Policy /Procedure Document	
Category/Source:	
Origination Date:	3/1/1995
Policy Number:	
Last Review Date:	08/10/2020
Last Revised Date:	08/10/2020
Next Review Due:	08/31/2022
Policy Owner:	Executive Director of Revenue Cycle
Required Approvals:	
	Chief Financial Officer
	Board of Directors

TITLE:	**Financial Assistance Policy**
SCOPE:	Patients at Elkhart General Hospital as a member of Beacon Health System receiving Emergency and/or Medically Necessary Care
PURPOSE:	• Ensure transparency, consistency and fairness towards uninsured (self-pay) patients and set guidelines for providing a financial adjustment to any uninsured or underinsured patient who obtains Medically-Necessary or Emergency Services from Elkhart General Hospital. This policy ensures that Elkhart General Hospital is compliant with the Patient Protection and Affordable Care Act and Internal Revenue Code section 501(r). This requires tax-exempt hospitals to limit amounts charged to uninsured patients for emergency and other medically necessary care to no more than those amounts generally charged to insured patients. • Screen uninsured patients for: their ability to pay, possible eligibility for health coverage programs or third party coverage, and all available resources in order to identify charity cases in a timely manner. Health coverage programs could include, but are not limited to, Medicaid, Medicare Savings Programs, subsidized insurance plans purchased through the "Marketplace" or Affordable Care Act (ACA) Exchange, or other state, federal and local programs. In order to qualify for financial assistance an individual must apply and comply with the application for any other possible payer source. • Provide program application assistance procedures, the method for applying for Elkhart General Hospital financial assistance, the policy for the basis of calculating eligibility for free or discounted care and the actions the hospital may take in the event of non-payment.
POLICY/PROCEDURE:	

Regardless of an individual's ability to pay or qualify under this Financial Assistance Policy, Elkhart General Hospital will provide, without discrimination, care for any emergency medical condition(s) as designated under the U.S. federal governments Emergency Medical Treatment and Labor Act (EMTALA) of 1986.

No person shall be discouraged from seeking emergency care.

No person shall be excluded from consideration for financial assistance based on age, color, creed, ethnic background, gender, national origin, physical disability, race or religion.

Patients that are uninsured (self-pay) will receive a 35% discount off their gross charges. This discount applies to all hospital services, and is exclusive to any other discounts or acceptance to the FAP.

This FAP applies to services provided and billed by Elkhart General Hospital. It does not apply to physicians who may provide services to patients of the hospital. Please see Attachment 2 for a list of provider groups who are not covered by this FAP.

In order to manage its resources responsibly and to allow Elkhart General Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the following guidelines for the provision of financial assistance have been established.

Definitions:

- Amount Generally Billed (AGB) – Elkhart General Hospital will apply the "look-back method" for determining AGB. In particular, Elkhart General Hospital will determine the AGB for emergency or other medically necessary care by multiplying the Gross Charges for such care by the AGB Percentage.
- AGB Percentage – Elkhart General Hospital will calculate the AGB percentage at least annually by dividing (1) the sum of payments on all claims allowed during the 12-month period in the prior calendar year by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by (2) the sum of the associated gross charges for those claims.
- Cosmetic Services – those services and procedures that enhance the patient's well-being, are typically not covered by any insurance, and are categorically excluded from any financial or economic assistance.
- Emergency Services – an emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate medical attention may result in serious medical consequences. Or as defined in Section 1867 of the Social Security Act
- Elective Services – Healthcare services and procedures that are needed to support the health and well-being of the patient whether or not they are deemed medically necessary. Such services are eligible for consideration under this policy. A physician order containing the reason for the test or procedure may be required.
- FAP – Financial Assistance Program as defined in this policy
- Gross Charge – An established price, listed on the hospital's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any contractual allowances, discounts or deductions.
- Household Unit – one or more persons who reside together and are related by birth, marriage, or adoption (i.e. parents and children who are filed as dependents on their tax return); or reside together and share joint assets, such as credit cards, bank accounts or real estate. Patients over the age of 18, such as adult children living with their parents, siblings or friends are not considered part of the household unit unless such persons are legally obligated for the debts of the patient.
- Income – Income includes salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment compensation, business income, pensions & annuities, farm income, rentals & royalties, inheritance, strike benefits, and alimony payments. Income is also defined as payments from the state for legal guardianship or custody.
- Medically Necessary – for the purpose of this policy is defined as a service that is necessary to treat a condition that in the absence of medical attention could reasonably be expected to result in jeopardizing the health or condition of the individual.
- Plain Language Summary – A statement written in clear, concise and easy to understand language notifying individuals that Elkhart General Hospital offers financial assistance under a FAP.
- Self-Pay or Uninsured – A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of workers compensation, automobile insurance or other insurance as determined and documented by the hospital.

- Underinsured patient – A patient and/or responsible party with third party coverage for healthcare service who may have an extraordinary amount due that they cannot pay due to household unit income.

Financial Assistance Program Availability
Elkhart General Hospital will widely publicize assistance availability using the following methods:

- At main patient access and registration points to the hospital, Elkhart General will post and/or make available a plain language summary of the FAP. Posted materials will include instructions on how to obtain a printed version of the plain language summary and the FAP application free of charge.
- The FAP summary and application will be available online at www.beaconhealthsystem.org/assist
- Information on how to apply for FAP will be included on patient's statements.

Printed copies of the Financial Assistance Policy and Application may also be obtained by:

- Calling Customer Service at (574) 285-4684
- Presenting to the Cashier's office located at:
  600 East Blvd., Elkhart, IN 46514
- Request by mail in writing to:
  Elkhart General Hospital
  Attn: Patient Accounts
  615 N. Michigan St.
  South Bend, IN 46601

Patients with balances after insurance (e.g. deductibles, co-pays, and co-insurance amounts) may be eligible for FAP if the eligibility requirements are met.

Patients who have exhausted policy limits are eligible for FAP if the eligibility requirements are met. (The remaining account balances after the policy limits are exhausted are considered uninsured and are eligible for the FAP) Medicare patients are eligible for FAP if the eligibility requirements are met.

Patient must co-operate in supplying all third-party insurance information and third-party liability information. The patient must exhaust insurance/third-party liability coverage prior to patient receiving financial assistance through FAP.

The patient must cooperate with pursuing enrollment in all affordable health coverage programs that are accessible to them prior to consideration of financial assistance approval. Assistance with the assessment and enrollment is provided as a service of the hospital free of charge to the patient by certified Indiana Navigators and Certified Application Counselors.

If the account is with a collection agency, the patient may still apply for FAP as long as the date of service is within 2 years of the application date.

Application for Assistance
The patient's eligibility for FAP will be determined through an application process. The Elkhart General Hospital Financial Assistance Application form is the valid application form for the application process. Elkhart General Hospital's Financial Assistance Policy and application will be made available to all patients.

- A signature is required on the application (the patient, guarantor or legal representative). It is the responsibility of the patient/guarantor to complete an assistance application.
- The application requires the patient to provide their name, current address and valid contact information and the names and ages of persons in their household.
- The application requires the patient to list all income amounts and their sources.

- Documentation of all information provided on the application is required to complete the assistance application. Elkhart General Hospital, or its designee, may use national databases from credit bureaus to verify or validate the information that is provided. A written statement from the individual(s) that are supporting the applicant may also be requested if current income or lack thereof is not sufficient to meet their daily living expenses.
- Patient advocates are available to help anyone wanting to apply for assistance and are available during business hours at the hospital and Patient Financial Services office. Verification of requested income and a complete list of all countable household members may be required.
- A FAP application may be used for covered services that are provided up to 6 months after the date the FAP application was approved.
- The patient may appeal the decision of denied financial assistance by writing:

  Executive Director of Revenue Cycle
  615 N. Michigan St, South Bend, IN 46601

Charges

Elkhart General Hospital will not charge patients approved for financial assistance under this FAP for emergency or other medically necessary care more than the amounts generally billed to individuals who have insurance (i.e., Elkhart General Hospital will not charge patients approved for Financial Assistance under this Policy for emergency or other medically necessary care more than the Gross Charges for such care multiplied by the AGB Percentage. Refer to AGB percentage in Attachment 1.

Financial Assistance Criteria

The policy set forth allows for patients to qualify for assistance by two means: financial or catastrophic. The Financial Assistance Program also allows for partial assistance or full assistance based on eligibility criteria set forth in this policy.

Financial Assistance

- A patient qualifying for financial assistance is a person who is uninsured or underinsured, receives medically necessary care and unable to pay their bill.
- To be eligible for assistance under the *financial* assistance guidelines, a person's income shall be at or below a percentage of the Federal Poverty Level (FPL) as determined by Federal Poverty Guidelines. (See Attachment 1 for a table of approval percentages based on % of FPL). Household size and income determines the % of FPL. Elkhart General Hospital, or its designee, may consider other financial assets and liabilities of the person when determining eligibility.
- Elkhart General Hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance. The poverty income guidelines are published annually in the *Federal Register* and for the purposes of this policy will become effective the first day of the month following the month of publication.
- To qualify under the Financial Assistance portion of this policy, a completed, signed Financial Assistance application must be submitted and proof of income, proof of no income, proof of lack of financial assets and other required documents must accompany the application.

Catastrophic Assistance Criteria

- A patient qualifying for catastrophic assistance is a person whose hospital bills exceed a specified percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill.
- To be eligible for catastrophic assistance the amount owed by the patient must exceed one hundred fifty (150) percent of the patient's annual gross income and the patient must be unable to pay the remaining bill. Elkhart General Hospital may consider other financial assets and liabilities of the person when determining ability to pay.
- If a patient has cash assets, those assets will be added to their income when determining eligibility for assistance
- If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should their financial circumstances change.

- After eligibility is determined under this provision, assistance will be provided to discount the bill by 75% of the current balance.

Factors to be considered for Financial Assistance

Household Size and Income

The following factors may be considered in determining the eligibility of the patient for assistance and must be provided by all income earning residents in the countable household unit unless they are not dependents based on IRS guidelines for determining whether a household member can be considered a dependent.

- Indiana workforce wage report for last 2 quarters (unemployment income)
- Last 3 pay stubs or a letter or printout from employer(s) providing verification of gross income if currently employed. This documentation should not be more than 30 days old from date of issue and include year-to-date information.
- Last 3 bank statements (including explanations of regular deposits not explained by pay stubs)
- Social Security award or entitlement letter or other proof of gross monthly award.
- Retirement income.
- Investment income.
- Statement from person(s) that are providing direct support
- Number of dependents.
- Most recent tax return (including W2 and all supporting schedules)
- Other financial obligations.
- The amount and frequency of hospital/medical bills.
- Other financial resources that produce income.
- If Self-Employed, Gross Income less Cost of Goods sold and employee salaries

Financial Capacity

- Individuals with the financial capacity to purchase health insurance coverage through the Health Insurance Marketplace may be required to purchase and will be provided access to meet with an Indiana Certified Navigator as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.
- Individuals who have been found to be ineligible for Medicaid or other affordable health care coverage must provide proof of denial.
- Food Stamps or Supplemental Nutrition Assistance Program (SNAP) will not be counted as income.
- Cosmetic Services are not eligible for any type of assistance and cannot be included in the amount of hospital/medical bills owed.

Reasons for not being eligible for FAP

- Household income exceeds the maximum of the FPL. However, the patient may be eligible for an adjustment of charges discount or catastrophic discount.
- If a patient is eligible for Medicaid, the Health Insurance Marketplace, (Healthcare.gov) or other state or federal programs and the patient fails to cooperate in the application, re-application, or appeal process, or the patient does not pay the required monthly premium, thereby making the patient ineligible for the State program.
- If the patient is eligible and enrolled in a Healthcare Marketplace plan and does not pay the required monthly premium, thereby causing the health plan to discontinue coverage.
- Patient is in the custody of a unit of Government, which is responsible for coverage of the medical needs of the patient.
- Services are not medically necessary or excluded from the program.
- Excluded services include, but are not limited to:
    - Cosmetic surgery
    - Infertility treatments, fertility services, birth control, sterilization, reversal of sterilization;

  - Services denied by your insurance due to non-compliance with your insurance coverage requirements;
  - Services deemed not medically necessary;
  - Services reimbursed directly to you by your insurance company;
  - Services reimbursed by another third party
  - Services required for employment, schools, or athletics

Presumptive Eligibility
A patient in any of the following circumstances will be automatically deemed eligible for financial or economic assistance (presumptively eligible). No assistance application is necessary if patient is deemed presumptively eligible for assistance. Documentation validating these circumstances may be required.

- Patient and/or responsible party reside at Salvation Army, Faith Mission, or any similar homeless shelter or they are homeless and are ineligible for Medicaid or other health coverage programs.
- Patient is deceased and no estate has been filed.
- Patient is enrolled in a limited benefit Medicaid program (i.e. Emergency Only, Family Planning, etc) and the current service is not covered by their Medicaid plan. There must be a denial of coverage from Medicaid prior to the balance being adjusted to charity.

Failure to Provide Appropriate Information
Failure to provide information necessary to complete a financial assessment may result in a negative determination, but the account must be reconsidered upon receipt of the required information. The account may also be submitted for approval if Elkhart General Hospital has been able to verify information from a reliable third party, i.e. Social Security, Medicaid, credit reporting bureau, etc.

A determination of eligibility for financial or catastrophic assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances. This will be approved at the discretion of the Executive Director of Revenue Cycle.

Patients who fail to provide required documentation or information will be provided notification.

No patient may be denied assistance due to their failure to provide information or documentation not specified in the FAP or application.

Financial Assistance Determinations
All complete applications will receive a determination for the award of financial assistance. The patient will be provided with a written copy of the final determination.

Favorable Determinations
A favorable determination will include the following information:

- The date of approval
- Percentage of approved assistance
- Length of time that approval is applicable

Unfavorable Determination
An unfavorable determination will include a reason:

- Services are categorically excluded from consideration (i.e. non-emergent or cosmetic)
- The individual is fully covered, or receives services fully covered by a third-party insurer or government program
- The eligibility standards under FPL were not met
- The individual did not take reasonable action to obtain third-party coverage they were determined to be eligible for.
- They have received payment from a third-party for services
- The individual has not complied with requests from third-party payer

Credit and Collections Practices
Elkhart General Hospital relies on timely payment of patient accounts receivable to allow the Hospital to continue to provide high-quality medical care and to secure the latest in health care technology for its patients. Elkhart General Hospital, recognizing the burden that unexpected health care expenses can place on patients and their families, will assist patients to resolve open accounts for hospital services by working with third party payers to adjudicate patient's insurance claims and by providing alternative payment plans for patients. With the exception of some Government and contracted care plans, ultimate responsibility for resolution or payment of accounts rests with the patient. Patients are expected to work with Hospital personnel to resolve accounts with their insurance companies and/or employers as appropriate. Where there is an estimated self pay balance due, Elkhart General Hospital will ask non-emergency patients to pay that balance prior to or at the time of admission/registration.

- Uninsured patients will be screened for other coverage through state assistance programs and/or financial assistance eligibility prior to requesting a deposit for care.
- Elkhart General Hospital may request and collect a deposit, based on the patient's total estimated portion of a bill, from appropriate non-emergency inpatient admissions, same day surgery patients, and patients scheduled for high-dollar outpatient procedures prior to or at the time of admission or registration. In the event that a request for payment is not made prior to or at the time of the patient's arrival, a Financial Counselor may calculate the estimated deposit amount and confer with the patient/guarantor for payment following the admission or registration process via a financial interview. (In some instances, this could occur while the patient is in his/her assigned room.) At the time of discharge, Emergency patients may be requested to pay any co-pay or deductible.

- Where appropriate, Elkhart General Hospital may identify and request payment of, aged patient balances as part of the request for deposit. Payment for open prior balances will not delay emergency or medically necessary care. Aged open prior balances will be considered by the Collection Staff in Patient Account Services whenever payment arrangements or an alternative payment program is developed for a patient.
- Uninsured patients are given a 35% discount from gross charges.
- Elkhart General Hospital will conduct financial interviews with patients and/or guarantors when necessary. All financial interviews will be conducted in an environment that is both private and professional.
- In addition to cash, check, and credit cards, the approved payment arrangement methods might include:
  - Hospital Payment Plan – A payment plan directly with the hospital is not to exceed three months. Exceptions must be approved by the Director or Manager of Patient Account Services or Executive Director of Revenue Cycle. Patients may be required to sign a promissory note based on the agreed upon payment arrangement.
  - CarePayment – An extended payment plan which allows the patient an extended period not to exceed 36 months at 0% interest to pay their balance between $100 and $15,000. Patients may be automatically enrolled in the CarePayment plan if their account has not been paid in full 2 months after their first statement. All patients are eligible provided that they provide a valid social security number, are not on a government watch list, are over 18 and have not previously defaulted on their CarePayment account.
  - Medicaid/ HIP – Patients who do not have coverage when they present to the hospital for treatment will be screened for other coverage through state assistance programs. An Eligibility Specialist will assist the patient/guarantor to complete and submit all necessary forms required by the Indiana Department of Public Aid for these types of programs.
  - Hospital Financial Assistance – Reasonable efforts will be made to determine if patients are eligible for Financial Assistance through the hospital Financial Assistance Program.
- If a patient does not qualify for financial assistance and does not pay their account according to the options provided or fails to pay their balance after applying qualified financial assistance,

then the patient's account will be processed for placement with a collection agency according to the Bad Debt Write Off policy.

- Patients will be issued a Final Notice 30 days prior to placing accounts with a collection agency and pursuing any extraordinary collection actions. Extraordinary collection actions will not be taken until after Elkhart General Hospital has made reasonable efforts to determine if a patient will qualify for financial assistance. Extraordinary collection actions may include suit, wage garnishment, lien or adverse credit bureau reporting

Failure of Patient to pay Remainder of Account after Financial Assistance
Failure of a patient/guarantor to pay the remainder of their account after deducting the assistance portion may cause the account to be placed with a collection agency. Patients will be issued a Final Notice 30 days prior to placing accounts with a collection agency. The remainder of the account will be subject to any collection action including legal recourse such as suit, wage garnishment, lien or adverse credit bureau reporting if it remains unpaid.

Processing and Approvals
Once a patient's financial assistance application has been processed, a request will be sent for approval. Approvals are required based on the below amounts:

Up to $250	Financial Counselor/Collector
Up to $4,000	Collection Supervisor
Up to $10,000	Patient Accounts Manager
Up to $25,000	Patient Accounting Director
Up to $50,000	Executive Director of Revenue Cycle
Unlimited (required over $50,000)	Chief Financial Officer

Financial Assistance will apply retroactively to all open accounts with dates of service that are within 2 years of the approval date.

	Document Revision History:		
Review Date:	**Revised Date:**	**Reviewed/Revised By:**	**Summary of Changes:**
11/22/2015	11/22/2015	Julie Phillips	Updated to new policy format. Expanded definitions for approval criteria. Added definition for Catastrophic Assistance. Added list of non-covered providers. Updated language surrounding calculation of AGB. Added limit for lookback timeframe for account approvals.
11/30/2017	1/7/2018	Julie Phillips	Added billing and collections practices into Financial Assistance Policy. Updated approval levels to add level for Executive Director. Updated Office address for Billing Office
8/10/2020	9/22/2020	Julie Phillips	Added approval level for Financial Counselor. Updated customer service phone number; added Beacon Health System affiliation in Scope.

SIGNATURES OF APPROVAL:

Date Signed	Signature	Name	Title
___________	_________________________________		
___________	_________________________________		

Attachment 1

Discount Schedule

Percentage of Federal Poverty Level (FPL)	Reduction Percentage
0% to 200%	100%
201% to 300%	75%
301% to 350%	66% (AGB Percentage*)

*AGB Calculation updated 3/12/20

Attachment 2

Providers Not Covered by Financial Assistance Policy

- Beacon Medical Group Physicians
- Elkhart Clinic Physicians
- Radiology, Inc
- Michiana Hematology/Oncology
- South Bend Medical Foundation
- General and Vascular Surgery
- Northern Anesthesia, Inc
- Apogee Physicians
- Elite Emergency Physicians, Inc. (formerly Elkhart Emergency Physicians)
- River Oaks Physicians
- Heart City Health Center
- OSMC