

Physician Enterprise Policy and Procedure

SUBJECT: Physician Enterprise (PE) Financial Assistance Policy (FAP)

ASSOCIATED DOCUMENTS:

PURPOSE: The purpose of this policy is to set forth guidelines for determining eligibility and processing applications for financial assistance. The policy will set forth the guidelines for determining a patient's inability to pay and resulting eligibility for financial assistance. Financial assistance may be applied to uninsured, underinsured or determined to be medically indigent.

This policy is separate and distinct from the CommonSpirit Health (CommonSpirit) Financial Assistance Policy (FAP).

DEPARTMENTS/SERVICES SCOPE: This policy applies to all clinic Medically Necessary Care provided by _____, except as otherwise required by: (a) state law or regulation; (b) clinic licensure requirements; or (c) participation by the clinic in a federal, state or local governmental payment program.

Presumptive qualifications (i.e., does not require an application) include:

- Services related to and 45 days' post hospital care where patients qualified under CommonSpirit FAP, eligible for federal, state or local assistance/low income programs or deceased with no known spouse or estate.
- Markets may also utilize computed based scoring models to qualify a patient for financial assistance under this policy.
- Patients receiving services via lines of business serving the indigent and who made formal arrangements with the CommonSpirit Health Division and have qualified for reduced costs via approved methods/procedures (i.e.) services to school aged students who qualify for free/reduced lunch; referrals from independent indigent clinics

PROCEDURE:

THE METHOD FOR APPLYING FOR FINANCIAL DISCOUNT

All patients must complete the then current Financial Assistance Application (FAA) to be considered for Financial Assistance, unless they are eligible for Presumptive Financial Assistance. The FAA used by the _____ will be reviewed from time to time but for ease of administration and patient compliance will be consistent, where possible, with the CommonSpirit FAP documents, required family and financial information.

- Staff, including clinicians, will offer a FAA to patients who may express financial concerns regarding their bill. All financial assistance processes and approvals will follow the _____ procedures.
- The Physician Enterprise Financial Assistance Policy process will be the payer of last resort. Revenue Cycle staff (or designee) can assist patients with qualification for other funds or assistance if needed.
- The patient or representative, must be, and remain, cooperative in applying for those programs, including Medicaid. If a patient is uncooperative and does not submit required paperwork or apply for Medicaid within 30 days from initial date of contact with patient regarding Medicaid enrollment, the patient will not be eligible for discount [if prohibited by state law, this dot point should be removed by the market].

- The application and qualification periods will be appropriately met.
 - Determine if patient is eligible for other programs/funds
 - Patient will provide required documents and information and is determined cooperative
 - Family information (household size, etc.)
 - Family gross monthly income
 - Provided documentation regarding family income and assets
 - May include but is not limited to,
 - Most recent filed income tax return; Current form W-2; Current pay stubs; or signed letter of support. The process may include other sources as deemed appropriate.
 - Asset review completed
 - Income review completed
 - Patient meets _____ of FPL (Y/N) (Market can customize % of FPL, unless SBO. If market is a SBO the FPL% must align with Acute NOTE: This is market minimum consistent standard.)
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- Discount will be equal to _____

- CommonSpirit Physician Enterprise standard charity adjustment codes will be used for discounted dollars associated with this policy
 - This financial assistance policy will supersede the self-pay discount, and self-pay will not apply
- If the _____ determines the individual is eligible for financial assistance, the following actions will be taken:
 - Credit the patient's account, and refund the patient as required by state law, any amount they paid for the qualifying service that exceeds the amount they are personally responsible for paying as a discount-eligible individual.
 - Take all reasonably available measures to reverse any extraordinary collection actions, including the removal of any adverse information reported to a consumer reporting agency or credit bureau from the individual's credit report.

Authority to Approve

- Markets will be required to seek approval of customizations of this policy and procedure document from:
 - Market PE Leadership, finance, legal, compliance representatives
 - PE RCM policy governance group (which includes national PE leadership (finance and RCM), Acute leadership (RCM), legal, compliance)
- Markets will be required to develop criteria for a medical necessity review process.

Policy and Definitions:

Amounts Generally Billed (AGB) Division calculates AGB on a market basis using the “lookback” method based upon past claims allowed under Medicare and private insurance.

Application Period means the time provided to patients by the _____ to complete the Financial Discount application

CommonSpirit FAP is the CommonSpirit Health Financial Assistance Policy that applies to all Emergency Medical Care and Medically Necessary Care provided in a Hospital Facility.

Eligibility Determination Period - For purposes of determining financial assistance eligibility, the PE assigned staff will review annual Family Income from the prior six-month (6) period, or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Eligibility Qualification Period - Markets can customize (unless SBO. If market is SBO the eligibility qualification period must align with Acute) After submitting the FAA and supporting documents, patients approved to be eligible shall be granted the applicable discount for all eligible accounts incurred for services received prior to determination date. If eligibility is approved based on Presumptive Eligibility criteria, the financial assistance will also be applied to all eligible accounts incurred for services received prior to the determination date.

Extraordinary Collection Actions (ECAs) - The Physician Enterprise medical group will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under this Policy. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal law; and
- Reporting adverse information about the individual to consumer credit bureaus. ECAs do not include any lien that a PE medical group is entitled to assert under state law on the proceeds of a judgment or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Facility provided care.

Family means (using the Census Bureau definition) a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service (IRS) rules, if the patient claims someone as a dependent on his or her income tax return, that person may be considered a dependent for purposes of the provision of a discount under the policy. If IRS tax documentation is not available, family size will be determined by the number of dependents documented on the Financial Discount application and verified by the appropriate PE staff.

Family Income is determined consistent with the IRS definition of Modified Adjusted Gross Income for the applicant and all members of the applicant's Family. In determining eligibility, [insert market or division PE name here] may consider the 'monetary assets' of the patient's Family. However, for purposes of this determination, monetary assets will not include retirement or deferred compensation plans.

Federal Poverty Level Guidelines (FPL) are updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Financial Assistance means a percent reduction of the patient's financial responsibility provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for the care covered under this policy and provided in a PE location eligible for Financial Assistance; and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Medically Necessary Care is defined as: Services and supplies provided by [insert market or division PE name here], needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted practice standards. Medically Necessary Care does not include hearing aids, optometric supplies, education classes, employment or school physicals, durable medical equipment rental, smoking nicotine blood tests, or care

relating to cosmetic procedures that are intended only to improve the aesthetic appeal of a normally functioning body part, except when intervention during after care is deemed medically necessary. Contraception and weight loss services that are not medically necessary are excluded from this policy.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in discounted care for the period during which the individual is presumptively eligible.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for care covered by this Policy.

Patient Cooperation

A patient must cooperate with the staff in providing the information and documentation necessary to determine eligibility. Such cooperation includes completing any required applications or forms. The patient is responsible for notifying the applicable revenue cycle staff of any change in financial situation that would impact the assessment of eligibility.

A patient must exhaust all other payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties prior to approval. An applicant for Financial Discount is responsible for applying to public programs for available coverage. He or she is also expected to pursue public or private health insurance payment options for care provided by a PE clinic location.

Guarantor means an individual who is legally responsible for payment of the patient's bill.

Self-Pay Discount

Financial Assistance described above supersedes a self-pay discount applied to the patient's balance. If it is determined that the application of Financial Assistance will further reduce the patient's bill, insert market or division PE name here] will reverse the self-pay discount and apply the applicable adjustments under the Financial Assistance Policy.

For those Uninsured patients who do not qualify for financial assistance described in this Policy, may apply an automatic (self-pay) discount to a patient's bill in accordance with guidelines and procedures.

Customize by Market/Division

REFERENCES:

APPROVERS:

DATE APPROVED:

EFFECTIVE DATE: