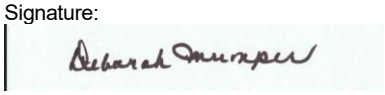
Policy Name: **Financial Assistance Policy**	Originator: **VP Revenue Cycle**	Origination Date: **07/12/2023**
Policy Section: **Revenue Cycle POD**		
Approved By: **Nicole Clawson, VP Revenue Cycle**	Signature: 	Revised Date:
Revised By: **Deb Mumper, Dir. Patient Access**	Signature: 	**08/25/14, 7/27/15, 03/28/17, 04/16/17, 9/15/17, 1/22/18, 2/15/18, 2/12/19,05/29/20, 06/25/20,02/25/21, 2/22, 1/19/23, 1/17/24, 3/5/24, 06/11/24, 6/24/24, 8/26/24, 4/24/25**
Note: The Financial Assistance Policy has historically been an inclusive part of the Patient Financial Obligations Policy. As of 6/11/24 it is a standalone policy.		

Policy: As a benefit and obligation to the community, the hospital recognizes its responsibility to provide medically necessary services and to provide financial assistance to patients paying for those services. As important, is the hospital's financial ability to provide future community benefits which necessitates that those with the ability to pay are required to do so and may be pursued to the fullest extent available within the laws of the Commonwealth of Pennsylvania governing debt collection. This policy will comply with all requirements of the IRS of a non-profit organization, and all other regulations, such as EMTALA, that relate to the provision of service. No one will be denied access to services due to inability to pay. There is a discounted /sliding fee schedule available based on family size and income (Appendix A).

Purpose: To provide a continuum of financial assistance/requirements across the entire patient experience, at all service entry/delivery points, that define the patient's financial obligations, provides the methodology for assistance, the available forms of assistance, and the processes to assist in the communication and understanding of the same by all involved.

Definitions:

Financial Assistance – Includes all forms of financial help for payment/resolution of patient liable balances including full or graduated reductions in liable balance or all payment arrangements.

Financial Liability - the amount calculated to reflect liability assigned to the patient. This may include full charges, discounted services after an appropriate approved self pay discount is applied, or balance after patient's insurance has processed a claim. This may include unmet deductible, coinsurance, and copay assigned by the insurance carrier and is the patient's or guarantor's responsibility.

Pre-collect Amount – the amount of the patient liability that a hospital may require a patient to pay in advance of elective, non-emergent services. This will be determined by each individual POD hospital.

Hospital – "Hospital" referenced in this document refers to all entities and lines of business where patient care is provided under the hospital's tax ID, including outpatient clinics, physician offices, and urgent care centers.

Medically Necessary Services – Services provided that are supported by patient diagnoses that meet the current definitions as defined by Medicare and other accepted criteria used by the

hospital. Services not meeting this definition include personal cosmetic and other services not required to treat a medical condition.

Emergency Care – Care provided in the section of the hospital designated as Emergency Room and/or those areas subject to EMTALA.

Guarantor – The person who is financially obligated to pay for out of pocket expenses for services to the patient.

Financial Assistance Policy (FAP) – Term used by the IRS for the policy of providing assistance for those in need.

AGB – Amounts Generally Billed to those covered by insurance.

ECA – Extraordinary Collection Actions that cannot be taken before expiration of 240 days or when there is an open/unprocessed FAP application.

Presumptive Score – A numerical value of the guarantor's ability to meet financial obligations based on income and family size information adjusted for statistical validity for the community served by the hospital.

Surgical Services - All services that are defined in the HCPCS code range of 10000 – 69999 with the exclusion of venipuncture.

Underinsured – Your out-of-pocket healthcare costs (excluding premiums) represent 10% or more of your household income. If you're living under 200% of the federal poverty level, the threshold drops to 5% of your income (which is less than or equal to $62,400 for a family of four in 2024).

Uninsured – You do not have health insurance coverage for any medical costs under Private health insurance under Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored plans or programs, or military health plans.

Family Size - Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family

Refusal to Pay – Verbal or written expression by a patient or guarantor of unwillingness to pay for service provided; failure to pay following the normal statement processing equal to or greater than 120 days following service.

I Requirements – General:

1) Patient obligations and related financial assistance levels is a continuum that is segmented enough to provide consistency as a guarantor's financial position moves from 100% debt forgiveness to requiring the guarantor to seek alternative external financing.
2) The framework for the determination of 1) above is found in Appendix A. Each hospital

and other covered entities will independently determine the percentages of the poverty used for the graduated benefit/requirements as needed to meet their FAP and financial goals of their respective organizations.

3) Each hospital will also identify the calculations used for determining the AGB, identify an effective date, record this information on Appendix A, and distribute the information each time there is a change. This calculation can be adjusted as needed but should be reviewed at least annually. AGB discount should be applied consistently across all lines of business including hospital outpatient clinics.

4) All providers under the hospital's tax ID will be covered under the Financial Assistance Plan.

5) Any available health insurance must be billed prior to Financial Assistance being applied to an account. For patients with income greater than 200% of the Federal Poverty Level, Medical savings, reimbursement and all other similar accounts must be used prior to applying any type of financial assistance to qualified accounts. The exception to this rule is the utilization of a presumptive score for active lower balance accounts or for all accounts upon return from the primary bad debt agency.

6) All Charges will be posted in a consistent manner regardless of the available insurance, available coverage and/or the patient's ability to pay.

7) Patients with no insurance coverage will have an adjustment applied to the gross charges as determined by the individual hospital. The amount billed to a patient with no insurance represents each hospital's respective AGB – Amounts Generally Billed to those covered by insurance. AGB discounts may be separate amounts for inpatient and outpatient services. A separate adjustment code will be used for the reduction of the balance to the AGB. AGB amounts are not to be classified as bad debt or charity (PFA) but is classified as uncompensated care.

8) For patients that have insurance coverage, financial assistance is limited to defined patient liabilities (deductible, coinsurance, co-pay) and non-covered services. Patient liabilities, includes deductible and coinsurance required by both public and private insurance payers in which the hospital has a contractual relationship. An approved FAP may also include non-covered charges for days exceeding the length-of-stay limit for patients covered by Medicaid or other indigent care programs, if known. For those with an approved PFA application at the time of the insurance payment, the amount of patient liability will be compared to the AGB as if the patient did not have any insurance. The patient liability will be reduced to the AGB when it exceeds the AGB.

9) Patients have the right to refuse insurance coverage for specific services. Due to the various legal requirements of this option, adherence to the following is required:

    a. This is only an option for elective services. No emergency related services may use this option

    b. This option is not available when a government insurance is on the account regardless of payer priority,

c. This option must be elected individually for each account.

d. An insurance named “Self Pay by Request” (do not update Demo recall) will be added to the account so that:

    i. Insurance is never added to the affected account after this option is elected.

    ii. All other parties that process the account can easily identify that this option was elected.

e. Medical records for these services cannot be sent to the patient’s insurance carrier. Releasing medical records to their insurance for a patient selecting this option may create a HIPAA disclosure violation.

f. The option must be elected prior to the service and prior to providing insurance information that has been eligibility verified and/or used to obtain authorization.

10) An AGB adjustment is applied regardless of the guarantor’s ability to pay and will be reversed when insurance coverage payment becomes available on the account. This adjustment does not apply to patient liabilities identified through a claim adjudication process or for when the patient elects not to use insurance coverage that is valid at the time of service.

11) The amount of approved financial assistance (debt forgiveness) will be classified/adjusted as charity but referred to in all communications as patient financial assistance.

12) Financial assistance applicants that make any material misrepresentations will result in the reversal of approval and denial of open applications.

13) There are two independent approval processes to identify financial assistance: 1) an approved Financial Assistance Application, and 2), a Presumptive Charity Score. For each process, a unique transaction code will be used to relieve the financial obligation on the account

    a. The Financial Assistance Application process is available from the inception of the account to the 120th day from placement of any open balances with the Primary Bad Debt Collection Agency. Full and partial PFA benefits are available using this process.

    b. The Presumptive Charity Score process occurs upon the return of uncollectable accounts from the Primary Bad Debt Collection agency. No reference is made to any Patient Financial Application processes or decisions as the score is a stand-alone independent identifier and approval of charity. Only full PFA benefit is available using this process. The utilization of the score is as follows:

i. Accounts with Medicare - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as indigent cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity –score transaction.

ii. Accounts with dual eligibility - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as dual eligible cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity–score transaction.

c. Under no circumstances are the same balances to be considered for both charity and Medicare bad debt (mutually exclusive).

d. Transaction codes will be established to differentiate/classify and support the varying definitions of charity and bad debt only when other information on the account cannot be used for such differentiation/classification. This position is necessary to keep the number and adjustment definitions at levels that promote accuracy and minimize confusion.

14) Patients may request the plain language summary and/or the entire Financial Assistance policy. Both will also be posted on the hospital's web site. Although historically hospitals have provided non-interest-bearing loan arrangements in the form of accepting monthly payments (with or without approval), the patient liability shift necessitates the reinforcement of the following payment arrangement requirements:

a. Each hospital may participate in debt financing of the patient liabilities, however all returned debt may immediately be placed with a collection agency as bad debt regardless of the time period (subject to governmental reimbursement requirements).

b. Agreed upon payment arrangements only include the debt at the time of the payment arrangement. The guarantor will need to discuss any new debt and seek a new payment arrangement.

15) Catastrophic circumstances may justify financial assistance to an individual that falls outside the score and/or income levels established in this policy. For these extenuating situations, patient financial assistance adjustments may be given upon documented recommendation of revenue cycle leadership and approval by the CEO or CFO. Criteria for determining such catastrophic circumstances is based on the judgement of the executive for the situation but should be a rare occurrence.

16) During the annual budget process, an estimated amount of Financial Assistance Program services will be placed into the budget as a deduction from revenue.

II Patient Financial Assistance Application Approval Process:

1) Financial Assistance provided to the patient in the form of balance forgiveness (charity) may be determined by application that indicates the patient's ability to pay.

2) The Financial Assistance application process includes the following:

    a. A completed application is presented to a Financial Counselor. The application form must be completed in its entirety. (See Appendix B)
    b. All supporting documentation is required with the application form, including proof of income; and if applicant is over 200% of the Federal Poverty Guidelines, proof of assets
    c. Financial Counselor will review and verify the completed application and supporting documentation (if required), using the Financial Assistance application checklist and guidelines. (See Appendix B)
    d. Determination will be made as to the patient's eligibility and level of balance forgiveness for which the patient qualifies.
    e. Copies of application and supporting documentation will be securely retained electronically by the facility for as long as record retention policies dictate, up to 10 years.
    f. Applications and supporting documentation must be treated with highest confidentiality. Documents will be scanned to a secure electronic folder on the hospital's computer system with limited access. Original documents will be destroyed or returned to the applicant. A log of applications including date received, date of completion, and approval status will be maintained for each calendar year and retrievable upon request. Data may be reviewed for auditing purposes.
    g. Open balance accounts will be reviewed for qualification of balance forgiveness and appropriate adjustments will be made.
    h. Patient will be notified in writing of the determination whether approved or denied for Financial Assistance. For those approved at 100%, approval will be good for 12 months.
    i. Patient will be instructed to present the letter of notification of eligibility or issued Financial Assistance card, when registering for services at the respective facility. All letters presented with an expired date will be removed from the account and the patient advised to re-apply.

3) Automatic approval for financial assistance may occur using a charity scoring system under the following circumstances:

Reclassification of Bad Debt to Charity using Presumptive Charity;

a. Guarantors may be scored to determine a presumptive approval for charity at the time the account is returned from the primary bad debt agency.
b. The referral for review of the scoring process will occur after the first placement collection agency has completed their attempts to collect and before placing the account with the second collection agency.
c. A presumptive score will work independent of the application process for only this population of patients to avoid excessive administrative expense of reviewing each account for application history.
d. A presumptive charity score may be used as an indicator to pursue/encourage the completion of an application for financial assistance.

This process should not be used to determine assistance eligibility for current or future services.

III Requirements – Communication:

1) The hospital will widely publicize the Patient Financial Assistance policy by completing the following:

a. Make available paper copies of the application when requested and provide the Patient Financial Assistance Policy without charge to distribute by mail, in person and at patient entry point locations throughout the organization including outpatient clinics.
b. Notification by way of postings on hospital website and social media accounts, brochures at patient check-in points and on patient statements.
c. Document the activities used to inform the community served about the program on a minimum of an annual basis. Information provided on the hospital web site and other electronic media on the policy and how to obtain additional information.
d. No one will be denied access to services due to an inability to pay. There is a discounted sliding fee schedule available based on family size and income. The Financial Assistance Policy is also available on our website at https://www.pah.org/download/?id=4124

IV. Requirements – Collections:

1. For those whose income is at or below 200% of the Federal Poverty Level, they will receive a 100% discount based on income and family size, therefore will not be sent to collections.

APPENDIX A

Medicare Part A deductible	$1,676					
Score						
Poverty Level	**100%**	**200%**	**250%**	**300%**	**350%**	**400%**
Family Size						
1	15,650	31,300	39,125	46,950	54,775	62,600
2	21,150	42,300	52,875	63,450	74,025	84,600
3	26,650	53,300	66,625	79,950	93,275	106,600
4	32,150	64,300	80,375	96,450	112,525	128,600
5	37,650	75,300	94,125	112,950	131,775	150,600
6	43,150	86,300	107,875	129,450	151,025	172,600
7	48,650	97,300	121,625	145,950	170,275	194,600
8	54,150	108,300	135,375	162,450	189,525	216,600
9	59,650	119,300	149,125	178,950	208,775	238,600
10	65,150	130,300	162,875	195,450	228,025	260,600
	Addt'l $5,500 per person at 100%					
	Addt'l $11,000 per person at 200%					
	Financial Assistance					
Reduction Percent	**100%**	**100%**	**75%**	**50%**	**25%**	**0%**
Source: Published January 20, 2025. https://aspe.hhs.gov/topics/poverty-ecnomic-mobility/poverty-guidelines						

APPENDIX B

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:		**Phone:**
Current address:		
City:	**State:**	**ZIP Code:**
Cell Phone:	E-mail Address:	
EMPLOYMENT INFORMATION		
***OPTIONAL*:** Please indicate if you are Employed/Retired		
Current employer (I/A):		
Employer address:		
City:	State:	ZIP Code:
Position:	**Annual income:**	
HOUSEHOLD CO-APPLICANT INFORMATION		
Name:		
Date of birth:		**Phone:**
Current address:		
City:	**State:**	**ZIP Code:**
EMPLOYMENT INFORMATION		
***OPTIONAL*:** Please indicate if the co-applicant is Employed/Retired		
Current employer (I/A):		
Employer address:		
City:	State:	ZIP Code:
Position:	**Annual income:**	

ADDITIONAL HOUSEHOLD MEMBERS AND INCOME, IF ANY		
Name and Age		Annual Income

ONLY IF INCOME >200% OF FPL. **(SEE "PROOF OF ASSETS" ON CHECKLIST) OTHER ASSETS OR SOURCES OF INCOME –**	
Description	Amount per month or value

APPENDIX B

FINANCIAL ASSISTANCE APPLICATION

ACCOUNTS RELATED TO APPLICATION REQUEST **(FOR OFFICE USE ONLY)**

Patient Name:	Account no.	Date of Service:	Amount:

I certify that the above information is true and accurate to the best of my knowledge. If income above 200% of FPG, I will exhaust all other sources of medical coverage and assistance that may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated health services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant	Date
Signature of co-applicant, I/A	Date

ELIGIBILITY DETERMINATION
(FOR OFFICE USE ONLY)

Date Received: _____ Verification Completed: Yes ____ No ____

The applicant was approved for a reduction of _____% of allowable charges. Date approved: _____

The applicant was denied for the following reason(s)

Date of Denial _____

Date Applicant Notified of Determination _____

Individual Completing Review: _____

APPENDIX B

Financial Assistance Application Checklist

Verification of the following *applicable* information is needed to complete your application for Financial Assistance. Failing to provide all the requested/required documents will cause a delay in application processing.
Proof of Medical Assistance application may be required if applicable.

- **Proof of Income**:
  - Household income household income is defined as all income for individuals in the household who have a tax/taxable relationship to the patient. (File joint return or is a dependent not on another individual's return) This follows the same definition guidelines as PA Medicaid.
  - Most recent Income Tax Return
  - Pay Stubs and/or Unemployment Compensation Income statements for the past three months (for applications April through December)
  - Unemployment Compensation
  - Social Security income verification
  - Pension
  - Workers Compensation
  - Sick Benefits
  - Self-Employment
  - Rental Income
  - Child Support
  - Interest or Dividends
  - Any other income into the household
  - MA162 with income information
  - Payments from personal insurance policies that provide additional income or payment to defray medical related incident costs.
  - Current Photo ID (Driver's license, State issued ID, Work Visa)

- ***Proof of Assets does not apply to applicants at or below 200% of the current Federal Poverty Level.***

- **Proof of Assets: **(Balance over $10,000/person or $15,000/couple not qualified for Financial Assistance.**
  - Checking Account – most recent statement
  - Savings Account – most recent statement
  - Certificate of Deposit (CD)
  - US Savings Bond
  - Stocks or Bonds
  - HRA, HSA, FSA, or any medical savings or reimbursement account

Disclaimer Points:

1. You must apply within 240 days from the date of self-pay balance or application will be denied.

2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed.

3. Services considered to be personal and/or cosmetic, and dental OR procedures, including those at IASA, will not qualify for Financial Assistance. Specialty lenses are not covered under the Financial Assistance Program.

4. Elective services provided to an individual at a facility deemed by the insurance carrier to be "out of network" or "noncontracted" will not qualify for the Financial Assistance discount unless the pt has out of network benefits in their insurance plan.

5. Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance if applicant's income exceeds 200% of the federal poverty level.

6. A PA Medical Assistance denial *may* be required before Financial Assistance eligibility can be determined, as stated in the application guidelines.