**CMP_01_112: Patient Financial Responsibility and Discount Guidelines**

## Department:

Regulatory Compliance

## Replaces Document Number:

**C-04-14** Patient Financial Responsibility and Discount Guidelines

## Purpose:

To establish specific and limited circumstances under which it is permissible for a Company healthcare facility to waive or reduce a Patient's obligation to pay.

## Persons Affected:

This policy is applicable to all teammates, business associates (contractors, consultants, temporaries, volunteers, physicians, clinicians, and other workforce members at SCA), including all personnel affiliated with third parties.

## Definitions:

## Policy Statement:

The federal government, state governments, commercial payor contracts, and other rules and regulations all impact how SCA may determine and collect patient financial responsibility. The following information is meant to provide general guidelines. For any professional courtesy discount / waivers to be provided to physicians please refer to ***RCO_02_103: Professional Discounts***.

### I. Financial Hardship

For all payors, including self-pay, a patient may request a Charity/Hardship Exemption/Waiver. The determination of financial need and any discount will require the following steps:

a. The patient must complete a Financial Disclosure Form that at minimum requests the monthly income and the number of people in the household. There should be some form of verification of income.

b. The amount of discount should be based upon the HHS Poverty Guideline. The approval should be made on a case-by-case basis.

c. Discounts given for financial hardship should be able to be tracked either through manual or automated means. Documentation must be retained in the patient financial record

### II. Other Waivers

#### A. Medicare Inpatient Hospital Waivers

A hospital provider may waive or reduce the co-insurance or deductible obligations owed by Medicare patients (including those members of affinity groups or programs, such as Senior Friends, who are Medicare beneficiaries), as long as the hospital strictly complies with all the of the four (4) requirements:

**Contracted Insurance Carriers / Payors**

a. The coinsurance or deductible amounts waived must be: (a) owed to the hospital, (b) for inpatient hospital services, and (c) reimbursed under a Medicare Part A prospective payment system (e.g., IPPS system);

b. The hospital must not later claim the amount reduced or waived as bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or the waiver onto Medicare, a state healthcare program, other payors, or individuals;

c. The hospital must offer to reduce or waive the coinsurance or deductible amounts without regard to:
(a) the reason for admission, (b) the length of stay of the beneficiary, or (c) the diagnostic-related group for which the claim for Medicare reimbursement is filed; and

d. The hospital's offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between the hospital and a third-party payor, unless the agreement is with the furnisher of a Medicare SELECT policy (but not a Medigap policy).

Medicare SELECT is a type of Medigap supplemental insurance, which provides full payment of benefits if services are furnished through a network of preferred providers.

B. Routine waiver of copays, co-insurance or deductible (other than for financial hardship) may only be granted with a signed consent from the patient's insurance company indicating approval.

**C. Non-Contracted Insurance Carriers / Payors**

a. If allowed by state law, a facility may match in-network benefits for beneficiaries of a health plan that has refused to conduct good faith contract negotiations with SCA. A decision to match in-network patient cost-sharing obligations (e.g., deductibles, copayments, and coinsurance) for a particular health plan must be approved by Regulatory Compliance and the VP for Managed Care. The facility must also notify the insurance carrier / payor that it is accepting in-network cost-sharing by including the following statement on the claim form: In-network cost-sharing obligations accepted. A decision to accept in-network cost-sharing may be communicated to patients or physicians receiving or furnishing services at the facility but should not be part of a marketing campaign to attract new patients or physicians to the facility.

b. Discounts given for non-contracted carriers should not be claimed as bad debt or charity care. Discounts given for non-contracted insurance carriers should be able to be tracked through manual or automated means.

**D. SCA Teammates**

SCA teammates with SCA Insurance - Under the Company's published teammate benefit plan (the ERISA document filed with the U.S. Department of Labor), teammates with health insurance benefits are given a significant discount on co-payments and co-insurance when using an SCA facility. This reduces out-of-pocket costs to the teammate. However, under the terms of the benefit plan, SCA facilities may not waive or further reduce any co-payment, coinsurance, or deductible beyond this designated amount. As stated within the Benefit Plan Summary/Guide, "*SCA facility fees are waived. However, enrollees in the Value or Select CDHP Plans must meet their deductible first.*"

1. **High Deductible Plans (Value or Select CDHP):** Services performed at SCA-owned ASCs are covered at 100% after the deductible has been met. Deductibles on this plan cannot be discounted or waived.

2. **PPO Plan:** Services performed at SCA Affiliated ASCs are covered at 100%. Deductible does not apply.

SCA teammates with health insurance benefits from other sources (e.g., a spouse's plan) are not eligible for any discounts and are treated the same as all other SCA patients for the purpose of this policy (In Network Insurance - See #B above, Out of Network Insurance - See #C above)

A Write-Off Approval Form must be completed and approved. See policy RCO 02_112 "SCA Teammate Discount" for the procedure steps and approval limits.

**E. No Insurance**

a. If an uninsured patient or a patient without insurance benefits (e.g., insurance does not cover the service, the patient's benefit coverage limit maximum has been reached, the patient does not have coverage due to an imposed waiting period for a pre-existing condition, etc.) does not qualify for or does not want to request a financial hardship waiver (see Section I above), then payment in full is requested from the patient at time of service. However, a facility may adopt a uniform payment plan agreement to offer to patients who are unable to remit payment in full on the date of service if the plan reverts to full charges if violated. The respective facility may adopt a uniform uninsured discount of charges provided that it is made available to all patients in a non-discriminatory manner.

b. Discounts given for no insurance patients should not be claimed as bad debt or charity care. Discounts given to uninsured patients should be able to be tracked though manual or automated means.

**F. Case-by-Case Waivers**

For all payors, waivers may be approved by Vice President level or above on a case-by-case basis to resolve a credible patient dispute where the quality of service furnished to a patient falls significantly below usual SCA standards (e.g., billing mistakes, poor service, or excessive waiting times for services). Approval levels for write-offs are specified in the Revenue Cycle Operations (RCO) policies.

**III. Collection of Patient Cost-Sharing Obligations at the Time of Service**

**Co-payments.** SCA is expected to collect patient co-payments (e.g., a flat $25 charge per visit or service) in accordance with the terms of payor contracts at the time of service.

**Deductibles and Co-Insurance.** Individual facilities may adopt procedures to collect for deductibles and coinsurance. The following procedures should be included:

a. **Contract Review Procedure** — The facility administrator or designee reviews each commercial payor contract (and applicable provider manuals) to confirm that the payor does not prohibit the collection of unmet deductibles and/or coinsurance amounts from the patient at the time of service.

b. **Insurance Verification** — The patient cost sharing obligation is confirmed with the payer and documented with the time and date of the contact and name of SCA Health representative and payer representative/portal.

c. **Calculation of the Cost-Sharing Obligation** — Documentation of the patient cost sharing obligation is maintained by the facility.

d. **Notification of Patient** — The patient is informed of his/her cost share amount before or at the time of service.

e. **Overpayment Resolution** — The facility has processes in place to identify and refund overpayments of cost-sharing obligations in a timely manner.

**Medicare Inpatient Deductibles.** If a Medicare patient confirms that he/she has not had a hospital stay in the past 60 days, the inpatient facility may collect the Medicare deductible amount from the patient upon admission.

IV. **Patient Balance Billing.** SCA may not bill a patient covered by government or commercial insurance for an amount greater than the amount indicated as patient responsibility on the Explanation of Benefits unless explicitly allowed by the contract or regulation. See ***RCO_04_107: Advance Beneficiary Notice of Noncoverage (ABN)***, for an exception where a Medicare patient has executed an ABN in advance of receiving service acknowledging his/her obligation to pay certain charges if Medicare does not.

**V. Other Policies**

The Company has developed two other business office policies further implementing this policy's requirements: ***RCO_02_108: Financial Hardships - Charity Discounts***; and ***RCO_02_109: Other Discounts***.

Please see ***RCO_02_103: Professional Discounts*** for information regarding professional courtesy discounts.

Classified as Confidential

## Enforcement:

Any teammate found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

Business associates found to have violated this policy may be subject to financial penalties, up to and including termination of contract.

These policies, procedures, and forms are compiled based on both legal and regulatory requirements as well as industry standard best practices. Persons are expected to use established practices and sound judgment in making decisions.

SCA policies and procedures are confidential proprietary information that should not be disclosed to individuals outside SCA. All confidential or proprietary information should be protected against theft, loss, and unauthorized disclosure.

## Review and Update:

This policy is to be reviewed annually to determine if the policy complies with current regulations and SCA practices. In the event that significant related changes occur, the policy will be reviewed and updated as needed.

## Referenced Documentation:

## Contact Information:

If you have questions or concerns regarding this policy, please click on "Approval Details" (on the top right) and email the "Approved By" person. Include the policy name and number in your email. If you cannot reach the policy approver or if you need further assistance, please email regcomp@scasurgery.com.

## Reviews and Approvals prior to the MCN system:

| Reviewed by | Date |
|---|---|
| C. Scott Thompson | 05/28/2009 |
| C. Scott Thompson | 12/16/2010 |
| C. Scott Thompson | 04/17/2013 |
| C. Scott Thompson | 08/05/2014, 09/01/2015, 7/7/2016 |

| Approved by | Date |
|---|---|
| Compliance Committee of SCA Board of Directors | February 2009 |
| P&P Task Force | June 2009 |
| | |