Financial Assistance/Charity Policy

Department(s)	Financial Counseling, Patient Financial Services, Patient Access
Original Effective Date	03/01/1998
Scope	Departmental

Cross Reference TJC Standard			
Current Review Date	01/08/2014, 12/22/2015, 05/18/2017, 02/14/2018		
Signatures Prepared by	Deborah Massey	Date	02/14/2018
		Title	PFS Director
Signatures Approved by	Lavonda Cravey	Date	02/14/2018
		Title	VP Corporate Revenue

PURPOSE

Coffee Regional Medical Center ("CRMC") is a non-profit healthcare provider recognized by the Internal Revenue Service as a tax-exempt organization under Internal Revenue Code Section 501(c)(3). CRMC's mission is to be the recognized regional center of health care excellence in South Georgia through the promotion of health and the delivery of health related services. We will work as a community partner, providing quality, cost-effective, personal and progressive healthcare, serving the health care needs of Coffee County and the surrounding area for more than half a century. "TO SERVE, TO HEAL, TO SAVE"

POLICY STATEMENT

CRMC is committed to providing Financial Assistance Program ("FAP") to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. CRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. CRMC will provide, without discrimination, care for emergency medical conditions (within the meaning of EMTALA) and medically necessary care to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy;

- Includes eligibility criteria for financial assistance – free and discounted (partial charity) care;
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy;
- Describes the method by which patients may apply for financial assistance;
- Describes how the hospital will widely publicize the policy within the community served by the hospital;
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the hospital for commercially insured or Medicare patients.

In order to manage its resources responsibly and to allow CRMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient financial assistance.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with CRMC's procedures for obtaining financial assistance or other forms of payment and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

The Financial Counseling Department will provide information and applications to all patients/guarantors seeking financial assistance for services rendered at CRMC that are deemed medically necessary.

Financial Counselors will discuss eligibility for Medical Assistance Programs through the Department of Family & Children Services and Social Security Administration. If eligibility is not met for any Medical Assistance Program, the Financial Counseling Department will seek eligibility through CRMC's FAP.

Funds available for patient care under the FAP are directly tied to annual allocations to CRMC by the State of Georgia Department of Community Health through the Indigent Care Trust Fund and are subject to variations in amounts from year to year. Per FAP guidelines, CRMC shall not be required to provide services without charge, or at a reduced charge once the Hospital's expenditures meet the medical indigence services requirement described on Page R-7 subsection II B(e)12(c) of the Financial Assistance Program manual, and as required meeting emergencies and as required by EMTALA.

Given the limited funding available through the FAP, priority for use of funds will apply to Emergency Room and Inpatient care provided to patients. Elective procedures, those services determined to be of a non-emergent nature, and services which can be performed in a lower cost setting, (i.e., outside of the hospital) will carry the lowest priority for use of Financial Assistance funds and will only be adjusted at maximum of 85%.

A. **Services Eligible Under This Policy.** For purposes of this policy, "financial assistance" refers to healthcare services provided by CRMC without charge or at a discount to qualifying patients. The following services are considered medically necessary and are eligible for financial assistance:

1. Emergency medical services provided in an emergency room setting or posing a threat to the patient's ongoing health or well-being;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at CRMC's discretion based on an examining physician's determination.

B. **Eligibility for Financial Assistance.** Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this FAP. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age,

gender, race, social or immigrant status, sexual orientation or religious affiliation. Each request for financial assistance will be reviewed independently and reviewed on a case-by-case basis.

C. **Method by Which Patients May Apply for Financial Assistance.**

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

    a. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;

    b. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

    c. Include reasonable efforts by CRMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;

    d. Take into account the patient's available assets, and all other financial resources available to the patient; and

    e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

2. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a six month period, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. CRMC's values of human dignity and stewardship shall be reflected in the application process, financial needs determination and granting of financial assistance. Requests for charity shall be processed promptly and CRMC shall notify the patient or applicant in writing within five (5) days of receipt of a completed application.

D. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, CRMC could use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;

2. Homeless or received care from a homeless clinic;

3. Participation in Women, Infants and Children programs (WIC);

4. Food stamp eligibility;

5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/subsidized housing is provided as a valid address; and

8. Patient is deceased with no known estate.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Financial Assistance: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims an individual as a dependent on his or her income tax return, the individual may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members. (Non-relatives, such as housemates, do not count).

Federal Poverty Guidelines (FPG): guidelines published annually in the Federal Register; amounts are driven based on income and family size; FPG is used as the basis for determining categorization of financial assistance program

Plain Language Summary: a description of the application process, appropriate times to apply for financial assistance, and contact information for CRMC's financial assistance counselor who can provide assistance with the application process

Insured: a patient with health insurance coverage

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities

Discount: an adjustment to reduce the balance due on an account

Gross charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Emergent Admission: a condition requiring immediate medical attention, time delay would be harmful to the patient; illness is acute and/or potentially threatening to life or function

Urgent Admission: a condition requiring medical attention within a short period; a possible danger exists to the patient if medically unattended

Non-Urgent Admission: a condition which does not require the resources of an Emergency Department or emergency services; referral for routine medical care may or may not be needed; illness is non-acute or minor in severity

PROCEDURES

1. Patients/guarantors requesting financial assistance are referred to the Financial Counselors (FC) or Benefit Specialist at the time of registration for outpatient services and emergency department, (after medical screening has been completed), social services request, physician offices request or from the Patient Financial Services Department. Patients admitted for inpatient or observation services may be visited by the FC after the patient has been placed in a room and stabilized.

2. FC will discuss with the patient/guarantor the FAP requirements and application process. If verification is not provided at the time of the interview, the patient/guarantor will be required to provide within 30 days. CRMC cannot deny assistance due to an applicant's failure to provide information or documentation not specified in the FAP or the application. The patient/guarantor will be required to complete a Financial Assistance application, provide proof of the following:

- Most recent bank statements for personal and business checking and savings accounts;
- Recent pay stub(s) with validation of pay frequency;
- Current year w-2 form and/or recent year tax return;
- Written verification of wage from employer;
- Written verification from public welfare agencies or other government agencies which can attest to the patients gross income status for the past 12 months;
- Social security award letter;
- Verification of pension or retirement income
- Attorney and/or child support court order or divorce decree;
- Statement of no income
- State of Georgia separation notice and status of unemployment filing;
- Verification of student status;
- Monthly expenses (i.e., utilities, auto payment, insurance, loans, etc.)
- Patients seeking assistance due to medical indigence may need to submit evidence of assets.

Applications made on behalf of deceased patients must have verification of income and information concerning the value of the patients' estate and provide a death certificate. CRMC will make an attempt to verify patient's estate through websites, court documents, and newspapers.

3. **CRMC shall make available on request, free of charge, by mail and at the hospital** (in at the emergency department and admissions) in English and Spanish: the FAP, application form, and plain language summary

4. Patients/guarantors may contact CRMC's financial assistance counselor directly at 912-383-6969, if they feel they may qualify for financial assistance. Financial Counseling services are also provided in, but are not limited to , the following points of service:

- All registration areas
- Insurance Verification/Pre-admission/Pre-certification
- Inpatient hospital rooms
- Direct contact with patients or their families/friends
- Physicians and/or office representatives
- Emergency room
- Billing and Collections
- All other departments in CRMC

4. Upon receipt of the completed application including necessary documentation, calculation of the household size and annual household income is computed and compared to the Federal Poverty Guidelines (FPL) to determine the percentage of assistance a patient/guarantor is eligible to receive. Patients whose annual household income is below the Gross Income Ceiling for potential Medicaid eligibility are required to apply for Medicaid. Assistance is provided to patients in filing for other benefits and completing Medicaid applications.

- Patients who choose not to utilize current benefits they are eligible for, i.e. Veterans benefits, Medicare, Medicaid, and commercial insurance will not be considered for the FAP Program.

- Patients who choose to apply CRMC's accounts for the purpose of meeting medically needy spend down to receive ongoing Medicaid will not be allowed to apply for the financial assistance program for that account.

- Patients/guarantors over eighteen (18) years of age, but classified as dependents for tax purposes due to student eligibility, will have a total household size including parents and subsequent income.

- Patients/guarantors under twenty-one (21) years of age living in the home with their parents will have a total household size including parents and parents' income. If the patient/guarantor can provide proof of self-sufficiency, the situation will be evaluated and may be considered on patient's/guarantor's income alone.

- Patients applying for prior year dates of service eligibility will be determined based on the income of that year.

4. Patients/guarantors not eligible for other medical assistance programs will be processed under the FAP guidelines using the following categories:

- **Indigent** - Patients whose annual household income is below 125% of the FPL, the applicable accounts will be adjusted to zero balances.

- **Charity** - Patients whose annual household income is greater than or equal to 125% but not greater than 200% of the FPL, the applicable accounts will be adjusted by the appropriate percentages.

    1. An adjustment of 85% of gross charges for emergency or other medically necessary care for patients whose annual household income is between 125% and 150% of FPL.
    2. An adjustment of 70% of gross charges for emergency or other medically necessary care for whose annual household income is between 150% and 175% of FPL.
    3. An adjustment of 62% of gross charges for emergency or other medically necessary care for whose annual household income is between 175% and 200% of FPL.

- **Catastrophic** - Patients whose annual household income is greater than 200% FPL may qualify for

charity adjustments on applicable accounts if consideration of CRMC patient obligations reduces the annual household income to the appropriate FPL.

1. In the instance that the patient's total annual household income is less than the total liability or charges, and the liability results in the income falling below the 200% of the FPL, then the patient may be eligible up to a maximum of a 85% adjustment.

5. Notification of status of completed application is provided to the patient/guarantor within five (5) working days of receipt of needed information. Approved applications are valid for ninety (90) days from the date of signature. After the initial ninety (90) days, a re-validation may be completed in writing or verbally between the financial counselor and patient/guarantor. A new financial assistance application is required after the six (6) month period.

6. Incomplete applications are held for thirty (30) days. If no documentation is provided to complete the application, a denial letter is sent to the patient/guarantor. The application may be completed if the patient/guarantor provides the requested information within fifteen (15) working days of the denial. Notification of status of completed application will be mailed within fifteen (15) working days of receipt of needed information.

7. The application and documentation will become property of CRMC and is to be kept confidential in the same manner as medical records. However, this information will be used for aggregate reporting purposes only.

8. Patients who are insured or have a third-party liability claim are only eligible to apply for financial assistance in the event they have a remaining balance after all payment resources are exhausted. Additionally, CRMC may make adjustments for medically indigent patients whose medical or hospital bills from all related and unrelated health care providers, after payment by all third-party sources, would cause the patient significant financial hardship

9. If a patient has already established a payment plan or made payments on their account, and subsequently approved for financial assistance, any payments over the co-pay amount will either be applied to other outstanding accounts, or refunded to the patient if no other outstanding accounts exist.

Calculations of amounts charged to patients

1. CRMC uses the look back method to determine the Amounts Generally Billed (AGB) to patients whom qualify for financial assistance. That means that CRMC reviews the actual past claims paid to the hospital by Medicare Fee-for service together with all private health insurers paying claims to the hospital. CRMC will not bill a financial assistance eligible person more that the AGB rate specific to emergency or other medically necessary care.

2. The AGB percentage is readily available upon request. For a written description of how CRMC determined this percentage please contact our Financial Counselor. CRMC will mail the patient a copy of the information free of charge.

3. CRMC does not bill or expect payment of gross/total charges from individuals whom qualify for financial Assistance, or who have no health insurance but does not qualify for financial assistance (i.e. self pay)

Publication of Policy

1. CRMC will take the following measures to publicize its FAP policy, free of charge:

- Provide copies of policy at access points in the facility
- Post this policy and FAP (in English and Spanish) on the CRMC internet page for the public to view and print.
- Include in the annual Community Benefit Report
- Provide/mail copies or email copies when requested via phone or mail from Financial Counselors, Financial Advisors, or any collection agencies working on our behalf.

- Offer a paper copy of the FAP, the application, and a plain language summary (in English and Spanish) to patients as part of the intake or discharge process

2. Plain language versions of the Financial Assistance summary document and application will also be provided in Spanish, free of charge, when requested. Spanish versions will also be posted on the CRMC internet site.

Patient Collections

CRMC makes reasonable efforts to ensure that patients are billed for their services accurately and timely. CRMC will attempt to work with all patients to establish suitable payment arrangements if payment in full cannot be made at the time services are provided on or upon the first patient bill being delivered to the patient. Typically, patients will receive their first statement within 6 days of discharge from the facility.

CRMC established a self-pay fee schedule to consistently discount uninsured patient bills. At the time of admission if a patient is uninsured the patient is registered as self pay. CRMC management system will automatically discount each self pay visit registered. Once a FAP is complete and approved the discount will be reversed and appropriate FAP discount applied.

Patient Billing Notices & Time Frames

- Uninsured patients will receive their first statement within 5 days of discharge from the facility
- The first three statements will include an overview of CRMC's FAP that will contain information about the program, contact information for CRMC Financial Counselor, where to obtain a copy of the FAP free of charge,
- Before pursuing extraordinary collection actions (defined below), CRMC makes reasonable efforts to determine whether an individual is FAP-eligible. The Patient Billing Supervisor has final authority for determining whether reasonable efforts have been made and the required information to submit with an application for financial assistance.
    - A plain language summary and application before discharge and in one post-discharge mailing
    - A "conspicuous written notice" (availability of FAP, phone number for assistance, and URL for FAP documents) with every bill during the 120 days post-discharge
    - Oral notice of intended ECA(s) during all oral communications with patients against whom ECA(s) are intended
    - At least one written notice of intended ECA(s)
- Patients **will not** be referred for collection agency follow up in less than 120 days from date of the first post-discharge billing statement. Patients will be allowed to request financial assistance up to 240 days from the date of the first post-discharge billing statement, or at any time during the collection process.

Extraordinary Collections Actions (ECA's)

- CRMC is responsible for its patient and/or guarantor collection process, to include pre-collection agency follow up and bad debt collection, hospital liens for accounts involved in litigation that could result in a financial judgment for the patient and Civil Action and Garnishments that would result in a financial judgment for the patient. However after 240 days accounts are subject to the following ECAs only after written notice (informing the individual of potential ECAs if the individual does not submit a complete FAP application or pay the amount due by a deadline specified in the notice) provided at least 30 days in advance of initiating intended ECAs
    - Placement with collection agency

- Credit Agency Reporting

If during the course of the collections follow up, a patient or guarantor requests financial assistance or indicates that they are uninsured and cannot pay for their care, they will be referred to CRMC Financial Advisors and Financial Counselor to be screened for potential program eligibility. If the Financial Assistance team determines a patient may be eligible for assistance, collection activity will continue until the patient returns the appropriate application. Once the application is received, regardless of the completeness, all further collection activity will be stopped pending a decision from the Financial Counselor.

Billing and Collection Policy

Department(s)	Patient Financial Services
Original Effective Date	07/14/2011
Scope	Departmental

Cross Reference TJC Standard			
Current Review Date	03/12/2014, 09/24/2019		
Signatures	Deborah Massey	Date	09/24/2019
	Deborah Massey	Title	Director of PFS
Signatures	Lavonda Cravey	Date	09/24/2019
Approved by	Lavonda Cravey	Title	VP of Corporate Revenue

POLICY

It is the policy of Coffee Regional Medical Center (CRMC) to provide outstanding medical care to our patients while maintaining patient confidentiality in accordance with the HIPPA established guidelines. CRMC's goal it to create a fair and efficient process of collecting payment for services rendered to the community it serves regardless of race, creed, color, sex, national origin, sexual orientation, handicap, age, or ability to pay.

CRMC has established a goal of meeting the needs of the community by treating all patients equally with dignity, respect, and confidentiality. Also CRMC goals is to respond promptly to patient inquiries regarding their bills and request for assistance, ensure hospital billing and collection guidelines are followed, and communicate financial responsibility to the patient before services are rendered when possible.

CRMC will evaluate all requests for financial assistance in accordance to the Financial Assistance/Charity policy for Coffee Regional Medical Center and will also communicate financial responsibilities prior to and/or after medical services have been rendered. All services will be billed in a timely and accurate manner, in accordance with all applicable federal, state and local laws and regulations.

CRMC will pre-admit/pre-register patients for services when possible. Pre-service payments will be requested prior to or at the time of service for uncovered portions of patient's charges. The amount requested for payment will be determined after verification of eligibility and insurance benefits.

Coffee Regional Medical Center as a courtesy will submit the standard UB or 1500 claim form to insurance carriers electronically and/or hardcopy if the patient provides required insurance information and signs a consent/assignment of benefits. Patient responsibility with insurance coverage will be determined by contractual agreements with third party payers and the patient's health benefit plan. Patients will be responsible for any unpaid balances including deductibles, co-pays, co-insurance, or non-covered services.

Internal collections and external collection agencies may be used to collect outstanding balances owed.