BAPTIST

OPERATIONS POLICY, PROCEDURE, AND GUIDELINE MANUAL

Effective Date: 8/17	**FINANCIAL ASSISTANCE POLICY FOR PROFESSIONAL SERVICES**
Reference #: S.FI.3075	

PURPOSE: To establish a framework and process 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. As a service to our community, Baptist offers financial assistance to our patients for 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 for professional services.

SCOPE:

The Baptist Financial Assistance Policy for Professional Services (Pro-FAP) applies to patient charges for professional services completed by Baptist Medical Group (BMG) and Medical Foundation of Central Mississippi's (MFCM) physician and non-physician providers, clinics and foundations and/or other services and procedures billed using a Form CMS-1500. This policy also includes services and charges by or at Baptist Home Medical Equipment, Baptist Minor Medical Group and Mid-South Minimally Invasive Surgery.

Professional services completed at hospital-based facilities (for example, a rural health clinic or a hospital-based cancer clinic) and billed on Form CMS-UB04 are excluded from this policy, as they are included in the Baptist Hospital Financial Assistance Policy (Hosp-FAP). Reference the Baptist website under "Financial Assistance" to view the current list of Pro-FAP and Hosp-FAP participating entities, as well as the entities not participating in either program.

DEFINITIONS:

Application Period - The period of time a patient has to submit a completed financial assistance application. For purposes of this policy, the patient has 10 days from the date of the first billing statement to submit a completed application and all required, supporting documentation.

Baptist FAP for Professional Services - As detailed herein, the Pro-FAP is the program developed to extend financial assistance benefits to patients with charges from qualifying professional services. The intent of this policy is to identify and measure the patients' eligibility for discounted financial assistance and to outline the practice for distributing funds in a consistent and efficient manner.

Discount **-** To decrease and/or make allowance. 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. If the patient's "encounter" is an inpatient stay, encounter charges would include all applicable professional services incurred during the stay.

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 Baptist Pro-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 professional charges in excess of $2,500 for a single encounter is deemed medically underinsured and would be eligible for assistance under this policy provision. 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 does not have a reimbursement contract with the insurance company and the beneficiary's plan does not include Baptist in their provider network.

Professional Charges - Billing for work performed by physicians, advanced practice providers, suppliers and other non-institutional providers for both 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 Pro-FAP does not cover charges for:

1. Services received at a hospital-based facility or in hospital-based clinic areas. Patients can apply for financial assistance for these services under the Hospital FAP.

2. 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 current lists of entities that fall under the Pro-FAP, the Hosp-FAP and those not participating in either program. Printed copies are for reference only.

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

4. 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.

5. Wellness services including, but not limited to the following: annual physicals, immunizations, flu shots, screenings, nutrition counseling and fitness programs.

6. Cosmetic procedures performed purely for the purpose of enhancing one's appearance.

7. Professional services relating to any of the following procedures: transplant and major organ surgeries, left ventricular assist device (LVAD) and related procedures, extracorporeal membrane oxygenation (ECMO), 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 insurances have been billed and all appropriate payments have been received.

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

1. Patients with insurance are 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 $2,500.

2. Medically underinsured patients are automatically eligible for a 25% discount off the patient liability greater than $2,500.

a) Example #1 - a patient has two bills for physician services. The total patient liability for the two bills is $9,900.

- One bill is from a hospital encounter. The patient's out of pocket liability for this account is $7,500. The medically underinsured discount will be $1,250 [($7,500-2,500=5,000); (5,000*.25)] and the adjusted patient liability on this account is $6,250 [$7,500-1,250].
- The second bill was for an outpatient procedure completed on a different date of service. The patient's out of pocket liability is $2,400. Since the total is not greater than $2,500, the patient would not be eligible for a medically underinsured discount on this account.
- The adjusted patient balance due for these two accounts is $8,650 [$6,250+2400].

b) Example #2 - a patient has two bills for physician services. The patient liability for the two bills is $9,900.

- The bills were from two different BMG physician groups for services received during one inpatient hospital encounter.
- The medically underinsured discount is $1,850 [($9,900-2500=7,400); (7,400*.25)].
- The adjusted patient balance due for these two accounts is $8,050 [$9,900-1,850].

D. Apply the discount.

1. The business office for each clinic group will apply the discount to the appropriate patient accounts.
2. 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.

B. Application requirements.

1. Uninsured patients applying for the Baptist Pro-FAP must request an application from the clinic, foundation or entity where services were received.
2. The completed application and all supporting documents must be returned to the address on the application within 10 business days from the date of the first billing statement.
3. If a patient's Pro-FAP eligibility status has been determined in the previous ninety days, the patient does not need to reapply.

4. If the patient's Hosp-FAP eligibility has been determined in the previous ninety days, the patient does not need to reapply. In this instance, patients shall notify the clinic, foundation or entity's staff of their approval status.

C. Process the Financial Assistance Application.

1. When the completed Financial Assistance Application and the required supporting documentation are submitted within the application period, documentation will be reviewed to determine the appropriate discount. Financial information requirements are detailed below.

2. The review for Pro-FAP eligibility will be completed within thirty days.

D. Determine the uninsured discount percentage.

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

- 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.

- Minor children's earned wages are not included in the income calculation.
- 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. Pro-FAP discount percentages are determined by referencing the family unit and the total family income in the appropriate Baptist Pro-FAP Discount Table. A copy of the discount table is available from the Business Office where services were received.

4. This table summarizes the Baptist Pro-FAP discounts by FPG level:

Baptist Pro-FAP Discount Summary	
FPG Income Range	**Discount**
≤ 100%	100%
101 - 175%	75%

176 - 200%	50%
201 - 400%	25%
> 400%	No discount

a) The income levels in this table are the levels established by 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.

b) The Baptist discount tables are updated with the new the AGB calculations and current FPG income thresholds annually by the Vice-President of the Revenue Cycle.

5. Documentation for tasks explained above in steps C and D shall to be entered into the BOC patient account notes.

E. Apply the Baptist Pro-FAP Discount.

1. Once the Baptist Pro-FAP discount determination has been made, a letter will be sent to the patient

a) For patients who are Pro-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 include the contact information for assistance with patient questions regarding the approval process or payment arrangements.

b) For patients deemed ineligible for Pro-FAP assistance, their denial letter will also include contact information for assistance with patient questions regarding the approval process or payment arrangements.

2. Patients are able to reapply for Baptist Pro-FAP after ninety days or if they have experienced a material change in family or income status.

3. The key factors in applying the Pro-FAP discount percentage are the types of services received and the date the initial discount was approved.

a) The approved discount will be applied to covered charges from qualified services billed on the account for which the application was submitted. Covered charges are medically necessary services that are not listed above as a Policy Exclusion.

- For visits after the Pro-FAP discount approval date, all covered charges for qualified services by eligible providers

for a period of ninety days (from the approval date) will be adjusted by the approved discount percentage.

- For visits before the Pro-FAP discount approval date, only covered charges for qualified services by eligible providers occurring on a service date within the application period (10 days from the first post-discharge bill of the account for which the application was processed and approved) are eligible to be discounted.

b) Eligibility for the Baptist FAP will be reassessed every ninety days. The application process to reapply is the same as the initial process; the application and updated financial information are submitted to the Business Office at the facility where services were received.

c) After the discount has been applied to the Pro-FAP-eligible encounters, the amount the patient is personally responsible for paying will be reduced by any amounts already paid. Net overpayments will be applied to any open account balances. After which, if the balance is $5 or more, it will be refunded to the patient.

d) 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. External References

- Tennessee Code Title 68 - Health, Safety and Environmental Protection Health § 68-1-109 and § 68-11-262, 268.
- Federal Register Poverty Guidelines.