501(r) REQUIREMENTS FOR TAX EXEMPT HOSPITALS

An Overview of Financial Assistance and Payment Programs

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501(r) Compliance

The Patient Protection and Affordable Care Act added Section 501(r) to the Internal Revenue Code which imposed four new requirements for 501(c)(3) tax exempt hospital organizations. The new requirements are:

- Community Health Needs Assessment,
- **Financial Assistance Policy,**
- Limitations on Gross Charges, and
- Limitations on Billing and Collections Practices.

Scheduling Practices

ALWAYS INFORM PATIENT THEY MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE

- You may be eligible for Financial Assistance for your medical bill.
- You may get a copy of the hospital Financial Assistance Policy from the Patient Accounts Department by calling ________________or logging onto our web site at ____________________.
- The Financial Assistance Policies are also available at the hospital Admissions Office or Emergency Room. Insert days and times the offices are open.
- All hospital locations have the hospital Financial Assistance Policy available by request.
- Financial Assistance is available by filling out the Financial Assistance Application and speaking to a Financial Counselor.
- The Financial Counselor will obtain information to see if the patient is eligible for insurance. The Financial Counselor will screen for the ability to meet the obligation and if eligible for free care or charity care.
- Translations of the Plain Language Summary, Financial Assistance Policy and application form are available, if needed.
- Patients applying for Financial Assistance may not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care.

*Debit and all major credit cards are accepted for the patient's convenience

Scheduling Procedure

Appointment Scheduling

Insurance Verified: "Your *insurance has been 'verified' and based upon the information provided today and according to your insurance benefits, the **ESTIMATED** out-of-pocket amount for your services is ($), which represents ($) for your deductible, ($) for your copay and ($) for coinsurance. This is a hospital **ESTIMATE** and is not a guarantee of final billed charges. Professional fees, such as physician, radiologist, anesthesiologist and pathologist fees are not included in this **ESTIMATE**. **You may also be eligible for Financial Assistance**. For your convenience, we accept debit and all major credit cards. Are you able and would you like to pay today?*

Insurance NOT Verified: *"Based upon the information provided, we are unable to verify your benefits. It is our hospital policy to ask for __% of the **ESTIMATED** total. This is a hospital **ESTIMATE** and is not a guarantee of final billed charges. Professional fees, such as physician, radiologist, anesthesiologist and pathologist fees are not included in this **ESTIMATE**. **You may also be eligible for Financial Assistance**. For your convenience, we accept debit and all major credit cards. Are you able and would you like to pay today?*

Does NOT apply to patients in the emergency room!

Cannot refuse to schedule patients for bad debt until 120 days have passed beyond the issuance of the first billing statement.

Be sure to notify the patient that they may qualify for financial assistance

HCAP Policy

Through HCAP, hospitals can offer basic, medically necessary hospital-level services free of charge to qualified individuals in compliance with Ohio's Hospital Care Assurance Program (HCAP).

- The patient cannot be a recipient of the Medicaid program
  - Accounts are first screened for Medicaid through the following programs: Aid to Families with Dependent Children, Aid to Families with Dependent Children-Healthy Start, or Medicaid Disability.
- The patient must be a resident of the state of Ohio.
- The patient must be at or below the federal poverty income level.
- HCAP applications are accepted within 3 years from the date of the first follow-up notice, which is approximately 3 years and 30 days from the date of service.

Document the account anytime a patient was counseled on payment options or handed applications to include their intent or refusal to fill out and return the applications!

Charity Care Plan
Financial Assistance Policy

The Charity Care Plan, is available for underinsured and uninsured patients

*Only available after all other methods of financing have been exhausted, such as insurance coverage, public assistance, Medicare, Bureau of Children with Medical Handicaps, Victims of Crime, Hospital Motor Vehicle Claims Programs, or any other financial resources

Federal Poverty Level (FLP)	% Discount on Charges
At or below 100% FPL	100% discount
101%-200% FPL	100% discount
201%-250% FPL	50% discount

What Do I Do If…

The Patient Has An Outstanding Balance

Always request the outstanding balance first, and then inform the patient about payment options.

The Patient Brings In An Application

Forward the application to Patient Financial Services. Hospital will use its best efforts to make a determination of eligibility within 30 days of receipt.

Someone Requests an Application on Behalf of a Patient

Provide the application as well as a HIPAA Authorization Form. Because financial information is protected under HIPAA, we cannot discuss payment plans without the authorization form if the patient's representative were to bring back the form.

The Patient Has Questions

Refer the patient to Patient Financial Services.

HIPAA

Frequently Asked Questions

What services are considered medically necessary?
Medically necessary includes inpatient and outpatient services or care rendered to a patient to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity. Elective cosmetic services are not medically necessary.

Who completes the applications for the various programs available?
The patient should complete and sign the Financial Statement application. If the patient is unable to do so, a hospital representative may be able to complete and sign the application, as well as document why the patient is unable to sign it.

What happens if the patient was initially denied, but circumstances have changed?
The patient should contact Patient Financial Services.

How will the patient be notified if they were approved/denied?
The patient should be notified in writing.

What happens if we receive an incomplete application?
The hospital should notify the patient in writing of the timeframe to complete the application.

Can a denied Financial Assistance Application's be appealed?
Yes. The responsible party may appeal by providing additional information, such as income verification or an explanation of extenuating circumstances within 30 days of the date of the written denial letter.

Debt Collection Policy

- It is unlawful to routinely waive and/or fail to collect copayments, deductibles, coinsurance, or other patient responsibility payments, in whole or in part, under federal and state law.
- Payment on patient accounts will be consistently pursued.

Procedure

- Billing statement is sent after the date of service.
- If a response is not received, the billing statement will be sent to Medicare and non-Medicare patients.
  - All hospitals are different as to how long they wait in between statements and how many statements the hospital sends.
  - This is in addition to any prompt pay discount.
- If the patient or guarantor has not responded or made an effort to pay the amount owed thirty (30) days after the final statement is sent to the patient or guarantor, the account can be assigned to a debt collector.
- Neither [Hospital] nor any of its contractors may engage in "extraordinary collection actions" before taking reasonable efforts to determine if the patient qualifies for the Charity Care Plan financial assistance for a period of 120 days after the first billing statement is issued. This includes refusing to schedule patients!

Time Track for 501(r) Activities							
Collection Action	Days from First Post Discharge Billing Statement						
	0-30	31-60	61-90	91-120	121-180	181-240	>241
First Post Discharge Billing Statement	✓	✓	✓	✓	✓	✓	
Patient may apply for FAP	✓	✓	✓	✓	✓	✓	
30 day notice re: pending ECAs				✓			
First date ECA may be initiated					✓		
Last Day for patient to apply for FAP						✓	

http://www.adreima.com/webfoo/wp-content/uploads/2016/01/Adreima_501r_FINAL.pdf

501(r) Timeline

Patient Has Visit

Day 1

Day 30

Patient receives billing statement

You can refuse to schedule patients with bad debt!!

Day 150

Day 1,125

Deadline to complete financial assistance application

ECAs

Hospital Practice to Mitigate 501(r) Impact on Collections

- No Show Fees
- Copays and Deductibles at the Time of Visit
- Patient Credit Card on File
- Repayment Plans
- Prompt Pay Discounts
- Deposits:
  - At Time of Scheduling
  - Self-Pay Patients