Aria Jefferson Health	**Department Manual:** Corporate Business Office	**Policy Number:**
Title: Financial Assistance Policy (FAP)	**Category:**	**Original Date:** 7/99
Policy Owner: Corporate Business Services	**Keywords:** Financial Assistance, uninsured, discount	**Last Review Date:**
Referenced With: EMTALA policy	**Review Cycle:** Periodically	**Last Revision Date:** Approved 3/19/18 by Aria Hospital Board of Trustees

Purpose:

Aria –Jefferson Health (AJH) is committed to providing medical care in a caring and compassionate manner regardless of the patient's financial circumstances, in compliance with the Department of Treasury Internal Revenue Service Section 501(r).

Policy:

The hospital Financial Assistance Policy (FAP) of AJH exists to offer financial assistance for medically necessary care to both uninsured and under-insured individuals based upon their ability to pay. The granting of financial assistance will not take into account age, gender, race, social status, sexual orientation or religious affiliation. Patients seeking emergency care shall be treated without regard to ability to pay for such care.

AJH shall operate in accordance with all federal, state and local requirements for the provision of health services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). Patients will not be subject to debt collection activities that would interfere with emergency medical care. See EMTALA policy.

Scope:

This Financial Assistance Policy (FAP) applies to patients residing in the Local Service Areas (see Attachment A) served by Aria –Jefferson Health, including their off-site outpatient departments. Whenever AJH is used in this Policy, it shall include all of the foregoing entities and services.

Other than the hospital facility itself and its staff, emergency and other medically necessary care in the hospital facility may be provided by providers who are not covered by this FAP. This policy does not include non-employed physicians and other services provided by outside vendors. A listing of providers covered under this policy for services rendered to hospital patients can be found in Attachment B. This will be updated quarterly.

It is not the intent of this policy to provide free or discounted care to patients who have health insurance with balances due to copays, deductibles or coinsurance unless a financial hardship is demonstrated. Certain services not medically necessary (such as elective cosmetic surgery) are priced at packaged rates with no additional discounts and all payments associated with such services are expected prior to or at the time of service.

Definitions:

Amount Generally Billed (AGB): amount generally billed by the hospital to insurers for emergency and other medically necessary services. If qualified for financial assistance, AJH will apply the appropriate discount to the amount that would have been paid if the patient were a Medicare beneficiary. This is known as the "Prospective Method" of calculating AGB.

Application Period: The period during which FAP applications will be accepted; ends on the 240th day after the first post-discharge billing statement or 30 days after written notice of extraordinary collection actions (ECA), whichever is later.

Extraordinary Collection Action (ECA): Any of several additional actions AJH may take in order to obtain payment, including legal or judicial action, selling a patient's debt to another party, or reporting adverse information against the individual to consumer credit bureaus.

Federal Poverty Levels (FPL): issued annually by the Department of Health & Human Services; along with household size, are used to determine financial eligibility.

Financial Assistance: Discounted rates for care provided to eligible patients who have family incomes not exceeding 600% of the FPL.

Household Family Income: A patient's family income includes the income of all adult family members in the household.

Local Service Area: Only patients residing in the local service area as listed in Attachment A are eligible for financial assistance, except those patients presenting to Aria –Jefferson Health under the aforementioned EMTALA.

Medically Necessary Care: Health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site and duration; and not primarily for the convenience of the patient, treating physician or other healthcare provider.

Notification Period: Begins on the date medical care is provided and ends on the 120th day after providing the first post-discharge billing statement for the care rendered.

Presumptive Financial Assistance Eligibility: When adequate information is not provided by the patient, but via other sources, AJH can presume that the patient qualifies for financial assistance at the same level as a patient for whom information has been provided.

Under-insured: A patient who has medical insurance coverage that is limited in the scope of covered services or policy maximums such that his or her medical bills are not fully covered.

Uninsured: A person without health insurance through an insurance company, an ERISA plan, federal health care program (Medicare, Medicaid, SCHIP and TRICARE), auto, workers' compensation, medical savings accounts or other coverage. Patients who have exhausted their insurance benefits are considered uninsured.

Uninsured Discount: For those not applying for or not eligible for financial assistance, the AJH Uninsured Discount will be applied in determining patient financial responsibility.

Procedure:

1. **Qualification for Government-Sponsored Programs:** If a patient is uninsured, AJH personnel shall first assist the patient in determining whether he/she is eligible for government-sponsored programs or other insurance coverage. An outside firm may be employed to assist in the formal state medical assistance program application process, including visiting the patient at home in order to obtain all necessary supporting documentation. The patient will be asked to provide AJH with all financial and other information needed to assist in enrollment in a publicly sponsored insurance program (e.g., Medicaid, HealthChoices, CHIP, AdultBasic, grants, etc.). Patients who do not cooperate in applying for such programs may be denied financial assistance.

2. **Eligibility:** A patient may qualify for discounts on medical care if there is no health insurance available, or has health insurance, but that insurance does not fully cover the medical care needed, such as exhausted benefits, and all of the following apply:
   - The patient is not eligible for State Medical Assistance or other available assistance programs, and,
   - The patient meets the criteria for financial assistance described in this policy, and
   - The patient provides the necessary documents and completes necessary paperwork.

   Eligibility for financial assistance is determined by the patient's or guarantor's ability to pay after all insurance has been utilized or liquid resources exhausted (excluding retirement funds). AJH will not consider the patient's house, car, retirement accounts, and other "non-liquid" assets. However, it is recognized that there is a small percent of the uninsured patient population that has substantial assets and could easily afford to pay for healthcare services, but whom, because of having tax-exempt income, will not have income reflected on a tax return. Such individuals may not qualify for financial assistance pursuant to this Policy.

   a) As a threshold matter, all uninsured patients will be entitled to the Uninsured Discount as further outlined in section #5 below.

   b) Eligibility for financial assistance is based upon financial need. Patients that fall below 300% of the FPL, based on total household income, with sufficient supporting documentation provided, will receive a 100% discount. Patients at 300% or above, up to a maximum of 600% of the FPL, are eligible for financial assistance based upon a sliding scale discount. These discounts are applied against the Medicare fee-for-service rates in place at time of determination (see attachment D).

   Financial assistance discount rates are provided below:

% of Federal Poverty Levels	Discount %
0% - 299%	100%
300% - 375 %	80%
376% - 450%	60%
451% - 525%	40%
526% - 600%	20%

3. **Financial Assistance Application (FAA):** If the patient requests to apply for Financial Assistance, the patient will be given or mailed an application, free of charge, (see attachment E) along with a summary of supporting documents needed. A patient will not qualify for Financial Assistance until the application is fully completed and the required supporting documents are provided.

   a) Patients must present income tax returns (IRS 1040, 1040A or 1040E2) as proof of income whenever possible. If the patient cannot provide a suitable tax return, as many of the following items as are available must be provided within 30 days.
      1. Social Security 1099 forms or W-2 Form (if applicable)
      2. Pay stubs from the last three months
      3. If self-employed, Schedule C and/or profit and loss statement
      4. Unemployment or workers' compensation award letters (if applicable)
      5. Bank Statements
      6. Other documentation – Shelter letters, Letter from employer, letters of financial support, patient letters detailing reason why proof of income is not available, a sponsoring person's income

   b) All patients must provide copies of the most recent statements (if applicable):
      1. Checking and/or Savings Accounts
      2. Stocks, bonds, certificates of deposit, high-yielding interest accounts or annuities
      3. Any other investments (including real-estate)
      4. Health Savings Accounts (HSA), Medical Savings Accounts (MSA), Flexible Spending Arrangements (FSA) or Health Reimbursement Arrangements (HRA)

   c) If an Application is submitted, any ECAs that have been initiated against the patient to collect amounts that are the subject of the Application will immediately be suspended until the later of (a) in the case of incomplete Applications, the last day on which the patient could submit information to complete their application; or (b) the date of a determination of eligibility for assistance as described in Section 7 of this Policy.

4. **Incomplete Applications**: If a FAA is submitted, but not complete, the Financial Counselor will provide the patient with written notice and describe additional information and/or documentation that must be submitted. That notice will include a Plain Language Summary (PLS). If the patient fails to complete the application within the time period described, ECAs may be initiated after a 30-day notice and a copy of the PLS is given; see Attachment C for a copy of the PLS.
   If the patient completes the application by the deadline, the patient's eligibility for financial assistance must be determined pursuant to Section 7 of this Policy and the patient must be informed of that determination.

5. **Uninsured Discount**: For uninsured patients, there is an automatic initial discount which shall equate to 50% off total charges for services rendered. In addition, for Emergency Department and Observation services for those treated and released (not admitted as inpatient) there will be a maximum liability of $1,600. For laboratory services, there is a further discount that is generally greater than 50% off charges. A patient unable to pay the uninsured rate is eligible to apply for financial assistance as outlined above.

6. **Presumptive Eligibility for Financial Assistance**. Before referring an account to a collection agency, AJH may review the patient's account for Presumptive Eligibility for Financial Assistance. This may entail review of credit reports and other publicly available information to determine, consistent with applicable legal requirements, estimated household size and income amounts. These data elements may be paired with other scoring attributes to develop a predictive financial assistance model so that time and costs are not allocated to pursuing payment from those who truly can't pay.

   The discounts applied will be the same as those under the full FAA process; however, these accounts will be adjusted using specific presumptive financial assistance transaction codes. In the event a patient does not qualify for 100% assistance under the predictive model, the patient may still provide supporting information within previously stated established timeframes and be considered under the traditional financial assistance application process for further assistance.

   Approval for presumptive eligibility will only apply to the date(s) of service on the accounts being evaluated. Eligibility will not apply to accounts for future service dates.

7. **Application Review**. Applications must be initially reviewed and approved by designated personnel within the Financial Services Unit.

   a) A copy of the completed FAA and supporting documents must be forwarded to the Financial Counselors.

   b) If an individual submitting a FAA may qualify for Medicaid, the facility may postpone making an eligibility determination until the Medicaid application has been completed submitted, and a determination made regarding eligibility.

   c) The patient will be notified in writing of the eligibility determination in a timely manner (ideally within 60 days of receipt) and the basis for this determination.

      1. If the patient qualifies for partial financial assistance or is deemed ineligible, the notice will include a billing statement that indicates the amount that the individual owes.

      2. If the patient is deemed ineligible for financial assistance or for partial assistance, the patient may appeal the decision in writing to the Vice President of Revenue Cycle Operations within thirty (30) days following receipt of the bill for which assistance was requested.

      3. Any individual payments in excess of the amounts owed under this Policy and for the episodes covered, the excess over $5.00 will be refunded.

      4. If any ECAs have been initiated to collect amounts due, the Hospital will take all reasonably available measures to reverse such ECAs.

8. **Length of Eligibility**. Once financial assistance has been approved, it is effective for all outstanding patient accounts incurred during the past 6 months and for all services provided within six (6) months after the approval. Financial assistance may be extended for an additional six months with confirmation of the patient's income or estimated income and household size. For AJH outpatient hospital-based clinic service, the assistance is effective for 12 months after the approval.

9. **Billing and Collections Efforts**:

a. While qualification for Financial Assistance is ideally determined prior to, or at the time of service, AJH will continue to review such determinations as other financial resources are discovered during the billing and collection process.

b. After an uninsured or under-insured patient's account is reduced to the Uninsured discount or the financial assistance discount rate, whichever is applicable, the patient is responsible for the remainder of any outstanding patient balances.

c. Patients will receive an initial statement indicating their balance due along with information regarding the availability of financial assistance and who to contact.

d. Selfpay balances go through a pre-collection agency placement process that may entail the mailing of statements or letters and/or phone calls in order to collect payment on open balances.

e. When the open balance accounts complete the pre-collection dunning cycle, (120 days or more) with no payment or proof of eligibility for financial assistance or other programs, the accounts will be transferred to a professional collection agency. If a FAA and appropriate supporting documents have been submitted and a decision is pending, the account will be held from agency placement.

f. In some cases, a patient eligible for financial assistance may not have been identified prior to sending the account to an external collection agency. Each agency will be made aware of the financial assistance policy and will work with the provider to ascertain patient eligibility as outlined under the policy.

g. No ECAs may be undertaken during the initial notification period of the 120 days from the first post-discharge billing statement and until such time as a 30 day initiation of ECA notice has been sent to the individual. The 30 day ECA initiation notice must contain the ECA action that the provider intends to undertake and the date at which time this would occur. A copy of the PLS must accompany the 30 day ECA initiation notice. If the patient submits a FAA, AJH will suspend any ECAs until the patient's financial assistance eligibility is determined and the patient is informed of their eligibility.

h. After the above-described steps have been taken, AJH may use ECAs with the respect to the patient account of an uninsured or under-insured and may further consider credit bureau reporting and/or legal action as appropriate. AJH General Counsel shall pre-approve all lawsuits.

i. If an account is to be referred to an outside agency, that agency must first agree to abide by this Policy in relation to its collection efforts. No external collection agency may engage in ECAs unless authorized by AJH and only by exception. Final authority for determining that AJH has made adequate attempts to inform a patient of the Financial Assistance Policy and may use ECAs rest with AJH's Vice President Director of Revenue Cycle Operations.

Methods for Publicizing the Financial Assistance Policy:

The following measures are used to publicize this policy to the community and patients. Communication will be written in consumer-friendly terminology and in languages that patients can understand. AJH will provide training to appropriate administrative and clinical staff that interacts with patients about financial assistance availability, how to communicate that availability to patients, and how to direct patients to appropriate financial assistance staff.

a) **Community Notification**. This Policy, application forms and a plain language summary will be made available to the community in English as well as any primary language of populations with limited proficiency in English that constitute the lesser of 5% or 1,000 individuals, whichever is less, of the primary communities served by AJH. These documents will be made available, free of charge as follows:

1. This policy, application forms, and plain language summary can be found on the AJH website: www.ariahealth.org/financialassistance

2. By mail when a patient calls or contacts AJH. Telephone inquiries should be directed to the Financial Services Unit at (215) ___- ____.

3. As part of the intake or discharge process, paper copies of the FAP PLS will be distributed to individuals who are provided care by the facility.

4. In person, without appointment, at the Financial Services Unit located within the Admissions Department at Torresdale Hospital.

b) **Personal Notification**. AJH will use reasonable efforts to notify patients of its Financial Assistance Policy. AJH will use the following methods to notify patients:

1. At the time of scheduling, pre-registration, or registration of elective services, the patient will be asked for insurance coverage. If the patient is an uninsured patient, the patient will be informed of the Financial Assistance Policy and, if requested, will be provided a plain language summary of the policy (See Attachment C).

   Unless the treating physician advises the Financial Counselor or Registration Representative that such treatment is medically necessary, patients requesting non-emergent admissions or outpatient services will not be scheduled for services until the patient has complied with meeting their financial obligations.

2. In the case of emergency or urgent services that are not scheduled, a Financial Counselor or Patient Representative will visit as necessary, with patients, in person, at service sites.

3. All billing statements will include a reference to the Financial Assistance Policy and a contact number and email address as well as reference to a web site for access to more information.

4. Staff will discuss the Financial Assistance Policy, when appropriate, during billing and customer service phone contacts with patients.

Authorizations:

(Signature on file) _____
Steven G. Littleson — Date
President
Aria - Jefferson Health

(Signature on file) _____
Michael Walsh — Date
Sr. Vice-President, Finance and Chief Financial Officer
Aria - Jefferson Health

(Signature on file) _____
Deborah Datte — Date
Sr. Vice-President, Legal Services and General Counsel
Aria – Jefferson Health

(Signature on file) _____
Kim Roberts — Date
Vice President, Revenue Cycle Operations
Aria – Jefferson Health

Attachments:

Attachment A: Local Service Area
Attachment B: Providers covered, not covered
Attachment C: Plain Language Summary
Attachment D: Federal Poverty Levels
Attachment E: Financial Assistance Application