



Reid Health Organizational Policy

Name: Financial Assistance Policy

Policy # 91

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Owner: Julie Morrison (Dir-Revenue Cycle Management)

Required Approvals: Enter list of required committees/individuals to approve

I. Purpose

As part of our mission to lead our communities to well-being, one person at a time; 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 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.
- Establish parameters that ensure financial assistance is not a substitute for personal responsibility. Reid's Financial Assistance Program should be considered a last resort. Patients are expected to cooperate with Reid Health's procedures for obtaining financial assistance and to contribute to the cost of their care based upon their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, and encouraged to utilize all other health care resources available to them.

II. Policy

Regardless of an individual's ability to pay or qualify under this Financial Assistance Policy, Reid Health Emergency Department and the qualified 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.

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.

III. Definitions

- a. **Assets – Liquid** – An asset that can quickly be converted into cash in a short amount of time such as cash balances in checking/savings accounts, CDs, stocks and bonds, mutual funds or other investments, etc.
- b. **Assets – Non-Liquid** – An asset that can be difficult to liquidate quickly such as land and real estate, equipment, vehicles, art and collectibles.
- c. **Amount Generally Billed (AGB)** – Reid Health will apply the "look-back method" for determining AGB. 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.
- d. **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.
- e. **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)
- f. **Co-payment** – This is a fixed fee paid at the time of service for medical services.
- g. **Cosmetic Services** – These are services and procedures that reshape structures of the body in order to alter the patient's appearance or alter the manifestation of the

aging process. These services are typically not covered by any insurance and are categorically excluded from any financial or economic assistance.

- h. **Emergency Medical Services** – Services provided to stabilize and treat a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.
- i. **Elective Services** - Health care services and procedures that can be delayed without undue risk to the current or future health of a patient.
- j. **FA Policy** - Financial Assistance Program as defined in this policy.
- k. **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.
- l. **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.
- m. **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.
- n. **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).
- o. **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.
- p. **Medically Necessary Care** – Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

- q. **Non-Covered Service** – A health care service or supply not included in an insured patient's current insurance coverage and for which the patient has not negotiated a contract or agreement with Reid Health for payment of the service.
- r. **Patient Financial Navigator** - A Patient Financial Navigator is a Reid employee, contractor, or volunteer designated to assist patients with screening, application for and enrollment in health coverage programs.
- s. **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.
- t. **Resident** – a person who lives in Reid Health's service area which consists of seven counties, across 2 states. The counties include Wayne, Fayette, Randolph, Franklin and Union in Indiana and in Ohio, Darke and Preble.
- u. **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
- v. **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

IV. Procedure

Eligible Providers

Eligible services provided by Reid Health and Reid Health Physician Associates are covered by the FA Policy. All non-employed providers and other clinical staff and facilities not owned by Reid Health are not included.

Communication of Financial Assistance Policy

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 Reid Health located at 1100 Reid Parkway, Richmond, IN 47374
- Request by mail in writing to Reid Health, 1100 Reid Parkway, Richmond, IN 47374

Financial Assistance Availability

Patients who are not permanent residents of the United States are not eligible.

Only residents in Reid Health's service area are eligible. Relocation for the sole purpose of receiving health care benefits does not satisfy the residency requirement. Individuals visiting or living temporarily in Reid's service area for personal or work-related reasons are not eligible for financial assistance.

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. An insurance premium less than or equal to 10% of the gross monthly income is considered affordable. Even after approval, ongoing evaluation of other health coverage programs will be completed as appropriate, specifically prior to any open enrollment period. If determined an application for other programs is warranted, the patient is required to cooperate with this process or Reid's financial assistance will be terminated. 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 determined during the application process the patient had access to health coverage through their employer or spouse's employer but declined coverage, the patient is not eligible for Reid's financial assistance policy regardless of the open enrollment period.

If the account is with a collection agency, the patient may still apply for Financial Assistance however these accounts may not be considered when determining eligibility or for inclusion with the financial assistance adjustment.

Services Eligible for Financial Assistance

- Any hospital or Reid Health Physician Associates (RHPA) service that determined to be an emergency and other medically necessary care 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.

Services Not Eligible for Financial Assistance

Excluded services include, but are not limited to:

- Elective services.
- Cosmetic surgery.
- Infertility treatments, fertility services, birth control, sterilization, reversal of sterilization.
- Co-payment amounts determined by your insurance company.
- Services denied by your insurance due to non-compliance with your insurance coverage requirements or determined to be non-covered.
- Services not paid by your insurance due to being out-of-network. The portion not paid (whether full or partial balances) by insurance is not eligible for financial assistance.
- Services provided after you signed an advanced beneficiary notice or notice of non-coverage acknowledging you agreed to take financial responsibility.
- Services deemed to be non-emergent or 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.

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 Financial Navigators 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 6 months after the date the FA Policy application was approved.

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 Reid Health's Chief Financial Officer.

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 Financial Navigator.

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 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 Financial Assistance Program only allows for full assistance based on eligibility criteria set forth in this policy.

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 200% of the Federal Poverty Level (FPL) as determined by Federal Poverty Guidelines. Household size and income determines the % of FPL.

Household liquid assets in excess of \$5,000 will be considered income in determining a patient's income for Financial Assistance eligibility. Non-liquid assets will not be included when calculating a patient's income. Patients who do not supply the asset information with current value and supporting verification will not be eligible for Financial Assistance. 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 with the following documents as appropriate:

- Medicaid decision letter (all pages) with application or documentation from contractor that assisted with government assistance. The letter/documentation must be dated within the last 90 days and must state a reason for denial.
- If no primary insurance coverage, the Marketplace print out stating the cost of the monthly premium. If premium is less than 10% of gross monthly income, premium is considered affordable and financial assistance cannot be granted.
- Most recent Federal 1040 Income Tax Return form and W2.
- Pay stubs for the last 30 days.
- Current Social Security Award letter.
- Pension Benefits letter, Dividend/Interest statement.
- Unemployment Benefit letter.
- Worker's Compensation Benefit letter.
- Letter of support filled out by the person(s) assisting or supporting the individual.
- Outstanding medical bills.
- Prescription drug list with prices from the pharmacy (Pharmacy receipt print out required).
- Current bank statement for all checking and/or savings accounts.
- Current investor statement for all CD's/Stocks/Bonds.
- Alimony documentation.

Any 3 of the following documents are acceptable for proof of residency in Reid Health's service area:

- Any document listed above that is required to be submitted with the financial assistance application and has a pre-printed address.
- Valid state-issued identification card.
- Recent (last 60 days) residential utility bill.
- Valid lease/rental/mortgage agreement.
- Current vehicle registration card.
- Voter registration card.
- Mail addressed to the patient at a Reid service county address from a Federal or State of Indiana government office.
- Award letter from school.
- Statement from a family member that the patient resides at the same address with one of the above residency verifications.

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.
- Income producing financial resources.

Reid Health reserves the right to use additional criteria to determine eligibility as deemed necessary, such as:

- Publicly available data sources that provide information on a patient's ability to pay, such as a credit score.
- Expenses such as mortgage/rent, utilities, child support, food, and other basic living expenses.
- Assets such as checking accounts, savings accounts, and certificates of deposit.
- Pension accounts, 401K, 403B, IRAs, and other retirement accounts will only be considered if the patient is receiving as part of their income.
- Payment scoring based on historical payment patterns.

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.

Services not eligible for any kind of assistance under this policy cannot be included in the amount of hospital/medical bills owed.

Reasons for not being eligible for Financial Assistance

Household income exceeds the maximum of the FPL. However, the patient may be eligible for an adjustment of charges 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.

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 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.

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 that may include the following:

- 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 or with a collection agency.
- 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.)

340B Medication Financial Assistance

Reid Health utilizes resources, including revenue from its participation in the federal 340B Drug Pricing Program, to support patient access to necessary prescription medications. In alignment with the organization's mission, patients facing financial hardship may be eligible for medication cost-sharing assistance when prescriptions are filled at a Reid Health-owned retail pharmacy.

Eligibility Criteria and Process:

Patients may be considered for 340B-supported medication financial assistance if they meet the following conditions:

- The prescription is filled at Reid Health Outpatient Pharmacy.
- The medication is deemed medically necessary and prescribed for treatment being provided by a Reid Health clinician.
- The patient expresses financial hardship or concern regarding medication affordability.

Assistance Determination:

Before assistance is granted, Reid Health Pharmacy staff will:

1. Refer the patient to applicable community resources and external assistance programs.
2. Confirm the medication is routinely stocked by Reid Health Outpatient Pharmacy.
3. Attempt to identify a lower cost therapeutic alternative, consulting the prescribing provider if necessary.

If no other resources are available, Reid Health Pharmacy staff will assess patient eligibility for financial assistance based on income criteria and complete all documentation of the determination in accordance with this policy.

Income-Based Sliding Scale:

% of Federal Poverty Level (FPL) Discount Applied to Cost-Sharing

$\leq 600\%$ 100%

- Patients may receive assistance amount up to a maximum of \$5,000 annually.
- Eligibility lasts for one year and is subject to re-evaluation if the patient's financial status changes.
- Assistance is available regardless of race, gender, national origin, or religion.
- Reid Health will not advertise this assistance program and does not offer waivers as inducements for choosing Reid Health services.

V. Related Documents

[Financial Assistance Application/Checklist](#)

Reid Hospital Medication Assistance Application

VI. References

Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4)
Limitation of Charges – Section 501(r)(5)
Billing and Collections – Section 501(r)(6)

VII. Approval Process

Reid Health Governing Board of Directors