PARALLON
HCA Healthcare

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured North Carolina Hospitals (Medical Debt Mitigation Policy)
PAGE: 1 of 7	REPLACES POLICY DATED:
APPROVED: 1/1/2025	EFFECTIVE DATE: 01/01/2025
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.OPS.016NC

SCOPE:
All SSC and Facility areas responsible for requesting and evaluating eligibility for financial assistance discount applied to the amount the patient owes at HCA-affiliated, non-partnership, acute-care hospitals in North Carolina (collectively "Hospitals" or “Facilities”, individually “Hospital” or “Facilities”). This policy is intended to capture the requirements of the Hospital Medical Debt Mitigation Policies specified by North Carolina’s Department of Health and Human Services (the “Department”) under the Healthcare Access and Stabilization Program (“HASP”).

PURPOSE:
To define the policy for providing partial or full financial relief to patients who (i) scheduled or received medically necessary services at North Carolina Hospitals, and (ii) meet certain eligibility or income requirements. In addition, where applicable, the policy establishes protocols with respect to presumptive screening as well as alternative pathways for Financial Assistance Application (“FAA”) and income validation.

POLICY:

General Scope

1) Services. To be eligible for a financial assistance discount review, a patient must have scheduled or received medically necessary, inpatient and/or outpatient Hospital services.[1]

2) Insured Patients. In circumstances where a patient has some form of third-party payer coverage for health care services, but such coverage is insufficient to pay the current bill, the remaining patient liability is eligible for consideration under this policy.

Medicaid Patient and FPL Lookbacks

1) Medicaid Patients:

   A. *Initial Debt Forgiveness Lookback.* On or before July 1, 2025, the Hospital shall reclassify as charity care any unpaid patient medical debt dating back to January 1, 2014 for individuals who are currently enrolled in Medicaid (including in limited benefit family planning coverage). This reclassification shall include any debts subject to a payment plan.

   B. *Ongoing Review and Debt Forgiveness.* Prior to July 1, 2025, the Hospital shall implement processes to evaluate patients who enrolled in Medicaid for past medical debt. Such evaluation shall occur within 60 days of each Medicaid enrollee’s inpatient discharge or outpatient encounter. The Hospital will also reclassify any past debt of Medicaid-enrolled patients that proactively contact the hospital to inquire about medical debt relief. All past medical debt must be reclassified as charity care. To implement this requirement, active accounts will be written off as charity, and historical accounts previously written off due to exhausted efforts will remain undisturbed and not be reopened.

[1] Pursuant to HASP, cosmetic surgery, as defined by DHB Clinical Coverage Policy No: 1-O-1, is excluded from financial assistance discount write-off application.

C. *Patient Notification*. The Hospital shall not advertise the policy but will inform the Medicaid enrolled patient about the policy during the patient's encounter at the Hospital. A notice will also be provided to the patients within 30 days of reclassification of the debt as charity care.

2) Income-based/FPL Level:

A. *Initial Debt Forgiveness Lookback.* The Hospital shall, on or before June 30, 2026 (or such other date as designated by the department), relieve all medical debt deemed uncollectible[2] dating back to January 1, 2014 for any individuals with incomes at or below 400% FPL or for whom total debt exceeds 5% of annual income (excluding any Medicaid-enrolled individuals whose debt was relieved or reclassified, as discussed above). For patients up to 300% FPL, any outstanding balance on a payment plan where the patient has made payments for more than 36 months will also be relieved.[3] Patients will qualify if income at the time of data analysis meets the specific income threshold.

B. *Patient Notification*. A notice will be provided to the patients within 30 days of reclassification of the debt as charity care.

Presumptive Eligibility Procedures

The following Presumptive Eligibility ("PE") procedures describe processes for screening patients to determine inability to pay for services. Patients are not required to provide documentation or other verification of meeting presumptive eligibility criteria. If a patient is not deemed presumptively eligible to apply for financial assistance, documentation may be submitted.

1) Non-Income-Based Presumptive Eligibility Review:

A. Patients who meet at least one of the following non-income-based criteria are deemed presumptively eligible for financial assistance discount write-offs:
- Homelessness;
- Mental incapacitation with no one to act on the patient's behalf;
- Enrollment in Medicaid of patient or a child in their household;
- Enrollment in another means-tested public assistance program (including, but not limited to Women, Infants and Children Nutrition Program, Supplemental Nutrition Assistance Program); or
- Patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy.

B. The Hospital shall screen patients for non-income-based PE and notify patients of the results based on the following timeline:

[2] At a minimum debt should be considered uncollectible after unsuccessful attempts at collecting on the debt (meaning the debt has not been paid in full or payment plan has not been established) have been made for at least two years from the date the first bill was sent to the patient and there is no active appeal with an insurer related to the debt.
[3] For payment plans in place where patients below 300% FPL in place for less than 36 months, such plans will be capped at 36 months with no change to the monthly payment amount.

i. *Non-emergency department services:*
   A. Screening: Prior to or at check in.
   B. Notification: Prior to discharge.

ii. *Emergency department services:*
   A. Screening: As soon as possible and prior to discharge if feasible.
   B. Notification: Prior to issuing bill to patient.

2) Income-Based Presumptive Eligibility Review: On or before January 1, 2026, the Hospital shall implement processes for income based presumptive eligibility screening. Patients with household income up to 300% of FPL will be considered presumptively eligible and will receive notice of income-based presumptive eligibility prior to issuing a bill to the patient.

Charity Processing based on Federal Poverty Guidelines

1) Patients with individual or household incomes of between 0-200% of Federal Poverty Guidelines: Qualifying patients that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off.

2) Patients with individual or household incomes of between 201- 400% of Federal Poverty Guidelines:

   A. Patients with incomes between 201% and 400% of FPL will have their balances capped according to the specifications below. Annual household income will be determined using the patient's FPL. Discounts must be applied to the amount the patient owes (i.e. accounting for contractual allowances and insurance payments, if applicable) or the “amount generally billed” for uninsured individuals.

      i. 201% - 250% - balances capped at the lessor of 3% of annual household income or 25% of the amount the patient owes

      ii. 251% - 300% - balances capped at the lessor of 3% of annual household income or 50% of the amount the patient owes

   B. For individuals with incomes between 200 - 300% FPL, the Hospital will offer an interest-free payment plan that does not exceed a duration of 36 months with monthly payments no greater than 5% of monthly household income (“36 month/5% income plan”). The Institution may offer alternative payment plans that exceed 36 months, but the aggregate amount collected from the patient shall not exceed what would have been collected under the 36 month / 5% income plan.

   C. 301% - 400% - balances capped at 4% of annual household income

i. *Note: uninsured and underinsured patients above 400% FPL may be eligible for other financial assistance pursuant to the Hospital's uninsured discount and patient liability protection policies.*

3) Income-Based Criteria & Verification / Alternative Path (Non-Presumptive) Documentation

A. For individuals who are *not* deemed presumptively eligible for a financial assistance discount, a Financial Assistance Application (FAA) should be submitted. Generally, the most current year's federal income tax return is the preferred supporting documentation. However, patients should be asked to provide any available documentation, including any of the following:

- Federal Income Tax Return for the most current year
- State Income Tax Return for the most current year
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report
- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Proof of Medicaid Eligibility

B. Electronic validation of patient income and family size, such as Experian may support a determination hereunder with or without completed FAA or complete supporting documentation, however, a completed FAA, specific supporting documentation, and/or asset review may be required prior to processing to the extent necessary to comply with applicable law, regulation or program requirements governing any applicable charity care reporting.

C. Medicare beneficiaries in particular should be encouraged to provide as much documentation as possible to support Medicare independent income and resource verification requirements. It is permissible to follow up with Medicare beneficiaries to request additional supporting documentation.

There may be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. Such extenuating circumstances may include:

i. *Patients identified as an undocumented residents or homeless through*:

- Medicaid Eligibility screening
- Registration process
- Discharge to a shelter
- Clinical or Case Management documentation
- Absence of a credit report

ii. *Patients that expire* - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse).

iii. *Medically Indigent* – In addition to the above, if a patient/responsible party meets any medically indigent status based upon state guidelines or requirements.

D. Patients/Responsible Party Deemed Eligible.

i. The patient/responsible party may be deemed to meet the charity guidelines if any of the non-income based presumptive criteria are determined to be applicable.

4) Patient Dispute Process: In the event a patient wishes to file a dispute and appeal their eligibility for a Charity write-off under this policy, the patient may seek review from the Operations Support Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.OPS.020).

Debt Collection Practices

1) Agreements with Collection Agencies: Any agency involved in patient collections will have a written agreement that it will adhere to the hospital's standards and scope of practices and comply with the hospital's definition and application of a reasonable payment plan. The Hospital will also ensure that all contracted debt collection entities comply with all requirements applicable to the hospital outlined in the HASP Hospital Medical Debt Mitigation Commitment.

2) Patient Debt Collection Protections

A. The Hospital shall not sell or transfer medical debt under any circumstances. The Hospital, SSC, CSO or any outside collection agency shall not take the following extraordinary collection actions under any circumstances: (i) charge interest on medical debt; (ii) report medical debt to credit bureaus; or (iii) pursue litigation activity that involves suing patients or filing liens on patient bad debt accounts. (iv) cause an individual's arrest to collect medical debt; (v) cause an individual to be held in civil contempt or imprisoned to collect medical debt; (vi) foreclose or an individual's real property to collect debt; (vii) garnish wages or state income tax refunds to collect medical debt.

B. Pursuant to HASP, an extraordinary collection action includes any of the following: selling an individual's debt to another party, except if prior to the sale, the medical creditor enters into a legally binding written agreement with the medical debt buyer establishing certain patient protections related to the debt collection; reporting adverse information about the patient to a consumer reporting agency; actions that require a legal or judicial process (e.g., placing a lien on an individual's property, commencing a civil action). The Hospital does not take any of these actions.

3) Liability for Medical Debt: No individual (except for spouses) will be held liable for medical debt of any other person 18 or older, but individuals may voluntarily assume liability. A spouse held liable for a patient's medical debt will be eligible for the same medical debt mitigation policies offered to the patient.

4) Insurance Appeals: Referral of debt to an external debt collector will not occur until at least 60 days from any insurance appeal or review.

REFERENCE:

- North Carolina Healthcare Access and Stabilization Program (HASP) Hospital Medical Debt Commitment Letter