pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
December 27, 2017	December 27, 2017	01-17-03

SUBJECT

Hospital Responsibilities Related to the Uncompensated Care Program and Charity Care Plans

BY

Leesa M. Allen, Deputy Secretary
Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this Medical Assistance (MA) Bulletin is to remind hospitals of the requirements for the Hospital Uncompensated Care Program (Program) and reinforce the responsibility of hospitals to actively engage patients when determining eligibility for the Program.

This MA Bulletin rescinds and replaces MA Bulletin 01-10-24, titled "Hospital Uncompensated Care Program and Charity Care Plans," issued and effective August 30, 2010.

SCOPE:

This MA Bulletin applies to all hospitals enrolled in the MA Program providing services to MA beneficiaries in both the Fee-for-Service and managed care delivery systems.

BACKGROUND:

The Tobacco Settlement Act (Act) (35 P.S. §§ 5701.1101-5701.1108), signed into law by Governor Tom Ridge on June 26, 2001, created the Program, which is administered by the Department of Human Services (Department). The Program provides for the disbursement of appropriations from the Tobacco Settlement Fund, as established in Section 5701.1103(a) of the Act, to annually compensate hospitals for a portion of the uncompensated care they provide to uninsured and underinsured patients. In order to receive Program payments,

hospitals are to meet the Program's uniform reporting requirements as established by the Department's Advisory Committee, in consultation with the Pennsylvania Health Care Cost Containment Council (PHC4) as set forth by public notice published in the *Pennsylvania Bulletin* on July 27, 2002, at 32 Pa.B. 3672. In addition, hospitals must submit an annual attestation of their compliance with the Program requirements of the Act to the Office of Medical Assistance Programs, Bureau of Fiscal Management, in the manner prescribed by the Department.

DISCUSSION:

In order for hospitals to be eligible for a payment from the Program, hospital designees must complete and sign the annual Attestation of Compliance with the Act (Attachment B). The Department, in discussions with Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Health Law Project, Community Legal Services of Philadelphia and MA beneficiaries, established "common practices" that clarify what constitutes compliance with the eligibility conditions listed on page 2 of the Attestation of Compliance.

Since the establishment of common practices, with the publication of MA Bulletin 01-10-24, it has come to the Department's attention that some hospitals are not following these guidelines. In response, the Department conducted a review of the charity care policy at various hospitals throughout the Commonwealth and found that several hospitals request more than one month of income and resource verification from patients. In addition, one hospital did not have permanent signs posted to advise patients of the hospital's charity care policy.

This MA Bulletin reinforces the requirements hospitals must follow when determining an individual's eligibility in order to qualify for a payment from the Program.

Uncompensated Care

Section 5701.1102 of the Act defines uncompensated care as "the cost of care provided to patients financially unable or unwilling to pay for services provided by a hospital." This cost shall be determined by the PHC4 utilizing reported data and the hospital's cost-to-charge ratio and shall include charity care and bad debt expense.

Charity Care

Section 5701.1102 of the Act defines charity care expense as "the cost of care for which a hospital ordinarily charges a fee but which is provided free or at a reduced rate to patients who cannot afford to pay but who are not eligible for public programs and from whom the hospital did not expect payment in accordance with the hospital's charity care policy."

Charity care is to be recorded by hospitals as the foregone charges for unpaid care consistent with the hospital's charity care policy and established schedule of fees. Shortfalls between third-party payments and a hospital's charges are not to be included in charity care. If a patient's third-party insurance does not provide any payment for specific services, these uncovered services are eligible to be included in charity care. If a hospital waives or reduces a

co-payment or deductible, those foregone fees may not be included in charity care; however, if a patient is unable to pay a co-payment or deductible, then the unpaid co-payment or deductible is eligible to be included in charity care.

All charity care expenses must be reported by hospitals as charges. Hospitals may not include charges for community service unless the service involves a medical service for which a fee is charged to the general patient population.

Bad Debt

Section 5701.1102 of the Act defines bad debt expense as "the cost of care for which a hospital expected payment from the patient or a third-party payer, but which the hospital subsequently determines to be uncollectible." Payments denied by third-party insurers may only be recognized as bad debt by hospitals if the services provided were beyond the scope of services covered by the insurer.

All bad debt expenses must be reported by hospitals as charges.

Plan to Serve the Uninsured and Procedures for Collecting Bad Debt

Section 5701.1104(b) of the Act provides that to be eligible to apply for payment under the Program, a hospital must have a plan in place to serve the uninsured and meet the following six specific eligibility requirements listed as follows:

- Accepts all individuals, regardless of the ability to pay for emergent medically necessary services within the scope of the hospital's service;
- Seeks collection of a claim, including collection from an insurer or payment arrangements with the person who is responsible for payment of the care rendered;
- Attempts to obtain health care coverage for patients, including assisting patients in applying for MA or the Children's Health Insurance Program (CHIP);
- Ensures that an emergency admission or treatment is not delayed or denied pending determination of coverage or requirement for prepayment or deposit;
- Posts adequate notice of the availability of medical services and the obligation of a hospital to provide free services; and,
- Provides necessary data to the PHC4.

To qualify for funding, a hospital will be required to annually complete a form supplied by the Department that will attest to the hospital's compliance with these requirements.

While the Act addresses emergent care twice in the above requirements, charity care is not limited to emergent care. Charity care can be provided in nonemergent situations.

Emergency Services

Under federal Emergency Medical Treatment and Labor Act requirements, Medicare participating hospitals must provide emergency treatment and stabilization, including hospital

admission, to patients without delay regardless of the patient's ability to pay for emergent medically necessary services provided by the hospital.

Collection of Claims

The Act does not address the manner in which hospitals should pursue account collections. Hospitals also have an obligation to assist patients with obtaining health care coverage. Therefore, the Department is providing clarification that hospitals should meet with patients to assist them in applying for publicly funded health care programs and the hospitals' charity care program prior to proceeding with direct collections from patients. Hospitals should maintain documentation of these steps in the patients' account file.

Attempts to Obtain Health Care Coverage for Patients

Section 5701.1104(b)(3) of the Act requires hospitals attempt to obtain health care coverage for patients, including assisting patients in applying for MA or CHIP. The Department understands that the level of assistance provided to patients varies among hospitals; however, all hospitals should provide a basic level of assistance.

Below is a list of the basic level of assistance that hospitals should take to provide assistance to patients who are applying for publicly funded programs:

- Meet with patients or obtain adequate individual patient information to assist them in completing a paper MA application (PA 600), paper CHIP application (CHIP 2), online COMPASS application for either health care coverage, or Presumptive Eligibility application (MA332) for qualified hospitals as defined in MA Bulletin 01-15-32, titled "Revised Procedures for Presumptive Eligibility as Determined by Hospitals" and effective November 30, 2015;
- Provide pregnant women with appropriate verification of pregnancy;
- Provide patients with a list of additional documentation needed for the application and contact information for the County Assistance Office (CAO);
- Provide copies of the patient's invoices to the CAO; and/or,
- Meet with patients to explain the hospital's charity care program, assist in the completion of a charity care application, and advise patients they may be eligible for the Program if they are not found eligible for publicly funded programs.

If patients are not found to be eligible for any publicly funded programs, hospitals should:

- Provide patients with information on the hospital's charity care program;
- Assist patients in completing the charity care application; and,
- Notify patient of charity care eligibility determination.

Model Charity Care Application

The Department developed a Model Charity Care Application (Attachment A). This Model Application reflects the applicant data and information the Department determined necessary for hospitals to use in evaluating patient eligibility for charity care. Hospitals should meet with patients to obtain accurate information required for the application. The Model Application identifies the maximum scope of information hospitals may collect from charity care applicants and use in the charity care eligibility determination. Hospitals may choose the format in which they wish to collect the applicant information (e.g., through an electronic or paper application), and the format, organization and layout of their application forms; however, a hospital may not collect from applicants any additional information beyond the information identified in the Model Application. Hospitals may choose to collect less information; however, hospitals should collect adequate information from the patient to determine eligibility based on the patient's current circumstances.

Section One of the Model Application captures applicant information about patient demographics, household members, monthly household income, and household countable resources. Household income includes income from employment, as well as unearned income from sources such as pensions, disability benefits, interest income and dividends. Countable resources include dedicated accounts such as Health Savings Accounts, and liquid assets such as cash and other negotiable assets that may be quickly and easily converted into cash. Countable resources do not include non-liquid assets such as the applicant's home, vehicle, household goods, IRAs, 401(k) accounts, etc.

Charity Care Income and Resource Eligibility Standards:

- The Department's recommended income eligibility standard for charity care is 200% of the current Federal Poverty Level (FPL) guideline, based on family size; and,
- The Department's recommended countable resource standard for charity care is $10,000.

The Department recommends an income limit of at least 200% of the current FPL because it encompasses the core population of patients that depend upon assistance to obtain medical care, is consistent with the income limits used by the majority of hospitals within the Commonwealth and is minimally burdensome for the hospital community.

Section Two of the Model Application includes optional questions related to monthly household expenses and monthly medical expenses. Monthly household expenses include monthly payments made for housing, utilities, child support, spousal support, automobiles and patient contributions toward Health Savings Accounts. Monthly medical expenses include monthly payments made for health insurance premiums, medical equipment, doctor visits and prescriptions. The expenses identified can be used by the hospital to determine the patient's eligibility for the hospital's charity care program in accordance with the charity care income and resource eligibility standards set forth above.

Section Three of the Model Application includes verification of income and countable resources and provides examples of the acceptable types of verification that may be requested from the applicant in support of the information provided on the charity care application.

Section Four of the Model Application includes a certification and signature from the applicant indicating that the information provided in the application is true and complete and that any falsification of the information will result in a denial of the charity care application.

Posts Adequate Notice

Section 5701.1104(b)(5) of the Act requires hospitals to post adequate notice of the availability of medical services and obligation of hospitals to provide free care. The Department will consider hospitals to be in compliance with this requirement when notice is provided:

- In multiple locations throughout the hospital, such as:
  - inpatient, outpatient and emergency room patient registration areas; and,
  - billing offices where patients meet with financial counselors
- On paperwork sent to patients, such as:
  - discharge paperwork; and,
  - invoices
- On the hospital's website, unless the hospital does not have a website.

While all locations do not have to provide detailed information regarding the hospital's charity care plan, the hospital's charity care policy should be available to patients when:

- Patients cannot or will not pay for services rendered by the hospital; and,
- Upon request.

The following is an example of notice language the Department considers acceptable to meet the adequate notice requirement.

> This hospital provides free care to persons who qualify. If you cannot afford the cost of care, you are encouraged to apply for free care. You may obtain information and an application at (specify a location on the premises) or by calling (insert telephone number) or you may download an application at (provide the web address).

Verification of Compliance

In signing the Attestation of Compliance, hospital designees are assuring the Department of their compliance with the requirements of the Act and clarifications established by the Department in this MA Bulletin.

PROCEDURE:

In order for hospitals to receive payment for charity care under the Act, hospitals must:

1) Complete and sign the annual Attestation of Compliance with the Act (Attachment B) and return the completed form to the Office of Medical Assistance Programs, Bureau of Fiscal Management;
2) Post adequate notice of the hospital's charity care policy in multiple locations throughout the hospital, on paperwork sent to patients, and on the hospital's website, unless the hospital does not have a website;
3) Attempt to obtain public health care coverage for uninsured and underinsured patients, including assisting patients in applying for MA or CHIP;
4) Provide the patient with information on the hospital's charity care program and assist the patient in completing the charity care application if the patient is not found to be eligible for any publicly funded programs; and,
5) Notify the patient of the hospital's charity care eligibility determination.

ATTACHMENTS:

Attachment A: Model Charity Care Application

Attachment B: Attestation of Compliance

MODEL CHARITY CARE APPLICATION

Section One: Required Questions

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for charity care.

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____

Current Health Insurance Company Name: _____

Policy Number: _____ Group Name/Number_____

Household Members

Please attach additional sheets of paper if household has more than eight members.

	Name:	Relationship:	Age:
1.	_____	Self	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Monthly Household Income

Wages/Salaries *(Before Taxes)*: _____ Pensions: _____

Social Security: _____ Other Disability: _____

SSI: _____ Cash Assistance: _____

Unemployment Compensation: _____ Workers Compensation: _____

Child Support: _____ Spousal Support: _____

Veteran's Administration (VA) Benefits: _____

Annuities: _____

Other Unearned Income *(includes Trusts, Interest/Dividends, etc):* _____

_____

_____

Household Countable Resources

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit: _____ Stocks or bonds: _____

Trust Fund: _____ Savings account: _____

Checking Account: _____ Savings Certificates: _____

U.S. Savings Bonds: _____ Christmas or Vacation Club: _____

Heath Savings Account (HSA) funds: _____

Other *(Please Explain):*_____

Section Two: Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lower-than-average expenses will not result in an adjustment of income upward.

Monthly Household Expenses

Mortgage/Rent: _____ Property Taxes: _____

Insurance: _____ Auto Loan: _____

Credit Cards (Total): _____ Water: _____

Gas: _____ Oil: _____

Electric: _____ Telephone: _____

Child Support: _____ Spousal Support: _____

Health Savings Account (HSA) Contributions: _____

Other (Please Explain): _____

Monthly Medical Expenses

Insurance Premiums: _____ Equipment: _____

Doctors' Visits: _____ Prescriptions: _____

Other (Please Explain): _____

Section Three: Verification of Income and Countable resources

Please attach proof of income from the past 30 days and current resources to this application. Please verify all income and resources listed in Section One. If you are unable to verify some or all of your income or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- ☐ Pay stubs or letters from employers, listing wages before taxes.
- ☐ Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- ☐ Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- ☐ Documentation of other sources of income.
- ☐ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- ☐ Health Savings Account (HSA) and other dedicated account statements.
- ☐ Checking and Savings account statements.
- ☐ Copy of Health Insurance Card(s), if applicable

Section Four: Certification

Please sign and return the completed application with the items listed in Section Three to <<Name of Office>>, located <<Location>>.

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of charity care.

Signed: _____ Dated: _____

FY 2017-2018

General Delivery Address
Commonwealth of Pennsylvania
Department of Human Services
Bureau of Fiscal Management
Division of Rate Setting
Commonwealth Tower, 9th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105

Federal Express Address
Commonwealth of Pennsylvania
Department of Human Services
Bureau of Fiscal Management
Division of Rate Setting
Commonwealth Tower, 9th Floor
303 Walnut Street
Harrisburg, Pennsylvania 17101

Attestation of Compliance with the Tobacco Settlement Act of 2001 (Act 77)

Hospital Name: _____

PROMISe ID Number: _____

Address: _____
Street City State Zip Code

I hereby attest that I have read the Tobacco Settlement Act of 2001 (Act 77), Chapter 11, Hospital Uncompensated Care, Section 1103(d)(2) and Section 1104(b) (page 2) and have examined the hospital's policies and procedures to serve the uninsured and provide uniform reporting of charity care. Based on that review, the hospital is in compliance with the requirements of Section 1103(d)(2) and Section 1104(b) of the Act. Furthermore, the hospital will continue to comply with these provisions to remain eligible for payment under the Hospital Uncompensated Care Program. I understand the statements made herein are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and to Section 1108 of the Act.

_____ _____
Signature of Chief Executive Officer/President/Vice President Date

_____
Print or Type Name and Title

_____ _____
Signature of Corporate Secretary/Treasurer Date

_____
Print or Type Name and Title

Attestation of Compliance with the Tobacco Settlement Act of 2001 (Act 77)

Part I.

Tobacco Settlement Act of 2001 (Act 77), Chapter 11, Section 1103(d)(2) – The hospital's charity care expense reporting shall address the following:

a. Patient eligibility for other public or private coverage.

b. Income eligibility threshold based on family size.

c. Consideration of other resources available to a patient or responsible party.

d. Patient or responsible party employment status and earning capacity.

e. Other financial obligations of the patient or responsible party.

f. Other sources of funds available to the hospital such as endowments or donations specified for charity care.

Part II.

Tobacco Settlement Act of 2001 (Act 77), Chapter 11, Section 1104(b) – The hospital is eligible to apply for payment from the Hospital Uncompensated Care Program if the hospital has a plan in place to serve the uninsured and:

a. Accepts all individuals, regardless of the ability to pay for emergent medically necessary services within the scope of the hospital's service.

b. Seeks collection of a claim, including collection from an insurer or payment arrangements with the person who is responsible for payment of the care rendered.

c. Attempts to obtain health care coverage for patients, including assisting patients in applying for Medical Assistance or the Children's Health Insurance Program.

d. Ensures that an emergency admission or treatment is not delayed or denied pending determination of coverage or requirement for prepayment or deposit.

e. Posts adequate notice of the availability of medical services and the obligation of hospitals to provide free services.

In addition, the hospital is in compliance with the Pennsylvania Health Care Cost Containment (PHC4) financial filing requirements.