Erlanger Health System
Policy and Procedure

Index Title: Financial Assistance Policy
Originating Department: Patient Financial Services
Number: 8227:038

Policy statement: In accordance with the long-standing Hamilton County Assistance Program, it is the policy of Erlanger Health System (EHS) to grant our patients access to essential or non-elective care, regardless of their ability to pay.

Scope: Erlanger Health System

Definitions:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider’s policy to provide healthcare services free or at a discount to individuals who meet established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;

- Non-cash benefits (such as food stamps and housing subsidies) do not count;
Determined on a before-tax basis;

Excludes capital gains or losses; and

If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

**Uninsured:** The patient has no insurance or third party liability or assistance to assist with meeting his/her payment obligations.

**Gross Charges:** The total charges at Erlanger Health System’s full established rates for the provision of patient care services before deductions from revenue are applied.

**Emergency Medical Conditions:** Defined within the meaning of section 1867 of the Social Security Act 942.U.S.C. 1395dd).

**Medically Necessary:** As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

**Health Insurance Market Place:** Organizations set up to facilitate the purchase of health insurance in every state of the United States in accordance with Patient Protection and Affordable Care Act. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies.

**Procedure:**

Charity assistance is available to all patients who qualify after providing the necessary documentation and completing the application process. If a patient qualifies for Charity assistance, the charges for qualifying medical services will be appropriately adjusted by Erlanger Health System. Financial Advocates are available to assist patients in making applications for charity care, which may be available for those who earn up to 200% of the Federal Poverty Guidelines. Applications for assistance are available at Erlanger Health System between 8:30 a.m. and 4:30 p.m. (Monday through Friday) and are available on-line at www.erlanger.org. Services eligible for Charity Care are medically necessary inpatient and outpatient services.
In addition to assisting with charity, Erlanger Health System staff is available to patients in determining eligibility for programs such as TennCare, Medicaid or the Affordable Health Care Act coverage. When patients qualify for TennCare, Medicaid or any other health insurance, those coverages will first be billed with payment pursued and collected prior to Charity Assistance being considered. Once those program eligibility/benefits are exhausted and resolved, then Charity consideration would be pursued for any remaining qualifying balance. The Financial Advocates are available to assist uninsured patients in determining a source of payment. For those patients not eligible for financial assistance, it is the policy of the Erlanger Health System to permit patients when eligible to make regular payments on a monthly basis. Erlanger Health System utilizes external collection firms on debt collection as needed. When appropriate, Erlanger Health System will refer past due accounts to collection attorneys for the purposes of collecting from those who have the ability to pay. In appropriate circumstances, attorney fees will be sought in addition to unpaid balances.

It is the policy of Erlanger to:

- Treat all patients equally, with dignity, respect, and compassion.
- Serve the emergency health needs of everyone, regardless of ability to pay.
- Assist patients who cannot pay for part or all of the care they receive at Erlanger Health System.
- Balance the needed financial assistance for some patients with broader fiscal responsibilities in order to keep the Health System viable financially.
- Respond promptly to patient’s questions regarding their bills and request for financial assistance.
- Make available information regarding our charity care policy.
- Have clear understanding of written policies to help patients determine if they are eligible for public or hospital-sponsored financial assistance programs.
- Ensure outside collection agencies follow hospital billing and collection guidelines.

The intent of the Erlanger Health System Financial Assistance Policy is to establish a fair and equitable system for determining hospital charity. General guidelines are established, allowing for evaluation of unique financial circumstances.

A patient is potentially eligible for financial assistance by income standards when the annual individual or family income does not exceed 200% of the Federal Poverty Guidelines as published annually in the Federal Register. Current income will be a factor in assessing hospital charity but will not be the sole determining factor. Among other elements to be considered are temporary factors such as short term layoff, unemployment, disability or other demonstrated hardship.

An evaluation of available assets will be necessary to determine eligibility for charity. If assets exist to pay the debt, charity could be denied. The State of Tennessee is a member of the Federal Healthcare Exchange Program. Therefore, applicants are required to apply for insurance through the Health Insurance Marketplace. If applicant fails to enroll during open enrollment, or qualifies for health insurance coverage through the Marketplace and chooses not to enroll, or allows insurance premiums to lapse, charity care may be denied.

PROGRAM GUIDELINES:

1. Charity is evaluated on the basis of assets as well as gross family income.

2. **For Hamilton County residents**, Charity is approved for up to six (6) months. Hamilton County residents must reapply for charity care if the six (6) month time period has expired.

   **For all other applicants** (who are not from Hamilton County, Tennessee), Charity may be approved for up to three (3) months. Non-Hamilton County residents must reapply for Charity if the three (3) month (or other approved time period) has expired.
3. Charity applies only after all other resources have been exhausted.

4. If a complete Financial Assistance Application has been timely filed by a patient, the Application will be processed even if there is available pending liability, litigation or other payer sources potentially available. However, the determination of whether the patient qualifies for Charity will be pending based on the payment outcome of the other payment sources.

5. A determination of the applicant’s eligibility is made as soon as practical after the application is completed.

6. In order to be considered for Charity the following financial information must be submitted with the Financial Assistance Application:

   a. Latest bank statement.
   b. Latest Federal income tax return (For self-employed applicants, all decisions will be based on gross income found on line 1, box 1 on the applicant’s Schedule C.) or most recent paycheck stub.
   c. List of lawsuits and potential claims/lawsuits you have that may lead to you receiving additional money

   Note:

   (a) A hardship letter can be included to justify your inability to pay.
   (b) Failure to provide the financial information after receiving written notice outlining the additional information needed and a reasonable opportunity to provide the information may result in Charity Care being denied.

7. Income Guidelines: To be eligible for charity care, gross family income must be at or below 200% of the current HH Poverty guidelines found on the U. S. Department of Health and Human Services website:

   http://aspe.hhs.gov/poverty/figures-fed-reg.cfm
8. Asset and credit investigations may be conducted on all charity cases. If it is determined that assets exist or the patient has the ability to pay the debt, charity may be denied.

9. Eligibility for Charity means the charges for qualifying medical services will be written off.

As the qualifying charges are written off, no patient eligible for financial assistance will be charged more for emergency or medically necessary services than the Amounts Generally Billed (AGB). Thus, the calculation of AGB as defined by IRS 26 CFR Section 501(r) is not necessary, as the policy meets both AGB calculation methods.

10. Anyone who applies for financial assistance, but does not provide the required documents for review:
    • will receive notice outlining the additional information needed, and
    • will be given a reasonable opportunity to provide the information.

    However,
    • if the patient does not provide the required documents,
    • refuses to apply for insurance in the Health Insurance Marketplace, or
    • allows insurance to lapse due to lack of payment

    the patient may not be considered for Charity and may be fully liable for payment of their bill.

11. Any applicant fraudulently misrepresenting his or her income level will be immediately disqualified for consideration for charity care. In the event the applicant makes fraudulent misrepresentations, the patient’s account balance will be billed to the responsible party.

12. Applicant must apply for charity within two hundred and forty (240) days after the date the Applicant receives their first post-discharge billing statement. This deadline may be extended in certain circumstances covered in 26 CFR § 1.501(r)(3). When an applicant applies for Charity, Erlanger Health System will review and consider all accounts within ninety (90) days from receipt of the completed application.
13. Charity approval on cases that fall outside the established guidelines must be approved by the Assistant Vice President, Revenue Cycle or designee and are purely discretionary.

**Uninsured, Self-Pay Patients:**

A Managed Care type discount will be applied to all self-pay accounts in accordance with Tennessee Code Annotated § 68-11-262. The self-pay discount is computed by the Tennessee Hospital Association, which sets a maximum collection rate for uninsured patients.

These discounts do not apply to programs or services that are elective in nature.

Examples of elective programs or services include (but are not limited to) wellness programs, cosmetic procedures, etc. Elective programs and services have specific pricing and are exempt from qualifying for charity care.

**Hamilton County Assistance Program**

The Hamilton County Assistance Program applies to all Hamilton County residents who qualify for charity care under the above-referenced federal poverty guidelines. Hamilton County residents who meet Erlanger’s charity care criteria are qualified for both in-patient and out-patient Erlanger services for a six-month period of time.

**340B:**

We utilize 340B medications for qualified patients of the hospital as that term is defined and applied within the Federal 340 B Drug Discount Program, see policy PC 220 340B Drug Purchasing and Compliance Policy.

**Prompt Pay Discount for Patients with Health Insurance**

For Erlanger hospital billed services, patients with health insurance (government, commercial or managed care insurance) will be eligible for a 10% prompt pay discount on balances that are the patient’s responsibility. Payment must be received and posted within fifteen (15) days from the date of the first statement sent to the patient. This prompt pay discount does not apply to Erlanger physician services billing.
Use of Outside Collection Agencies Or Attorneys:

When the patient has not responded to our request for payment and failed to pay their debt owed, the account will be referred to an outside collection agency or collection attorney. In appropriate circumstances, attorney fees will be sought in addition to unpaid balances.

Litigation:

When appropriate, hospital reserves the right to seek judgments and ultimately garnishments and levies on non-exempt wages and/or assets from those patients who have not paid the outstanding debt. Hospital will not take any action to have patient removed from their property, but where appropriate will seek judgment for the amount owed and place judgment liens against patient’s real property. Before pursuing litigation, the hospital will review the patient’s financial condition via credit reporting to ensure litigation is appropriate according to Erlanger’s guidelines.

Credit Reporting:

Erlanger routinely uses data provided by outside agencies to verify information such as credit scores, assets, etc. This information is often used in deciding whether the patient is eligible for charity, determining medical indigency, and assessing the viability of collection on the patient’s account.

Monthly Payment Arrangements:

Efforts will be made by Erlanger to collect balances in full either by cash, check or credit card, prior to establishing monthly payment arrangements. Payment arrangements may be granted only after all other payment options have been exhausted. In lieu of payment arrangements, Erlanger reserves the right to refer eligible patients for bank loans to pay off their hospital account. Erlanger does not charge interest on monthly payment plans, therefore long term arrangements are discouraged wherever possible. The minimum monthly payment is dependent on the balance of the account. Please see the following:

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<th>ACCOUNT BALANCE</th>
<th>PAYMENT SCHEDULE</th>
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$25.00 - $600.00  Minimum payment of $25.00 per month
$601.00-$1200.00   Minimum payment of $50.00 per month
$1201.00-$1800.00  Minimum payment of $75.00 per month
$1801.00-$2400.00  Minimum payment of $100.00 per month
$2401.00-$3000.00  Minimum payment of $125.00 per month
$3001.00-$3600.00  Minimum payment of $150.00 per month
$3601.00-$4200.00  Minimum payment of $175.00 per month
$4201.00-$4800.00  Minimum payment of $200.00 per month

Approval must be obtained from the AVP, Revenue Cycle or designee to accept a payment plan that is less than what is described in the schedule. Likewise, payment arrangements may be declined if the term of the payments does not meet a reasonable period of time to settle or liquidate the debt owed. Payment arrangements exceeding 24 months must have the approval of a PFS Manager or AVP, Revenue Cycle, and it is within their discretion to approve.

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References:
Department of Health and Human Services Poverty Guidelines.
http://aspe.hhs.gov/poverty/figures-fed-reg.cfm
Federal Register, Vol. 77, No. 17 January 26, 2012
Safety Net Hospitals for Pharmaceutical Access