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Owner	Monica Linely: Patient Access Representative
Area	Patient access

Financial Assistance

Purpose:

To identify guidelines for approving financial assistance applications.

POLICY:

Drew Memorial Health System has a financial assistance program that offers discounted charges for services to eligible patients that may cover all or part of the patient responsibility portion of their bill. The program reduces the patient bill based on income/family size. The reduction is based on a sliding fee scale. Charges for uninsured patients (which will be further discounted in accordance with the sliding fee scale) shall be initially determined based on "amounts generally billed," or "AGB," by Drew Memorial Health System, as opposed to gross charges for the services.

A. SERVICES COVERED UNDER POLICY

All emergency and other medically necessary healthcare services provided by Drew Memorial Health System are eligible for financial assistance, depending upon qualifications of the patient. Elective and non-medical services are not eligible for financial assistance. **Appendix A** to this Policy includes a list of providers, other than Drew Memorial Health System, which deliver emergency or other medically necessary care in the Health System and also specifies whether such providers are covered under the Health System's Financial Assistance Program.

B. EMERGENCY SERVICES

Drew Memorial Health System will provide, without discrimination, care for emergency medical conditions to individuals, regardless of their eligibility under this financial assistance policy. A separate emergency medical care policy is attached hereto as **Appendix B**.

C. ELIGIBLE PATIENTS

Eligibility for financial assistance is based upon a determination of financial need in accordance with the sliding fee scale described in this Policy. A person whose individual or family income is not more than 225% of the current Federal Poverty Guidelines (FPG) of the United States Department of Health and Human Services will be eligible for assistance at least at some level, as described herein. Eligibility may also be determined based upon whether the patient or guarantor meet certain criteria or are eligible based on certain socio-economic circumstances (presumptive eligibility) as described in detail in this Policy. If the patient or guarantor does not meet the presumptive eligibility criteria or circumstances, a financial assistance application must be completed to determine eligibility.

D. INELIGIBLE PATIENTS

Anyone who does not meet the organization's financial assistance criteria, including the presumed eligibility criteria, or who refuses to provide the information necessary to determine eligibility will be determined as ineligible for financial assistance. Patients refusing to make reasonable application for medical assistance or similar programs (for example, Medicaid), as reasonably suggested by Drew Memorial Health System, will also be ineligible for financial assistance under this policy.

E. DEFINITIONS

AMOUNTS GENERALLY BILLED ("AGB")— Amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

MEDICALLY NECESSARY SERVICES –

1. Are consistent with the person's symptoms, diagnosis, condition, or injury;
2. Are recognized as the prevailing standard of care and are consistent with generally accepted professional medical standards;
3. Are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would or could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
4. Are not furnished primarily for the convenience of the person or the provider; and
5. There is no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

FAMILY UNIT – Consists of individuals living alone; or an individual and any spouse and/or children under age 21 living in the same household. A family unit may include minor children living with a legal guardian.

GROSS INCOME – Total family unit income before taxes for the applicable period of calculation. Family unit income may include earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, 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. Noncash benefits (such as food stamps and housing subsidies) do **not** count toward gross income. If a person lives with a family unit, gross income includes the income of all family members. Non-relatives, such as housemates, do not count.

PRESUMED ELIGIBILITY – Eligibility based on certain socio-economic factors or circumstances that qualify the patient for charity care discounts without the completion of a financial assistance application.

F. AMOUNT OF FINANCIAL ASSISTANCE

The hospital bill may be discounted (at varying levels depending on family unit income) if the qualified patient income does not exceed 225% of the Federal Poverty Guidelines (family unit adjusted). (See sliding fee scale included in this Policy).

Patients who qualify for a reduction in their patient bill or do not financially qualify for a reduction can arrange for installment payments. After a financial assessment, the appropriate monthly payment will be assigned with a prescribed timeframe.

G. APPLYING FOR FINANCIAL ASSISTANCE; DETERMINATION PROCEDURES

In order to determine if a patient is eligible for assistance, an application for financial assistance must be completed by the patient or guarantor. The Health System will then review the application and make a determination of eligibility. The Health System will accept FAP applications at least two hundred forty (240) days from the date of the first post-discharge billing statement. The Health System will notify individuals who submit an incomplete FAP applications during the application period about how to complete the application (and provide contact information for assistance), and suspend any extraordinary collection activities for these individuals until eligibility is determined. **Appendix C** includes a listing of non-profit organizations or government agencies which may be sources of assistance for patients completing FAP applications.

The availability of financial assistance will be widely publicized. Applications for free or reduced charge care will be distributed by a Patient Financial Advisor, Patient Financial Collector, Cashiers Department, Social Services, or other related departments of Drew Memorial Health System.

Approval is valid for a period of one (1) year without re-application. A patient must apply (or reapply) or meet the presumptive eligibility criteria, for free or reduced charges with current financial information if it has been more than one (1) year since the patient last applied.

In order to qualify for assistance, the patient must:

- Complete an application form.
- Provide documentation of gross income for the last three (3) months, including where applicable:
    - Federal tax form 1040; and

        - Last three pay stubs for all household members (or if unavailable, letter from employer stating weekly wages).
    - Provide bank statements for the last two months for all household members.
    - Be determined eligible for financial assistance by Drew Memorial Health System.

If an individual does not have the listed documentation needed to apply for financial assistance, he or she may contact the Director of Patient Access to discuss other documentation that may be provided to demonstrate eligibility.

Upon completion, the application and related material will be forwarded to the Patient Access Manager for eligibility determination. If additional information is needed to complete the determination process, the application will be placed in a "HOLD" status until the required information is obtained. An application will be considered in a "HOLD" status if third party coverage is discovered that will pay for the related services.

If the application is approved, it will be forwarded to the Revenue Cycle Director for final approval and processing. Upon final approval, the eligible amount will be adjusted off the patient balance and a "DETERMINATION LETTER" will be mailed to the patient informing them of the results of their application. This process will be completed with reasonable promptness.

If the application is not approved, a "DETERMINATION LETTER" will be mailed to the patient informing them of the results of their application. If the patient believes the initial decision regarding his or her eligibility is incorrect, he or she may request reconsideration of this determination directly to the Patient Access Manager. This right to reconsideration will be explained in the determination letter, and a decision regarding the reconsideration will be made within five (5) working days.

It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be made at any point in the collection cycle prior to legal action. The need for financial assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than one (1) year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

Questions regarding the financial assistance application process should be directed to: Director of Patient Access, at the following phone number 870-460-3532.

H. PRESUMPTIVE ELIGIBILITY

If a patient or guarantor meets any of the following criteria or circumstances, the patient will automatically qualify for 100% discount of amounts then due from the patient:

1. **Dual-Eligible Beneficiaries**. Dual-eligible beneficiaries (Medicare beneficiaries who also qualify for Medicaid) may be presumed to automatically qualify for financial assistance as long as there is evidence of compliance with the Medicare "Must Bill" requirements (i.e. billing Medicaid for any unpaid copayments and deductibles and obtaining a Medicaid remittance advice (RA) to demonstrate said compliance prior to applying financial assistance). Maintain the RA in the patient's file as documentation of compliance with "Must Bill" requirements.

2. **Participation in Public Benefit Programs**. Patients that participate in any public benefit program such as Arkansas Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families Program (TANF), Children's Health Insurance Program (CHIP), Country Indigent Health Care Program, or any other similar indigent related program at the time their healthcare services are received, may be presumed to automatically qualify for financial assistance. The patient or guarantor should provide proof of participation in the public benefit program at the time the patient received services. The patient's participation may be verified by contacting the local office of the Arkansas Health & Human Services Commission. Maintain documentation of participation in the patient's file.
3. **Medicaid Patients**. Financial assistance may be presumed to automatically apply to patients who participate in the Medicaid program and coverage has been denied for the following reasons:
    i. Patient has reached a thirty ("30") day maximum confinement period; or
    ii. Medical services are not covered under the Medicaid program; or
    iii. The patient's medical diagnosis is not covered under the Medicaid program. Obtain documentation of the denial and maintain in the patient's file as consideration of financial assistance.
4. **Deceased Patients or Guarantors**. Patients or guarantors who are deceased with no estate in probate may be presumed to automatically qualify for financial assistance. Obtain documentation or proof of no estate in probate and maintain in the patient's file as documentation for approval for financial assistance.
5. **Declaration of Bankruptcy**. Patients or guarantors who have declared bankruptcy within the past twelve (12) months may be presumed to automatically qualify for financial assistance. Patient or guarantor must provide documentation demonstrating the bankruptcy proceedings. Maintain documentation in the patient's file.
6. **Homelessness**. Patients or guarantors determined to be homeless may be presumed to automatically qualify for financial assistance. Any documentation available to make this determination should be maintained in the patient's file.
7. **Uncollectable Accounts Under Certain Circumstances**. Any accounts that are returned from the collection agency as "uncollectable" due to any of the above-listed reasons may be presumed to automatically qualify for financial assistance. Obtain documentation from the collection agency as to why the determination was made and maintain in the patient's file.

If none of the criteria/circumstances apply to the patient or guarantor, a financial assistance application must be completed to determine eligibility.

I. COLLECTION ACTIONS

For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, Drew Memorial Health System may offer extended payment plans. In these cases, the Health System will not send unpaid bills to outside collection agencies and will cease all collection efforts.

In addition, Drew Memorial Health System will not impose extraordinary collections actions (described

below) without first making reasonable efforts to determine whether that patient is eligible for financial assistance under this Policy. Reasonable efforts shall include:

1. Verifying that the patient owes the unpaid bills;
2. Offering information to the patient regarding the availability of financial assistance;
3. Providing determination of eligibility on a timely basis;
4. Requesting that the patient identify all sources of third-party payments;
5. Determining that the health system has pursued collections from the third-party payment sources identified by the patient;
6. The Health System has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the Health System's application requirements;
7. Provide verbal and written notice about the FAP (including a summary statement of the FAP and notice of any extraordinary collection actions which the Health system plans to initiate), at least thirty (30) days prior to initiating any extraordinary collection actions; and
8. If applicable, documenting that the patient has been offered a payment plan but has not honored the terms of that plan.

The Health System will not initiate any extraordinary collection actions for at least one hundred twenty (120) days from the date of the first post-discharge billing statement for the care at issue. The Health System will accept FAP applications at least two hundred forty (240) days from the date of the first post-discharge billing statement. The Health System will suspend any extraordinary collection activities if an FAP application is submitted anytime during the two hundred forty (240) day application period.

Drew Memorial Health System may take extraordinary collection actions ("EACs") after these reasonable efforts have been completed, as determined by Health System Administration. Extraordinary collection actions may include the following: (A) placing a lien or foreclosing on patient property (does not include medical liens against third parties); (B) attaching or seizing a bank account or other patient property (does not include medical liens or attachments against third parties); (C) filing suit against the individual; (D) garnishing wages; (E) reporting to consumer credit reporting agencies or bureaus; (F) sale of medical debt to a third party; (G) turning patient account over to collections; or (H) denying medically necessary care based upon previous non-payment (in some circumstances).

If an individual requests a copy of DMHS' Billing and Collections policy, it must be provided to the individual free of charge.

J. MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE POLICY

Drew Memorial Health System's Financial Assistance Policy, FAP Summary, and FAP Application are available to the public using various means, which may include, but are not limited to, the posting of these materials (or a summary thereof):

- In patient bills;

- In the emergency room, admitting and registration departments, hospital business office, and patient financial service offices that are located on both hospital campus and at off-campus locations, and at other public places as Drew Memorial Health System may elect;
- On the Health System website;
- In brochures available in patient access sites; and
- At other places within the community served by the hospital as Drew Memorial Health System may elect.

Patients will be offered a plain language summary of the FAP either upon patient intake or patient discharge. Paper copies will be available, without charge, both for distribution in public locations within the facility and by mail, if requested. And the Health System will inform members of the community about the availability of financial assistance in a manner reasonably determined by reach those members of the community most likely needing financial assistance (i.e., distributing FAP information to local government agencies and non-profit organizations).

Referral of patients for financial assistance may be made by any member of the Health System staff or medical staff, including physicians, nurses, patient access representatives, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

At any time the Health System determines that the lesser of 1,000 individuals or five percent (5%) of the community served by the Health System or the population likely to be affected or encountered by the Health System, is a Limited English Proficiency language group, then the Health System will provide written translation of financial assistance policy documents in the applicable language.

K. AMOUNTS GENERALLY BILLED (AGB)

Following a determination of eligibility of an individual for financial assistance, the individual will not be charged more than amounts generally billed for emergency or other medically necessary care. AGB will also be used in connection with the sliding fee scale as a starting point for discounts and reductions.

Drew Memorial Health System calculates AGB based upon the look-back method, which is a average of actual past claims paid to the Health System by Medicare fee-for-service and other third party insurers. On or before April 1 of each year, the Health System will determine AGB based upon previous calendar year data. This AGB shall be effective until the following April 1. Members of the public may request and obtain a written description of the AGB percentage(s) that the Health System uses to determine AGB and a description of how the Health System calculated the percentage(s) from the Patient Access Department. This information shall be provided free of charge to any individual who requests it.

DREW MEMORIAL HEALTH SYSTEM

FAP SLIDING FEE SCALE

At Drew Memorial Health System, free or discounted services are available for medically necessary inpatient and outpatient services to qualifying individuals. Discounts are applied only to the patient responsibility portion of the bill. To be eligible to receive free or reduced-charge care, your family unit income must be no more than 225% of the U.S. Department of Health and Human Services Federal

Poverty Guidelines, based upon family size. If you think you may be eligible for free or reduced-charge services, you may make this request to Drew Memorial Health System. A written conditional or final determination of your eligibility will be made to you with reasonable promptness after your request. The following table describes the current Drew Memorial Health System sliding fee schedule (updated annually):

2023 Financial Assistance Sliding Scale					
2023		150% of FPG	175% of FPG	200% of FPG	225% of FPG
Family Size	Federal Poverty Guidelines	100% Discount (From AGB)	75% Discount (From AGB)	50% Discount (From AGB)	25% Discount (From AGB)
1	$13,590	$20,385	$23,783	$27,180	$30,578
2	$18,310	$27,465	$32,043	$36,620	$41,198
3	$23,030	$34,545	$40,303	$46,060	$51,818
4	$27,750	$41,625	$48,563	$55,500	$62,438
5	$32,470	$48,705	$56,823	$64,940	$73,058
6	$37,190	$55,785	$65,083	$74,380	$83,678
7	$41,910	$62,865	$73,343	$83,820	$94,298
8	$46,630	$69,945	$81,603	$93,260	$104,918

L. UNINSURED ALLOWANCE

This financial assistance policy explained above intends to serve as a limitation of charges to ensure patients who qualify for financial assistance are not charged more than amounts generally billed to individuals who have insurance.

Patients without insurance and who are not eligible for any third-party or government benefits and do not qualify for any financial assistance are eligible for a discount (upon request) on gross charges that is equal to the discount that Medicare and all third-party insurers receives on a combined average basis. As described in section K (AMOUNTS GENERALLY BILLED (AGB)) above, that percentage is re-calculated every year based on prior years' experience. For 2023, the discount is 51% for inpatient services, 32% for outpatient, and 35% for emergency services.

APPENDIX A

List of Other Providers	Covered by FAP?
Drew Memorial Health System	Yes
Drew Outpatient Professional Services	Yes
Drew Memorial Home Health	Yes

Drew Specialty Clinic (Specialty Physicians)	No
Drew Memorial Cancer and Infusion Center	Yes
Emergency Staffing Solutions (ER Physicians)	No
YPS (Anesthesia Providers)	Yes
JRMC Monticello Medical Clinic	No
Connelley Family Healthcare	No
Reinhart Family Healthcare	No
Specialty Eyecare	No
Dr. Ali Al-Nashif – Pulmonologist/Sleep Medicine	No
Arkansas Pathology	No
Woodside Medical	No
Quest Diagnostics	No
James L. Workman M.D. Radiology	No

APPENDIX B
EMERGENCY MEDICAL CARE POLICY

Drew Memorial Health System will not engage in any action which may discourage an individual from seeking emergency medical care, such as demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities in the emergency department or in other areas of the Health System where such activities could interfere with the provision, without discrimination, of emergency medical care.

Reference is made to Drew Memorial Health System's EMTALA and ancillary emergency services policies. This policy is not intended to limit or restrict any patient rights or regulatory requirements contained in any of said policies.

APPENDIX C
ORGANIZATIONS PROVIDING ASSISTANCE IN COMPLETING FAP APPLICATIONS

Drew Memorial Health System
Patient Financial Advocate
778 Scogin Drive
Monticello, AR 71655
870-460-3514
www.drewmemorial.org

Approval Signatures

Step Description	Approver	Date
Final Approval	Jenny Guthrie: Director of Health Information	01/2023
Policy Owner	Monica Linely: Patient Access Representative	01/2023