Reid Health

Financial Assistance Program Policy

PURPOSE

As part of our mission to enhance wholeness for all those we serve in body, mind and spirit through our conviction and commitment for compassion, service, excellence and value; Reid Health provides financial assistance to patients who lack the ability to pay for hospital or physician services. A formal process exists for the express purpose of providing information on financial assistance programs, and support in qualifying for those programs, including those administered or subsidized by government entities.

The Financial Assistance (FA) Program policy shall be approved by the Reid Health Board of Directors and is consistent with the organization's mission and reflects responsiveness to the community's health needs.

The purpose of this policy and procedure is to:

- Ensure transparency, consistency and fairness towards all patients and set guidelines for providing a financial adjustment to any uninsured or underinsured patient who obtains medically-necessary or Emergency Services from Reid Health. This policy ensures that Reid Health is compliant with the Patient Protection and Affordable Care Act, enacted March 23, 2010, 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 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 Reid Health 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

Regardless of an individual's ability to pay or qualify under this Financial Assistance Policy, Reid Health Emergency Department and the qualified NHSC (National Health Service Corps) clinics will provide, without discrimination, care for any emergency and/or medically necessary 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, sexual orientation national origin, physical disability, race or religion.

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

In order to manage its resources responsibly and to allow Reid Health 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) – Reid Health will apply the "look-back method" for determining AGB. In particular, Reid Health 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 -- Reid Health will calculate the AGB Percentage at least annually by dividing the sum of all claims that have been paid in full for emergency and other medically necessary care by Medicare fee-for-service and all private health insurers together as the primary payer(s) of these claims during a prior twelve (12)-month period by the sum of the associated Gross Charges for those claims. For these purposes, Reid Health will include in ''all claims that have been paid in full'' both the portions of the claims paid by Medicare or the private insurer and the associated portions of the claims paid by Medicare beneficiaries or insured individuals in the form of co-insurance, copayments or deductibles.

Certified Application Counselor – This is an individual who has successfully achieved required training from the Center for Medicare and Medicaid Services (CMS) as a member of a designated Certified Application Organization (CAO). The training covers the basics of health insurance marketplaces, how to assist consumers and privacy and security standards. The counselor is trained to help the uninsured to understand their new health coverage options, apply for financial help with coverage and enroll in private health plans through the new health insurance marketplaces. (www.healthcare.gov)

Cosmetic Services – These are 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 – Emergency Services are 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 attention may result in serious medical consequences; or as defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd)

Elective Services - These are health care 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.

FA Policy - Financial Assistance Program as defined in this policy.

Gross Charge - A Gross Charge is an established price, listed in 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 - A Household Unit is defined as 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 income, business income (IRS Schedule C), pensions & annuities, farm income (IRS Schedule F), rentals & royalties, inheritance, strike benefits, and alimony income. Income is also defined as payments received from the state for legal guardianship or custody.

Indiana Certified Navigator - Individuals who are registered with the Indiana Department of Insurance and met the requirements of IC 27-19 to help Indiana residents complete health coverage applications on the federally-facilitated Marketplace and/or insurance affordability program applications (such as Medicaid, the Children's Health Insurance Program ("CHIP"), or the Healthy Indiana Plan ("HIP") - dfrbenefits.in.gov).

Insured Patient – An insured patient is defined as one who has third party coverage or whose injury is a compensated injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

Medically Necessary - For the purpose of this policy, this 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.

Patient Benefit Specialist - A Patient Benefit Specialist is hospital employee, contractor, or volunteer designated to assist patients with screening, application for and enrollment in health coverage programs.

Plain Language Summary - A statement written in clear, concise, and easy to understand language notifying individuals that Reid Health offers financial assistance under a FA Policy.

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 is considered Self-Pay or Uninsured

Underinsured Patient - A patient and/or responsible party with third party coverage for health care services who may have an extraordinary amount due that they cannot pay due to household unit income is considered an Underinsured Patient

Financial Assistance Program Availability

Reid Health will widely publicize assistance availability using the following methods:

- At main patient access and registration points to the hospital, Reid Health will post and/or make available a plain language summary of the FA Policy. Posted materials will

include instructions on how to obtain a printed version of the plain language summary and the FA Policy application free of charge.
- Signage is also posted in all NHSC clinics.
- The FA Policy summary and application will be available online at www.ReidHealth.org/FinancialAssistance
- Information on how to apply for FA will be included on patient's statements.
- Periodically Reid Health may also provide information about its enrollment assistance and FA Policy through ads in the local newspaper, radio or television media.

Printed copies of the Financial Assistance Policy and Application may also be obtained by:
- Calling Customer Service at (765) 983-3184

Presenting to the Patient Financial Services Office located at 600 East Main Street, Richmond, IN 473
- Request by mail in writing to:
  Reid Health
  1100 Reid Parkway, Richmond, IN 47374

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

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

Medicare patients are eligible for Financial Assistance if the eligibility requirements are met.

Patient shall 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 the FA Policy.

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 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 Financial Assistance.

Services Eligible for Financial Assistance
- Any hospital service that is an emergency or a service that is medically 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.
- Any Reid Health Physician Associates (RHPA) services provided in relationship to the approved hospital service(s) and RHPA services that are deemed medically necessary.

Application for Assistance

The patient's eligibility for Financial Assistance will be determined through an application process. The Reid Health Financial Assistance Application form is the valid application form for

the application process. Reid Health'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. Reid Health, or its designee, may use other sources 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 Benefit Specialists 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 FA Policy application may be used for covered services that are provided up to 1 year after the date the FA Policy application was received.

All FA Policy applications will be retained for a minimum of 7 years.

Any exceptions to this policy in the awarding of financial assistance must be approved by the FA Policy Executive Committee.

The patient may appeal the decision of denied financial assistance by writing:

Director of Revenue Cycle, 1100 Reid Parkway, Richmond, IN 47374.

Application and Notification Period

An indication of an inability to pay for services will be treated as a request for assistance. This request may be made by or on behalf of the individual seeking services. A request for assistance may be made at any time but should be made no later than 30 days after service/discharge, or final bill.
Requests for assistance are not required to be in writing. However, once a request has been made, an application for assistance must be completed and signed by the person making the request or their guarantor or guardian, and can be completed with the help of a Patient Benefit Specialist.

Charges

Reid Health will not charge patients approved for financial assistance under this FA Policy for emergency or other medically necessary care more than the amounts generally billed to individuals who have insurance (i.e., Reid Health 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.) Patients may request the AGB Percentage in effect at any particular time by contacting the Reid Health Financial Counseling Department or Billing Office at the addresses and phone numbers provided above.

Actions Reid Health May Take In the Event of Non-Payment

The actions that Reid Health may take in the event of non-payment are described in the Billing and Collections Policy available online at www.ReidHealth.org/FinancialAssistance.

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 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. Household size and income determines the % of FPL.

Reid Health 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 Financial Assistance application must be submitted and proof of income, and proof of no income must accompany the application.

Catastrophic or Economic 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 fifty (50) percent of the patient's annual gross income and the patient must be unable to pay the remaining bill. Reid Health may consider other financial assets and liabilities of the person when determining ability to pay.

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 to fifty (50) percent of the patient’s annual gross income.

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.

- Adjusted Gross Income if self-employed (include schedule C from tax return; line 37 from 1040) or if taxes are not filed a completed income and expense report.
- Indiana workforce wage report for last 2 quarters (unemployment income)
- At least two 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.
- 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.
- Other financial obligations.
- The amount and frequency of hospital/medical bills is considered for Catastrophic Assistance but not Financial Assistance
- Income producing financial resources.

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 health care services, for their overall personal health, and for the protection of their individual assets.

Individuals have been found they are 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 kind of assistance and cannot be included in the amount of hospital/medical bills owed.

Reasons for not being eligible for FA Policy assistance

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 the responsible guarantor reside(s) at Salvation Army, Women's Shelter or any similar shelter; is currently incarcerated but services were provided prior to incarceration or homeless and they are ineligible for Medicaid or other health coverage programs.

- Patient /guarantor is on a fixed income at or below FPL but is considered over resource limits for any Medicaid program.

- Patients who are currently enrolled in any state Medicaid program that have exhausted their benefits for the month are considered automatically qualified under this financial assistance policy. Accounts for any patient who qualifies for Medicaid but whose coverage does not include services within the past ninety (90) days will be presumptively eligible for a charity adjustment. 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 Reid Health 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.

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

A determination of eligibility for financial assistance may be made without a completed eligibility form if the patient or information is not reasonably available and eligibility is warranted under the circumstances.

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

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.
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.

General Procedure for Determinations of Eligible Services and Possible Third Party Coverage

Reid Health, or its designee, will determine if the individual may be eligible for other coverage under any third-party insurer including Medicaid and any other county, state or federal program including but not limited to an affordable healthcare plan through the federal Marketplace Exchange.

Reid Health, or its designee, will determine if the type of services provided are eligible for coverage under the financial assistance policy.

Reid Health, or its designee, will verify income using any reasonable method to establish eligibility including W-2 withholding forms, pay stubs, income tax returns; payroll printouts; documents approving or denying unemployment compensation or workmen's compensation benefits; oral or written verification of wages from employer, oral verification from public assistance agencies, or at the option of Reid Health income verification and estimation available from credit reporting bureaus.

If the verification process indicates the family's claim of income to be untrue or incomplete, Reid Health, or its designee, will determine the patient ineligible and provide the applicant with a written, dated denial with the reason for the denial.

It may not be possible to verify a claim of little or no income. A credit inquiry may be performed in these cases and an approval of assistance given if the inquiry supports the claim of no or little income.

Conditional approval may be given based on the applicant furnishing any information reasonably necessary to substantiate eligibility.

Reid Health, or its designee, will periodically audit applications that include attested information and may request that documentation verifying income and assets be provided for the patient to be eligible for financial assistance.

Financial Assistance Determinations

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

Favorable Determinations

A favorable determination will include the following information:

- The dates of service, accounts, and services if applicable
- The date of the request
- The date of the determination
- The income and household size that was used in the determination.

Unfavorable Determinations

An unfavorable determination will include an explanation or 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.
- Accounts have been placed in bad debt.
- The eligibility standards under FPL were not met.
- The individual did not take reasonable action to obtain third-party coverage if stated as a condition of eligibility under this policy.

- The individual has not taken reasonable action to pay outstanding balances. Reasonable action is defined as seeking payment plan options and timely payments on the plan.