MHA
AN ASSOCIATION OF
MONTANA HEALTH
CARE PROVIDERS

MHA Billing, Collection, Financial Assistance & Charity Care Policy

(Applies to all MHA member hospitals.)

- Financial Assistance for the Uninsured of Limited Means
  - MHA members are expected to provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion or national origin.

  - Financial assistance provided by organizations to uninsured people of limited means should in no way substitute for state efforts to provide or expand coverage to the uninsured.

    State Medicaid programs should be required, at a minimum, to sustain a "maintenance of effort," keeping programs' eligibility at least at their current levels.

    Further, state Medicaid programs also should be required to expand coverage to all individuals at or below the poverty level.

    Until that time, **facilities should have policies to provide services to uninsured patients below 100 percent of the federal poverty level at no charge.**

    Existing clinical and geographical criteria used by facilities to determine eligibility for certain services would apply. (E.g. certain typical eligibility criteria for admission to services – like the three-day stay for SNF, homebound status for home health, a terminal diagnosis for hospice – wouldn't change.)

  - MHA members are expected to provide **financial assistance to all uninsured patients between 100 and 200 percent of the federal poverty level.**

    - For these patients, facilities may provide discounts on a sliding scale that takes into consideration the patient's income, other liquid assets and other special.
    - The discounts should be similar to those extended to public and private insurers.

    Facilities may choose to provide greater assistance such as extended payment schedules, limiting charges to a percentage of the patient's annual income or otherwise limit the patient's charges.

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- MHA members may offer financial assistance to uninsured patients with incomes **in excess of 200 percent of the federal poverty level at their discretion.**

- Financial assistance is contingent on the cooperation of a patient in providing the information necessary for a facility to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from facilities shall have a responsibility to pay according to the terms of that policy.

- Cosmetic surgery and other non-medically necessary services are exempt.

- MHA members will make information about a facility's financial assistance policy easily available to the public.

- Facilities that have financial assistance policies that meet or exceed those above shall have immunity from related class action lawsuits.

- **Ensuring Fair Debt Collection Policies (Applies to all Members)**
  - If using outside debt collection organizations, MHA member organizations will obtain written assurances that the organization complies with the Fair Debt Collection Practices Act and the ACA International's Code of Ethics and Professional Responsibility.

  - MHA member organizations will have written policies as to when and under whose authority a patient account is advanced for collection. If a patient has completed a facility's application for financial assistance, that account should not be advanced for collection pending determination of eligibility.

  - MHA member organizations will have written policies as to when and under whose authority a lien can be placed on a patient's primary residence.

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MHA Reporting Community Benefit (Applies to MHA-member non-government, not-for-profit organizations)

- MHA member organizations are expected to conduct a periodic community needs assessment, with a frequency to be determined by the organization. (This can be done collaboratively with other community organizations.)

- MHA member organizations are expected to assign responsibility for a community benefit plan to an organization employee.

- MHA member hospitals are expected to identify and compile the benefits they provide their communities using one of three methods:

    - List the community benefit activities the organization engages in (Appendix A includes a list of the activities compiled by CHA that could count as community benefit activities), plus the amount of bad debt and charity care (at cost) and unpaid costs of government-sponsored health care programs (including Medicaid, Medicare and public and/or indigent care programs.)

    - List the community benefit activities the organization engages in, including the direct costs for as many of these programs as possible, plus the amount of bad debt and charity care (at cost) and unpaid costs of government-sponsored health care programs (including Medicaid, Medicare and public and/or indigent care programs.)

    - Complete the Community Benefit Guidelines outlined in CHA/VHA's Community Benefit Reporting document, including, in addition, the organization's direct and indirect costs of subsidized health care services, charity care, bad debt and the unpaid costs of government-sponsored health care (including Medicaid, Medicare and public and/or indigent care programs.)

- MHA member extended care organizations are expected to identify and compile the benefits they provide their communities. CHA has developed a list of eligible activities for aging services providers – very similar to the list for hospitals – that should form the basis for developing a community benefit report.

- MHA member organizations are expected to report their community benefits to their community at least once a year. They also may attach their report to their Form 990.

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Appendix A

Community Benefit Activity Planning Form (CHA)

Community Health Services

- Community health education
- Community-based clinical services
- Health care support services
- Other

Health Professions Education

- Physicians/medical students
- Scholarships/funding for professional education
- Nurses/nursing students
- Technicians
- Other health professional education
- Other

Subsidized Heath Services

- Emergency and trauma services
- Neonatal intensive care
- Hospital outpatient services
- Burn unit
- Women's and children's services
- Renal dialysis services
- Hospice/home care/adult day care
- Behavioral health services
- Other

Research

- Clinical research
- Community health research
- Other

Financial Contributions

- Cash donations
- Grants
- In-kind donations
- Cost of fundraising for community benefit programs
- Other

American Hospital Association

Hospital Billing and Collection Practices

Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure. America's hospitals are united in providing care based on the following principles:

- Treat all patients equitably, with dignity, with respect and with compassion.
- Serve the emergency health care needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all of the care they receive.
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care in a community.

Hospitals' work is made more difficult by America's fragmented health care system ... a system that leaves *millions* of people unable to afford the health care services they need ... a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid or privately insured patients ... a system in which payments do not recognize the unreimbursed services provided by hospitals ... a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients. Today's fragmented health care system does not serve Americans well in many ways. It is in need of significant change as each day leaves more and more hospitals unable to make ends meet.

While most Americans have insurance coverage for their unexpected health care needs, more than 43 million people do not. Some of these people can pay for the health care they

may need, but America's hospitals treat millions of patients each year who can make only minimal payment, or no payment at all. In the absence of adequate insurance coverage for all, America's hospitals must find ways to both serve and survive.

Unfortunately, a vast and confusing array of federal laws, rules and regulations make it much more difficult than it should be for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills. Government must commit to removing these regulatory barriers to allow hospitals to do even more to make care affordable for patients who cannot pay for part or all of the care they receive.

The following guidelines outline how hospitals can better serve their patients. Hospitals have been following some of these guidelines for years as they work each day to find new ways to best meet their patients' needs.

Guidelines

Helping Patients with Payment for Hospital Care

Communicating Effectively

- Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.
- Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance.
- Hospitals should use a billing process that is clear, concise, correct and patient friendly.
- Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services.

Helping Patients Qualify for Coverage

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

Making Care More Affordable for Patients with Limited Means

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts (pending needed federal regulatory clarification). Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf, and should obtain agreement to these standards in writing from such agencies.
- Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection.

Hospitals in some states may need to modify the use of these guidelines to comply with state laws and regulations.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. These guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring.