pennsylvania
DEPARTMENT OF PUBLIC WELFARE

MEDICAL ASSISTANCE BULLETIN

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SUBJECT
Hospital Uncompensated Care Program and Charity Care Plans

BY
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Office of Medical Assistance Programs

PURPOSE:

The purposes of this Medical Assistance (MA) Bulletin are to remind hospitals of the requirements for the Hospital Uncompensated Care Program (Program) and clarify what constitutes compliance with the Program requirements.

SCOPE:

This MA Bulletin applies to all hospitals enrolled in the MA Program providing services to MA recipients in both the Fee-for-Service, including ACCESS Plus, 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 Public Welfare (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. Additionally, the Department announced the requirement that hospitals submit an annual attestation of their compliance with the Program requirements of the Act to the Office of Medical Assistance Programs, Bureau of Fee-for-Service Programs, in the manner prescribed by the Department.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs Web site at www.dpw.state.pa.us/PartnersProviders

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 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, the unpaid co-payment or deductible is eligible to be included in charity care.

All charity care expenses must be reported 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 payor, but which the hospital subsequently determines to be uncollectible”. Payments denied by third-party insurers may only be recognized as bad debt if the services provided were beyond the scope of services covered by the insurer.

All bad debt expenses must be reported as charges.

Plan to Serve the Uninsured and Procedures for Collecting Bad Debt

Section 5701.1104(b) of the Act states 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, the Children's Health Insurance Program (CHIP) or the adultBasic (aB) Coverage Insurance Program.
- 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.
- 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, the Department reminds hospitals that charity care is not limited to emergent care. Charity care can be provided in nonemergent situations.

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 (HAP), the Pennsylvania Health Law Project (PHLP), Community Legal Services of Philadelphia (CLS) and MA consumers, established 'common practices' that will clarify what constitutes compliance with the following eligibility conditions listed on page 2 of the Attestation of Compliance:

Emergency Services

Under federal Emergency Medical Treatment and Labor Act (EMTALA) 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 assist patients 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, CHIP and aB. The Department understands that the level of assistance provided to patients varies among hospitals; however, all hospitals should be providing a basic level of assistance.

Below is a listing of basic steps that hospitals should be taking to provide assistance to patients who are applying for publicly funded programs:

- Assist patients in completing a paper MA application (PA 600) or online COMPASS application
- Assist patients in securing applicable medical forms such as the Employability Assessment Form (PA 1663) and/or the Health-Sustaining Medication Assessment Form (PA 1671)
- 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
- Advise patients if they are not found eligible for publicly funded programs they may be eligible for the hospital's charity care program

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

Model Charity Care Application

The Department developed a Model Charity Care Application, which is included as Attachment A to this bulletin. This Model Application reflects the applicant data and information the Department determined necessary for hospitals to use in evaluating patient eligibility for charity care. 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.

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 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.
- The Department's recommended countable resource standard for charity care is $10,000.

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 recipient'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
  - billing offices where patients meet with financial counselors
- on paperwork sent to patients, such as:
  - discharge paperwork
  - 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, detailed information should be available to patients 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. A copy of the Attestation of Compliance is included as Attachment B to this bulletin.

Attachments:

Attachment A: Model Charity Care Application

Attachment B: Attestation of Compliance