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

Policy statement: 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 the 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 (Obamacare). 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 written off by Erlanger Health Services. Financial Counselors 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). 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. When patients qualify for TennCare, Medicaid or coverage pursuant to the Affordable Care Act, 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 Counselors 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 does utilize 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 Charity 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 determined eligible 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 will be denied.

**PROGRAM GUIDELINES:**

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

2. Charity is approved for a six (6) month period. Applicants must reapply for charity care if the six (6) month time period has expired.

3. Charity applies only after all other resources have been exhausted.

4. If a complete Charity Care Application has been timely filed by a patient and there is available pending liability, litigation or other payer sources, the charity care application will be processed to determine if patient qualifies for Charity/Financial assistance without regard to the pending liability, litigation or other payer sources. If the only reason a patient does not qualify for Charity/Financial assistance is the liability, litigation or other payer sources, charity care will be pending based on the outcome.

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

6. In order to be considered under the Erlanger Charity Policy the following financial information must be submitted with the Charity Care Application for financial status verification. Please see Attachment A.

   a. The last 4 paycheck stubs.
b. Documentation of Social Security benefits.
c. Unemployment benefits.
d. Retirement income.
e. Latest bank statement.
f. 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.)*
g. Proof that the patient was denied insurance through the Health Insurance Market Place or received an exemption from the U.S. government.

**Note:** *If applying through an EHS designated Certified Application Counselor (CAC), the insurance denial will be routed to a Financial Counselor to be scanned into EHS’s imaging system to expedite the processing of the application.*
h. Government Issued Picture ID.
i. A list of all claims and lawsuits.

**Note:**

(a) Applicant is responsible for providing all information noted above. 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 will 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](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. No patient eligible for charity assistance will be charged more for emergency or medically necessary services than the Amounts Generally Billed (AGB). As the balance for healthcare services qualifying for Charity is written off, the calculation of AGB as
defined by IRS 26 CFR Section 501(r) is not needed since the policy meets both calculations.

10. Any applicant for charity who does not provide the necessary documentation for review after receiving written notice outlining the additional information needed and a reasonable opportunity to provide the information, or who refuses to apply for insurance in the Health Insurance Marketplace or allows insurance to lapse due to lack of payment will not be considered for Charity and the patient will 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, all charges for services previously rendered 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 ninety (90) days from receipt of the completed application.

13. If you have insurance coverage you are not eligible for charity assistance.

14. Charity approval on cases that fall outside the established guidelines must be approved by the Senior Director, Revenue Cycle or designee and are purely discretionary.

Uninsured, Self Pay Patients:

A Managed Care type discount of fifty-five percent (55%) will be applied to all self-pay accounts with a date of service after August 31, 2013. These discounts do not apply to programs or services which are deemed to be elective in nature.

Examples of these include wellness programs, cosmetic procedures etc. These type programs have specific pricing and are exempt from receiving the charity care.
Hamilton County Assistance Program:

An Assistance program is available to qualifying Hamilton County residents.

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

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.

Use of Outside Collections Agencies Or Attorneys:

When it is determined the patient has not responded to our request for payment and failed in paying their debt owed, the account will be referred to an outside collection agency or collection attorney for collections. 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 appropriately. Hospital will not take any action to have patient removed from their property, but where appropriate will seek judgment for amount owed and place judgment liens against patient’s real property. Prior to pursuing litigation, the hospital will review the detailed financial condition of patient via credit reporting to ensure litigation is appropriate according to its guidelines.

Credit Reporting:

Erlanger routinely utilizes data provided by external agencies to verify information as to credit score, assets, etc. This information is frequently used in assessing charity eligibility, determining medical indigency, and the viability of collection on the patients account.

Monthly Payment Arrangements:
Efforts will be made by the hospital 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, hospital reserves the right to refer eligible patients for bank loans to pay off hospital account. The hospital does not charge interest on monthly payment plans, therefore long term arrangements are discouraged wherever possible. See attached schedule of payments. The minimum monthly payment is dependent on the balance of the account.

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

Approval must be obtained from the Senior Revenue Cycle Director 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 Senior Director, Revenue Cycle, and it within their discretion to approve.
## Committee Approval/Date

<table>
<thead>
<tr>
<th>Committee</th>
<th>Approval/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Medical Director Approval/Date

<table>
<thead>
<tr>
<th>Medical Director</th>
<th>Approval/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### References:

- Safety Net Hospitals for Pharmaceutical Access