Crawford Memorial Hospital
Business Office
Policies & Procedures

Title/Description:	**Financial Assistance (formerly Charity)**		
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Effective Date:	9/1994	Last Review Date:	6/2021
Review Due:	11/2021	Last Revision Date:	6/2021
Applies To:	Business Office	Approved By:	CFO/Board

PURPOSE:

To establish a policy for providing financial assistance for patient accounts and to specify the notification requirements, including additional assistance for uninsured patients

POLICY:

Financial assistance may be granted upon completion of requirements by Patient Financial Services Manager. Patients whose family income is less than 400% of the Federal Poverty Guidelines will qualify for partial or full assistance under this policy. Financial Assistance patients will not be charged more than amounts generally billed to insured patients. Exceptions may be granted only by CFO approval. Attached is a listing of providers covered under this policy, which may be updated without revising this policy.

Presumptive Eligibility
Uninsured patients will be screened for presumptive eligibility criteria prior to the first billing. Presumptive eligibility for 100% assistance includes any patient who is homeless, deceased with no estate, mental incapacitation with no one to act on patient's behalf and current Medicaid eligibility. No application will be required for patient's meeting presumptive eligibility criteria; however, proof of status and/or application for potential insurance coverage may be requested.

Application-based Eligibility
Financial assistance will be granted based on percentages of the most recent poverty guidelines as established by the Federal Government Services Agency. Other criteria may also be taken into consideration. Proof of current income will be required. Any patient that we believe may qualify for Medicaid or other insurance will be required to apply and submit the result, including possible backdating of Medicaid coverage.

Uninsured patients will be considered for additional financial assistance based on the Illinois Hospital Uninsured Patient Discount Act passed in 2008, amended in 2012. Uninsured patients, who are deemed by us to be Medicaid eligible if they apply, but refuse to, will not qualify for full financial assistance. These Medicaid-eligible uninsured patients will receive a maximum discount of 60%.

If partial financial assistance is granted, remaining portion will need to adhere to “Payment Plan Policy”.

Financial assistance will only be granted after all available sources of payment have been exhausted. The same guidelines will be followed for both uninsured and insured patients. See “Financial Assistance Chart” associated with “Payment Plan Policy”.

The Financial Assistance application form will adhere to the information request limits contained in the Fair Patient Billing Act and will contain a required certification statement signed by the applicant.

Notification of Financial Assistance will be placed in conspicuous locations including point of service, statements, web site and other places specified in the procedure section of this policy.
This policy adheres to Public Act 094-0885, an Illinois 2006 law, Public Act 095-0965, an Illinois 2008 law and Public Act 097-0690, an Illinois 2012 law and Section 501(r) of the Internal Revenue Code.

PROCEDURES:

We will publish notification of financial assistance in various areas of the hospital and clinics. Clinic reception areas and patient admitting areas will have signs. Business office and any other secondary areas identified will also have signs. Notification and copies of the forms will also be placed on the hospital website. A notice will also appear on statements and bills to patients.

Patients being referred to a collection agency will be mailed a summary of the financial assistance process prior to any extraordinary collection actions (ECAs) Collection agencies will be required to script an offer of financial assistance in the collection calls.

Patient statements will contain contact information for billing inquiries, as well as how a patient may apply for financial assistance and that an itemized bill is available upon request.

Patients applying for financial assistance may be reviewed through an online healthcare credit scoring tool and be awarded financial assistance from that data. The consent for this screening is on the financial assistance application. Online scoring and financial assistance determination will be retained in the same manner as paper financial assistance applications and approvals.

A patient may obtain a Financial Assistance Form in any clinic, registration area, the business office, the clinic billing office, or the Hospital website. The application may be filled out by any person who knows the patient's financial situation and can provide the requested documents. Questions about the form should be addressed to the Business Office.

After a patient has requested financial assistance, they have 30 days to return requested documentation to the collector. After all information is collected, the Financial Assistance Analysis Form should be completed. The Hospital must respond back to the patient in writing within 14 days of receiving the application and required documents. When a patient requests a financial assistance form, the patient representative should inquire if there are any other related accounts, such as RHC, Hospital, or Home Health and notify other billing staff as appropriate.

The AR patient representative will turn completed financial assistance forms including necessary documentation in to the Patient Financial Services Manager for approval. The manager may approve the form with the highest discount of the "Financial Assistance Chart", the IL Hospital Uninsured Discount calculation, or the Affordable Care Act's "Amounts Generally Billed" discount, if applicable. Any special situations that do not fall within the parameters of this chart but that the manager recommends financial assistance for must be approved by the CFO. Assets, liabilities, and expenses as well as the gross income of the patient may be taken into consideration for final determination of financial assistance. Approved forms should be shared with Clinic Billing when needed.

Financial Assistance will be available to patients who must have received medically necessary care, and all other sources of payment (Medicare, Medicaid, insurance, liability, etc) must be exhausted. Uninsured patients that refuse to apply for Medicaid or other insurance but otherwise meet the requirements will be granted a 60% discount. Accounts that are over 240 days old for which legal action has been initiated may not be considered for financial assistance because the hospital and collection agencies have invested significant costs to collect the debt and the patient had been given opportunities to request assistance before legal action had been initiated.

A patient who does not qualify for financial assistance initially may re-apply at any time that there is significant change in their financial situation as long as their accounts are in good standing. All patients will have at least 120 days from the first statement date (considered the notification date) to submit an application before going to a collection agency. Any applications received until 240 days from the first statement date or notification of financial assistance will result in immediately suspension of collection activity until the application is processed.

The Hospital will not pursue legal action for non-payment of bills against financial assistance patients who have clearly demonstrated that they have neither sufficient income nor assets to meet their financial obligations. The Hospital will not place a lien on a financial assistance patient's primary residence. The Hospital will not execute a lien by forcing the sale or foreclosure of a financial assistance patient's primary residence to pay for an outstanding medical bill. The Hospital will not use body attachment to require the financial assistance patient or responsible party to appear in court.

The Hospital will ensure that the guidelines outlined above are followed by any external collection agency engaged in extraordinary collection action to assist in obtaining payment on outstanding bills from financial assistance patients. Extraordinary collection actions consist of credit bureau reporting, legal actions, and denying/deferring future non-emergency care. The Hospital may deny or defer medically necessary care due to non-payment of past medical bills that are over 240 days old and not within 30 days of the patient initiating a financial assistance application. A patient being denied care will be given a financial assistance application and policy summary. Both written and oral required notification of financial assistance availability must be documented.

Emergency care will always be provided without discrimination according to EMTALA laws. Application for or award of financial assistance will not affect a patient's access to treatment for emergency medical conditions. Amounts billed to a patient qualifying for financial assistance will not exceed the amounts generally billed to patients with insurance coverage of the same care.

“Amounts generally billed” (AGB) is calculated per the Affordable Care Act Look-Back Method for claims paid in the prior calendar year (regardless of the service date). The calculation under the look-back method divides total amount “allowed” by Medicare and all private health insurers by total gross charges. “Allowed” amount is the amount reimbursed by insurance plus the amount to be paid by the patient, regardless of whether the amount is actually paid. To obtain information about the discount percentage amount free of charge, the patient may contact the Hospital Business Office at (618) 943-2568.

CRAWFORD MEMORIAL HOSPITAL

Listing of Providers covered by Hospital Financial Assistance Policy

- Emergency Room Physician Group
- Radiologists
- Anesthetists
- Pathologists
- Hospitalists
- Sleep Medicine physician
- Bone and Joint Center – Orthopedic providers
- General Surgery Clinic – General surgeons
- Urology and Gynecology services provided in the Consulting Clinic
- CMH Home Health services
- Wound Clinic providers
- Pain Clinic providers

Listing of Providers covered by Clinic Financial Assistance Policy

- CMH Rural Health Clinic
- CMH Rural Health Clinic – Oblong
- CMH Rural Health Clinic – Palestine
- CMH Med Center Rural Health Clinic
- Orthopedic services provided by CMH providers outside of CMH
- General Surgeon services provided by CMH providers outside of CMH

Providers/Services NOT covered

- Local physicians that are not in the CMH Rural Health Clinics, including those physicians' hospital visits and procedures
- Consulting Clinic physician services (Neurologist, Ophthalmologist, Otolaryngologist, Cardiologist, Bariatrics, Oncologist, Audiologist, Podiatrist)
- Surgeon fee when performed by a Consulting Clinic physician
- Cardiologist interpretations of outpatient pulmonary tests
- Event Monitor contracted services for 24 hour alerting to critical events
- Providers of Durable Equipment, Orthotics, Prosthetics, other home use devices
- Hospice services
- Cosmetic Services, even if performed by covered providers listed above