BAPTIST

OPERATIONS POLICY, PROCEDURE, AND GUIDELINE MANUAL

Effective Date: 9/03	**FINANCIAL ASSISTANCE POLICY**
Last revision: 8/2004; 5/06, 12/06; 3/08; 4/09; 4/10; 6/14; 8/16 **Reviewed: 4/11; 9/12; 9/2016**	
Reference #: S.FI.3025.07	

PURPOSE: To establish a framework for providing financial assistance to qualifying patients and for an effective and consistent method of administration and allocation.

POLICY:

Baptist is committed to treating all patients equitably, with dignity, respect and compassion. Baptist provides services in anticipation of payment by the patient and/or guarantor for services rendered. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), emergency and medically necessary care will not be delayed or withheld based on a patient's ability to pay. Any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with EMTALA and all applicable State and Federal regulations.

As a service to our community, Baptist offers financial assistance to our patients for emergency and/or medically necessary care. This financial assistance opportunity is contingent upon meeting the income eligibility criteria based on the Federal Poverty Income Guidelines and established herein. No patient will be denied financial assistance due to their race, religion, national origin or any other basis prohibited by law.

OBJECTIVES:

- To identify patients who qualify for financial assistance in accordance with the stipulations defined in this policy
- To establish a consistent, efficient and compliant methodology for applying financial assistance

SCOPE:

Financial assistance under the Baptist Financial Assistance Policy (FAP) includes both free care and discounted care. The Baptist FAP covers charges for emergency and medically necessary services by all BMHCC-owned providers. This includes all Baptist Hospitals, Baptist Trinity Home Health, Baptist Hospice, Baptist Home Medical Equipment, Baptist Minor Meds and Baptist Medical Group physicians and clinic services. The most updated list of covered providers can be found on the Baptist website under Financial Assistance. Printed copies are for reference only.

DEFINITIONS:

Amounts Generally Billed (AGB) – The amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care. Baptist-FAP eligible patients will not be charged more than this AGB percentage. In accordance with Internal Revenue Code Section 501(r) requirements, Baptist uses the "Look Back Method" to determine the AGB percentage based on claim data from the prior fiscal year. AGB percentages are calculated separately for hospital facilities by totaling the amounts allowed by Medicare fee for service, plus all other commercial and private health insurers, then dividing by the respective gross charges. The AGB percentages will be recalculated annually by the Baptist Vice-President of the Revenue Cycle.

Application Period – Period of time a patient has to submit a completed application for financial assistance. For each date of service, the application period begins on the date medical care is provided and ends on the later of 240 days after the first post-discharge billing statement or thirty days after the hospital (or an authorized third party) provides a written notice to the patient outlining pending extraordinary collection actions.

Baptist Financial Assistance Program (FAP) – As described in this policy, the Baptist FAP is the program developed to identify and measure patients' eligibility for either free or discounted financial assistance and to outline the practice for distributing funds in a consistent and efficient manner.

Designated Third-party Qualifier – An individual who works with both the provider and the patient to identify and qualify the patient for any available insurance coverage options.

Discount - To decrease and/or make allowance from. In the context of this policy, this is generally referring to deductions from the gross charges.

Episode of Care - Consists of all clinically-related services for one patient for a discrete diagnostic condition from the onset of symptoms until treatment is complete.

Extraordinary Collection Actions (ECA) - Collection activities that Baptist will not undertake before making reasonable efforts to determine if the patient is eligible for financial assistance. As described in 501(r), ECA are certain actions taken against an individual related to obtaining payment for a hospital bill. No ECA will be taken sooner than 121 days from the date of the first post-discharge bill and at least thirty days after the patient was sent a written notice outlining pending ECA.

The following are ECA alternatives that Baptist might engage against an individual related to collecting payments owed:

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
- Actions that require a legal or judicial process, including but not limited to:
    - Placing a lien on an individual's property.
    - Attaching or seizing an individual's bank account
    - Commencing a civil action against an individual.
    - Garnishing an individual's wages.

Financial Assistance – A reduction in the amount that the patient owes for medical services determined by the provisions of this policy. This reduction is generally determined as a percentage which is applied to the total [gross] charges.

Gross Charges – The full, undiscounted price of medical services consistently and uniformly charged to the patients before applying any contractual allowances, discounts, or deductions.

Insured - Patients with any type of insurance coverage and/or third-party payor program which reimburses for, compensates or discounts medical expenses. For purposes of the Baptist FAP, patients are considered to be insured even if their benefits have been exhausted, they are out of network, and/or their insurance does not cover a specific treatment.

Medically Underinsured – For the purposes of this policy as any insured patient who has incurred out of pocket liability for technical charges in excess of $5,000 in a single encounter and/or an out of pocket liability for professional charges in excess of $2,500 for a single episode of care during a calendar year. This discount provision does not have family status or income requirements for qualifying.

Out of Network Coverage **–** Occurs when Baptist has not contracted with an insurance company for reimbursement at a negotiated rate and the beneficiary's plan does not include Baptist as part of their provider network.

Out-of-Pocket Estimator – This is the name of the Baptist electronic cost estimator. It is available on the BMHCC Intranet and can be utilized in estimating the patient out-of-pocket cost associated with a hospital procedure. The Estimator's results are used to determine the reasonable estimate of the patient payment requested prior to the service. Upfront payments are never requested for any medically necessary emergent care.

Professional Charges – This billing is for work performed by physicians, suppliers and other non-institutional providers for both outpatient and inpatient services.

Series Account – Series accounts are those accounts which represent the same services received in multiple encounters by single patient in a thirty-day period which are for the same diagnosis and ordered by the same physician.

Single Encounter – One interaction or visit with a care provider for the purposes of this policy.

Technical Charges – This billing is for the use of equipment, facilities, non-physician medical staff, and supplies (etc.) in areas such as hospitals, skilled nursing facilities and other institutions for outpatient and inpatient services.

Third-Party Liability Claims – Any claim a patient may have against another individual, insurer, or entity responsible for covering that patient's cost of medical services.

Uninsured - Patients for whom there is not a third party responsible for their medical expenses.

POLICY EXCLUSIONS:

The Baptist FAP does not cover charges for patients or treatments with the following conditions:

1. The patient has any third-party insurance coverage. The one Baptist FAP benefit exception for insured patients is the provision for the medically underinsured.
2. The patient's primary residence is outside the United States.
3. The patient is currently in the custody of a correctional facility.
4. The patient is eligible for financial assistance under another city, county, state, federal or another assistance program which supersedes the FAP.
5. If patient charges resulted from a work-related accident, patients are not eligible to apply unless they can provide proof of no third party coverage.
6. If patient charges resulted from an auto accident, patients are not eligible to apply unless they can provide proof of no third party coverage.

The Baptist FAP does not cover charges for the following non-covered services:

1. Charges for related services by providers who do not participate in the Baptist FAP program are not covered under the FAP. A non-inclusive list of examples of which may consist of outside or specialty laboratory services, radiologists, pathologists, ambulance services, non-participating physicians, as well as services provided at facilities that are not owned by Baptist. The most updated list of facilities that are not Baptist-owned can be found on the Baptist website under Financial Assistance. Printed copies are for reference only.

2. Special promotion/package priced procedures which have already been discounted or have associated special pricing arrangements.

3. Cosmetic surgery performed purely for the purpose of enhancing one's appearance.

4. The following transplant and major organ surgeries: kidney, liver, heart, lung, stem cell, pancreas and intestines.

5. The following procedures are also excluded: left ventricular assist device (LVAD) and related procedures, extracorporeal membrane oxygenation (ECMO), wellness services, tubal reversal procedures and male penile implant procedures.

POLICY APPLICATIONS:

I. Medically Underinsured

A. Verify that the patient has insurance coverage.

B. Determine if the patient meets the medically underinsured requirements.

1. Patients with insurance will be deemed medically underinsured if their out of pocket liability after all insurance payments, exceeds the following established levels. For technical charges in excess of $5,000 in a single encounter or professional charges in excess of $2,500 in a single encounter, they are eligible for a 30% discount on their out-of-pocket liability in excess of $5,000 or $2,500 respectively.

a) For mother and newborns, both accounts will be combined as a single encounter for applying this discount.

b) Hospital series accounts as defined in this policy will be combined for applying this discount.

2. Patients should contact the business office at the facility where their services occurred if they qualify for this discount.

II. Financial Assistance for Self-Pay Patients

A. Verify that the patient is uninsured.

1. Baptist has contracted with a designated third-party qualifier to evaluate the status of all uninsured patients. The qualifier works with the patient and Baptist to determine if the patient qualifies for federal, state or local assistance programs.
2. Once the patient is determined to be eligible for financial assistance under the Baptist FAP, total charges will be adjusted to the AGB by applying the minimum self-pay discount to total gross charges. The AGB rates are different for each Baptist facility; the discount rate applied will be the discount rate of the Baptist facility where the patient received the service. AGB discount tables will be updated annually; the most recent can be located on the Baptist website under Financial Assistance. Printed copies are for reference only.
3. This self-pay minimum discount will automatically be applied before the first post-discharge billing statement. Application of this discount ensures that charges for emergency and/or other medically necessary care for Baptist FAP eligible individuals are limited to and not more than, the average billed to individuals with insurance covering such care, in accordance with Internal Revenue Code Section 501 (r)(5).

B. Initiate the application process.

1. Uninsured patients applying for the Baptist FAP must complete the Financial Assistance Application. To make reasonable efforts to determine whether a patient is eligible for financial assistance, free copies of the application and a plain language statement explaining the Baptist FAP is readily available from several sources.
    a) A copy is given to the patient during the admissions and/or discharge process for each visit for medical treatment.
    b) A copy is sent with the first post-discharge billing statement.
    c) Copies will be posted and available upon request at all Admissions, Emergency and Business Office department areas at all Baptist facilities.
    d) They are also available for download and printing online on the Baptist website under “Financial Assistance” or by contacting the facility where services were received and requesting a copy by mail or email at FAP@BMHCC.org. In addition, Baptist will

provide all of the FAP-related documents electronically to any individual who indicates that is their preference.

2. All patients will be eligible to apply for financial assistance at any time during their continuum of care or billing cycle. Patients are given the opportunity to apply for financial assistance for the later of 240 days from the date of the first post-discharge billing statement or thirty days after the hospital (or an authorized third party) provides a written notice to the patient outlining pending ECA.
3. If a patient's Baptist-FAP eligibility status has been determined in the previous ninety days, the patient does not need to reapply.
4. The key factor in applying the Baptist FAP discount percentage is the date the initial FAP discount was approved.
    a) The approved discount will also be applied to the gross charges for all other open, qualified accounts related to this episode of care. Additional qualified accounts will not include service dates older than 240 days and/or will not cover dates of services prior to October 1, 2016.
    b) Charges for emergency and medically necessary care for a period of ninety days from the approval date will be adjusted by the approved discount percentage.
    c) This Baptist FAP discount will be applied to open accounts and covers emergency and medically necessary care for all other Baptist providers participating in the FAP program. Patients do not need to apply at each hospital or clinic.
        1. Patients may need to submit a copy of their approval letter to the other participating providers as proof of a previous approval.
        2. To minimize confusion, it is important to note that the minimum discount is different at each facility.
        3. The discount percentage applied to each account is based on the facility where the medical treatment was received.
        4. With the exception of the BMG clinics, the minimum discount is the only discount tier that will vary between facilities.
    d) Eligibility for the Baptist FAP is to be reassessed every ninety days. The application process to reapply is the same as the initial process; an application and updated financial information need to be submitted to the Business Office at the facility where services were received.

C. Process the patient's Financial Assistance Application.

1. When the Financial Assistance Application and supporting documentation is received within the Application Period, documentation will be reviewed to determine the appropriate discount according to the Baptist FAP. Financial information requirements are detailed below. The review for FAP eligibility will be completed within thirty days. Once the Baptist FAP eligibility determination has been made, a letter will be sent to the patient advising them of the decision.

2. For patients who are FAP eligible, the approval letter will indicate the discount percentage granted and how much, if any, the patient owes after the discount has been applied. This letter will also include contact information, if the patient has questions regarding the approval process or payment arrangements.

3. If the application is incomplete or lacks the necessary supporting documentation, a letter will be sent notifying the patient and requesting the missing information. All supporting information must be received before the end of the patient's application period. This letter will also include contact information, if the patient has questions regarding the approval process or payment arrangements.

    a) If the patient provides the required information within the application period, the application will be re-processed as outlined above.

    b) If the patient is unable or unwilling to provide the necessary financial documentation, the patient is not eligible for any further discounts identified in this policy. Patient charges will remain at the balance determined after the AGB adjustment detailed above.

4. For patients who are deemed ineligible for any further discounts identified in this policy, their denial letter will also include contact information, if the patient has questions regarding the approval process or payment arrangements.

    a) The amount the patient owes will remain at the balance determined after applying the self-pay minimum discount as explained herein.

b) Patients are able to reapply for Baptist FAP after thirty days or if they have experienced a material change in family or income status.

5. ECA efforts will be suspended after the application has been received and while it is reviewed. Baptist will take all reasonably available measures to reverse or resume the ECA, as appropriate after the assistance eligibility determination.

6. For any FAP-eligible episodes, the amount the patient is personally responsible for paying will be reduced by any amounts already paid. The patient will be refunded any net-overpayments for these dates of service, unless the net is less than $5.

D. Determine the uninsured discount percentage.

1. Determine size of the patient's family unit using the documentation provided, including but not limited to, the application and financial supporting documents.

a) A family unit is a group of two or more persons related by birth, marriage, or adoption who live together. Generally, all related persons living in one physical location are considered members of one family unit. A child who is a full-time student living away from home at an accredited college can be counted in the family size.

1. For example, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family and the household size or family unit would be seven.

b) Unrelated individuals are excluded from the household size determination. An unrelated individual may be living in a house or apartment in which one or more persons also live who are not related to the patient by birth, marriage, or adoption. In this context, examples of unrelated individuals include friends, roommates, lodgers, foster children, employees or others living in group quarters such as a rooming house.

c) When necessary, the primary address/residence of individuals claimed in a family unit can be verified using tax returns or federal, state or governmental court documents establishing residency.

2. Determine the total gross income for the patient and the patient's family unit.
    a) Money income: Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, disability payments, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
        1. Minor children's earned wages are not to be included in determining income.
        2. Court-ordered or state/federally issued assistance related to a minor is to be included in determining income.
    b) The value of non-cash benefits (such as food stamps and housing subsidies) does not count as income; however, these documents may be used to substantiate the family unit and/or corresponding income totals.
    c) The patient must provide supporting documentation to verify the total gross income of all family members.
    d) In order to accurately substantiate the family income, any of the following documents may be utilized. Always use gross income for determining the patient's financial status. Most recent income information is given priority in determining financial status. Therefore, attempt to obtain the following documents in this order:
        1. Pay stubs for the last three months
        2. Income tax return for the previous year
        3. W2 Form for the previous year
        4. State/Federal assistance documents
        5. Bank statements for the last three months
        6. Legal documents including divorce decree and/or child support and alimony
        7. Pension/retirement statements
    e) Annualize all income sources and then, calculate the total gross income for the complete family unit.

3. The Baptist FAP discount percentages are determined by referencing the family unit and the total family income in the appropriate Baptist FAP Discount Table. Discount tables for each facility have been created to facilitate the discount percentage determination. A copy of the discount table is available from the Business Office where services were received.

    a) Tables will be updated annually by the Baptist Vice-President of the Revenue Cycle. These will be updated with the new ABG calculations and updated FPG income thresholds.

    b) The following table summarizes the Baptist FAP discounts:

Baptist FAP Discount Summary	
FPG Income Range	**FAP Discount**
< 200%	100%
201-250%	95%
251-300%	90%
301-350%	85%
351-400%	80%
> 400%	Varies by Facility

    c) The income levels in this table are the levels established as the Federal Poverty Guidelines. These levels are published annually by the U.S. Department of Health and Human Services. The current FPG income thresholds can be found at http://aspe.hhs.gov/poverty/index.cfm.

4. Applying the Baptist-FAP discount
    a) Once the Baptist FAP discount determination has been made, a letter will be sent to the patient indicating the discount percentage granted and how much, if any, the patient owes after the discount has been applied. This letter will also include contact information, if the patient has questions regarding the approval process or payment arrangements.

    b) The discount will be applied as stated above.

    c) Baptist reserves the right to reverse financial assistance and pursue appropriate reimbursement or collections as a result of newly discovered information, including insurance coverage or payment to the applicant or pursuit of a personal injury claim related to the services in question. All payments received after the

Baptist FAP discount is awarded will result in the reversal of the adjusted amounts to resolve the remaining self-pay balance without creating a balance due or a credit.

III. Billing and Collections

A. Actions may take in the event of non-payment are described in the Baptist Billing and Collections Guidelines. A free copy of this policy may be obtained on the Baptist webpage or by contacting the billing office at the facility where services were received.

B. Baptist will not engage in ECA before it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this policy.

IV. External References

- Tennessee Code Title 68 - Health, Safety and Environmental Protection Health § 68-1-109 and 68-11-262, 268
- Emergency Medical Treatment and Active Labor Act [EMTALA]
- Federal Register Poverty Guidelines
- Internal Revenue Service Code Section 501(r)