

Revised 8/24/15
Montrose Memorial Hospital

TITLE: Financial Assistance Policy

Objective:

Montrose Memorial Hospital, a not-for-profit community hospital, will not discriminate in providing medically necessary services to those in need regardless of their ability to pay. Patients deemed unable to pay will be eligible to receive available financial assistance. The patient is ultimately responsible to fulfill their financial obligation to Montrose Memorial Hospital and is not granted financial assistance until the application has been completed and approved. The Financial Assistance Policy must be approved by the Montrose Memorial Hospital Inc.

Method for Applying for Financial Assistance:

- Contact the Business Office at 970-252-2687 or in person (lower level)

Measures to Publicize the Financial Assistance Policy:

Montrose Memorial Hospital will advise patients and their families of Financial Assistance through the following means:

- Direct patient contact, in person or over the phone.
- Notice of availability of Financial Assistance will be posted in each registration area and Emergency Department and other waiting areas.
- Notice of availability of Financial Assistance – This statement will be printed on each patient initial bill.
- Availability of Financial Assistance will be printed on applicable letters and statements.
- Notice of availability will be posted on the hospital's website.
 - Policy and application downloadable and printable without special software
- Published in additional languages if needed by more than 10% of the population.

- Outreach to community most likely to utilize the FAP to include Outreach to public agencies and other non-for-profit agencies
 - Outreach is performed by Executive Management to include Public Relations, Chief Operating Officer or Chief Executive Officer
- Availability of Financial Assistance will be posted annually in the local paper.

Procedure for Determining Eligibility:

A request for financial assistance may be made by any person who could reasonably be expected to act for the patient, has a reasonable basis to believe that the person may qualify for uncompensated services, and can provide the information required to establish eligibility.

Eligibility Criteria:

1. Eligibility for financial assistance is determined after all other third party coverage's have been exhausted. If an individual is not currently covered by a third-party, and is a legal resident of Colorado, he must apply for Medicaid and show a Medicaid denial to be eligible for financial assistance services. Montrose Memorial Hospital personnel will assist individuals by directing them where to apply for Medicaid. In the event that third-party coverage is discovered at a later date, any financial assistance write off will be reversed and third-party insurance will be filed.
2. The patient, or representative, must fill out an application for financial assistance prior to being deemed eligible. The application shall be submitted along with all required documents. (see attachment A)
3. Eligibility is determined based on gross income and assets. The applicant's family income must be at or below 400% of the Federal HHS poverty guidelines. (see attachment B) The HHS poverty guidelines are published each year in the Federal Register and shall be published where the availability of Financial Assistance is published along with the asset guidelines. Montrose Memorial Hospital follows the income criteria for the Colorado Indigent Care Program (CICP), a snapshot of the patient's financial situation. If an individual is normally employed seasonally, their yearly income shall be used for making this determination.

4. The amount of financial assistance per patient shall be determined as follows:
 - a. Total charges will be reduced down to the AGB. The calculation for AGB will be completed yearly using the look back method.
 - b. After AGB adjustment, refer to Attachment C – Miss Sliding Scale for percentage patient will owe.
5. Montrose Memorial Hospital adopts the “household income” definition for this policy.
6. All medically necessary services will qualify for charity care consideration, including any physician services received at Montrose Memorial Hospital or any MMH off site clinic.
7. If an individual gives the facility a payment before applying for financial assistance, that amount may be refunded to the patient. Individuals can apply if they have an open account at MMH or MMH clinics and the eligibility is valid for three months after the determination.
8. Upon completion of each application, the patient will receive a card stating their “rate” for financial assistance. Informing him of the eligibility determination, the amount of financial assistance given, any remaining balances owed by the patient, and the suggested repayment plan. The monthly payment arrangements will be made in accordance to the Montrose Memorial Hospital time payment policy.
9. Patients denied Financial Assistance will be advised at the end of the application process.
10. Montrose Memorial Hospital's business office will keep a log of financial assistance provided each fiscal year, along with all applications, of those approved and denied. Accounts notes will be maintained as well.

Basis for calculating amounts charged collected from patients:

In accordance with section §1.501(r)-5(b) in the of the 501R regulations persons qualifying for the financial assistance program will be charged not more than the Amounts Generally Billed other payers. That amount is determined by the Montrose Memorial Hospital and updated yearly utilizing the look back method. Montrose Memorial Hospital Board of Trustees must approve each periodic update to the AGB's. Revised AGB's must be implemented within 45 days of Board approval.

AGB = Amounts Generally Billed – 2015 = 60% of gross charges

Calculation:

Medicare Average Reimbursement = 47%

Commercial Average Reimbursement = 74%

Definitions

Amounts Generally Billed (AGB) – This is a calculation performed by the hospital annually. This calculation identifies a percentage that an eligible patient may be billed for services.

Criteria

The hospital performs this calculation by evaluating all accounts with Insurance and Medicare for a year prior to the calculation taking place. A comparison is done from the total charges of the overall accounts to the amounts that were adjusted due to the hospitals contractual agreements with said payor sources this calculation determines the average contractual percentage for patients with a payor source. This percentage is established as an adjusted amount and the remaining difference is the amount established as the Amounts Generally Billed (AGB) percentage and is therefore billable to the patient. Patients who are approved for financial assistance through Montrose Memorial Hospital will not be billed for more than the amounts generally billed (AGB). Patients who participate in the partial approval program will be held responsible for a discounted amount based on the amounts generally billed (AGB) percentage that is established in the annual evaluation.

Patient Collections Practices:

Inpatient and Observation status patients listed as self-pay are visited while in-house to discuss payment arrangements, need for financial assistance or to determine if insurance is available.

The first business day after account final bills a statement is sent to the patient. Itemization of charges is available upon request.

One week after the account has final billed, a call is placed to the patient to see if they are able to pay in full, if payment arrangements need to be established or if there is a need for financial assistance.

At day 31 the account is picked up by our extended business office for further collection.

Extended Business Office Operating Plan

SPL1 letter

Phone attempts

SPL2

Phone attempts

SPL3 letter at day 100

(SPL = Self Pay Letter)

All letters contain the required financial assistance notification.

The only exceptions to this schedule are: returned mail, no working phone number or if two consecutive payments are missed and we are unable to rectify with the patient.

Returned mail is checked with Passport or comparable software provided by the hospital for current address information.

Accounts are not normally placed with a collection agency until they are 120 days old from date of service or date of placement with the extended business office, which ever is longer, unless there is not a valid address for the patient and/or guarantor.

Billing Patients that do not apply for Financial Assistance:

Patients are billed full charges if they do not apply for financial assistance statements. Requests for financial assistance within the 240 day application period will suspend the ECA's (Extraordinary Collection Action) until an eligibility determination is made.

In-house payment plans may be set up for a length of 10 months or the patient's can obtain medical financing through Bank of Colorado at 10% interest for a length of up to 5 years. Accounts that default on their financing agreement are automatically forwarded to bad debt for collection after approval is received from the PFS Director.

Accounts may have the following types of write-offs:

20% Discount - This is granted for payment in full at time of service or within 30 days of date of service on an uninsured account. The account status would be AR.

10% Discount - This is granted for payment in full or within 120 days of date of service on an uninsured account or a patient's co-ins or co pay. The account status would be AR.

ACICP or AMISS – These are write-off adjustments associated with financial need and indigence. Any adjustment granted based on financial need is only granted after the applicant has completed the application process and financial need has been determined utilizing the federal poverty guidelines as a basis. CICP guidelines for application are followed as outlined in the CICP manual and application exceptions or deadline extensions are granted only with approval of management through a management exception.

The Hospital will assist individuals that do not qualify for Medicaid to Connect for Health Colorado counselors to help qualify them for health insurance on the Insurance Exchange.

Individual State Indigent/Charity Care Mandates:

The facility will comply with all state mandated indigent or charity care programs including but not limited to CICP (Colorado Indigent Care Program).