DEKALB HEALTH

SUBJECT:	Financial Assistance Policy (FAP)	Page 1 of 14
SECTION:	Financial Counseling	EFFECTIVE: 10/19/90
DEPARTMENT:	Financial Counseling	REVIEWED:
APPROVED BY:	Board of Directors	REVISED: 12/06/16

Purpose:

As part of our mission to provide service, excellence and value: DeKalb Health provides financial assistance to patients who lack the ability to pay for hospital services and employed physician services associated with the hospital (see appendix A). 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 purpose of this policy and procedure is to:

- Ensure transparency, consistency and fairness towards uninsured patients and set guidelines for providing a financial adjustment to any uninsured or underinsured patient who obtains Medically-Necessary or Emergency Services from DeKalb Health. This policy ensures that DeKalb 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 in order to identify charity cases in a timely manner. Health coverage programs could include, but are not limited to, Medicaid, HIP 2.0, 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 DeKalb 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.

Policy:

Regardless of an individual’s ability to pay or qualify under this Financial Assistance Policy, DeKalb Health will provide, without discrimination, care for any emergency medical 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, national origin, physical disability, race or religion.

Patients that are uninsured (self-pay) will receive a discount off their gross charges. This discount applies to both hospital and hospital physician services, and is exclusive to any other discounts or acceptance to the FAP.

In order to manage its resources responsibly and to allow DeKalb 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.

Definitions:

- **Amount Generally Billed (AGB)** – DeKalb Health will apply the "look-back method" for determining AGB. In particular, DeKalb Health will determine the AGB for emergency or other medically necessary care by multiplying the Gross Charges for such care by the AGB Percentage.

- **AGB Percentage** – DeKalb Health will calculate the AGB Percentage at least annually by dividing the allowable of all processed claims 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 allowable of the associated Gross Charges for those claims. For these purposes, DeKalb 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.

Certified Application Counselor - Individual that 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 marketplace (www.healthcare.gov).

- **Cosmetic Services** - Are those services and procedures that enhance the patient’s well- being, are typically not covered by any insurance and are categorically excluded from any financial or economic assistance.

- **ECA**-Extraordinary Collection Action-Hospital may not engage in ECAs before making reasonable efforts to determine if individual is eligible for assistance under FAP 501(r)(6)

- **Emergency Services** - an emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences. Or as defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd)

- **FAP** - Financial Assistance Program as defined in this policy.

- **Gross Charge** - 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.

- **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. If a child is over 18 years old and claimed on their parent's tax return then the total household income/dependents will be taken into consideration.

- **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.

- **Indiana Certified Navigator** - Individuals who are registered with the Indiana Department of Insurance and meet 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).

- **Insured Patient** - A patient 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.

- **Medically Necessary** - for the purpose of this policy, is defined as a service that is necessary 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.

- **Patient Advocate** - A hospital employee, contractor, or volunteer designated to assist patients with screening, application for and enrollment in health coverage programs.

- **Plain Language Summary** - A statement written in clear, concise, and easy to understand language notifying individuals that DeKalb Health offers financial assistance under the FAP.

- **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.

- **Underinsured Patient** - A patient and/or responsible party with third party coverage for healthcare services who may have an extraordinary amount due that they cannot pay due to household unit income.

Financial Assistance Program Availability

DeKalb Health will widely publicize assistance availability using the following methods:

- At main patient access and registration points to the hospital, DeKalb Health will post and/or make available a plain language summary of the FAP. Posted materials will include instructions on how to obtain a printed version of the plain language summary and the FAP application free of charge.

- The FAP summary and application will be available online at www.dekabhealth.com.

- Information on how to apply for FAP will be included on patient's statements.

Printed copies of the Financial Assistance Policy and Application may also be obtained by:

- Calling Customer Service at 260-333-7699

- Presenting to the Central Business Office at:

  1700 East 7th Street
  Auburn, IN 46706

  Central Business Office hours are Monday through Friday 8:00am-4:30pm

- Presenting to the Financial Counselor located in the hospital (Use Door Entrance #5 and proceed to 2nd floor Patient Access Area)

Financial Counselor hours are Monday through Friday 8:00am-4:00pm

- Request in writing by mail:

  DeKalb Health
  P.O. Box 542
  Auburn, IN 46706

Hours are subject to change*

Patients with balances after insurance (e.g. deductibles, co-pays, and co-insurance amounts) may be eligible for FAP if the eligibility requirements are met.

Patients who have exhausted policy limits may be eligible for FAP 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 FAP.

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. Assistance with the assessment and enrollment is provided as a service of the hospital free of charge to the patient by certified Indiana Navigators and Certified Application Counselors.

Services Eligible for Financial Assistance

1. Any hospital service that is an emergency or a service that is medically necessary 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.

2. Any DeKalb Health Medical Group (DHMG) services provided in relationship to the approved hospital service(s) and DHMG services that are deemed medically necessary (see Appendix A).

Application for Assistance

The patient's eligibility for FAP will be determined through an application process. The DeKalb Health Financial Assistance Application form is the valid application form for the

application process. DeKalb 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.

- The following documents are required: Verification of all income for everyone in the household, most recent bank statement for all checking and savings accounts, and most recent federal tax form (1040)

- Documentation of all information provided on the application may be required to complete the assistance application. DeKalb 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.

The financial counselor is available to help anyone wanting to apply for assistance and is available during business hours at the hospital and Central Business Office. Verification of requested income and a complete list of all countable household members may be required.

- An FAP application may be used for covered services that are provided up to 3 months after the date the FAP application was received.

- All FAP 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 the CFO or designee.

- The patient may appeal the decision of denied financial assistance by writing:
  Dekalb Health
  Attn: Chief Financial Officer
  1316 East 7th Street
  Auburn, IN 46706

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 240 days after service/discharge, or final bill.

If the account is with a collection agency, the patient may still apply for FAP.

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 the Financial Counselor.

Charges

DeKalb Health will not charge patients approved for financial assistance under this FAP for emergency or other medically necessary care more than the amounts generally billed to individuals who have insurance (i.e., DeKalb 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 particular time by contacting the DeKalb Health Financial Counselor at the addresses and phone numbers provided above.

Actions DeKalb Health May Take In the Event of Non-Payment

DeKalb will ensure all reasonable efforts are made to collect the self-pay account balances as well as any balances remaining after insurance processes a claim.
The actions that DeKalb Health may take in the event of non-payment are described in the Billing and Collections Policy available online at www.dekalbhealth.com.

Financial Assistance Criteria

The policy set forth allows for patients to qualify for assistance by two means: financial or catastrophic. The Financial Assistance Program also allows for partial assistance or full assistance based on eligibility criteria set forth in this policy.

Financial Assistance

- A patient qualifying for financial assistance is a person who is uninsured or underinsured, receives emergency or medically necessary 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 250% of the Federal Poverty Level (FPL) as determined by Federal Poverty Guidelines. Household size and income determines the % of FPL. DeKalb Health, or its designee, may consider other financial assets and liabilities of the person when determining eligibility. Other sources can also be used to determine eligibility for Financial Assistance. See Presumptive Eligibility section of the policy.

- DeKalb 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 and additional documents such as proof of income, proof of no income and proof of lack of financial assets may be requested to accompany the application.

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 one pay stub 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.
- The amount and frequency of hospital/medical bills.
- Other financial resources that produce income.

Financial Capacity

- Individuals with the financial capacity to purchase health insurance coverage through the Health Insurance Marketplace may be required to purchase such. They will be provided access to meet with an Indiana Certified Navigator as a means of assuring access to healthcare services for their overall personal health, and for the protection of their individual assets.

- Individuals have 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.

- Cosmetic services are not eligible for any kind of assistance and cannot be included in the amount of hospital/medical bills owed.

Reasons for not being eligible for FAP

- Household income exceeds the maximum of the 250% FPL.
- 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, 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.
- Services are not medically necessary or excluded from the program.

- Excluded services include, but are not limited to:
  - Cosmetic surgery.
  - Infertility treatments, fertility services, birth control, sterilization, reversal of sterilization.
  - Failure to satisfy the insurance companies request for additional information/documentation (ex: Accident Details, Coordination of Benefit Form, etc).

- Services reimbursed directly to you by your insurance company.
- Services reimbursed by another third party.
- Services required for employment, schools, or athletics.
- Services reimbursed under a negotiated contract with a specific company or employer.

Financial Assistance Coverage for Physician Services

To determine if a physician is covered under DeKalb Health's FAP refer to Appendix A & Appendix B. These documents are maintained for physicians who are covered and non-covered under DeKalb Health's FAP. They can be located at www.dekalbhealth.com or free of charge by:

- Calling Customer Service at 260-333-7699
- Presenting to the Central Business Office at:

  1700 East 7th Street
  Auburn, IN 46706

- Presenting to the Financial Counselor located in the hospital (Use Door Entrance #5 and proceed to 2nd floor Patient Access Area)
- Request in writing by mail:

  DeKalb Health
  P.O. Box 542
  Auburn, IN 46706

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
- Patient /guarantor is on a fixed income at or below FPL but is considered over resource limits for any Medicaid program.

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. It is the patient's responsibility to provide a denial letter from Medicaid if the Medicaid application was not completed through a navigator on site at DeKalb Health. DeKalb Health understands that certain patients may be unable to complete a financial assistance application, comply with the requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for financial assistance is established without completing the formal assistance application. Under these circumstances, DeKalb Health may utilize other sources of information to make an individual assessment of financial need. A determination of eligibility for financial or catastrophic 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. This information will enable DeKalb Health to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

DeKalb Health may utilize a third-party to conduct an electronic review of the patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for DeKalb Health financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows DeKalb Health to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy. If the patient is determined eligible through the electronic review a notification will be sent to the patient.

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 patient will have 10 days from the date of the request letter to return the requested information. The account may also be submitted for approval if DeKalb Health has been able to verify information from a reliable third party, i.e. Social Security, Medicaid, credit reporting bureau, etc.

Patients who fail to provide required documentation or information will be provided notification.

No patient may be denied assistance due to their failure to provide information or documentation not specified in the FAP or application.

Failure of Patient to pay Remainder of Account after Financial Assistance

Failure of a patient/guarantor to pay the remainder of their account after deducting the assistance portion may cause the account to be placed with a collection agency. The remainder of the account will be subject to any collection action including legal recourse such as suit, wage garnishment, lien or adverse credit bureau reporting if it remains unpaid.

Billing and Collections

Accounts for hospital services and/or hospital-owned physician services (see appendix A), for patients who are able, but unwilling to pay are considered uncollectible bad debts and will be referred to an outside agency for collection. The unpaid discounted balances of patients who qualify for the FAP are considered uncollectible bad debts and such patients will be referred to an outside agency for collection. The Billing and Collection Policy is posted on the hospital website. In addition, a free copy of the Billing and Collection Policy can be obtained by a request to the Central Business Office (contact information above).

Statements and phone call attempts are made to the patient to try to collect any outstanding balances prior to the account being considered uncollectible bad debt. The patient is notified prior to any ECAs.

The Central Business Office has the responsibility for monitoring and ensuring that a reasonable effort to determine whether an individual is FAP-eligible and for determining whether and when extraordinary collection actions may be taken in accordance with this policy and the Billing and Collection Policy.

General Procedure for Determinations of Eligible Services and Possible Third Party Coverage

DeKalb 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.

DeKalb Health, or its designee, will determine if the type of services provided are eligible for coverage under the financial assistance policy.

DeKalb 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 DeKalb 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, DeKalb 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.

DeKalb 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.

The financial assistance write-off is calculated by the balance on the account at the time the patient is approved for financial assistance. If a patient is deemed eligible for financial assistance any payment (coinsurance, copayment, deductible, etc.) made at the time of service will not be refunded.

Unfavorable Determinations

An unfavorable determination will include an explanation or reason.

- 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.
- 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.

Discount Schedule

Percentage of Federal Poverty Level	**Reduction Percentage**
0% to 200%	100%
201% to 250%	54%