



BAPTIST

OPERATIONS POLICY, PROCEDURE, AND GUIDELINE MANUAL

Effective Date: 9/03	HOSPITAL FINANCIAL ASSISTANCE POLICY
Last revision: 8/2004; 5/06, 12/06; 3/08; 4/09; 4/10; 6/14; 8/16; 6/17 Reviewed: 4/11; 9/12; 9/16	
Reference #: S.FI.3025.07	

PURPOSE: To establish a framework for providing financial assistance to qualifying patients with 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 (FPG) 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 determining and administering financial assistance.

SCOPE:

The Baptist Hospital Financial Assistance Policy (FAP) applies to charges for emergency and medically necessary services by BMHCC owned and operated facilities, including all Baptist hospitals, Baptist Hospice, Rural Health Clinics, hospital-based physician clinics and the Oxford Diagnostic Center. Financial assistance for physician professional services not covered under this policy is included in the Baptist Financial Assistance Policy for Professional Services (Pro-FAP). Reference the Baptist website under “Financial Assistance” to view the current list of Hospital FAP, Pro-FAP participating entities, as well as the entities not participating in either program.

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 each hospital facility 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 are 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 the purposes of this policy, 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 Hospital Financial Assistance Program (FAP) – As detailed herein, the Baptist FAP is the program developed to identify and measure the patient’s 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 attempt to 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.

Encounter - An interaction or visit with a care provider. For outpatient treatments, an encounter generally refers to one treatment date or one clinic visit. The exception being series accounts as defined below. If the patient’s “encounter” was an inpatient stay, the encounter charges would include all applicable technical charges incurred during the stay.

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 defined by 501(r) regulations, 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.

Family Unit - A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered to be members of one family. For instance, if an older married couple, their daughter, her husband and two children, plus the older couple's nephew lived in the same house or apartment, they would be considered members of a single family of seven.

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 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 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, any insured patient who has incurred an out of pocket liability for hospital (technical) charges in excess of \$5,000 for a single encounter is deemed medically underinsured and would be eligible for assistance. Patients are not required to complete a financial assistance

application, as this discount provision does not have qualifying family status or income requirements.

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 calculate amount requested from the patient prior to the service. Upfront payments are never requested for any medically necessary emergent care.

Professional Charges – Billing for work performed by physicians, advanced practice providers, suppliers and other non-institutional providers for both outpatient and inpatient services.

Series Account – Accounts that combine multiple encounters of repetitive services on one claim. This claim is generally reflective of charges for a thirty-day period for which services were ordered by the same physician under the same diagnosis set.

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, hospital-based clinics 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 all or any portion of their medical expenses.

POLICY EXCLUSIONS:

Patients are not eligible to apply for assistance under this policy if:

1. The patient has any third-party insurance coverage. The one exception to this exclusion is the provision for medically underinsured patients as detailed below in section “I.”
2. The patient’s primary residence is outside the United States.
3. The patient is in the custody of a correctional facility at the time of service.
4. The patient is eligible for financial assistance under another city, county, state, federal or other assistance program which supersedes this policy.
5. The patient charges resulted from a work-related accident, unless the patient provides proof of no third-party coverage.

6. The patient charges resulted from an auto accident, unless the patient provides proof of no third-party coverage.

The Baptist FAP does not cover charges for:

1. Services furnished by providers who do not participate in either Baptist FAP program. Examples include, but are not limited to the following: outside or specialty laboratory services, radiologists, pathologists, ambulance services, non-participating and/or non-employed physicians, as well as services provided at select facilities that are not fully owned and operated by Baptist. Reference the Baptist website under “Financial Services” to view the current lists of entities that fall under the Hospital FAP, the Pro-FAP and those not participating in either program. Printed copies are for reference only.
2. Special promotion/package priced procedures which have already been discounted or have associated special pricing arrangements.
3. Retail purchases including, but not limited to the following: eyeglasses, contacts, hearing aids, wigs, cosmetic goods and any items in which sales tax is applied or is appropriate.
4. Cosmetic procedures performed purely for the purpose of enhancing one's appearance.
5. The following transplant and major organ surgeries: kidney, liver, heart, lung, stem cell, pancreas and intestines.
6. The following procedures: 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. Financial Assistance for the Medically Underinsured

- A. Verify that the patient has insurance coverage.
- B. Verify insurance(s) have been billed and all appropriate payments have been received.
- C. Determine if the patient meets the medically underinsured requirements.
 1. Patients with insurance will be deemed medically underinsured when their out of pocket liability for in a single encounter (after all insurance payments and allowances are applied) is in excess of \$5,000.
 2. Medically underinsured patients are automatically eligible for a 25% discount off the patient liability greater than \$5,000.

- a) Mother and newborn accounts are to be combined when applying this discount.
 - b) Hospital series accounts as defined above are also considered one encounter when applying this discount.
3. Patients can contact the business office at the facility where their services occurred if they qualify or if they have questions about 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 is eligible for any federal, state or local assistance programs.
 2. If the patient is qualifies for financial assistance under the 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 are 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 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. Church Health Provision – Church Health is a health care ministry in Shelby County. Baptist has established partnerships and sponsorships with Church Health which unite our missions of providing quality health care to this community. Church Health completes their financial needs assessment for program enrollment based on the same tenets included herein.
 1. The Church Health progress was initially reviewed by Baptist Corporate Audit and Consulting Services in June 2017. Results of which concluded the variances in the Church Health patient approval and evaluation methodologies are not material and reasonably aligned with the Baptist FAP. Audit agreed that it was reasonable to recommended reliance on their approval process and correlation of discount percentages, when appropriate.
 2. Therefore, our financial assistance determination process for patients referred by Church Health will allow for expediting the approval process -

reducing duplication, enhancing efficiency, as well as improving patient convenience.

C. 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 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 are 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.
 - e) In addition, Baptist will provide all of the FAP-related documents electronically to any individual who indicates that is their preference.
2. All patients are 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 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 or for emergent, medically necessary services during the approval period.

The provision applying the discount to additional, qualified hospital accounts will be limited by the service dates (not older than 240 days) and/or it does not cover dates of service prior to August 31, 2017. Prior dates of service are covered under the previous policy for the applicable hospital.

- 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.
- d) For any FAP-eligible accounts, 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.
- e) Eligibility for the Baptist FAP is to be reassessed every ninety days. The process to reapply is the same as the initial process; an application and the updated financial information shall be submitted to the Business Office at the facility where services were received.

D. Process the Financial Assistance Application.

- 1. When the Financial Assistance Application and supporting documentation is received within the Application Period, it will be reviewed to determine the appropriate discount. Financial information requirements are detailed below.
- 2. The review for FAP eligibility will be completed within thirty days.
- 3. Once the eligibility determination has been made, a letter will be sent to the patient advising them of the decision.
- 4. For patients who are FAP eligible, the approval letter will indicate the discount percentage granted and how much the patient owes after the discount has been applied. This letter will also include contact information for assistance with patient questions regarding the approval process or payment arrangements.
- 5. 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 include contact

information for assistance with patient 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.
6. For patients who are deemed ineligible for any further discounts identified in this policy, their denial letter will also include the contact information for assistance with patient 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 ninety days or if they have experienced a material change in family or income status.
7. 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.

E. 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 supporting financial 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, her husband and two children, plus the older couple's nephew 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 is 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 and/or federal, state or governmental court documents establishing residency.

2. Determine the total gross income for the patient's family unit.

- a) Money income including: 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 included in the income calculation.
 - 2. Court-ordered and state or federally issued assistance related to a minor is included in the income calculation.
- 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 Forms for the previous year
 - 4. State/Federal assistance documents

5. Bank statements for the last three months
 6. Pension/retirement statements
 7. Legal documents including divorce decree and/or child support and alimony
- 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. A copy of the discount table is available from the Business Office where services were received.
- a) 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

- b) The income levels in this table are the levels established as the FPG. 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>.
- c) The Baptist discount tables will be updated with the new AGB calculations and current FPG income thresholds annually by the Baptist Vice-President of the Revenue Cycle.
4. Applying the 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 pursuant to a personal injury claim related to the services in question and/or verification that requested information was intentionally falsified.

III. Billing and Collections

- A. Actions that may taken 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 business 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.
- Federal Register Poverty Guidelines.
- Internal Revenue Service Code Section 501(r).