SAINT FRANCIS Care Policy	**Title:** **BILLING AND AR COLLECTION POLICY**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Business Office	**Number**	**Level** ☐ **System** ☐ **Division** ☒ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date**	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE: It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a complete bill detailing encounter specific information including dates of service, itemized charges, discounts applied, and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial relief program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.

SCOPE:

This policy applies to the Business office and hospital staff

POLICY:

Self-Pay Billing: Execution of the self-pay billing cycle.

Primary self-pay balances, or those balances for which there is no insurance coverage, will receive a series of four statements beginning at day five (from billing). Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, a bill is generated and the account balance associated with the patient encounter is moved from pre-receivable status to active accounts receivable status in the hospital's billing and accounts receivable system.
- Second, a statement displaying total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Finally, a file containing the billed inventory is electronically transferred to one of two contracted self-pay collection agents to initiate account resolution activities.

Each statement includes a specific message based upon the status of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement will receive an alternative self-pay dunning cycle.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay accounts are assigned to one of the two contracted collection and customer service agents from the day of billing. The contracted agents receive daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through the State of Connecticut's Medicaid Assistance program as well as St. Francis' internal financial relief program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt by changing the financial class and written of at the end of the month.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

Effective 3/1/2011: Review of bad debt accounts are as follows:
$5,000-$24,999 requires a Manager's approval
$25,000-$50,000 requires the Director of Patient Financial Services approval
$50,000-and greater requires the VP of Revenue Management approval

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 270 days and perform similar referral management and collection activities as described above.
- Upon culmination of the 270 day holding period, any unpaid balances will be returned to the hospital and a final adjustment transaction will be posted to relieve the bad debt receivable.

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber	Date: 2/21/2011	Vice President(s): Nicole Schultz	Date: 2/21/2011

REPLACES: 3/1/03

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11

SAINT FRANCIS Care Policy	**Title:** **FINANCIAL RELIEF FUNDS POLICY AND PROCEDURES**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** DEPARTMENT OF BUSINESS OFFICE	**Number**	**Level** ☐ **System** ☐ **Division** ☒ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date**	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center & The Rehabilitation Hospital of CT to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by Saint Francis Hospital and Medical Center and The Rehabilitation Hospital of CT for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures and private room differentials.

SCOPE:

This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

POLICY:

All self pay patients are given a 35% discount off of the published charges. For patients in need of additional assistance, the completion of the financial relief application is required for a determination to be made for the applicable Free Bed funding and/or hospital financial relief.

Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided.
   a. family size
   b. income verification three most current pay stubs; previous year's tax return or a letter from an employer or government agency which verifies income).

   If any of the above mentioned documents are not received the application will be denied.
3. An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% poverty. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on our sliding fee scale. If a patient is approved for Medicaid, they will automatically be eligible for financial assistance. Bills applied towards a patient's spend down which results in active coverage will be adjusted off to the financial relief allowance code 97000384.

4. Eligibility is determined on income and total medical bill obligations.

    a. Income eligibility is based on the federal poverty guidelines. Patients with income levels under 150% of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief. Sliding scale arrangements are available for patients with income under 250% of the federal guidelines. Discounts range from 35% to 100% (full eligibility).
    b. An assessment is made on the patient's total medical bill obligations. If the patient responsibility is greater than 50% of their total annual income, they are eligible for additional discounts.
        i. A self pay patient will be entitled to the above stated 35% discount off of charges along with an additional 21% financial relief resulting in a total of 56% discount off of hospital charges.
        ii. A patient with insurance coverage who has medical bill obligations after insurance payment that is 50% greater than their total income will be eligible for a flat 20% discount.

5. The Patient Access Manager and appropriate personnel determine eligibility within 30 days of receipt of the completed application. Any patient granted partial assistance is required to sign an agreed upon payment plan for the balance within thirty days of approval. Long and short term budget plans are available for patients.

6. Assessment for free bed funding is completed as part of the financial assessment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit or Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber	Date: 1/21/11	Vice President(s): Nicole Schultz	Date: 1/21/11

REPLACES:

REVISED DATE: 10/1/03; 3/15/04;9/01/04; 11/01/04; 03/07/05; 10/01/05; 10/1/06; 3/1/07; 4/11/08; 5/22/09

SAINT FRANCIS
Hospital and Medical Center

Mount Sinai
Rehabilitation Hospital

a SAINT FRANCIS *Care* Provider

Mt Sinai Campus

APPLICATION FOR FINANCIAL RELIEF

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Home Phone#: _____

Employer's Name & Address: _____

Number - Household Members: _____ Other Family Income: $_____

Patient's gross income: $_____ Total Family Income: $_____

Service Date(s): _____ Acct #: _____ Balance: $_____

Proof of income provided: _____ Pay stubs *(4 current)* _____ Fed'l Tax Return (most recent) _____ Other: *SSI, State denial*

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance *(Medicaid, Medicare, Insurance, etc.)* which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance.

I understand that this application is made so that the hospital can judge my eligibility for Financial Relief, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action that is appropriate.

I also understand that all information requested must be received within ten (10) working days from date of request.

_____ _____ _____

Date of request | Person Completing Application | Applicant's signature

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ELIGIBILITY DETERMINATION *(For Office Use Only)*

Date application received: _____ Documentation received: _____

The applicant is **eligible** for %_____ = $ _____ Financial Relief Funds. New balance: $ _____.

_____ The applicant's request for Financial Relief Funds has been **denied** for the following reason(s):

_____ Over-income _____ Did not pursue available resources or failed to comply _____ No income

_____ Other reason: _____

Date determination (deny/eligible): _____ Authorized Signature: _____

1704313 (Rev. 12/07)

SAINT FRANCIS
Hospital and Medical Center

The Rehabilitation Hospital of Connecticut

Mt Sinai Campus

APLICACIÓN PARA ASISTENCIA FINANCIERA

Nombre: _____

Dirección: _____

de Seguro Social: _____ # de telefono: _____

Nombre y dirección del empleador: _____

Numero de dependientes: _____ Ingreso de otros familiares: _____

Ingreso del paciente: _____ Ingreso total de la familia: _____

Fecha(s) de servicio: _____ # de cuenta: _____ Balance: _____

Prueba de ingreso:	Talonarios ___ (4 recientes)	Forma de Impuestos: ___ (2005)	Otros: _____ (SSI, State denial)

Certifico que la información suministrada es cierta segun mi leal saber. Ademas, haré cualquier aplicación para asistencia (medicaid, medicare, seguros, etc.) las cuales servirán para cubrir las deudas del hospital. Tomaré cualquier acción que sea razonablemente necesaria para obtener dicha asistencia.

Yo entiendo que esta aplicación esta hecha para que el hospital pueda juzgar mi elegibilidad para asistencia financiera, basados en el criterio establecido en los archivos del hospital. Si cualquier información que yo haya proveido prueba ser falsa, yo entiendo que el hospital re-evaluara mi **estado** financiero y tomará la acción que sea apropiada.

Entiendo que la prueba de ingreso debe ser sometida dentro de 10 dias laborables ha partir de la fecha del pedido.

_____ _____ _____

fecha del pedido Persona completando la Aplicación Firma del aplicante

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DETERMINACIÓN DE ELEGIBILIDAD *(uso de la oficina)*

Fecha de haber recibido la aplicación: _____ Verificación de Ingreso: _____

El/La aplicante es elegible para % _____ = $ _____ ayuda financiera. Balance actual: $ _____

El/La aplicante es elegible para _____% ayudo financiera

___ El pedido del aplicante para servicios gratis o reducidos ha sido negado por la(s) razon(es) siguientes:

___ Sobre Ingreso ___ No aplicó para los recursos disponibles ___ Ningun Ingreso
___ Otros

Fecha Determinante de eligibilidad: _____ Firma Autorizada: _____

Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 10/01/2010

Remains the same as 2009 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	250%
1	10,830	21,660	27,075
2	14,570	29,140	36,425
3	18,310	36,620	45,775
4	22,050	44,100	55,125
5	25,790	51,580	64,475
6	29,530	59,060	73,825
7	33,270	66,540	83,175
8	37,010	74,020	92,525
9	40,750	81,500	101,875
10	44,490	88,980	111,225

SLIDING SCALE

Rate A = PAT. OWES 65%
B = PAT. OWES 44%
C = FULL ASSIST 100%

WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL INCOME	SLIDING SCALE FAMILY SIZE 1	2	3	4	5	6	7	8	9	10
0 - 415	0 - 1,805	21,660	C	C	C	C	C	C	C	C	C	C
416 - 519	1,806 - 2,256	27,075	B	C	C	C	C	C	C	C	C	C
520 - 559	2,257 - 2,428	29,140	A	C	C	C	C	C	C	C	C	C
560 - 702	2,429 - 3,052	36,620	A	B	C	C	C	C	C	C	C	C
703 - 846	3,053 - 3,675	44,100	A	A	B	C	C	C	C	C	C	C
847 - 878	3,676 3,815	45,775	A	A	B	B	C	C	C	C	C	C
879 - 989	3,816 - 4,298	51,580	A	A	A	B	C	C	C	C	C	C
990 - 1,057	4,299 - 4,594	55,125	A	A	A	B	B	C	C	C	C	C
1,058 - 1,133	4,595 - 4,922	59,060	A	A	A	A	B	C	C	C	C	C
1,134 - 1,237	4,923 - 5,373	64,475	A	A	A	A	B	B	C	C	C	C
1,238 - 1,276	5,374 - 5,545	66,540	A	A	A	A	A	B	C	C	C	C
1,277 - 1,420	5,546 - 6,168	74,020	A	A	A	A	A	A	B	C	C	C
1,421 - 1,563	6,169 - 6,792	81,500	A	A	A	A	A	A	B	B	C	C
1,564 - 1,595	6,793 - 6,931	83,175	A	A	A	A	A	A	B	B	B	C
1,596 - 1,707	6,932 - 7,415	88,980	A	A	A	A	A	A	A	B	B	C
1,708 - 1,775	7,416 - 7,710	92,525	A	A	A	A	A	A	A	B	B	B
1,776 - 1,954	7,711 - 8,490	101,875	A	A	A	A	A	A	A	A	B	B
1,955 - 2,133	8,491 - 9,269	111,225	A	A	A	A	A	A	A	A	A	B