# Patient Financial Assistance Policy

**PURPOSE:**

To define the eligibility, application and approval processes for Financial Assistance. Financial Assistance is offered to uninsured patients and patients who indicate an inability to pay for emergency and other medically necessary care provided at Regional One Health.

**DEFINITIONS:**

**Amounts Generally Billed (AGB):** The amount generally billed to a Regional One Health patient who has insurance coverage as defined in IRS Code of Regulations Section 1.501.(r)-1(b).

**Application Process:** A process by which a patient or their appropriate representative completes a paper or electronic form that provides Regional One Health with information on the patient's income and family size. All applications will be evaluated on a case-by-case basis by appropriate Regional One Health representatives taking into consideration medical condition, employment status, and potential future earnings.

**Eligible Health Care Services:** Services which are emergent and other medically necessary care. Eligible health care services exclude:

- Charges disallowed through utilization reviews or denials
- Any contractual allowances
- Cosmetic services or elective services that are not medically necessary
- Write-offs of amount due from third party payers
- Shortfall between reimbursement from government programs for the uninsured and the cost of services provided
- Write-offs of patients' balances when there is not an indication that the patient is unable to pay

**Extraordinary Collection Actions (ECA):** Actions which require a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. Regional One Health will determine charity eligibility prior to taking any extraordinary collection action. Written notice must be provided at least 30 days in advance of initiating specific ECAs and meet informational requirements. As defined under IRS Codes Section 501 (r), such actions that require legal or judicial process include:

- Attachment or seizure of a bank account or other personal property
- Commencement of a civil action against an individual
- Wage garnishment

**Family:** The patient, the patient's spouse (regardless of whether s/he lives in the home) and all of the patient's children (natural or adoptive) under the age of eighteen (18) who live at home. If the patient is under the age of 18, "Family" includes the patient, his or her natural or adoptive parents (regardless of

whether they live in the home), and the parent's other children (natural or adoptive) under the age of 18.

**Family Assistance or Financial Assistance Discounts:** Discounts or elimination of amounts for Eligible Health Care Services provided to eligible patients with documented and verified financial need.

**Financial Counselor:** Regional One Health representatives responsible for assessing a patient's liability, identifying and assisting with public funding options (Medicare, Medicaid, etc.), determining if patient is eligible for financial assistance, and establishing payment plans.

**Federal Poverty Guidelines (FPG):** Federal poverty guidelines published annually by the U.S. Department of Health and Human Services and in effect at the date(s) of service for which financial assistance may be available.

**Look-Back Method:** The methodology specified by IRS Code of Regulations Section 1.501(r)-5(b)(1) and selected by Regional One Health to determine Amounts Generally Billed (AGB) which uses allowed amounts from Medicare or a combination of Medicare, Medicaid and commercial insurer payments.

**Medically Necessary Care:** Care which is called for according to generally accepted standards of medicine in the community or to a treating physician's determination.

**Screening Process:** A process to determine if a patient qualifies for financial assistance that does not involve completing a financial assistance application. The screening process may be in person or on the telephone and utilizes a third party vendor.

**Uninsured Discount:** A discount on charges for medical services for patients identified by Regional One Health as having no insurance coverage. The uninsured discount amount is the lesser of the amount as determined by the Look-Back Method or the method defined by the *Uninsured Patients* law set forth in the Tennessee Code Section 68-11-262. The uninsured discount amount is available by visiting the Patient Financial Services Department or by calling Patient Financial Services at 901-545-6644.

## POLICY:

Regional One Health is committed to providing Eligible Health Care Services regardless of a patient's ability to pay. Additionally, Regional One Health is committed to providing a fair discount to uninsured patients. Patients who meet the criteria set forth in this Policy will be eligible for Financial Assistance for amounts owed for Eligible Health Care Services.

Patients are informed of Regional One Health's Financial Assistance Policy primarily through the Regional One Health website at www.regionalonehealth.org, Financial Counselors, patient financial service representatives, signage, and brochures distributed in Regional One Health clinics and upon inpatient admission. The website information is listed on all billing statements with a link to a plain language summary of this Policy. These communications are available in English and Spanish. For patients without internet access, this Policy is available as disclosed via a phone call to Regional One Health Patient Financial Services at 901-545-6644.

This Policy establishes three types of Financial Assistance: (i) Financial Assistance based on a patient's income, (ii) Financial Assistance based on the amount of the patient's medical expenses; or (iii) Financial Assistance based on the patient's status of being uninsured.

**Eligibility Criteria and Financial Assistance Available Based on Patient's Income**

The eligibility criteria for Financial Assistance based on a patient's income will be based on the annual adjusted gross income of the patient (or patient's household if filing taxes jointly) for the current or prior year. To meet the eligibility criteria for this type of Financial Assistance, the adjusted gross income of the patient (or the patient's household if filing taxes jointly) for the current or prior year may not exceed 2.0 times the Federal Poverty Guideline (FPG). For patients with adjusted gross income of less than or equal to 3 times the FPG, a 100% Financial Assistance Discount will be applied after a required payment of $25 is met (see chart below). This type of Financial Assistance is only available for Eligible Health Care Services.

| Patient's Income | Amount of Financial Assistance |
|---|---|
| At or below 300% of the FPG | Patient is eligible for 100% Financial Assistance after a $25 payment is met. |

**Eligibility Criteria and Financial Assistance Available Based on Patient's Medical Expenses**

The eligibility criteria for Financial Assistance based on a patient's medical expenses is as follows: if the patient can demonstrate that their Family's total medical expenses at Regional One Health exceed the Family's total income for the prior 12 month period, a 100% Financial Assistance Discount will be applied after a required payment of $25 is met (see chart below). This type of Financial Assistance is only available for Eligible Health Care Services.

| Annual Household Income | Amount of Financial Assistance |
|---|---|
| The patient's Family income for the prior 12 months period is less than the total amount of the Family's total medical expenses | Patient is eligible for 100% Financial Assistance after a required payment of $25 is met. |

**Eligibility Criteria and Financial Assistance Available for Uninsured Individuals**

All uninsured patients, as determined by Regional One Health, will be provided an Uninsured Discount prior to the first billing statement. In accordance with the Tennessee regulations, uninsured patients are not to pay for services in an amount that exceeds one hundred seventy-five percent (175%) of the cost for the services provided (calculated using the cost to charge ratio in the most recent State of Tennessee joint annual report).

Regional One Health staff shall be responsible for verifying Uninsured Discount eligibility, working with the patient to determine ability to pay, and connecting the patient with the appropriate resources that will ensure timely care and facilitate the liability evaluation and resolution process for the patient. Only Eligible Health Care Services will be considered for an Uninsured Discount.

**Basis for Calculating Patient Charges**

Regional One Health uses the Look Back Method in determining the Amounts Generally Billed (AGB) for services provided to Regional One Health patients.

AGB is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charges for those claims. AGB% = Sum of Claims Allowed Amount $/Sum of Gross Charges $ for those claims Allowed Amount = Total Charges less Contractual Adjustments. If no contractual adjustment is posted then total charges equals the allowed amount. Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

-Look Back Method is used. A twelve (12) month period is used.

- Includes Medicare Fee for Service, Medicaid and commercial payers.

On an annual bases the AGB is calculated, and is available by visiting the Patient Financial Services Department or by calling Patient Financial Services at 901-545-6644.

**Method for applying for Financial Assistance**

Financial Assistance applications can be obtained at www.regionalonehealth.org, by calling the Patient Financial Services Department at 901-545-6644 or contacting any Regional One Health Financial Counselor.

Patients will have one hundred twenty (120) days from the date of the first "post discharge" billing statement to complete the Application Process or Screening Process before any Extraordinary Collection Actions are taken by Regional One Health. If the patient begins the Application Process or Screening Process during the 120 day period but cannot complete this Application Process, the patient will be provided at least another 120 days after the date of application to complete the Application Process before Extraordinary Collection Actions are taken by Regional One Health or entity contracted by Regional One Health.

To apply for Financial Assistance a formal application may not be required. There are informational questions that a patient will need to answer for Regional One Health to complete the determination for Financial Assistance. If a formal application is required, proof of Family income must be provided by means of Forms W-2, year-to-date pay information from employer, federal or state assistance award letters, an income statement from accountant, food stamp letter or other third-party documentation.

Financial Assistance applications should be submitted to Regional One Health Patient Financial Services Department at 877 Jefferson, Memphis, TN 38103. The Patient Financial Services Department will begin processing a patient's application when it is complete. Determinations of eligibility are normally completed within thirty (30) business days after receipt of the completed application.

For Pharmacy Medication Assistance Program, you may bring or fax your completed forms to Regional One Health Pharmacy:

- 880 Madison Ave Phone: 901-545-7970 Fax: 901-545-7557
- 6555 Quince Rd Phone: 901-515-5656 Fax: 901-515-5658
- 1977 S. Third St. Phone: 901-515-4646 Fax: 901-515-5649
- 3901 Walnut Grove Rd Phone: 901-515-3434 Fax: 901-515-3439

**Actions that may be taken in the event of nonpayment**

Patients will receive monthly bill(s) for amounts greater than $50 that Regional One Health determines are their responsibility, after any insurance plan payments have been applied.

Patients will be contacted via billing statements or by phone calls during a one hundred twenty (120) day period reminding them of their bill(s). During this period, patients will be expected to pay their bill(s) in full, establish a payment plan, or apply for Financial Assistance.

Regional One Health strives to assist all patients prior to enlisting the assistance of a collection agency. In select cases, Regional One Health may choose to engage an attorney in a collection action. This step would occur only after Regional One Health has thoroughly reviewed the patient's account and determined the patient is not eligible for Financial Assistance.

**Eligibility information obtained from other sources**

Regional One Health understands that certain patients may be unable to complete a financial assistance application, comply with documentation requirements, or are otherwise non-responsive to the application process.

There is often information available from other sources to consider for charity care determinations. Presumptive eligibility may be determined on the basis of individual socio-economic factors that include but are not limited to the following:

- Patient resides in a Homeless Shelter, Halfway House or Recovery Center
- Patient receives SNAP Benefits (Food Stamps)
- Patient is eligible or retro-actively eligible for Medicaid.
- Patient resides in a Homeless Shelter, Halfway House or Recovery Center
- Patient resides in Section 8 Housing as a verified address.
- Patient is Deceased with no known estate

If patient submits a complete Financial Assistance application and is determined to be eligible, Regional One Health will refund any amounts the patient has paid for Eligible Health Care Services that exceed the amount they are determined to be personally responsible for paying.