounts for Uninsured Patients with the Ability to Pay

Self-pay and prompt pay discounts applicable to accounts for uninsured patients with the ability to pay shall be recorded on a standardized basis in all MBO patient accounting systems.

Self-pay and prompt pay discounts shall be posted to patient accounts only when payment is received in full, satisfying the entire patient financial obligation, or when patient arrangement plans have been memorialized in some manner in the patient billing information system.

MBOs shall develop and maintain a tracking mechanism in the patient accounting system to quantify the number of accounts and associated amounts related to self-pay and prompt pay discounts. These tracking mechanisms/codes shall be appropriately named *self-pay and prompt pay discounts* to reflect the type of discount recorded. These codes shall be unique to self-pay discounts and therefore shall not be used for any other type of adjustment posted to a patient account.

A report of self-pay and prompt pay discounts shall be generated on a monthly basis and shall be reviewed for compliance by the MBO Director of Patient Financial Services or equivalent position. This report shall include patient name, patient number, date of service, self pay balance, date(s) of self-pay payment(s) and the amount/type of discount. The same report shall be generated on a monthly basis and provided to the MBO Chief Financial Officer for review.

Self-pay and prompt pay discounts shall be mapped to a revenues deduction account in the general ledger and shall be recorded as a revenues deduction item in the financial statements in the same period the discount is earned.

Non-Contracted Payors

Third-party discounts to non-contracted payors shall be recorded on a standardized basis in all MBO patient accounting systems.

Third-party discounts shall be posted to patient accounts only when payment is received in full to satisfy the entire payor financial obligation. If interim payments are made, these payments shall be posted to the patient account as received; however, the discount shall be posted to the account only if the final interim payment is received and occurs within the stated discount period.

A tracking mechanism shall be developed and maintained in the MBO patient accounting system to quantify the number of accounts and associated amounts related to third-party discounts. This tracking mechanism/code shall be called *third party discounts* and shall measure only third-party discounts. This code shall be unique to third-party prompt-pay discounts and shall not be used for any other type of adjustment posted to a patient account.

A report of third-party discounts shall be generated, preferably on a weekly basis but no less than on a monthly basis, and shall be reviewed for compliance by the MBO Director of Patient Financial Services or equivalent position. This report shall include patient name, patient number, name of payor, date of service, insurance balance, date(s) of insurance payment(s) and the third-party discount. The same report shall be generated on a monthly basis and provided to the MBO Chief Financial Officer for review.

Third-party discounts shall be mapped to a revenues deduction account in the MBO general ledger and shall be recorded as a revenues deduction item in the financial statements in the same period the discount is earned.



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Members of CHI Participating Congregations

Discounts for members of CHI participating congregations shall be recorded on a standardized basis in all MBO patient accounting systems. (Please reference *Exhibit I* and its *Attachments A* and *B* regarding the relationship between CHI and its participating congregations.)

Discounts for members of CHI participating congregations shall be posted to patient accounts as soon as the discount has been determined.

A tracking mechanism shall be developed and maintained in the MBO patient accounting system to quantify the number of accounts and associated amounts related to participating congregation discounts. This tracking mechanism/code shall be called *participating congregation discounts* and shall measure only participating congregation discounts. This code shall be unique and shall not be used for any other type of adjustment posted to a patient account.

A periodic report of participating congregation discounts shall be generated, preferably on a daily basis but no less than on a weekly basis, and shall be reviewed for compliance by the MBO Director of Patient Financial Services or equivalent position. This report shall include patient name, patient number, date of service, insurance balance, date(s) of insurance payment(s) and the participating congregation discount. The same report shall be generated on a monthly basis and shall be provided to the MBO Chief Financial Officer for review.

Participating congregation discounts shall be mapped to a revenues deduction account in the MBO general ledger and shall be recorded as a revenues deduction item in the financial statements in the same period the discount is earned.

Contact Information

Please contact the Revenue Cycle Management team or your Financial Reporting contact, the Financial Reporting Manager or the Director, CHI Finance at with any questions related to this policy.