HONORHEALTH™

Subject: FINANCIAL ASSISTANCE POLICY	
Manual: Finance	Policy # AD1057
Section: Finance	
Distribution: **John C. Lincoln, Deer Valley, Scottsdale Shea, Scottsdale Osborn, Scottsdale Thompson Peak, Greenbaum Specialty Hospital, Sonoran Health and Emergency Center**	Approved by: Board of Directors
Review Dates: 6/1/15, 1/1/16, 1,1,17, 1/1/18, 9,5/18	Effective Date: 6/15/2015

PURPOSE

Ensure a consistent mechanism for the application of Financial Assistance Policy to our uninsured and underinsured customers. The policy provides:

Consistent application throughout HonorHealth hospitals
Compliance with the Internal Revenue Code section 501R for tax exempt status

POLICY

HonorHealth ("Network") is committed to providing the best care possible for all of our patients and assisting each person entrusted to our care to enjoy the fullest gift of health possible. In pursuit of this goal, the Network will provide financial assistance for emergency and other urgent medically necessary hospital care to uninsured and underinsured patients who meet the financial and documentation criteria defined in this Financial Assistance Policy ("Policy"). The Network has a responsibility to operate in a prudent manner that enables it to continue its services; therefore, the Network seeks to objectively evaluate the circumstances of individual patients and responsible parties and to offer free or discounted services where it is needed and appropriate with respect to sound business practices.

This Policy does not apply where the Network has lien rights pursuant to A.R.S. Sections 33-931 – 33-934, meaning if there is a lien settlement the Network will collect lien funds. Each situation will be reviewed independently and allowances will be made for extenuating circumstances based on the following procedure:
Basic Financial Assistance - Uninsured self-attestation <500% of federal poverty guideline – 81% discount
Enhanced Financial Assistance - Uninsured and underinsured demonstrated need offers assistance up to 100% depending upon income or assets noted in Schedule A.

PROCEDURE

A. Definitions
Emergency and Other Medically Necessary Care. Non-elective emergency or other urgent care is limited to care defined as medically necessary according to Arizona State Medicaid guidelines.
Family Income: Total compensation received by all family members age 18 or older living in the same household.
Uninsured: Individuals without health insurance who do not qualify for Medicaid.
Underinsured: Individuals_without an adequate health insurance coverage or who can't afford their liability.

B. Charges for Emergency and Other Medically Necessary Care: No person who is eligible for assistance under this Financial Aid Policy will be charged more for emergency or other medically necessary care than Average Gross Billed "AGB" defined as the average amount paid by insured payers. The Network's AGB percentage is 19% of gross charges and therefore most an individual eligible for financial assistance will pay is 19 % of gross charges. Financial assistance applies to facility charges only. Discounts do not apply to third parties involved in a patient's care. Examples of third parties involved in patient's care include but are not limited to all physicians, Emergency Room Physicians, Pathologists, Radiologists, and Anesthesiologists. Applications received prior to service require Charity Committee approval.

C. Eligibility Criteria for Financial Assistance: In determining whether a patient meets the eligibility criteria for financial assistance, the Network considers the extent to which the person has income or other assets that could be used to satisfy his or her financial obligation. The Network will consider employment status to determine the likelihood of future earnings sufficient to meet the healthcare related obligation within a reasonable period of time (*e.g.*, patient is temporarily unemployed, but when employed can pay obligation). Financial assistance is not available to those who have insurance but choose not to bill it or patients who do not cooperate with insurance procedures. Where a patient does not have assets other than income that can be used to satisfy their Network bill, financial assistance is available as follows:

1. Free Care. A patient will receive a full (100%) discount against gross charges if he or she can demonstrate family income at or below 200% of federal poverty guidelines.

2. Discounted Care. Other financial assistance discounts against gross charges are available at higher income levels and are listed on **Attachment A**. All discounts are subject to the Network's income and asset verification processes and other Network financial assistance eligibility requirements.

3. Financial Assistance Attestation Process: Uninsured only - patients may qualify for a discount based on an attestation process which provides an 81% discount from billed charges. Such self-pay patients may complete an attestation of income and assets in lieu of a full financial assistance application. Additional discounts are available if patient can demonstrate income below the federal poverty limit of 300% as per appendix A.

4. Discretionary Authority, In case of extreme hardship or for compassionate circumstances, the Director of Patient Financial Services ("Director") has discretionary judgment to grant assistance to patients who would not otherwise qualify for financial assistance. In cases where the patient is unable or unwilling to cooperate, or if documentation provided is insufficient to fully evaluate a patient's financial situation, the Director will use best efforts to identify potential needs using credit reports, prior or current AHCCCS enrollment, and other information readily available. In such cases, the Director will have discretionary authority to grant free or discounted care to a patient where the authorized employee is satisfied that the client is unable to pay rather than unwilling to pay his or her financial obligation. The discretionary authority to grant free or discounted care due to extreme hardship or compassionate circumstances is as follows:

5. The Network's use of federal poverty guidelines will be updated annually in conjunction with the federal poverty guidelines published by the United States Department of Health and Human Services.

D. Communication of Financial Assistance Policy: The Hospital will communicate the availability of financial assistance to all patients using languages that are appropriate for the Hospital's service areas. Methods the Hospital uses to communicate the policy include, but are not limited to, the following:

- Signage, information and brochures in appropriate areas of the Hospital
- Plain Language Summary will be posted conspicuously in English and Spanish in Registration areas and will be provided to patients during the billing process.
- Individuals are assigned to explain the Hospital's financial assistance policy
- Hospital statements note financial assistance availability and a phone number to call for information

- Information regarding the availability of financial assistance is posted on the Hospital's website

E. Method of Applying for Financial Assistance. Patients will be encouraged to apply for financial assistance before, during, or within a reasonable time after care is provided.

1. Financial Assistance Application: Patients may apply for financial assistance at the Patient Financial Services office either in person, through a surrogate, through a family member or through another appropriate party. The patient, or his or her surrogate, must provide the Network with financial and other information needed to determine eligibility under this Policy. The Patient must also provide the Network with financial and other information needed and apply for other existing financial resources that may be available to pay for his or her health care. (*e.g.*, Medicare, Medicaid, AHCCCS, third-party liability, etc.). Visits within 6 months of treatment may be covered without having to complete a new financial assistance application pursuant to the discretion of the Director of Patient Financial Services.

2. Notification of Decision: The Network will notify the patient within a reasonable period of time (usually 30 days) after receiving the patient's request for financial assistance and any financial information or other documentation needed to determine eligibility for financial assistance. The Network will also advise the patient of his or her responsibilities under these financial assistance guidelines. When the patient has been approved under the Network's Policy for a discount, the Network will work with the patient or responsible party to establish a reasonable payment plan that takes into account available income and assets, the amount of the discounted bill(s), and any prior payments.

3. Changed Circumstances: In the event they do not initially qualify for financial assistance after providing the requested information and documentation, patients may reapply if there is a change in their income, assets, or family size responsibility. In addition, the discount may be reversed if subsequent findings indicate the information relied upon was in error.

F. Billing and Collections

1. Reasonable Inquiry: The Network will make reasonable efforts to determine whether an individual is eligible for financial assistance before referring the patient to a collection agency. The Network will not pursue legal action for non-payment of bills against financial assistance patients who have clearly demonstrated that they have neither sufficient income nor assets to meet their financial obligations.

2. Collection Methods: However, legal action, including the garnishment of wages, may be taken by the Network to enforce the terms of the payment plan when there is evidence that a financial assistance patient or responsible party has sufficient income or assets to meet his or her obligation or where sufficient evidence to determine income or assets was not provided. The Network will not execute a lien by forcing the sale or foreclosure of a financial assistance patient's primary residence to pay for an outstanding medical bill. The Network will not use body attachment to require the financial assistance patient or responsible party to appear in court. The Network may report financial assistance patients to credit rating agencies when they fail to honor their reduced payment plans and there is evidence that the financial assistance patient has sufficient income or assets to satisfy his or her obligation. The patient is responsible for communicating changes in income that may affect their ability to pay to The Network. The Network will ensure that the guidelines outlined above are followed by any external collection agency engaged to assist in obtaining payment on outstanding bills from financial assistance patients.

G. Patient Responsibilities: To be considered for free or discounted care under the Financial Assistance Policy, a person must:

1. Apply for financial assistance either in person, through a surrogate, family member or other appropriate party. However, a Financial Assistance application does not need to be completed in the following cases.

   - Expired Patients. Expired patients without an estate.

- Homeless Patients. All that is required for homeless cases is a note somewhere in the system referring to the patient's homelessness

- AHCCCS Qualified. Determinations from other agencies (this includes patients who become eligible within 30 days of the date of service). All that is required is documentation from the agency.

- Propensity to Pay. Any account evaluated through a background check and deemed "likely" to qualify for charity based specific credit reporting service algorithm.

- Follow-up Care within 6 Months. Follow-up care on an account approved for charity care within the prior six (6) months. In such cases, all that is required is a note in the system stating that the account is follow-up care to a previously approved account and references that account number.

- Undocumented non-citizen (formerly Section 1011): Any account that would have previously been qualified under Section 1011 eligibility. Documentation will be completed during the admission/patient access process and all accounts appropriately netted.

2. Provide the Network with financial and other information needed to determine eligibility under the Policy.

3. Actively participate with the Network and its representatives to apply for other existing financial resources that may be available to pay for his or her health care. (*e.g.*, Medicare, Medicaid, AHCCCS, third-party liability, etc.) by providing financial and other information needed to the Network, its representatives and governmental agencies. A denial for services rendered by government agencies or third party payers is required for financial assistance to be pursued/approved.

4. Cooperate with the Network to establish a reasonable payment plan, which takes into account available income and assets, the amount of the discounted bill(s), and any prior payments.

5. Make a good faith effort to honor the payment plans for their discounted Network bills.

6. Communicate to the Network any change in their financial situation that may impact their ability to pay their discounted Network bills or to honor the provisions of their payment plans.

H. Financial Recordkeeping

HonorHealth records the value of its financial assistance healthcare services at cost.

As individual patient accounts receivable are determined to meet financial assistance criteria, these individual accounts are written off from receivables and debited against the allowance for financial assistance services (receivables contra account). Documentation concerning the eligibility for financial assistance service is retained in the patient account financial file.

I. Basis for Calculating Amounts Generally Billed "AGB". The Network determines AGB by multiplying the gross charges for any emergency or other medically necessary care it provides to an eligible individual by an AGB percentage of 19%. The Network calculated the AGB percentage of 19% is based on all claims allowed by Medicare and private health insurers over a specified 12-month period, divided by the associated gross charges for those claims. The AGB will be updated annually within 120 days of the last day included in the previous year's calculation.

J. Income Guideline for Patients - determine level of assistance provided (where sufficient assets are not available)

Gross charges owed by Patient	**$101 to $25,000**	**$25,001 to $50,000**	**$50,001 and over**
Income Level			
0-200% FPL	100%	100%	100%
201-300% FPL	85%	85%	85%
301-500% FPL (related to catastrophic care)	81%	81%	81%

Federal Poverty Limits used will be based by annual published poverty guidelines at Health and Human Services website. The website can be found at: https://aspe.hhs.gov/poverty-guidelines

1. Initial applications for financial assistance should be received within 120 days of discharge, however will be considered up to 240 days. We will make every effort to determine if you are eligible for assistance within 30 days of receipt of your application and supporting documentation.

K. Adjustments. Granting of financial assistance is limited to the Network's financial assistance budget in any given year; therefore, HonorHealth reserves the right to modify or adjust this Policy with respect to one or more of its hospitals if in good faith it believes that changed circumstances warrant such an adjustment.

Financial Assistance - Attachment A
2018 AGB Percentage

Minimum Charity Adjustment Based On Look Back

	2016	2017	2018
Basic Financial Assistance	78%	79%	81%
Average Gross Billed (AGB)	22%	21%	19%