Flagler Health+	***Enterprise-Wide Policy and Procedure***
Policy: E – PFS – BO – Financial Assistance	
Policy Number: E-PFS-BO-	
Responsible Department:	**Patient Financial Services**
Coordinating Departments:	**N/A**
Original Issue Date:	**October 15, 2009**
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Medical Director/Staff Approval: (if applicable)	**N/A**
Legal and Regulatory References:	**N/A**
Other References/Corresponding Policies:	**Formally: policy MGMT-033 Charity Care and Financial Assistance**

I. Objective

Flagler Hospital is committed to providing financial assistance for all emergency and other medically necessary care to persons who have ("urgent or emergent") healthcare needs and are uninsured, underinsured, ineligible for a government programs, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Flagler Health+ strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Flagler Health+ will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

In order to manage its resources responsibly and to allow Flagler Health+ to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of financial assistance.

In implementing this Policy, Flagler Health+ shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

II. Scope

Services Eligible Under This Policy:

For purposes of this policy, "financial assistance" refers to healthcare services provided by Flagler Health+ without charge or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance.

- Emergency medical services provided in an emergency room setting.
- Services for a condition which, if not promptly treated ("urgent"), would lead to an adverse change in the health status of an individual.
- Non-elective services provided in response to life-threatening circumstances ("urgent") in a non-emergency room setting; and
- Medically necessary services, evaluated on a case-by-case basis at Flagler Health+'s discretion.

Eligibility for Financial Assistance:

Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit programs, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. If a patient fails to cooperate or provide all requested documents required to finalize a court

case, qualify for government assistance, or prove their financial need, once again, it will be up to the discretion of Flagler Health+ to determine if the patient is eligible for financial assistance.

III. Definitions

a. Financial Assistance: Medical services that have been or will be provided free or discounted to patients who meet certain eligibility standards and are unable to pay for their medical care.

b. Family: Per 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 must be considered a dependent for purposes of the provision of financial assistance.

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

   i. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rental income, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
   ii. Noncash benefits (such as food stamps and housing subsidies) do not count;
   iii. Determined on a before-tax basis;
   iv. Excludes capital gains or losses; and
   v. If a related person lives with a family, includes the income of all family members Non-relatives, such as housemates, do not count.

d. Patient: Person receiving services, guarantor signing for financial responsibility or the person supporting or acting on patient's behalf.

e. Uninsured: The patient has no level of insurance or third party assistance but still has patient financial responsibility that exceeds his/her financial abilities.

f. Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

g. Gross charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

h. Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

i. Medically necessary: As defined by Medicare- Services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

IV. Policy

This written policy:

a. Includes eligibility criteria for financial assistance – free and/or discounted care.

b. Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.

c. Describes the method by which patients may apply for financial assistance.

d. Describes how the hospital will widely publicize the policy within the community served by the hospital.

e. Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to the amount generally billed (received by) the hospital for commercially insured or Medicare patients.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Flagler Health+'s procedures for obtaining financial assistance or other forms of payment, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow Flagler Health+ to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity.

V. Procedure

a. Method by Which Patients May Apply for Financial Assistance:

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need, and may:

i. Include an application process, in which the patient, the patient's guarantor or supporting person/persons are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need (such as but not limited to tax returns, bank statements, proof of assets etc…)

ii. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as but not limited to credit scoring, tax and property records etc…)

iii. Include reasonable efforts by Flagler Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;

iv. Take into account the patient's available assets, and all other financial resources available to the patient; and

v. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

vi. Patients will be asked to certify all information provided is true. If any information is determined to be false or the patient fails to cooperate with any alternative source of payment all discounts afforded to the patient may be revoked, making the patient or patient's guarantor responsible for the full charges for services rendered.

1. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent, medically necessary services. However, the request for financial assistance must be received within 240 days (8 months) after the first billing statement is sent. If the last financial evaluation occurred within the past 180 days (6 months) prior to a subsequent time of service, that financial evaluation will suffice as proof in determining financial assistance for the most recent date of service. The patient also has the ability to apply for financial assistance up to 180 days (6 months) from the date an account was placed with an external collection agency.

2. Flagler Health+'s values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly and Flagler Health+ will provide a letter of financial assistance approval at the patient's request. If the patient complies with all application requirements and is found not eligible for financial assistance Flagler Health+ will mail the patient a financial assistance denial letter and list the reason for the denial.

3. Each financial assistance application will be compiled and signed off by the PFS Financial Assistant and a PFS Manager. If financial assistance eligibility is determined and the financial assistance adjustment is applied to the patient's account, Flagler Health+'s PFS Director of Revenue Optimization will review and sign off on each application packet.

b. Presumptive Financial Assistance Eligibility

i. There are instances when a patient may appear eligible for financial assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance.

ii. In the event there is no evidence to support a patient's eligibility for financial assistance, Flagler Health+ may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or receives care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down, Medicaid exhausted benefits, Medicaid SLMB and QMB);
7. Low income/subsidized housing is provided as a valid address; and
8. Patient is deceased with no known estate.

iii. Additionally, Flagler Health+ has contracted with a Self-Pay Early- Out Vendor who will also be utilized to identify potential Presumptive Charity accounts utilizing their own proprietary scoring system. Vendor will send a series of statements/letters for a 120-day timeframe as part of its standard collection practices. All true self-pay accounts will be reviewed and scored and can be done so anytime during the cycling process. The accounts that are deemed to be Presumptive Charity will be identified via this process. Presumptive Charity accounts will be identified separately by the vendor on the monthly close/return report that is received by the hospital. These particular accounts will then be adjusted off to the presumptive charity adjustment code rather than sending to a primary bad debt collection agency.

c. Eligibility Criteria and Amounts Charged to Patients:

i. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination.

ii. Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) for emergency or other medical care provided to individuals with insurance covering that care.

iii. At Flagler Health+ the AGB is determined through the "Look-back method" which is calculated as follows:

1. The AGB is calculated by reviewing all past claims that have been paid in full to the hospital facility for medically necessary care by Medicare fee-for-service together with all private health insurers paying claims to the hospital in a prior 12-month period. This amount can include co-insurance; copayments and deductibles.

2. The AGB for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages").

   (a) The percentages are calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.
   (b) Multiple AGB percentages may be calculated for separate categories of care (for example, in-patient verses out-patient care; or care provided by different departments) or for separate items or services.

3. Patients who do not have insurance coverage will be given an automatic discount of 50% off of total billed charges. In special cases, a larger discount may be granted. See “Section F” below which contains the patient discount matrix. Discounted balance amounts need to be paid timely and in accordance with any established payment plan guidelines. Failure to pay on amounts owed may result in the account being sent to a primary collection agency. Patients will receive billing statements reflecting the discounted amount.

4. Patients whose family income is at or below 200% of the FPL are eligible to receive free medical care, including mental health services.

5. Patients whose family income is above 201% but not more than 400% of the FPL are eligible to receive services in accordance with the Discount Matrix below. Patients who quality for financial assistance under this policy will be billed amounts no greater than the amounts generally billed to (received by the hospital for) commercially insured or Medicare patients for their medical and mental health care.

6. Additionally, patients may be eligible to receive discounted rates for medical and mental health care on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Flagler Health+. Must be approved by the VP of Revenue Optimization and the PFS Director of Revenue Optimization.

7. If Flagler Hospital determines that a patient qualifies for free care but may be eligible for another alternative pay source/coverage, the patient will be asked to fully cooperate in the process and resolution of that alternative pay source/coverage. If the patient is not cooperative in the financial process and the resolution of the alternative pay source/coverage, Flagler Health+ will determine if there will be any additional financial reduction on the account and also the specific amount of that reduction.

8. After the application process and submission of all requested and complete proof of income and assets, the attached matrix will be followed for the appropriate adjustment amount.

d. Flagler Health+ – Medical Patient Discount Matrix

INCOME	Uninsured Assistance Discount Percentage	Underinsured (Balance After Insurance) Discount Percentage
Up to 200% FPG **201% - 300%** **301% - 400%**	100% Charity 85% Charity 75% Charity	100% Charity 25% Charity 10% Charity
Uninsured	50% Automatic Self Pay Discount	N/A

FLAGLER HEALTH+ – MENTAL HEALTH DISCOUNT MATRIX:
*Same as Medical Patient Discount Matrix

FINANCIAL ASSISTANCE SLIDING F.P.L. SCALE:
*See attached Federal Poverty Income Guidelines and Flagler Health+ Matrix

e. Communication of the Financial Assistance Program to Patients and Within the Community:

   i. Notification about financial assistance available from Flagler Health+, which shall include a contact number, shall be disseminated by Flagler Health+ by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the Conditions of Admission form, admitting and registration departments, and the patient financial services office that is located off of the facility campus, and at other public places as Flagler Health+ may elect.

   ii. Flagler Health+ shall also publish a summary of this charity care policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital as Flagler Health+ may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Flagler Health+.

   iii. Referral of patients for financial assistance may be made by any member of the Flagler Health+ staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

f. Relationship to Collection Policies:

   i. Flagler Health+ management shall develop policies and procedures for internal

and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from Flagler Health+, and a patient's good faith effort to comply with his or her payment agreements with Flagler Health+.

ii. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, Flagler Health+ may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts.

iii. A collection agency may be used to obtain payment. Flagler Health+ currently uses outside vendors to attempt the collection of self-pay balances. You will be contacted three times (via billing statements) during a 120-day period reminding you of your bill(s). During this period, you will be expected to pay your bill(s) in full, establish a payment plan or apply for financial assistance.

iv. If the balance is unpaid after the 120-day period or a payment plan has not been established, your account will be sent to a collection agency where it may remain for at least 6 months if an adequate payment plan has not been established.

v. Flagler Health+ will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

(a) Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital;
(b) Documentation that Flagler Health+ has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the hospital's application requirements;
(c) Documentation that the patient does not qualify for financial assistance on a presumptive basis;
(d) Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.
(e) This amount can include co-insurance, co-payments and deductibles.