Hospital Financial Assistance Program

Effective Date: 02/2006 **Current Revision Date:** 01/2020

Policy:

Hospital Financial Assistance Program (FAP)

Procedure:

Aultman Alliance Community Hospital (AACH) provides services without charge or at a reduced rate to patients who cannot afford to pay for hospital care. To be eligible, patients must complete a financial assistance application and family income must be at or below 300% of the federal poverty level income guidelines. This policy meets the guidelines of Ohio's Hospital Care Assurance Program (HCAP) as well as the IRS Regulation under IRC Section 501(r) that hospitals must meet in order to maintain their tax-exempt status.

ELIGIBILITY GUIDELINES

- Assistance is limited to acute hospital services that are deemed emergent or medically necessary. AACH determines medical necessity by the list of "covered revenue codes" as defined in Appendix I of the Ohio Department of Medicaid Office of Benefits Hospital Billing Guidelines:
  http://benefits.ohio.gov/
- Financial assistance is only available for services at Aultman Alliance Community Hospital. Professional fees are not included. Specifically, balances for physician offices (Alliance Community Medical Foundation, Alliance Medical Associates), radiology fees (Radiology Associates/RadPartners), anesthesia fees (Anesthesia Associates of Alliance), Community Care Center, Alliance Visiting Nurse, Alliance Hospice, etc. are not covered by the hospital's financial assistance policy.
- Patients or their representatives must complete a financial assistance application to determine eligibility. Hospital may obtain information orally if patient is unable to complete application in writing.
- Gross income for all members of the family must be reported. The definition of "family" shall include:
  - Parent(s)
  - Spouse(s)
  - Children, natural or adoptive, under the age of eighteen who live in the home
- Gross income is defined as income from employment of jobs, self-employment, public assistance, Social Security, unemployment compensation, Worker's Compensation, pension, inheritance, disability, child support, alimony, interest earned, and rental income BEFORE TAXES.
- The income reported on the application that was earned in the three months prior to hospital services will be projected as a year of income. The lower of the projected year of income or the actual 12 months of income preceding the hospital services will be used to determine eligibility.

Hospital Financial Assistance Program

- Family income must not exceed 300% of the poverty income guidelines published in the Federal Register. Federal poverty guidelines are updated annually.
- Third party coverage is always primary to financial assistance. Patients with third party coverage must comply with all of the requirements of their coverage such as pre-certification, prior authorization, COB requests and referrals as a condition of eligibility for financial assistance.
- Patients must indicate the date of service for which they are requesting assistance.
- The Patient Financial Services office will determine eligibility and will mail a formal eligibility determination letter to the patient.

ELIGIBILITY DETERMINATION AND RECORD-KEEPING PROCEDURES:

I. Applications will be given to the colleague(s) responsible for performing eligibility determinations.
II. Eligibility determination will be made in accordance with the following policies:
    a) Hospital Care Assurance Program – HCAP
    b) Hospital Financial Assistance Policy to include IRS 501(r) regulations

Alliance Community Hospital is required to provide emergent or medically necessary healthcare without charge to persons who cannot afford to pay for care.

Individuals are eligible for medically necessary healthcare at no cost if their family does not exceed the Federal Poverty Income Guidelines. See schedule below.

If an individual has health insurance coverage provided by their employer, self-insured, or Medicare, etc. they would receive medically necessary services at no cost or a reduced cost if they are not paid by the plan and qualify for financial assistance. If it appears that they may be eligible for assistance from Federal or State agencies, they may be asked to apply to these agencies before a request for financial assistance is finalized.

Individuals are eligible for medically necessary healthcare at a reduced cost if their gross family income does not exceed 300% of the Federal Poverty Income Guidelines. Patients that are at or below the poverty guidelines will qualify for a 100% reduction according to the Hospital Care Assurance Program (HCAP). The code to be used for this adjustment is ASPHCAP. Patients that have a household income between 100% and 300% of the Federal Poverty Guidelines may qualify for a reduction of 53% to 75% of total charges. The code to be used for these charity adjustments is ASPCHAR.

Hospital Financial Assistance Program

Income Guidelines as of **January 15, 2020** (dates of service):

Size of Family	Maximum Income For Care at 100% Reduction - No Cost	Maximum Income For Care at 75% Reduction	Maximum Income For Care at 53% Reduction
1	$12,760	$25,520	$38,280
2	$17,240	$34,480	$51,720
3	$21,720	$43,440	$65,160
For each additional family member add			
	$4,480	$8,960	$13,440

DEFINITIONS:

- **Plain Language Summary** means a written, easy-to-read and understand statement that notifies an individual that AACH offers financial assistance under the FAP for hospital services
- **Application Period** means the period during which AACH must accept and process an application for financial assistance under the FAP. The Application Period begins on the date the care is provided and ends on the 240th day after AACH provides the first post discharge billing statement.
- **Billing Deadline** means the date after which AACH or a collection agency may initiate an extraordinary collection action against an individual who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the individual provided at least 30 days prior to such deadline, but no earlier than 120 after the first post discharge statement.
- **Completion Deadline** means the date after which AACH or a collection agency may initiate or resume an ECA against an individual who has submitted an incomplete FAP if that individual has not provided the missing information and/or documentation necessary to complete the application or denied application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) Thirty days after AACH provides the individual with this notice; or (2) the last day of the Application Period.
- **Extraordinary Collection Action (ECA)** means any action against an individual responsible for a bill related to obtaining payment on a self-pay account that requires a legal or judicial process or reporting adverse information about the responsible individual to consumer credit reporting agencies/credit bureaus. ECA also includes the sale of aged bad debt accounts receivable to a third party collection agency. ECAs do not include transferring of a self-pay account to another party for purposes of collection without the use of any ECAs.
- **Financial Assistance Policy (FAP)** means AACH's Financial Assistance Policy which includes eligibility criteria, the basis for calculating charges, the method for

Hospital Financial Assistance Program

applying the policy, and the measures to publicize the policy, and sets forth the financial assistance program.

- **PFS** means Patient Financial Services, the operating unit of AACH responsible for billing and collecting self-pay accounts.
- **Responsible Individual** means the patient and any other individual having financial responsibility for a self-pay balance on an account. There may be more than one responsible individual.
- **Self-Pay Account** means that portion of a patient account that is the individual's responsibility of the patient or other responsible individual, net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of an assistance program, as applicable.
- **Amounts Generally Billed (AGB) -** Individuals eligible for financial assistance under this policy shall not be charged more than the amounts generally billed (AGB) to individuals who have insurance. This value shall be calculated using the "look-back" method based on actual paid claims from Medicare fee-for-service and private health insurers. The current AGB is **53%** and is updated annually.

501 (r) REGULATION GUIDELINES:

A. Subject to compliance with the provisions of this policy, AACH may take any and all legal actions, including Extraordinary Collection Actions, to obtain payment for medical services provided.

B. AACH will not engage in ECAs, either directly or by any debt collection agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a responsible individual is eligible for assistance under the FAP.

C. All patients will be offered a Plain Language Summary and an application form for financial assistance under the FAP as part of the discharge or intake process from AACH.

D. At least three separate statements for collection of self-pay accounts shall be mailed or emailed to the last known address of each responsible individual. It is the responsible individual's obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

E. At least one of the statements mailed or emailed will include written notice that informs the responsible individual(s) about the ECAs that are intended to be taken if the responsible individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the responsible individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement.

F. Prior to initiation of any ECAs, an oral attempt will be made to contact the responsible individual by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During at

Hospital Financial Assistance Program

least one conversation, the patient or responsible individual will be informed about the financial assistance that may be available under the FAP.

G. ECAs may be commenced as follows:

1. If any responsible individual fails to apply for financial assistance under the FAP by 120 days after the first post discharge statement, and the responsible parties have received a statement with a billing deadline described, then ACH or the collection agency may initiate ECAs.
2. If any responsible individual submits an incomplete application for financial assistance under the FAP prior to the application deadline, then ECAs may not be initiated until after each of the following steps has been completed:
    a. PFS provides the responsible individual with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the plain language summary.
    b. PFS provides the responsible individual(s) with at least 30 days' prior written notice of the ECAs that AACH or collection agency may initiate against the responsible individual(s) if the FAP application is not completed or payment is not made; provided, however, that the completion deadline for payment may not be set prior to 120 days after the first post discharge statement.
    c. If the responsible individual(s) who has submitted the incomplete application completes the application for financial assistance, and PFS determines definitively that the responsible individual(s) is ineligible for any financial assistance under the FAP, AACH will inform the responsible individual(s) in writing the denial and include a 30 days' prior written notice of the ECAs that AACH or collection agency may initiate against the responsible individual(s); provided, however, that the billing deadline may not be set prior to 120 days after the first post discharge statement.
    d. If the responsible individual(s) who has submitted the incomplete application fails to complete the application by the completion deadline set in the notice provided, then ECAs may be initiated.
    e. If an application, complete or incomplete, for financial assistance under the FAP is submitted by a responsible individual(s), at any time prior to the application deadline, AACH will suspend ECAs while such financial assistance application is pending.

H. After the commencement of ECAs is permitted, collection agencies shall be authorized to report unpaid accounts to credit agencies, and to file judicial or legal action, garnishment, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior approval of PFS shall be required before initial lawsuits may be initiated. AACH and external collection agencies may also take any and all legal other actions including but not limited to telephone calls, emails, texts, mailing notices, and skip tracing to obtain payment for medical services provided.

Hospital Financial Assistance Program

OTHER ASSISTANCE AVAILABLE:

Self-Pay Discount

Balances for self-pay individuals who do not complete a FAP or do not qualify will be automatically reduced by **20%** at first statement. These amounts will be considered Self-Pay Charity adjustments and written off to the code ASPACA.

> If a patient later applies and is qualified for an **HCAP** (Hospital Care Assurance Program) adjustment and is at or below 100% of FPG, the ACA discount of 20% will be reversed and the **entire amount** will be adjusted to HCAP using the adjustment code ASPHCAP.
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> If a patient later applies and is qualified for a **charity** adjustment, the ACA discount of 20% will stay on the account, but the additional discount will be deducted from the account using adjustment code ASPCHAR, not to exceed 53% or 75% in total according to income level.

Prompt Pay Discounts

Patients are eligible for a "prompt pay discount" (ASPPP) of **7.5%** if the balance is paid in full before the second statement. Self-pay balances or balances after insurance that include co-payments, co-insurance or deductible amounts are eligible for prompt pay discounts. This also includes discounts for colleagues for emergency room co-payments. Patients that receive a charity discount **greater than 20% are not eligible for a prompt pay discount**. The same prompt pay discount code should be used for both hospital colleagues and non-colleagues.

Administrative Adjustments

A self-pay administrative adjustment (ASPADM) is only appropriate when a patient has a service or quality concern that has been approved by the Risk Adjustment or Patient Financial Services Director.

Deceased Patients

For persons who are deceased with an estate to bill, the statement will be changed and sent to "The Estate of Deceased Patient". For persons who are deceased with no estate, the balance will be adjusted to an adjustment indicated the patient is deceased with no estate (ASPEXP). Death certificate and notarized letter stating there is no estate must be provided.

Payment Arrangements

Payment arrangements will be accepted based on the schedule below according to account balance. Account balances may be combined for ease of payment and posting. A Financial Agreement Form must be completed and signed by the patient for extended payment arrangements.

Hospital Financial Assistance Program

Account Balance	Monthly	Per Pay (ACH Colleagues Only)
$0-100	Full	Full
$101-500	30	15
$501-750	40	20
$751-1,000	50	25
$1,001-1,500	80	40
$1,501-3,000	100	50
$3,001-Up	Balance divided by 36 months = payment	

Minimum payment of $25 per month required

Packaged-Pricing Arrangements
The discounts listed in this policy do not apply to pre-negotiated, packaged-pricing arrangements involving other providers.

Medically Indigent/Catastrophic Assistance:
Medically indigent means patients whom AACH determine are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements of AACH's Financial Assistance Policy for free or discounted care. Patients who have excessive medical expenses that have resulted in a balance due to AACH that is greater than 25% of the patient's Annual Family Income qualify for medically indigent assistance. The code to use is ASPADM.

POLICY AVAILABILITY

- Questions regarding financial assistance should be directed to the Patient Financial Services at 330-596-7584 between the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday.

- To request a copy of the FAP or FAP application form please contact Patient Financial Services or visit our website under the Patient Resources section at:

  https://aultmanalliance.org/patients-and-visitors/insurance-and-billing/financial-assistance/

Hospital Financial Assistance Program

- A paper copy of our policy can be obtained at our facility located at 200 East State Street, Alliance, Ohio 44601 in the Patient Financial Services Cashier Office, the Admitting/Registration area, or in the Emergency Department.

Approved by: Lisa Geiger

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