Status **Active** PolicyStat ID **11734880**

Origination	07/2016	Owner	Stacie French
Last Approved	05/2022	Policy Area	Revenue Cycle
Effective	05/2022	Applicability	Monument Health System-Wide
Last Revised	05/2022		
Next Review	05/2023		

Monument Health Charity Care Discounting Policy

Policy Number: CS-8211-02

GENERAL POLICY

It is the policy of Monument Health to provide financial relief for medical expenses incurred by households who do not have access to financial resources to pay for their health care services. Relief is provided to those who are requiring medically necessary treatment, after exhausting all other sources of payment or funding.

The Monument Health charity care budget defines annual charity care resources available within which management will seek to administer this policy and its Financial Assistance Program. Charity Care Discounts are determined using both external criteria such as credit scores, and internally obtained criteria such as residency as well as income, asset and other fund sources availability considered in relation to the nature and extent of medical services required.

Based upon these criteria, applicants will be eligible to receive a 100% write-off of the guarantor's/ patient's responsibility if their calculated household gross annual income is at or below 250% of the most recently published federal poverty guidelines and discount to the Medicare Best Rate if the calculated household gross annual income is between 251% and 300%, of the most recently published HHS federal poverty guidelines.

Evaluation and Management (E & M)/Office Visit fees will be assessed a sliding payment based on the most recent published federal poverty guidelines as indicated in Attachment D – Evaluation and Management (E & M) Sliding Payment Scale

Gross income at or below FPL	Write off Amount
250%	100%
251% - 300%	Medicare Best Rate

Attachments to the policy:

A - Financial Assistance Program Exclusions
B - Financial Assistance Program Definitions
C - Financial Assistance Service Area Zip Code
D - Evaluation and Management (E & M) Sliding Payment Scale

Please refer to monument.health for the following information:

- Financial Assistance Program Application
- Financial Assistance Policy Income and Debt Reduction Matrix
- Financial Assistance Policy Plain Language Summary
- Providers Covered by the Financial Assistance Policy
- Providers Not Covered by the Financial Assistance Policy

SCOPE

This policy applies to (1) Monument Health Inc.'s wholly-owned or controlled subsidiaries; and (2) any other entity or organization in which a Monument Health subsidiary owns a capital or profit interest that is treated as a partnership for federal tax purposes or that is disregarded for federal tax purposes and that provides emergency or medically necessary care in a Monument Health Location.

DEFINITIONS

For purposes of this Policy, the following terms and definitions apply:

A. Affordable: A health plan is considered affordable and meets the "minimum value" standard.as follows:

B.

Applicant Only	10% of household gross income
Applicant + Spouse	13% of household gross income
Applicant + Children	12% of household gross income
Applicant + Family	18% of household gross income

- The insurance plan used to define affordability is the lowest priced plan covering the applicant and additional beneficiaries as listed above. This definition remains true even if enrolling in a plan with higher premiums.
- For job-based health coverage, the cost is the amount the applicant would pay for the coverage, not including the amount paid by an employer on their behalf to reach the plan total premium.

- The applicant's total household income as defined in the definition of household income is use.
-

C. Assets: Property, real or personal, and tangible or intangible, that has monetary value. Asset value, other than the value of the primary residence and a primary vehicle, will be considered in determining eligibility and may serve as the basis for denying eligibility for charity care discounting despite eligible household income.

D. Authorization / Pre-certification: The process of obtaining authorization from all applicable insurances (i.e., primary, secondary, and tertiary payers) for medical services, which often involves an appropriateness review against medical criteria. Pre-certification is also known as pre-admission certification or pre-admission review.

E. Amounts Generally Billed (AGB): The amount generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with Section 1.501(r) – 5(b). The Prospective Medicare Method is used to determine AGB

F. Catastrophic Hardship: Financial assistance that is provided as a discount to eligible applicants with annualized household income in excess of 250% of the Federal Poverty Guidelines and/or the total out of pocket expense liability resulting from a single health crisis event where the guarantor's/patient liability for the related medical services provided by Monument Health exceed 15% of annual household income and all criteria related to financial clearance (definition J 1 - 8) have been satisfied.

G. Elective Procedure/Non Emergent Condition: Patient condition is such that a reasonable delay in treatment to permit the physician to exercise scheduling choices will typically not unfavorably affect outcome.

H. Federal Poverty Level (FPL): A measure of income issued every year by the Department of Health and Human Services (HHS).

I. Financial Assistance/Charity Discounting: Financial assistance is the provision of health care services free of charge or at a discount to individuals who meet the established criteria. The terms ‘Financial Assistance’ and ‘Charity Care’ are used interchangeably.

J. Financial Clearance: Guarantors/Patients who have met the following criteria are considered financially cleared:

1. Necessary demographic and insurance information has been provided to facilitate billing and reporting requirements, and outstanding balances have been reviewed
2. Insurance benefits have been verified for 100% coverage. Determine whether the services are covered, based on the verification of the benefits with the insurance carrier and on the determination made by the insurance carrier
3. Pre-certifications/authorizations and/or provider referrals as required have been obtained
4. Acceptable payment arrangements have been made for any identified financial

liabilities

5. Alternative funding sources, community based programs and services are explored
6. Medicaid applications are completed as appropriate
7. The applicant(s) is/are compliant with providing required information necessary to complete the financial clearance process
8. All identified guarantor/patient responsible amounts and/or deposits will be collected pursuant to accepted protocols to include prior to service, at the time of service, and at discharge

Source: Electronic Code of Federal Regulations, Title 42: Public Health PART 405 FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED Subpart D—Private Contract

K. Financial Support: For purposes of this policy Financial Support is money, shelter, or food and associated expenses provided for an applicant by a party other than a member of the household for a period of six (6) months or less due to a short term medical situation, unemployment, relocation, etc. The monetary value of support will be determined by the total average cost of community rent, the average cost of household utilities, and the average cost of food as determined by the use of an external, publicly available data source. This value will be translated into a monthly income benefit for the applicant. If the support is provided for a term longer than six (6) months, the support will be deemed to be permanent and the applicant(s) considered being a member of the other party's household.

L. Geographical Residency and Monument Health Service Area (MHSA): Eligibility for financial assistance is based on an applicant's permanently established residence as it relates to Monument Health's primary, secondary, and tertiary service areas.

1. Service Area eligibility will be determined by Monument Health using the ZIP code of the guarantor's/patient's permanently, established residence. *Attachment – Service Area ZIP Code List.*
2. Applicants whose resident county and zip code lies outside of the Monument Health primary and secondary services areas but within the tertiary Monument Health Service Area will be considered eligible for Charity Care discounting ONLY IF the patient is unable to obtain the same or alternatively acceptable services deemed medically necessary under a single encounter or plan of care within the county or a contiguous county of their permanent established residence.
3. Applicants whose permanent established residence lies outside of any of the defined MHSAs are not eligible for Charity Care discounting.
4. The PRIMARY Monument Health Service Area (MHSA) represents the area as defined in the most recent Community Health Needs Assessment (CHNA) and includes those postal zip codes within the counties from which 80% of the Monument Health hospital's admissions are derived. The area is comprised of all

ZIP codes within:

a. South Dakota counties: Butte, Custer, Fall River, Lawrence, Meade, Oglala Lakota (formerly Shannon) and Pennington

b. Wyoming counties: Crook

5. The SECONDARY Monument Health Service Area includes those ZIP codes within the county boundaries where a Monument Health healing environment is physically located. This area is comprised of all ZIP codes within:

    a. South Dakota counties: Harding

    b. Wyoming counties: Weston

6. The TERTIARY Monument Health Service Area includes those ZIP codes among those counties whose boundaries lie within 35 miles of a Monument Health healing environment. This area is comprised of all ZIP codes within:

    a. Montana counties: Carter

    b. Nebraska counties: Sioux, Dawes

    c. North Dakota counties: Bowman

    d. Wyoming counties: Campbell, Niobrara

M. Guarantor: The party responsible for full payment of health care services provided when not covered by another payer source or third party. The guarantor may or may not be the patient (the person who received services).

N. Household: Shall include the guarantor and all other adults and/or all adult or minor children living within a residence/residential property. It may also encompass any dependent relationship such as a child or other dependent attending an educational or technical training program, such as a dependent child attending a college or technical institute, Job Corp training, Outward Bound, and the like which may require temporary absences from the residence.

O. Household Income: Household income is determined by calculating the following sources of income for all qualifying household members.

1. Wages, salaries, tips
2. Business, Ranching, and Farming income
3. Social Security and Disability income
4. Pension or Retirement Income
5. Dividends and Interest
6. Rent and Royalties

7. Income from Estates and Trusts
8. Unemployment or Workers' compensation income
9. Spousal support including alimony as well as orders of child support
10. Awards, Benefits, Public Assistance or any other Program stipends such as SNAP, TANF, Public Housing, Veteran's benefits, etc.
11. Legal Awards. Judgments, or Insurance and Annuity payments
12. Cash, bank accounts, money market accounts, certificates of deposit, mutual funds, bonds, personal shares, or other convertible investments
13. Financial Support provided by another person/persons (See definition of *Financial Support*)
14. Other Income, such as income from trust funds, charitable foundations, educational assistance, grants or awards, student loan stipends, etc.
15. Secondary vehicles including those but not limited to recreational use. (See definition of *Assets*)
16. Business/Farming Assets may be considered
17. Items that are not considered in determining income include:
    a. Value of Primary Residence
    b. Value of a Primary Vehicle

P. Insurance Eligibility: The process of validating a patient's insurance coverage with the payer by telephone or through on line verification. The eligibility verifies: payable benefits, patient details, pre-authorization number, co-pays, co-insurance details, deductibles, patient policy status, effective date, type of plan and coverage details, plan exclusions, claims mailing address, referrals and pre-authorizations, life time maximum and additional information.

Q. Non-Elective Procedures/Emergency: The care or treatment for emergency medical conditions as defined by Emergency Medical Treatment and Active Labor Act (EMTALA): Term used to describe a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual or unborn child in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A. Service Area: The list of zip codes comprising the Monument Health service market area as further defined by geographical residency.

B. Resident: Pursuant to South Dakota Codified Law 28-13-14, an occupant or patient of any licensed health care facility shall not establish residency by virtue of becoming and remaining an occupant or patient of such facility. For the purposes of eligibility, the terms resident/ residence/residency are defined as a person who:

    1. Resides within a Monument Health Service Area on a permanent, long-term basis, has no present intention of leaving, and whenever absent, intends to return
    2. Is not a dependent of another person(s) residing outside of the Monument Health Service Area
    3. Has maintained residency for a minimum of 60 days prior to receiving health care services. The 60 days is not inclusive of time spent as an occupant or patient of a health care facility
    4. Can demonstrate the preceding by providing evidence of resident eligibility documentation when requested

C. Resident Eligibility Documentation: Applicant(s) must be permanently established residents within the defined Monument Health Service Area (MHSA) for a minimum of 60 days prior to the date of service as demonstrated by evidence of residency documentation.

Requested evidence would include the following documents INCLUDING the applicant(s) name(s):

1. A copy of one of the following:
    - A copy of current rental, lease or mortgage agreement listing physical address of residence
    - A copy of current homeowner's or rental insurance policy
    - A copy of applicant(s) as property owner's tax document
    - Utility billing statements for electricity, water, natural gas, propane, or waste collection services (not inclusive of a mobile phone billing)
    - A residential rental receipt (must indicate full business name and name and phone number as contact for leasing /property management company)
    - Proof of employment within the Monument Health Service Area in the form of paystub/earnings information
    - Letter of support for adults living with family, friends, or others (See definition of *Financial Support, Household, Household Income*)

D. Under-insured: The patient has some level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. but still has out-of-pocket expenses that exceed his/her financial ability to

pay for health care services at Monument Health.

E. Uninsured: An individual who does not have “coverage” related to payment for their health care expense through a non-governmental third-party commercial and/or managed care payer, or through a government-sponsored payer such as Medicare or Medicaid.

F. Urgent: Term used to describe the condition of a patient requiring admission to the hospital for a clinical condition that would typically require admission for diagnosis and treatment within 48 hours; otherwise the patient’s life or well-being could be threatened.

POLICY GUIDELINES

A. General Requirements

1. Applicants are provided an explanation of the policies and procedures Monument Health used to determine if the applicant(s) qualifies for the Monument Health Charity Care Discount program. Notification of the availability of financial assistance will be distributed for public viewing and access in accordance with the requirements of Internal Revenue Code 501(r). The Charity Care Discount policy, plain language summary, and application are also available on the Monument Health website, www.monument.health.

2. All policies and procedures applying to financial assistance and financial clearance are applied consistently and include reasonable efforts to ensure that financial assistance/counseling is offered before any collection agency assignment or extraordinary collection action (ECA) is taken.

3. Monument Health reserves the right to reverse a discount previously recorded if it is determined that additional third party payer resources were available, or that the information provided was false.

B. Emergency Services

1. Monument Health will comply fully with all obligations imposed by the emergency Medical Treatment and Active Labor Act (ETMALA) and related regulations including but not limited to providing without regard to a guarantor's/patient’s ability to pay (and without the necessity of any pre-treatment financial screening) the provision of a medical screening exam to any patient who comes to a Monument Health Emergency Department and requests an examination or treatment for a medical condition, including active labor, and the provision of either stabilizing treatment or an appropriate transfer for patients with emergency medical conditions.

2. Also without regard to a guarantor's/patient’s ability to pay and without requirement of a pre-admission financial screening or clearance, Monument Health will provide to any patient who requests services for an emergency medical condition the full range of medically necessary services required to treat such condition that are routinely provided by the applicable Monument Health Hospital to other patients with the

same condition.

3. Patients who are provided services pursuant to paragraph a and b above may be referred for determination as to whether they wish to apply for assistance pursuant to Monument Health Charity Care Discounting Policy, on a post-admission basis, for any portion of charges not covered by insurance or other third party payment.

CHARITY DISCOUNT DETERMINATION WORKFLOW

Applicants may be approved for Charity Care Discounts by use of an oral application, without completion of a written application or without their knowledge when Monument Health personnel believe with a high degree of certainty the guarantor may not have the ability to pay for services provided. Monument Health may use an electronic a Presumptive Charity determination process by direct interface between the electronic health record and an external, publicly available data source. Using the information provided as well as the self-reported household size and income, Monument Health will determine the amount of charity discounts to be applied for balances under $500 and according to the Federal Poverty Level table. Examples of such services may include office visits and all other ambulatory services.

Evaluation and Management (E & M)/Office Visit fees will be assessed a sliding payment based on the most recent published federal poverty guidelines as indicated in Attachment D – Evaluation and Management (E & M) Sliding Payment Scale

Gross income at or below Federal Poverty Level	Write off Amount
250%	100%
251% - 300%	Medicare Best Rate

A. Presumptive Charity

Monument Health recognizes that not all applicants are able to complete the financial assistance application or provide the required documentation. There may be instances when charity discounts are warranted and the guarantor qualifies for assistance, despite the lack of formal applications and income assessment described in this policy.

In the normal course of assessment of a guarantor's ability to pay, Monument Health, in its sole discretion, may declare the guarantor's account noncollectable and classify the account as meeting eligibility criteria.

Presumptive eligibility may be granted to applicants based on life circumstances such as, but not limited to:

1. Gross income below 200% of the federal poverty limit as determined by the use of an external, publicly available data source
2. Homelessness or receipt of care from a homeless clinic

3. Participation in Women, Infants and Children programs (WIC)
4. Receiving SNAP (Supplemental Nutritional Assistance Program) benefits
5. Receiving TANF (Temporary Assistance for Needy Families) benefits
6. Eligible for other state or local assistance programs, such as Victims of Violent Crimes
7. Deceased patient with no surviving spouse or known estate
8. Catastrophic Hardship
9. Bad Debt accounts closed and returned as deemed inability to pay by 3rd party collection vendors
10. Prior Charity Care approval

B. Charity Discount Determination

For balances over $500 Monument Health will request documentation to support a charity discount. An essential element of the charity discount determination process involves provision by the applicant(s) of complete information and verification as needed about all relevant income and asset information for the applicant(s). This information includes but is not limited to completion of the Monument Health Financial Assistance Application and provision of any related verifications requested. Applications and all related verification documents may be dropped off at any point of entry in all Monument Health care sites or may be mailed to PO Box 3450, Rapid City, SD 57709-3450.

To complete the charity discount determination process, an applicant must cooperate fully with staff and other potential payers to exhaust the possibility of qualifying for third party payment for medical services requested or received. If an applicant refuses or otherwise fails to answer any or all questions or provide the supporting documentation for the questionnaire or Monument Health Financial Assistance Application a charity discount will not be applied, except in cases of application of presumptive eligibility consideration.

Charity Care will be available only for medical services that are reasonable and necessary for diagnosis and treatment of illness or injury. Services that are considered elective, cosmetic or for patient convenience do not qualify for Charity Care. Monument Health's determination of whether care or services are medically necessary is final.

The following entities are excluded from qualification for a charity discount:

- Long Term Care
- Assisted Living Center
- Home+ HME/DME (exclusive of Respiratory Therapy supplies)
- Any other service not typically provided within the inpatient or outpatient departments of an acute care hospital

- Services received from care providers not employed by Monument Health. A list of providers who are NOT included under the Monument Health Charity Care Discounting Policy is available on the Monument Health website, www.monument.health

The following persons and/or partial list of procedures are excluded from qualification for a charity discount. See Attachment A – Financial Assistance Program Exclusions for full list:

- International patients
- Persons residing outside of the Monument Health Service areas (MHSA) as defined
- Persons who opt out of any/all affordable insurance coverage (see definition)
- Persons who fail to reasonably comply with insurance requirements, such as obtaining authorization, certification, or referrals
- Patient and Guarantor accounts or services received by a guarantor or patient who is involved in pending litigation that relates to or may result in a generation of recovery based on charges for services performed at Monument Health
- Cosmetic services and surgery
- Bariatric and Weight Management services and surgery
- Elective vision and dental surgery
- Reproduction-related procedures (such as in-vitro fertilization, sterilization reversal, etc.) excluding the interruption of pregnancy to preserve the life of the mother
- Acupuncture and other non-traditional care, tests, or treatment
- Other non-covered services such as laser eye surgery, hearing aids, etc.

The charity discount determination process involves consideration of both assets and income. The assessment of assets is an inherently subjective determination made by taking into account a variety of factors believed to be relevant including but not limited to the nature and extent of the assets, the magnitude of the guarantor's financial obligation to Monument Health, the impact of the assets on the guarantor's eligibility for coverage of medical expenses by other third party payers such as Medicaid, the nature and extent of the financial needs for which the assets are currently utilized and the age and income of the guarantor and/or other responsible parties.

All charity discounts allowed by Monument Health as reductions in the guarantor’s financial obligation to Monument Health will be written off and eliminated from the applicants account. Applicants who are provided charity discounts by Monument Health will be notified in writing as to the amount of the discount and any residual balance owed to Monument Health via the next scheduled monthly billing statement and/or account transaction summary/detail bill when requested.

Only the guarantor/patient account balance owed after the application of any applicable contractual adjustment from any third party(s) will be subject to charity discount consideration

All outstanding debts for dates of service which precede the application date and for which the first billing statement was generated 240 days or less ago, will be subject to the approved discount reduction. Monument Health will refund the guarantor/patient any personal payment made in excess of the amount owed after application of approved discount is reversed as described in Monument Health's Refund Process Policy. Applications will not be accepted or discount considered for dates of services which exceed 240 days from the date of the first billing statement.

Applicants previously approved under a document supported charity discount and who require future services may be reevaluated 6 months from the initial application approval date or earlier if notification that a change in household financial status has occurred.

Prior Dates of Service From First Billing Statement Date	Future Dates of Service From Application Approved Date
240 days	6 months

OTHER CHARITY DISCOUNT PROGRAM CONSIDERATIONS

Approval for Financial Assistance and any care provided which is covered by the Charity Care Discount Program does not obligate Monument Health to provide continuing care unless otherwise required by federal or state law or regulation.

When making determinations in regards to discounting, Monument Health is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service or any other classifications protected by federal, state, or local laws.

REFERENCES

(The References used during the creation of the policy)

A. Refund Process Policy PFS-8261-09
B. Collection of Accounts Policy CS-8211-19

REGULATIONS / STANDARDS

A. *Electronic Code of Federal Regulations, Title 42: Public Health PART 405 FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED Subpart D—Private Contract*
B. *EMTALA. Centers for Medicare and Medicaid Services Web site. Available at:* https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html

All Revision Dates

05/2022, 06/2021, 06/2021, 09/2020, 01/2020, 05/2019, 04/2019, 01/2017, 11/2016, 09/2016

Attachments

A: Financial Assistance Program Exclusions

B: Financial Assistance Program Definitions

C: Financial Assistance Service Area Zip Code

D: Evaluation & Management (E&M) Sliding Payment Scale

Approval Signatures

Step Description	Approver	Date
	Theodore Syverson: VP Revenue Cycle	05/2022
	Teresa Burroff: General Counsel	05/2022
	Stacie French: Senior Director of Enterprise Admissions and Regis	05/2022