Subject	No.	Page
FINANCIAL ASSISTANCE POLICY	000 - 0000	Page 1 of 7
Author	**POLICY MANUAL:**	Effective Date
CHIEF FINANCIAL OFFICER	**ADMINISTRATIVE**	07/01/2017

I. PURPOSE

The purpose of this policy is to define the eligibility criteria and application process for financial assistance for patients who receive emergency or medically necessary healthcare services at University Medical Center Inc., *dba* University of Louisville Hospital (ULH) and James Graham Brown Cancer Center (JGBCC) and who are uninsured, underinsured, ineligible for any government healthcare benefit program, or unable to pay for their care based upon a determination of financial need in accordance with this policy. ULH/JGBCC also seek to describe the types of financial assistance available and ensure patients have access to information about these programs. Lastly, pursuant to Internal Revenue Code (IRC) section 501(r), to remain tax exempt, ULH/JGBCC is required to establish a written Financial Assistance Policy (FAP) and an Emergency Medicine Policy, which applies to all emergency or medically necessary services provided in the facility; this policy is intended to satisfy the FAP requirement.

II. POLICY

A. ULH/JGBCC is committed to providing financial assistance in the form of charity care (also referred to in this policy as “Financial Assistance”) to uninsured and underinsured individuals who seek and obtain emergency or medically necessary healthcare services from ULH/JGBCC but are not able to meet their payment obligations to ULH/JGBCC without assistance. ULH/JGBCC desire to provide this assistance in a manner that addresses patients’ individual financial situations; satisfies the hospital’s not-for-profit and teaching missions; and meets its strategic, operational, and financial goals.

B. Financial Assistance is not to be considered a substitute for personal responsibility. Patients are expected to cooperate with ULH/JGBCC’s Financial Assistance requirements and to contribute to the cost of their care based on their individual ability to pay.

C. This written policy:

1. Includes eligibility criteria for Financial Assistance.
2. Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this policy.
3. Describes the method by which patients may apply for Financial Assistance.
4. Establishes a methodology for determining amounts generally billed as required under IRC section 501(r).
5. Describes the methods used to widely publicize the policy within the communities served by ULH/JGBCC.

III. DEFINITIONS

- **Amounts Generally Billed (AGB):** The AGB for healthcare services to individuals who have insurance covering such care. The hospital determines AGB using the Medicare Prospective Payment System method. However, only patients eligible for Financial Assistance will be extended free care under this policy. Thus, no FAP-eligible individual will be charged more than AGB for healthcare services. Therefore, it is not considered necessary to take additional measures to determine if a patient is responsible for more than AGB for healthcare services.
- **Application Period:** The time provided to patients by ULH/JGBCC to complete the Financial Assistance application (FAA). It begins on the first day care is provided and ends on the 240th day after ULH/JGBCC provides the individual with the first post-discharge billing statement for the care provided.
- **Charity Care:** Healthcare services that have been or will be provided but are not expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.
- **Community Needs Assessment:** Conducted by the hospital at least once every three years pursuant to IRC section 501 (r)(1)(A), including applying any changes necessary that are identified through this assessment.
- **Eligibility Qualification Period:** After submitting the FAA and supporting documents, patients deemed eligible shall be granted Financial Assistance prospectively for a period of six months from the determination date. Financial Assistance will also be applied to all eligible accounts incurred for services received six months prior to the determination date. If eligibility is approved based on presumptive eligibility criteria, Financial Assistance will be applied to all eligible accounts incurred for services received six months prior to the determination date.
- **Emergency Medical Condition:** As defined within section 1867 of the Social Security Act (42 U.S. Code [USC] 1395dd).
- **Essential Living Expenses:** Expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and phone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.
- **Family:** Using the Census Bureau definition, a group of two or more people who reside together and are related by birth, marriage, or adoption. Per Internal Revenue Service (IRS) rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of Financial Assistance.
- **Family Assets and Other Resources:** Include cash and noncash assets, such as the following:
  - Cash in bank accounts, such as checking accounts, savings accounts, money market accounts, and CDs
  - Investment accounts, including stocks, bonds, and retirement accounts
  - Equity in real estate and personal property, such as homes and automobiles

- **Family Income:** Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
  - Includes 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
  - Excludes noncash benefits (such as food stamps and housing subsidies)
  - Is determined on a before-tax basis
  - Excludes capital gains or losses
  - If a person lives with a family, includes the income of all family members (nonrelatives, such as housemates, do not count)
- **Federal Poverty Guidelines:** Are updated annually in the Federal Register by the U.S. Department of Health & Human Services under the authority of subsection (2) of 42 USC 9902. Current guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines.
- **High Medical Costs:** Annual out-of-pocket costs incurred by the patient with ULH/JGBCC that exceed 10% of the family's income during the last 12 months or annual out-of-pocket expenses incurred with any provider that exceed 10% of the family's income during the last 12 months.
- **Medically Necessary:** A healthcare service, including emergency care, which, in the opinion of a ULH/JGBCC treating physician, is a service, item, procedure or level of care that:
  - Is necessary for the proper treatment or management of the patient's illness, injury, or disability.
  - Is reasonably expected to prevent the onset of an illness, condition, injury, or disability or is routine, generally accepted preventive care.
  - Is reasonably expected to reduce or ameliorate the physical, mental, or developmental effects of the patient's illness, condition, injury, or disability.
  - Will assist the patient to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the patient and those functional capacities that are appropriate for the patient's age.
- **Self-Pay:** Patients who do not have third-party coverage from a health insurer, healthcare service plan, Medicare, or Medicaid and patients who do not have an injury that is compensable through workers' compensation, automobile insurance, or other insurance. "Self-pay" does not refer to patients who have third-party coverage but refuse to use it.
- **Underinsured:** Patients who have some level of insurance or third-party assistance but still have out-of-pocket expenses that exceed their financial abilities.
- **Uninsured:** Patients who have no level of insurance or third-party assistance to aid with meeting their payment obligations.

IV. PROCEDURE

A. All patients must fill out an FAA to be considered for Financial Assistance, unless they are eligible for Presumptive Financial Assistance.

B. Applications must be received within 240 days after the patient has received their first post-discharge statement.

C. The following criteria must be met for a patient to qualify for Financial Assistance:

- The patient is being seen for emergency or medical necessary services.
- The patient is not eligible for Medicaid, Medicare (including patients who may be "pending" approval for these programs), or any other government healthcare benefit program.
- The patient is uninsured or underinsured.
- The patient/guarantor is unable to pay for services provided.
- The patient/guarantor is unable to accept an installment payment arrangement.
- The patient has a minimum account balance of $35.00. Multiple accounts may be combined to reach this amount. Patients with balances below this amount will be eligible for establishment of a payment plan.

D. Services rendered to patients who are eligible but have not applied for medical insurance or assistance programs sponsored by federal, state, or local government are excluded from this policy.

E. Patients who identify themselves or are identified by facility staff (e.g., medical or nonmedical staff, including physicians, nurses, financial counselors, social workers, case managers, and chaplains) to be considered for financial hardship or charity care will be required to submit a completed application and additional information, which may include the following:

- IRS Form 4506-T (Request for Transcript of Tax Return) or a copy of the individual's most recently filed federal tax return
- Two most recent paycheck stubs (if employed)

Additional information may be requested from the applicant if needed to clarify information provided in the application and/or tax returns, such as copies of bank account statements, unemployment check documentation, Social Security check documentation, rental property documentation, mortgage statements, and real estate tax assessments.

F. ULH/JGBCC may, at its discretion, rely on evidence of eligibility other than that described in the FAA or herein. Other evidentiary sources may include:

- External publicly available data sources that provide information on a patient's/guarantor's ability to pay.
- A review of the patient's outstanding accounts for prior services rendered and the patient's/guarantor's payment history.

- Prior determination of the patient's/guarantor's eligibility for assistance under this policy, if any.
- Evidence obtained through exploration of appropriate alternative sources of payment and coverage from public and private payment programs.

G. Services eligible under this policy will be made available to the patient in accordance with financial need determined utilizing calculations based upon the federal poverty levels in effect at the time of the determination. The levels are as follows:

1. Patients whose family income is at or below 300% of the federal poverty level are eligible to receive full Financial Assistance.

   ULH/JGBCC patients whose family income is above 300% of the federal poverty level are not eligible to receive Financial Assistance or discounted care under this policy.

2020 Annual U.S. Federal Poverty Levels		
Family Size	**100%**	**300%**
1	$12,760	$38,280
2	$17,240	$51,720
3	$21,720	$65,160
4	$28,200	$84,600
5	$30,680	$92,040
6	$35,160	$105,480
7	$39,640	$118,920
8	$44,120	$132,360

H. Patients who have been treated and released from the Emergency Room may be assumed to qualify for financial hardship at the sole option of ULH/JGBCC if they reside in a zip code where the average household income does not exceed 300% of the federal poverty level.

I. Only emergency and/or medically necessary, nonelective services are eligible for a discount under this policy. Patients must also have been denied Medicaid or otherwise be known to not qualify for state, local, or federal medical assistance programs before the FAP will be applied to their account. This policy applies only to services provided by ULH/JGBCC.

J. Once a patient has been determined by ULH/JGBCC to be eligible for Financial Assistance, and for the period in which the patient remains eligible under this policy, the patient shall not receive any bills or statements.

K. Unless an applicant is informed otherwise, Financial Assistance provided under this policy will be valid for six months beginning on the first day of the month of the determination and will also apply to any qualifying services rendered six months prior to qualifying. ULH/JGBCC

reserves the right to reevaluate an applicant's eligibility for Financial Assistance during that period, if any change to the applicant's financial status is identified.

L. An applicant who is not granted Financial Assistance under this policy may be offered a no-interest, extended payment plan with terms negotiated by ULH/JGBCC and the applicant based on the applicant's financial circumstances, medical costs, and other relevant factors. Individuals with questions regarding payment plan options may contact a ULH/JGBCC financial counselor.

V. PRESUMPTIVE FINANCIAL ASSISTANCE

A. ULH/JGBCC recognize that not all patients and guarantors are able to complete the FAA or provide the requisite documentation. Financial counselors are available to assist any individual seeking application assistance. For patients and guarantors who are unable to provide the required documentation, ULH/JGBCC may grant presumptive Financial Assistance based on information obtained from other resources.

B. Presumptive eligibility may be determined based on the following:

- Recipient of state-funded prescription programs
- Homeless or one who received care from a homeless clinic
- Participant in Women, Infants, and Children programs
- Eligible for food stamps
- Eligible for subsidized school lunch program
- Eligible for other state or local assistance programs (e.g., Medicaid spenddown)
- Low-income/subsidized housing is provided as a valid address
- Deceased with no known estate

C. If the patient is determined to be presumptively eligible, they will be granted Financial Assistance for a period of six months ending on the date of presumptive eligibility determination. Financial Assistance will be applied to all eligible accounts incurred for services received six months prior to the determination date. The presumptively eligible individual will not receive Financial Assistance for emergency or medically necessary services rendered after the date of determination without completion of a new FAA or a new determination of presumptive eligibility.

VI. NOTIFICATION

A. Once a patient or their guarantor is deemed eligible for Financial Assistance, any open or unpaid account for services with ULH/JGBCC that fall within the eligibility qualification period will be reviewed to determine if the services are applicable for this eligibility period.

B. Business office staff will review the submitted documentation to determine if the patient is eligible for Financial Assistance.

C. Patients/guarantors will be notified within 30 days from the date of receipt of the completed application and required documentation.

D. Patient Financial Services staff will apply applicable discounts to patient accounts that fall within the eligibility qualification period. In addition, they will scan all documentation into the patient account(s) with appropriate documentation to ensure Financial Assistance remains in place over the subsequent six months.

E. Patients who do not qualify for Financial Assistance may request a review of their application if there is a significant change in their financial status.

Revised Date: 2020 Poverty guidelines updated from Federal Register 1/15/2020

References:

1. Healthcare Financial Management Association Patient Friendly Billing Project, 2005.
2. Patient Protection and Affordable Care Act, Public Law 111–148, section 9007(a) (creates a new section 501(r) of the IRC).
3. Notice 2010-39, 2010 IRB 24.
4. Section 1867 of the Social Security Act (42 USC 1395dd).
5. U.S. Department of Health & Human Services Federal Register under the authority of subsection (2) of 42 USC 9902.