Policy Name: **Patient Financial Obligations**	Originator: **Chip Giffin**	Origination Date: **07/12/13**
Policy Section: **Revenue Cycle Pod**	Approved By:	Approved Date:
		Revised Date: **08/25/14 7/27/15, 03/28/17, 04/16/17**

Policy: As a benefit and obligation to the community, the hospital recognizes its responsibility to provide medically necessary services and to provide financial assistance to patients paying for those services. As important, is the hospital's financial ability to provide future community benefits which necessitates that those with the ability to pay are required to do so and may be pursued to the fullest extent available within the laws of the Commonwealth of Pennsylvania governing debt collection. This policy will comply with all requirements of the IRS of a non-profit organization, and all other regulations, such as EMTALA, that relate to the provision of service.

Purpose: To provide a continuum of financial assistance/requirements across the entire patient experience at all service entry/delivery points that define the patient's financial obligations, provides the methodology for assistance, the available forms of assistance, and the processes to assist in the communication and understanding of the same by all involved.

Definitions:

Financial Assistance – Includes all forms of financial help for payment/resolution of patient liable balances including full or graduated reductions in liable balance or all payment arrangements.

Medically Necessary Services – Services provides that are supported by patient diagnoses that meet the current definitions as defined by Medicare and other accepted criteria used by the hospital. Services not meeting this definition include personal cosmetic and other services not required to treat a medical condition.

Emergency Care – Care provided in the section of the hospital designated as Emergency Room and/or those areas subject to EMTALA.

Guarantor – The person who is financially obligated to pay for out of pocket expense of services to the patient.

Financial Assistance Policy (FAP) – Term used by the IRS for the policy of providing assistance for those in need.

AGB – Amounts Generally Billed to those covered by insurance.

ECA – Extraordinary Collection Actions that cannot be taken before expiration of 240 days or when there is an open/unprocessed FAP application.

Presumptive Score – A numerical value of the guarantor's ability to meet financial obligations based on income and family size information adjusted for statistical validity for the community served by the hospital.

Surgical Services - All services that are defined in the HCPCS code range of 10000 – 69999 with the exclusion of venipuncture.

Writ of Body Attachment -It is the civil equivalent of a bench warrant issued by a court. Typically, it is used where someone has failed to obey a civil court order, such as not paying child support, refusing to turn over property or ignoring a subpoena. The Sheriff will arrest the miscreant & bring him before the judge to explain why he shouldn't be committed to jail for civil contempt.

I Requirements – General:

1) Patient obligations and related financial assistance is a continuum that is segmented enough to provide consistency as a guarantor's financial position moves from 100% debt forgiveness through relaxed payment arrangements to requiring the guarantor to seek alternative external financing.

2) The framework for the determination of 1) above is found in Appendix A. Each hospital and other covered entities will independently determine the percentages of the poverty used for the graduated benefit/requirements as needed to meet their FAP and financial goals of their respective organizations.

3) Each hospital will also identify the calculations used for determining the ABG, identify an effective date, record this information on Appendix A, and distribute the information each time there is a change. This calculation can be adjusted as needed but should be reviewed at least annually. The person assigned this duty will be responsible for providing written notification to the POD Director of Access along with an explanation of the calculation that will be posted on the hospital's web site. The POD Director of Access will provide this information to the hospital's web site maintenance owner.

4) The providers included in the hospital FAP will be identified in Appendix A and in the Plain Language Summary. The complete listing of providers, whether or not covered by this policy that perform services within the entities included in this policy will be maintained by the medical staff office or as assigned by the CFO. This listing will be posted on the hospital's web site and printed listings will be available by request from the office of the CFO. Reference copies of the policy will also be maintained by each financial counselor.

5) Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance. The exception to this rule is the utilization of a presumptive score for active lower balance accounts or for all accounts upon return from the primary bad debt agency.

6) All Charges will be posted in a consistent manner regardless of the available insurance, available coverage and/or the patient's ability to pay.

7) Patient with no insurance coverage will have an adjustment applied to the gross charges as determined by the individual hospital. The amount billed to a patient with no insurance represent each hospital's respective AGB – Amounts Generally Billed to those covered by insurance. See Appendix A for calculation method, amount for current fiscal year, and update responsible party. AGB discounts may be separate amounts for inpatient and outpatient services. A separate adjustment code will be used for the reduction of the balance to the AGB. AGB amounts are not to be classified as bad debt or charity (PFA).

8) For patients that have insurance coverage, the financial assistance is limited to defined patient liabilities (deductible, coinsurance, co-pay) and non-covered services. For those with an approved PFA application at the time of the insurance payment, the amount of patient liability will be compared to the AGB as if the patient did not have any insurance. The patient liability will be reduced to the AGB when it exceeds the AGB. The same process will be followed for subsequent PFA approved applications as they are determined. A spreadsheet with the calculations will be made available to the financial counselors to assists with this review process. Spreadsheet layout can be reviewed in Appendix

9) Valid health insurance coverage will be accepted in lieu of immediate payment and a claim will be sent on behalf of the patient provided that the patient fully cooperates with any and all requirements needed to process the claim including but not limited to;

    a. Steps necessary to obtain required notifications, authorizations, or approvals.
    b. Provide accurate and comprehensive demographic and insurance information.
    c. Assignment of insurance benefits.
    d. All necessary information releases.
    e. Prompt responses to insurance and/or hospital correspondence or communication necessary to adjudicate the claim such as COB questionnaires, etc.

    Failure to adequately or promptly respond to these requirements may require a demand of immediate and full payment of the account balance. No Self pay discounts would apply as the insurance should remain on the account and the balance moved to the patient responsibility. In addition, acceptance of the insurance does not lessen the financial obligation of the debtor.

10) Patients have the right to refuse insurance coverage for specific services. When the services are non-emergency in nature or performed in an emergency room, patients who refuse insurance assignment (ability to bill their insurance) will require an pre-payment of 100% of the estimated charges payable prior to the service being performed,

11) Balances after an insurance claim has processed will be billed to the patient based on the type of coverage or denial classification as determined in Appendix C. Additional explanations to Appendix C are as follows

    a. **NON-COVERED** Services denied as non-covered (No benefit type denial) will be considered as no benefit coverage was available for that type of service. Non-covered denials will not be

considered provider liable regardless of contractual language or misclassification of the denial by the insurance coverage entity.

b. **EXPERIMENTAL** Services classified by an insurance company as experimental will be patient liable provided that the service is a medically acceptable practice. However, the insurance coverage entity should use a denial that is classified as Medically Appropriate. All other cases will be the considered a non-covered service and therefore a patient liability as the insurance has deemed the service to be non-covered based on their benefit determination.

12) An AGB adjustment is applied regardless of the guarantor's ability to pay and will be reversed when insurance coverage payment becomes available on the account. This adjustment does not apply to patient liabilities identified through a claim adjudication process.

13) The amount of approved financial assistance (debt forgiveness) will be classified/adjusted as charity but referred to in all communications as patient financial assistance.

14) Financial assistance applicants that make any material misrepresentations will result in the reversal of approved and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.

15) There are two independent approval processes to identify financial assistance; 1) an approved Financial Assistance Application, and 2), a Presumptive Charity Score. For each process, a unique transaction code will be used to relieve the financial obligation on the account

a. The Financial Assistance Application process is available from the inception of the account to the 120th day from placement of any open balances with the Primary Bad Debt Collection Agency. All applications require a Medicaid denial of eligibility when the patient liability equals or exceeds the current Medicare Part A deductible. Full and partial PFA benefits are available using this process.

b. The Presumptive Charity Score process occurs upon the return of uncollectable accounts from the Primary Bad Debt Collection agency. No reference is made to any Patient Financial Application processes or decisions as the score is a stand-alone independent identifier and approval of charity. Only full PFA benefit is available using this process. The utilization of the score is as follows;

i. Accounts with Medicare - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as indigent cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity –score transaction.

ii. Accounts with dual eligibility - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as dual eligible cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity–score transaction.

c. Under no circumstances are the same balances to be considered for both charity and Medicare bad debt (mutually exclusive).

d. Transaction codes will be established to differentiate/classify and support the varying definitions of charity and bad debt only when other information on the account cannot be used for such differentiation/classification. This position is necessary to keep the number and adjustment definitions at levels that promote accuracy and minimize confusion.

16) Patients may request either the plain language summary of the entire PFO policy. Both will also be posted on the hospital's web site. The matrix in Appendix A will be included as part of the Plain Language Summary. Although historically hospitals have provided non-interest bearing loan arrangements in the form of accepting monthly payments (with or without approval), the patient liability shift necessitates the reinforcement of the following payment arrangement requirements;

a. The monthly payment amount requirements are indexed using the poverty levels and family size to determine the minimum amount. This provides a method of automatically adjusting the required minimum monthly payment for new payment arrangements. This indexing only applies to current debt being considered for payment arrangements and is not retroactively applied to previously accepted existing payment arrangements without a discussion with the debtor to consolidate the payment arrangement

b. Payments arrangements must be approved by the hospital and are not automatically accepted based on consecutive received monthly payments. Statement messaging will be configured to communicate this requirement. Patients who pay a monthly amount equal to or exceeding the Medicare Part A deductible amount for the current year of the payment will automatically be considered as an approved monthly amount.

c. Monthly payment minimums identified in Appendix A are considered extended payment arrangements. All other cases must be paid within 90 days or the guarantor must seek alternative financing through a bank or like financial entity that provides loan services. Only if a guarantor receives and produces a copy of a loan denial will hospital extended payment arrangements be considered.

d. Each hospital may participate in debt financing of the patient liabilities however all returned debt may immediately be placed with a collection agency as bad debt regardless of the time period (subject to governmental reimbursement requirements).

e. Agreed upon payment arrangements only include the debt at the time of the payment arrangement. The guarantor will need to discuss any new debt and seek a new payment arrangement.

17) Prompt pay discounts are not available and are not to be offered. However, a settlement (accepting less than full payment of balance as payment in full) may be considered on individual cases provided that the following conditions are met;

a. The patient balance on the account(s) represents a minimum of 150% of the current year's part A deductible. Settlements are not available for smaller balances.

b. Settlements that are less than 90% of the open balance require the approval of the CFO.

c. Settlements cannot be combined with any type of extended payment arrangements.

d. The payment must be received within 10 days of the settlement agreement.

e. The discount is not taken until the settlement amount is received.

18) Settlement campaigns of payment arrangement accounts exceeding 6 months in duration may be occasionally offered. However, this approach should not be routine or be on a fixed schedule to avoid payment delays (awaiting a scheduled campaign).

19) Catastrophic circumstances may justify financial assistance to an individual that falls outside the score and/or income levels established in this policy. For these extenuating situations, patient financial assistance adjustments may be given upon documented recommendation of revenue cycle leadership and approval by the CEO or CFO. Criteria for determining such catastrophic circumstances are based on the judgement of the executive for the situation but should be a rare occurrence.

20) Agreements with the Amish or other groups that self-fund their health insurance expense are processed like other contracts and are excluded from this process when a financial agreement exists with the family clan or governing body.

21) Patients who choose to restrict the reporting/sharing of all medical information will;
    a. Be advised that such a restriction will not be in effect until total payment is received for all restricted services;
    b. Service that requires prepayment will require 100% payment of the estimated amount prior to performing the service or the service will be re-scheduled. Patients who drop the privacy restriction will only be required to pay the amounts designated in section VI using the hospital specific matrix.

22) No information obtained from this process may be disclosed to any party that is not a part of their position responsibilities. Inappropriate discloser will result in disciplinary action and/or dismissal.

II Patient Financial Assistance Application Approval Process:

1) Financial Assistance provided to the patient in the form of balance forgiveness (charity) may be determined by application that indicates the patient's ability to pay.

2) The Financial Assistance application process includes the following:

a. A completed application is presented to a Financial Counselor. The application form must be completed in its entirety. (See Appendix B)
b. All supporting documentation is required with the application form, including proof of income and proof of assets
c. Financial Counselor will review and verify the completed application and supporting documentation, using the Financial Assistance application checklist and guidelines. (See Appendix B)
d. Determination will be made as to the patient's eligibility and level of balance forgiveness for which the patient qualifies.
e. Copies of application and supporting documentation will be retained by the facility for as long as record retention policies dictate.
f. Open balance accounts will be reviewed for qualification of balance forgiveness and appropriate adjustments will be made.
g. Patient will be notified in writing of the determination approved or denied qualification for Financial Assistance.
h. Patient will be instructed to present the letter of notification of eligibility or issued Financial Assistance card, when registering for services at the respective facility. The letter is valid for Medicare patients for a period of 1 year and non-Medicare for a period of 6 months. All letters presented with an expired date will be removed from the account and the patient advised to re-apply.

3) Automatic approval for financial assistance may occur using a charity scoring system under the following circumstances:

Reclassification of Bad Debt to Charity using Presumptive Charity;

a. Guarantors may be scored to determine a presumptive approval for charity at the time of the account is returned from the primary bad debt agency...
b. The referral for review of the scoring process will occur after the first placement collection agency has completed their attempts to collect and before placing the account with the second placement agency.
c. A presumptive score will work independent of the application process for only this population of patients to avoid excessive administrative expense of reviewing each account for application history.
d. A presumptive charity score may be used as an indicator to pursue/encourage the completion of an application for financial assistance.
e. This process should not be used to determine assistance eligibility for current or future services.

III Requirements – Communication:

1) The hospital will widely publicize the Patient Financial Assistance policy by completing the following;
    a. Make available paper copies of the application when requested and provide a plain language summary available without charge to distribute by mail, in person and at public locations in the hospital.
    b. Notification by way of postings.
    c. Document the activities used to inform the community served about the program on a minimum of an annual basis. Information provided on the hospital web site and other electronic media on the policy and how to obtain additional information.

IV Requirements – Emergency Care:

1) No financial interactions will occur before patient is medically screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, conversations regarding patient liability payments will only occur during the discharge process.

2) Patients will be registered as soon as possible without interfering with the provision of care.

3) *Financial counseling***:** Patient is offered information regarding the provider's financial counseling services and assistance policies upon request

4) *Prior balance and patient share discussions:* These discussions will occur upon discharge. All hospital employees will provide the support necessary to ensure that the patient returns to the discharge area. This stipulation will be implemented based on the schedule for each hospital as it is dependent upon the transition of the community toward increased payment obligations and the skills of the employees necessary to administer this provision. The provider representative will:

    a. Provide as much information as possible about patient's likely financial obligations, including a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.

    b. Inform patient that actual charges may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.

    c. *Balance resolution:* Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have.

V Payment Requirements – Advance of Care (Large Dollar Cases):

1) The scope of services for this section of the process includes scheduled high dollar services including but not limited to;

    a. Inpatient elective
    b. Outpatient Surgery included under the definition of surgery
    c. MRI/CT/PET and any other hospital defined procedures
    d. Nuclear stress testing
    e. Chemo therapy
    f. Radiation therapy
    g. Infusions involving high dollar drug therapies.
    h. Any other hospital specific identified tests.

2) Services considered to be personal cosmetic and personal services require 100% of the estimated charges be paid prior to receiving the service.

3) Non Emergency Room services will be considered elective and are subject to the requirements contained in this Advance of Care section.

4) Services are to be scheduled in advance as much as possible but a minimum of 7 days is preferred in order to ensure ample time to provide the patient with complete financial counseling and assistance.

5) Prior to service payment requirements are identified in Appendix A by hospital. This includes the minimum payment amounts when either time or information is unavailable to determine the patient' ability to pay. The following process will be used when advance payment requirements are not met;

    a. Advise the ordering/scheduling physician that the service may be re-scheduled due to advance payment requirements.

    b. If the ordering/scheduling physician is in disagreement with re-scheduling the patient, they will contact the hospital's chief clinical representative which would include the Medical Director, or clinical coverage person (VP Nursing or similar position) and discuss the medical needs of the patient. Should the re-scheduling delay be unacceptable, the clinical justification should be communicated to the Patient Financial Counseling representative to approve the elective service without meeting the minimum pre-service payment requirement. All referred cases that are approved in this manner will be tracked and submitted at least on a monthly basis to the hospital CFO. Review of these cases by the hospital's executive team is recommended to ensure an acceptable level of application of the intent and requirements of this process.

6) Patient Financial Interactions in Advance of Service;

a. Appropriately trained provider representatives will have these discussions with the guarantor. Guarantor should be given the opportunity to request a patient advocate or family member to assist them in these conversations.
b. Discussions will occur using the most appropriate means of communication for the patient. These conversations may take place via:
    i. Outbound contact to patient in advance of a scheduled service.
    ii. Inbound contact from patient inquiring about their upcoming service.
    iii. Scheduling / Contact center when appointment is made.

7) All discussions with patients will occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient's ability to pay.

8) All Representatives will maintain a record of conversations that occurred with the patient so that these conversations will not occur again.

9) The representative will first gather basic registration information including, insurance coverage, as well as determining the potential need for financial assistance.

10) The representative will review insurance benefit details with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.

11) Guarantor is offered information regarding the provider's financial counseling services and assistance policies.

12) *Financial counseling***:** Patient is offered information regarding the provider's financial counseling services and assistance policies.

13) *Prior balance and patient share discussions:* These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance interactions, the provider representative will:

    a. Provide as much information as possible about patient's likely financial obligations, including a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.

    b. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.

    c. Ask the patient if they are interested in receiving information regarding payment options.

    d. Ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.

14) *Balance resolution:* Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have.

15) Upon request, the patient will receive in writing, information regarding the provider's supportive financial assistance programs, and a summary of the financial implications for the services rendered, including a phone number to call with questions.

V Requirements – At Time of Service (Non Emergency Care):

1) All co-pays are due at the time of service and are to be requested prior to completing the service.

VI Requirements – Collection Process:

1) Patients will receive a minimum of 4 statements over a period of 120 days prior to consideration for placement as bad debt with a third party agency.

2) Accounts associated with the same guarantor may be tied or grouped for the purpose of consolidated statement processing and for attempting to contact the guarantor. Other than the first notice of payment from the patient, new accounts entering the self-pay collection cycle will be moved to the progressive step of existing accounts in the active collection flow. The hospital reserves the right to move active self-pay account balances directly to bad debt when repetitive and current account history indicates defiant and consistent avoidance in the resolution of account balances.

3) Guarantors who explicitly state that they will not pay the account and will not make any arrangements to pay the account may be placed directly to a final notice status without completion of the normal collection flow.

4) Mail returns that a correct address cannot be obtained will also be sent directly to a bad debt agency for skip trace processing.

5) Patients who are insulting and/or abusive may be disconnected after professional attempts have been made to advise the patient to refrain from such activities. The account may be placed directly to a final notice status without completion of the normal collection flow.

6) The hospital reserves the right to record telephone conversations provided the notice requirements have been fulfilled.

7) Partial payments on an account that are not part of an existing approved payment arrangement will be considered as payment on account and are not to be construed as an acceptance to a payment arrangement or the prepayment of future payment arrangement requirements. Subsequent statements will so advise the guarantor to avoid any misunderstanding of an offer and acceptance.

8) Partial payments will be applied to the oldest account in the self-pay flow so to ensure appropriate statement messaging and support character recognition and payment allocation technology. Exceptions to this requirement would be web and IVR payments that are account specific. However, the statement messages are not to be reset unless the minimum payment requirements of an agreed upon payment arrangement, or the minimums set in f. above, are satisfied.

9) ECAs or extra collection actions are not permitted when a PFO application has been received during the first 240 days of a collection cycle. The collection cycle includes both active and bad debt periods. ECS include, but may not be limited to;

   a. Place a lien on an individual's property

   b. Foreclose on an individual's real property

   c. Attach or seize an individual's bank account or other personal property

   d. Commence a civil action against an individual,

   e. Cause an individual's arrest,

   f. Cause an individual to be subject to a writ of body attachment

   g. Garnish an individual's wages

   h. Reporting to credit agencies.

10) The self-pay collection flow will be as follows to ensure compliance to Medicare and 990 requirements:

   a. Medicare patients should receive a patient balance statement within 90 days of Medicare payment or 60 days of a secondary/tertiary claim payment when such insurance exists.

   b. Active self-pay collection flow will be a minimum of 120 days. A minimum of 4 statements will be sent with the third as a Final Notice and the forth a Third Party Collection attempt. Outbound phone attempts may occur at any time after 10 days from the initial statement. PFA applications will be accepted during this entire period.

   c. Accounts not paid or in an acceptable payment arrangement will be referred to a primary collection agency (bad debt) for a period of 6 months. No ECAs are permitted during this period. PFA applications not completed during an above will be continued through this period. New PFA applications will be accepted during this period through the 120 days of placement. The period in a and b meet the required 240 days from the first statement sent to the guarantor as required by the proposed 990 regulations. All incomplete and open PFA applications at 150 days of will be sent a letter that to request the application be finished or it will automatically be denied at the end of the 6 month placement cycle.

d. All balances returned in step b above will be placed with a second agency (bad debt). No PFA applications will be accepted or processed during this period. All ECAs that are approved by the hospital will be utilized during this period. All secondary placements will be immediately reported to the credit reporting agencies.

VI Requirements – Responsible Parties:

PFO Process Updating	PMHA VP Finance/Revenue Cycle
PFA Application and Procedure	RC Pod Director Access
Emergency Care Policy	Hospital Assignee: Director Emergency Services
Community Needs Assessment	Hospital Assignee: Hospital Executive Team
AGB Discount:	
Percent Calculation	Hospital Assignee: Controller/Director Reimbursement
System Updating	Hospital Assignee: Onsite Rev Cycle Supervisor
Outreach:	
Publications	Hospital Assignee: Public Relations
Website	Hospital Assignee: CIO Assignee
Handouts	Hospital Assignee: Onsite Access Supervisor
Signs	Hospital Assignee: Public Relations

Appendix A

ACMH Hospital									
Part A Deductable	1,288								
Score									
Poverty Level Percent		167%	234%	300%	350%	400%	450%	500%	550%
Family Size									
1	12,060	20,140	28,220	36,180	42,210	48,240	54,270	60,300	66,330
2	16,240	27,121	38,002	48,720	56,840	64,960	73,080	81,200	89,320
3	20,420	34,101	47,783	61,260	71,470	81,680	91,890	102,100	112,310
4	24,600	41,082	57,564	73,800	86,100	98,400	110,700	123,000	135,300
5	28,780	48,063	67,345	86,340	100,730	115,120	129,510	143,900	158,290
6	32,960	55,043	77,126	98,880	115,360	131,840	148,320	164,800	181,280
7	37,140	62,024	86,908	111,420	129,990	148,560	167,130	185,700	204,270
8	41,320	69,004	96,689	123,960	144,620	165,280	185,940	206,600	227,260
				Financial Assistance					
Reduction Percent	100%	75%	50%	25%	0%	0%	0%	0%	0%
				Minimum Monthly Payment					
Monthly Pmt Min %		0.5%	0.8%	1.0%	1.2%	1.4%	1.6%	1.8%	2.0%
Monthly Payment Min Amt									
Family Size									
1	-	29	64	103	145	193	248	310	379
2	-	26	58	93	130	173	223	279	340
3	-	23	51	82	115	154	198	247	302
4	-	20	45	72	101	134	173	216	264
5	-	20	45	72	101	134	173	216	264
6	-	20	45	72	101	134	173	216	264
7	-	20	45	72	101	134	173	216	264
8	-	20	45	72	101	134	173	216	264
				Pre-Service Payment Requirements					
Min % of Est Liability	10%	25%	50%	75%	100%	100%	100%	100%	100%
Min % of Prior Bad Debt		10%	20%	30%	40%	50%	60%	70%	80%
Percent and maximum amount when ability to pay is unknown:					50%	to max of $1,000			

Appendix A Continued

AGB Calculation:

Fiscal Year	Calculation Method	Effective Date Claim Date	AGB Percent
2017	ACMH Hospital utilized the look-back method to determine AGB. The percentage was calculated using all claims for both inpatient and outpatient services. Total expected payment from allowed claims was divided by total billed charges for such claims.	7/1/16	41%
2018	ACMH Hospital utilizes the look-back method to determine AGB. The percentage was calculated using all claims allowed by Medicare and all private health insurers for both inpatient and outpatient services having discharge dates from April 1, 2016 through March 31, 2017. Total expected payment from allowed claims was divided by total billed charges for such claims.	7/1/17	44%

Appendix B

FINANCIAL ASSISTANCE APPLICATION			
APPLICANT INFORMATION			
Name:			
Date of birth:	SSN:	Phone:	
Current address:			
City:	State:	ZIP Code:	
Cell Phone:	E-mail Address:		
EMPLOYMENT INFORMATION			
Please indicate if you are Employed/Retired/Disabled:			
Current employer (I/A):			
Employer address:		How long?	
City:	State:	ZIP Code:	
Position:	Annual income:		
HOUSEHOLD CO-APPLICANT INFORMATION			
Name:			
Date of birth:	SSN:	Phone:	
Current address:			
City:	State:	ZIP Code:	
EMPLOYMENT INFORMATION			
Please indicate if the co-applicant is Employed/Retired/Disabled:			
Current employer (I/A):			
Employer address:		How long?	
City:	State:	ZIP Code:	
Position:	Annual income:		
ADDITIONAL HOUSEHOLD INCOME			
Name	Relationship to Applicant	Annual Income	
ACCOUNTS RELATED TO APPLICATION REQUEST			
Patient Name:	Account no.	Date of Service:	Amount:

FINANCIAL ASSISTANCE APPLICATION

OTHER ASSETS OR SOURCES OF INCOME	
Description	Amount per month or value

I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant	Date
Signature of co-applicant, I/A	Date

ELIGIBILITY DETERMINATION
(FOR OFFICE USE ONLY)

Date Received: _____ Verification Completed: Yes ____ No ____

The applicant was approved for a reduction of _____% of AGB charges.

The applicant was denied for the following reason(s)

_____

Date of Determination: _____ Date Applicant Notified: _____

Individual Completing Review: _____

Appendix B Continued

Financial Assistance Application Check List

Verification of the following information is needed to complete your application for Financial Assistance:

- Proof of Medical Assistance application may be required if applicable
    - Proof of Income:
        - Household income
        - Income Tax Return (if applying in first three months of calendar year)
        - Pay Stubs for one month (for applications April through December)
        - Unemployment Compensation
        - Social Security verification
        - Pension
        - Workers Compensation
        - Sick Benefits
        - Self-Employment
        - Rental Income
        - Child Support
        - Interest or Dividends
        - Any other income into the household
        - MA162 with income information
        - Payments from personal insurance policies that provide additional income or payment to defray medical related incident costs.
    - Proof of Assets
        - Checking Account balance
        - Savings Account balance
        - Certificate of Deposit (CD)
        - US Savings Bond
        - Stocks or Bonds

- HRA, HAS, FSA, or any medical savings account

Appendix B Continued

Disclaimer Points:

1. You must apply within 240 days from date of self-pay balance or application will be denied.
2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.
3. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance.
4. Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance

Financial Assistance Guidelines:

Household size includes:

Guarantor that is not claimed on another individual's income tax

Child over 18

Disabled over 18

Emancipated Minor

Dependents defined as:

Applicant/Co-applicant – significant other at the time of the application

Child- income tax or proof of child support

Automatic Eligibility:

Scoring Results

Not Qualified:

Cosmetic Surgery

Pre-Collection Amounts

Amish and/or like contract

If any data is misrepresented

If Medical Savings Account Exists with Balance

Appendix B Continued

Medicaid denial not related to low income, i.e. incomplete application

Medicaid Application

Medicaid Applications are required for high dollar encounters, i.e. Inpatients, Observation, SDC's (Same Day Outpatient Surgeries)

Accounts with no insurance until presumptive scoring is used for automated approvals of financial assistance for active accounts (non-bad debt).

Insurance deductibles of $1000 or more

Approval Period:

Medicare eligible individual – 1 year

Non-Medicare individual - 6 months

Insurance will be deleted from demo recall based on the expiration dates.

Appendix C

Denial Categories

Classification	Denial Type	Patient Liable		Comments
		Non-regulatory Ins	Regulatory Ins	
Authorization	Clinical	No - unless ABN	No - unless ABN	Billable to patient if no contract exists or is out of network and is considered medically acceptable practice
Billing	Administrative	No	No	
COB	Administrative	No	No	Possibly billable to patient if non-cooperative with providing necessary information
Coding	Clinical	No	No	
Documentation	Clinical	No -unless ABN	No - unless ABN	
Duplicate Claims	Administrative	No	No	
Eligibility	Coverage	Yes	Yes	
Exhaust Benefits	Coverage	Yes	Yes	
Experimental	Coverage	Yes	No - unless ABN	Cannot bill Medicare or Medicaid without advanced notice
Info Request NP	Administrative	No	No	Possibly billable to patient if non-cooperative with providing necessary information
Medical Necessity	Clinical	No - unless ABN	No - unless ABN	Billable to patient if no contract exists and is considered medically acceptable practice
Non-covered	Coverage	Yes	No - unless ABN	Patient does not have benefit coverage for this service. Cannot bill Medicare or Medicaid without advanced notice or the items are considered exclusions
No Pay Claim	Administrative	No	No	
Other Adjustment	Administrative	No	No	
Pending	Administrative	No	No	
Payer Initiated Reductions	Administrative	Yes	No	Patient is liable if initial payment is reversed for coverage reasons
PMT Reduced	Administrative	No	No	Possibly billable only if no contract exists
Registration	Administrative	No	No	
Review Required	Administrative	No	No	
Untimely Filing	Administrative	No	No	Billable if no contract provision to the contrary exists or the patient is not cooperative
PR	Coverage	Yes	Yes	

Appendix D

501r AGB Discount Calculation For Balances after Insurance.

		Calculation		
a	Total Account Charges			
b	AGB Payment Rate			
c	AGB Discount Amount	= (1-b)*a	-	
d	Maximum Amount Billed to Patient (AGB)	= a-c		-
e	Account Balance Due From Patient			
f	Percent Charity Discount			
g	Charity Discount Amount	= e*f	-	
h	Balance of Patient Liability	= e-g		-
i	Amount of AGB Discount (calculate difference only when line 22 exceeds line 12)	= h-d		
j	Max Billable to Patient	= h-i		-