

Title: Charity Care/Financial Assistance	Original Date	5/90
Graham Health System Business Office	Review Date:	12/99, 3/02
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APPROVED BY: CFO & VP of Finance/Graham Board of Trustees		

MISSION

Graham Health System is a not-for-profit health system serving the needs of Fulton County and surrounding areas. Graham Health System provides emergency/urgent medically necessary care to patients regardless of their ability to pay or availability of third party coverage. In the event that third party coverage is not available, accounts will be reviewed for alternative payment sources. Allocation is made each year for funds to be available for charity or low income, uninsured patients.

PURPOSE

Financial assistance is also made available for income eligible patients according to financial need. Whenever possible, a determination of eligibility for charity or financial assistance will be initiated prior to, or at the time of admission/procedure/physician consultation by a Patient Financial Advocate. All discounts as described throughout this policy only apply to services provided and billed by Graham Health System (GHS), which encompasses Graham Hospital, Graham Emergency Room, Graham Extended Care, Graham Medical Group and Graham Home Medical Equipment. Emergency admission, treatment, screening and/or stabilization services will not be delayed or denied due to an inability to pay.

POLICY

Graham Health System (GHS) provides financial assistance for medically necessary services to Illinois residents without the financial resources to fulfill their payment obligations for health care received at Graham Health System.

This policy includes a discount on all medically necessary services, except those billed for the following:

- Radiology readings completed by Central Illinois Radiological Associates
- Pathology readings completed by Peoria-Tazewell Pathology Group
- Any professional physician services by physicians not a part of Graham Medical Group

The Chief Financial Officer has established requirements related to qualifications for application and related discounts under this policy, which shall be consistent with the Fair Patient Billing Act, the Hospital Uninsured Patient Discount Act and regulations prescribed hereunder. The Senior Director of Revenue Cycle shall be responsible for implementing the policy according to the requirements.

GHS shall file its annual Hospital Financial Assistance Report as required by statute or regulatory agency. GHS, upon request, will provide any member of the public and any other regulatory agencies with a copy of this policy. In addition, information about financial assistance and contact information will be made available in all registration areas through signage and brochures and on GHS' publically available websites.

DEFINITIONS

The following terms are meant to be interpreted as follows within this policy:

1. **Charity Care:** Healthcare services provided which are not expected to result in cash inflows; medically necessary services rendered without expected payment to individuals meeting established criteria.
2. **Medically Necessary:** Hospital services or care rendered either inpatient and outpatient, to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, and threaten to cause or aggravate a handicap, or result in overall illness or infirmity. One annual preventive office visit will be covered under Charity Care for adults. Well-child visits will be covered for children.
3. **Emergency Care:** Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
4. **Urgent Care:** Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if not treated within 12 hours.
5. **Uninsured:** The patient is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible insurance plans, workers' compensation, accident liability insurance, or other third party liability.
6. **Amounts Generally Billed (AGB):** The amounts billed to patients eligible for financial assistance seeking emergency or medically necessary care.
 - a. GHS will apply the "look-back method" when determining AGB. This will be completed by multiplying the gross charges for that care by the AGB percentage. The AGB percentage will be calculated annually using the CMS Provider Statistical and Reimbursement System Report ran for the prior fiscal year. The total allowed amounts will be divided by the total gross charges for all providers of the health system to calculate an overall AGB percentage.
7. **Extraordinary Collection Actions (ECA):** Any actions taken by GHS (or any agent of GHS, including a collection agency) against an individual related to obtaining a bill covered under this policy, that requires a legal or judicial process (such as a court order or judgment). Placing an account with a third party for collections is not an ECA.

PROCEDURE

Hospital financial assistance programs available to uninsured patients include **Charity Care, Discounted Care and the Uninsured Patient Discount** (in accordance with 210 ILCS 89 – Hospital Uninsured Patient Discount Act). Patient Financial Advocates are available to discuss the various Financial Assistance Program options available to GHS patients.

- A. **Determining Eligibility for Financial Assistance:** Financial assistance will generally be provided on a prospective basis unless there is evidence of a pending application for public aid and/or social security disability coverage at the date of the application.

Applications are available upon registration, or to anyone requesting an application at any time. If requested by phone, an application will be mailed. Applications can also be found on any Graham Health System website (www.grahamhealthsystem.org). Eligibility will be approved for a maximum of one year, beginning with the date of approval by GHS.

- **Eligibility Requirements:**

- The patient is an Illinois resident at the time of application; and
- The patient is receiving, scheduled to receive, or has received a medically necessary service as defined by this policy; and
- The patient satisfies the requirements of Patient Responsibilities under this policy

- **Application Requirements:**

- A fully completed GHS Financial Assistance Application
- Copy of most recent federal tax return
- Proof of income for applicant (and spouse if applicable), such as recent pay stubs, unemployment payment stubs, or sufficient information on how patients are currently supporting themselves
- Other information as requested by the Patient Financial Advocate

All completed applications are acknowledged within 30 days, informing the patient of the decision regardless of assistance awarded. Applications are approved by the Patient Financial Advocates, Assistant Director of Business Services, Senior Director of Revenue Cycle, or the Vice President of Finance. Applications will be accepted up to 240 days from the first billing period. Incomplete applications will result in suspension of ECAs for a reasonable amount of time, during the notification and application period (120 days and 240 days from service, respectively). Patients will be billed full charges if they do not apply for financial assistance.

The Federal Poverty Income Guidelines are used as a calculation base for Charity Care/Discounted Care. Patients with income/ up to 300% of the Federal Poverty Guideline may be awarded full, or partial, financial assistance through evaluation of the completed application and provided information.

Federal Poverty Guidelines (FPL) for 2019

Person in Family Unit	Fed Poverty Guideline
1	\$ 12,490
2	\$ 16,910
3	\$ 21,330
4	\$ 25,750
5	\$ 30,170
6	\$ 34,590
7	\$ 39,010
8	\$ 43,430

B. Calculating Financial Assistance:

GHS will provide a discount from its medically necessary charges to any uninsured patient who applies for and qualifies for financial assistance. Eligible patients will not be charged more, for emergency or other medically necessary care, than the amounts generally billed (AGB) to individuals with insurance covering such care. Graham Health System’s AGB Discount is 71.98% for 2018. Those eligible for the uninsured discount may not be charged more than of 25% of their annual family income over a period of one year.

- Once eligibility is determined and approved, bills for medically necessary services will be further reduced by the following:

0% - 180% of FPL	100% Discount off AGB
181% - 190% of FPL	90% Discount off AGB
191% - 200% of FPL	80% Discount off AGB
201% - 210% of FPL	66% Discount off AGB
211% - 220% of FPL	53% Discount off AGB
221% - 230% of FPL	39% Discount off AGB
231% - 240% of FPL	25% Discount off AGB
241% - 250% of PFL	5% Discount off AGB
251% - 300% of FPL	AGB Only

C. Presumptive Charity: Presumptive charity/exceptions to the application process, based on ability to pay, include:

- a. Soft credit checks by a collection agency may determine eligibility status for those unable to provide an application
- b. Accounts deemed uncollectible by a contracted collection agency
- c. Out of state Medicaid patients may meet charity status if emergent
- d. Food stamp eligibility
- e. Homelessness
- f. Deceased with no estate
- g. Mental incapacitation with no one to act on patient’s behalf
- h. Medicaid eligibility, but not on date of service or for non-covered service
- i. Incarceration in a penal institution
- j. Patient enrolled in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria. Patient or family income must be below 180% federal poverty level for 100% write off
- k. Special circumstances such that income exceeds poverty guidelines but medical bills are high, the Senior Director of Revenue Cycle and/or Chief Financial Officer may determine partial or full eligibility provided proper documentation is available.
- l. Circumstances where patient does not complete an application and there is adequate information to support that patient’s inability to pay will be forwarded to the Senior Director of Revenue Cycle and/or the Chief Financial Officer for consideration

D. Prompt-Pay Discounting

Patients who do not qualify for charity discounting will be eligible for a 20% prompt-pay discount (for medically necessary services), if paid prior to the date of service, on the date of service or within 30 days from the first statement date. The patient is responsible for calling the Business Office to request the 20% discount if not paid at time of service. If actual billed charges exceed the estimated amount paid at the time of service, a 20% prompt-pay discount will be applied to the total charge amount. Charity discounts and prompt-pay discounts cannot be combined, nor combined with any other discount offered by the hospital, or its affiliates.

This prompt-pay discount only applies to Graham Hospital balances. It does not apply to any balances for services provided at Graham Medical Group. Professional fees of GMG Surgeons, for surgeries at Graham Hospital, are allowed the 20% discount if all other criteria is met. Professional anesthesia fees are also allowed the 20% discount.

Patients who were provided an estimate at time of service and chose not to pay are not eligible for the prompt-pay discount within 30 days of the first statement date.

Notwithstanding any requirements of this policy, individual uninsured cases may be considered for charity at the sole discretion of the Chief Financial Officer or President/Chief Executive Officer.

BILLING PROCEDURES

- A. Uninsured patients are screened for eligibility under Medicaid or other state programs as soon after admission as possible. Patient Financial Advocates meet with uninsured patients and patients with deductibles and co-insurance to identify the payment source, to make payment arrangements, and/or to provide information regarding financial assistance. Financial counseling is available to all patients to address concerns regarding financial options.
- B. Co-payment and deductible and/or estimated co-insurance amounts are requested from Emergency Department patients at the time of discharge. Co-payment and deductible amounts (or estimated amounts thereof) are requested from Clinic, Inpatient, Observation, Imaging, and Same Day Surgery patients at pre-registration, registration, or prior to discharge.
- C. All uninsured and self-pay patients presenting to Graham Medical Group, who do not qualify for assistance, are requested to pay \$75 on the day of service in order to be seen. This is NOT payment in full, only a down payment toward services rendered. The balance will be billed to the patient or guarantor.
- D. All elective procedures will be estimated and the patient will be required to pay 100% of the physician charge, as well as the facility charge, prior to services being rendered. Payment plans for the remaining balances can be arranged with the Patient Financial Advocate. Failure to meet the requirements of the payment arrangement will result in collection efforts.
- E. Returned Checks will result in a \$25 service fee being applied to the patient account, in addition to the insufficient funds amount. Patients may be placed on a "cash-only" basis if deemed necessary.
- F. It is the patient's responsibility to provide GHS with all necessary information to bill the patient's insurance(s). GHS staff will complete and submit claims on the patient's behalf. Patients will be billed for balances remaining after third-party payments and adjustments are

applied. Even though insurance is carried, the patient is ultimately responsible for providing payment for services rendered. If the patient's insurance rejects or denies payment for services, GHS will bill the patient, unless GHS is contractually prohibited from doing so.

- G. If an Uninsured patient receives an Uninsured Discount and subsequently provides valid insurance information, the Uninsured Discount will be reversed when GHS bills the third party.
- H. The patient billing cycle begins with the production of a final bill (in the case of Uninsured patients) or with payment or denial by the insurer (in the case of Insured patients). The billing cycle is as follows:
 - a. Day 1 – 1st statement
 - b. Day 30 – 2nd statement
 - c. Day 60 – 3rd statement
 - d. Day 90 – 4th statement
 - e. Day 120 – Collection Notice sent to patient, requesting payment or contact from patient
 - f. Day 150 – If payment in full has not been received, the account may be turned over to an external collection agency
- I. Patient concerns are handled by the GHS Patient Financial Advocates. Any unresolved patient concerns are referred to the Assistant Director of Business Services. If questions regarding patient charges arise, the manager of the clinical department is consulted. If there is a material dispute regarding the charges on the patient's bill, the collection process may be put on hold until the dispute is resolved. Write-offs done as resolution to a patient concern or patient care issue must be approved by the Assistant Director of Business Services, Senior Director of Revenue Cycle, the Chief Financial Officer and the President/Chief Executive Officer.

NON-PAYMENT

Unresolved Patient accounts, in which financial assistance has not been requested, may be referred to a collection agency 150 days after the patient bill is produced. Patients whose accounts have been referred to a collection agency are to request financial assistance.

GHS requires the approval of the Assistant Business Office Director, or the Senior Director of Revenue Cycle, to engage in an "extraordinary collection action" (ECA) on a patient account. The Assistant Director and/or Senior Director have the final authority and responsibility for determining whether GHS made reasonable efforts to decide whether a patient is eligible for financial assistance, prior to engaging in ECAs. Either will confirm the following actions were taken with regard to a patient prior to approving ECAs on the patient's account:

- The patient received the notice of an ECA no earlier than 120 days after first billing;
- The notice of a potential ECA specified the potential actions that would be taken if the patient did not submit a completed FAP application or pay the amount due by the deadline (specified in the notice); and
- The potential ECA notice was provided to the patient 30 days prior to the ECA deadline. The Assistant Director or Senior Director will also inspect the patient's billing file prior to approving ECAs on the patient's account.
- The following communications be noted in the billing file:
 - A plain language summary application for financial assistance was provided before discharge;
 - All billing statements and other billing communication were provided in plain language;

- Any oral communication with the patient provided financial assistance information in plain language; and
- At least one notice of potential ECAs was provided to the patient.
- The collection agency is authorized by GHS to take the following ECAs to obtain payment of a patient bill. The collection agency is not authorized to pursue these ECAs at any time GHS itself would be prohibited from pursuing ECAs:
 - Placing a lien or foreclosing on an individual's property;
 - Attaching or seizing individual's bank account or any other personal property;
 - Garnishing wages;
 - Filing a civil lawsuit

PATIENT RESPONSIBILITIES

This policy requires the cooperation of the patient, as a condition of receiving assistance. That cooperation includes, but is not be limited to, the following:

- The patient must cooperate with GHS by providing information on third-party coverage. If GHS finds that there is a reasonable basis to believe that the patient may qualify for such assistance, the patient must cooperate in applying for third-party coverage that may be available to pay for the uninsured patient's medically necessary care, including coverage from a health insurer, a health care service plan, Medicare, Medicaid, automobile insurance, worker's compensation, or other insurance available under the Affordable Care Act.
- The patient must provide GHS with financial and other information requested to determine eligibility for financial assistance. Generally, information to support application materials must be received within 30 days of the date of service or discharge.
- Generally, the patient, or a person, acting on his or her behalf must request assistance from GHS. Although, GHS has full discretion to identify specific cases for potential charity needs based on financial and other information that is made available to the organization.
- The patient who has a payment obligation to GHS must cooperate to establish and comply with a financial plan. The patient who enters into a financial plan agreement shall promptly inform the appropriate GHS billing entity of any change in circumstances that will impair his or her ability to comply with the financial plan.
- The patient must notify GHS of any change in financial status that could disqualify the patient for financial assistance.
- Any patient who fails to satisfy his or her responsibilities under this policy may be billed by GHS and is subject to collection activities consistent with organizational billing and collection policies and practices for patients who do not qualify for assistance under this policy.

FINANCIAL ASSISTANCE PROGRAM: PUBLICATION

The Financial Assistance Policy, FAP application, and plain language summary is available on GHS website at www.grahamhealthsystem.org. The FAP, FAP application, and plain language summary are also available by request, free of charge, by mail, from a Patient Financial Advocate, or at all GHS patient registration and cashier areas in paper form.

Co-workers shall refer any patient who requests financial assistance or who indicates he/she is unable to pay the entire amount of his/her account balance to a Patient Financial Advocate, by calling Business Services. Co-workers other than those persons working in Business Services shall not make specific representations or promises to patients concerning whether a patient may

qualify for any type or amount of financial assistance. Notwithstanding the foregoing, coworkers in the Emergency Department shall follow EMTALA policies and procedures in responding to inquiries from Emergency Department patients regarding charges and related

CONTACT INFORMATION

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