JOHNSON MEMORIAL HOSPITAL
Franklin, Indiana

HOSPITAL WIDE POLICY **CODE: LD.70.25**

Reviewed/Revised Date: 1/2017	Next Review Date: 1/2018	Approved by: Strategic Focus Group: 1/23/17 Approved by: Board of Trustees: 1/24/17	Effective Date: 1/27/17

FINANCIAL ASSISTANCE POLICY AND BILLING AND COLLECTIONS POLICY

I. PURPOSE:

A. To ensure that reasonable efforts are made to determine whether a JMH patient is responsible for payment of all or a portion of a patient account and whether the patient is eligible for assistance under the Financial Assistance Policy (FAP) offered by Johnson Memorial Hospital (JMH).

B. To set forth actions that JMH will take in the event of non-payment of the portion of patient account(s) for inpatient or outpatient hospital services, post-acute facility services, medical services, and/or home health services that are the responsibility of the individual patients and not covered by insurance or other third-party payment source. This policy relates to the provision of Financial Assistance to persons who are unable to pay for all or a portion of their bill.

C. This policy covers the billing and collections of self-pay accounts for both uninsured patients and patients with insurance, including co-payments, co-insurance and deductibles. This policy does not cover actions to be taken to enforce a statutory lien that may exist in favor of JMH with respect to the proceeds of any third party recovery to which the patient may be entitled.

II. OBJECTIVE:

As part of its mission to provide quality healthcare services for our community, JMH is committed to serving the healthcare needs of all its patients regardless of their financial situation. To assist patients in meeting those needs JMH has established this Financial Assistance Policy and Billing and Collections Policy to provide financial relief to eligible patients receiving emergency or medically necessary services.

This policy was developed and is used to determine a patient's financial ability to pay for services rendered. No individual will be denied medically necessary hospital services based on a demonstrated inability to pay for those services. It is not the intent of the hospital to collect amounts that

exceed an individual's ability to pay or prevent an individual from seeking or receiving medically necessary services.

This policy was developed and is used as a policy for billing and collection of accounts that are not covered in whole or in part by insurance or another third-party payment source.

This policy includes:

- Eligibility criteria for Financial Assistance –free and discounted (i.e., partial Financial Assistance) care;
- Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this policy;
- Describes the method by which patients may apply for Financial Assistance;
- Describes how JMH will widely publicize the policy within the community served by JMH;
- Limits the amount JMH will bill the patient for emergency or other medically necessary care provided to individuals eligible for Financial Assistance to amounts generally billed by JMH for commercially insured or Medicare Patients; and,
- Describes JMH's Billing and Collections Policy.

III. DEFINITIONS:

A. Amounts Generally Billed (AGB) (26 CFR Part 1 §1.501(r)-(1)(b)(1)) means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

B. AGB percentage (26 CFR Part 1 §1.501(r)-(1)(b)(2)) means a percentage of gross charges that JMH uses to determine the AGB for any emergency or other medically necessary care it provides to an individual who is eligible for assistance under its FAP. The AGB percentage is calculated annually and within 60 days of the close of the hospital's fiscal year and used to determine AGB percentage collection ratio for the presumptive eligible uninsured patients, i.e., the "Look-Back" method.

C. Application period (26 CFR Part 1 §1.501(r)-(1)(b)(3)) means the period during which JMH must accept and process an application for Financial Assistance under the FAP submitted by an individual in ordered to determine whether the individual is FAP-eligible under §1.501(r)-6(c). The application period begins on the date the care is provided and ends on the later of 240thday after the date that the first post-discharge billing statement for the care is provided or per the exceptions listed in 26 CFR Part 1 §1.501(r)-(1)(b)(3)(i) and (ii).

D. Billing and collections policy (26 CFR Part 1 §1.501(r)-(1)(b)(5)) means a written policy that includes all required elements of (§1.501 – 4(b)(4)(i)).

E. Date Provided 26 CFR Part 1 §1.501(r)-(1)(b)(6)), means, in the case of any billing statement, written notice or other written

communication,(including electronic, or hand delivered) that is mailed, the date of mailing. The date that a billing statement, written notice, or other written communication is provided can also be the date such communication is sent electronically or delivered by hand.

F. Discharge (26 CFR Part 1 §1.501(r)-(1)(b)(7)) means to release from a hospital facility after the care at issue has been provided, regardless of whether that care has been provided on an inpatient or outpatient basis. Thus, a billing statement for care is considered "post-discharge" if it is provided to an individual after the care has been provided and the individual has left the facility.

G. Extraordinary Collection Action (ECA) (26 CFR Part 1 §1.501(r)-(1)(b)(11) means any action against an individual related to obtaining payment of a Self-Pay Account that requires a legal or judicial process or involves selling of a Self-Pay Account to another party or reporting adverse information about the patient or Responsible Individual to consumer credit reporting agencies or credit bureaus or deferring a medically necessary care because of non-payment for previously provided care. ECAs do not include an action to perfect the statutory lien on claims of liability or indemnity granted to health care provided under Indiana Law.

H. Financial Assistance Policy (FAP) (26 CFR Part 1 §1.501(r)-(1)(b)(12)) means JMH's Financial Assistance Policy. It consists of a two-part program which is for (1) uninsured individuals who, based upon their insured status, will be given the uninsured AGB assistance and (2) individuals who wish to apply for further assistance by completion of a Financial Assistance Application (which is assistance based on 300% of the Federal Poverty Level of income and/or assets).

I. FAP-Eligible Individual (26 CFR Part 1 §1.501(r)-(1)(b)(15)) means an Individual eligible for Financial Assistance under the FAP without regard to whether the individual has applied for assistance.

J. Gross Charges, or the Charge Master Rate (26 CFR Part 1 §1.501(r)-(1)(b)(16)), means JMH's full, established price for medical care that JMH consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

K. Hospital Plain Language Summary of the FAP (26 CFR Part 1 §1.501(r)-(1)(b)(24) means a written statement that notifies an individual that JMH offers Financial Assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP. Copies of the policy are available free of charge to the public. Copies of the policy are available in the hospital's Patient Financial Services Office and Registration Office. FAP information is included on each billing statement, on the JMH website and may be requested by mail.

L. Patient Response (payment or FAP Application) Deadline Date means the date that JMH may initiate an Extraordinary Collection Action (ECA)

against the responsible individual who has failed to pay or submit an application for Financial Assistance. This date (1) cannot be earlier than 120 days after the 1st Plain Language Summary Statement (PLS) and Financial Assistance Application (FAA) unless the party failed to provide a proper legal address for contact, and (2) cannot be earlier than 30 days after the individual has been notified that ECAs may be initiated. An example of the process timeline is presented below:

First PLS	**02/02/15**	
Second Notice	**03/01/15**	**29 days**
Third Notice	**04/15/15**	**45 days**
Fourth Notice & notice if payment or application due by 30 days +1	**05/30/15**	**45 days**
30 days +1	**07/01/15**	**@ approximately 149 days**
		Referral to a Collection Agency may occur

M. Self-Pay Account means the patient's balance after all possible payments and adjustments have been received/applied from insurance or other third-parties.

N. Responsible Individual means a parent, guardian, or other person who is financially responsible or is a guarantor of a patient's account. It may also mean a health care representative or other person who may consent to the patient's care and receive information regarding the patient.

O. Underinsured means persons who have large deductibles where no payment is received for their insurance plan, will be eligible for the uninsured or underinsured discount equal to 35%. (The difference between their Insurance Contractual and 35%) These individuals may also apply for Financial Assistance.

In order to manage its resources responsibly and to allow Johnson Memorial Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Trustees establishes the following guidelines for the provisions of patient Financial Assistance.

IV. SCOPE:

Johnson Memorial Hospital; Johnson Memorial Home Health Services, Johnson Memorial Hospital Immediate Care Service and JMH Employed Physicians Practices.

V. EXCEPTIONS:

Exceptions to this policy are:

- services that do not meet Medicare's medical necessity guidelines;

- Services that are offered as a packaged discounted price which include bariatric surgery, maternity delivery services and any other packaged service offered by JMH;
- Services that are non-urgent (i.e. immunizations, physicals, birth control procedures, etc.)

VI. ELIGIBILITY:

Eligibility for Financial Assistance will be considered for those individuals who are underinsured, uninsured, and ineligible for any government health-care benefit program and who are unable to pay for their care based upon the determination of financial need in accordance with this policy. The granting of Financial Assistance shall be based upon an individualized determination of financial need, and shall not take into account age, gender, race, immigrant status, sexual orientation or religious affiliation.

A. Presumptive eligibility for Financial Assistance will be awarded to any uninsured individual prior to the submission of the bill to the patient for payment. The presumptive eligibility adjustment amount will be based upon the Medicare DRG-based reimbursement for inpatient stays, and per fee-for-service guidelines for Observation & Surgery visits. All other services will receive a percent discount determined annually based on the AGB percentage of gross charges and collections of Medicare –fee-for service and private insurance plans.

B. Persons receiving the uninsured discount may apply for assistance under the Financial Assistance Policy. Individuals who are awarded Financial Assistance must re-apply annually. Those who are awarded assistance will receive a FAP eligibility card that identifies when the assistance ends. Co-payment for services may apply.

C. Eligibility for Financial Assistance will be determined based upon a patient's household income and number of members in the household. Household is defined as a family/group of two or more persons related by birth, marriage or adoption who live together. The patient is eligible for Financial Assistance when the patient's:

    a. Household income is equal to or less than 300% of the federal poverty guidelines;
    b. Household income is greater than 300% of the federal poverty guidelines (as published below and to be updated annually) and the patient is an uninsured patient and qualifies based on established sliding fee scale;
    c. An insured patient with a specific line item of service not covered by their insurance plan such as Medicare outpatients and self-administered drugs;
    d. Patients who are pending Medicaid approval;
    e. Homeless patients;
    f. Patients who have large deductibles or coinsurance that may not be a reasonable amount to pay due to limited insurance coverage.

Table I Family Income Ranges for Financial Assistance

FEDERAL POVERTY GUIDELINES FOR 2015					
FAMILY SIZE	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1	$11,770	$17,655	$23,540	$29,425	$35,310
2	$15,930	$23,895	$31,860	$39,825	$47,790
3	$20,090	$30,135	$40,180	$50,225	$60,270
4	$24,250	$36,375	$48,500	$60,625	$72,750
5	$28,410	$42,615	$56,820	$69,775	$85,230
6	$32,570	$48,855	$65,140	$71,025	$97,710
7	$36,730	$55,095	$73,460	$91,825	$110,190
8	$40,890	$61,335	$81,780	$102,225	$122,670

VII. Patient Liability:

Financial Assistance is not a substitute for personal responsibility. Patients are expected to cooperate with Johnson Memorial's procedures for obtaining Financial Assistance or other forms of payment. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health and for the protection of their individual assets. Some patients will have a cost-share responsibility for their services. This cost share is set to encourage patients to use healthcare services wisely and for medically necessary services. These cost shares are defined in Table II:

Table II	Amount of Discount and Patient Responsibility					
	less than 100% FPL	101-150% FPL	151-200% FPL	201-250% FPL	251-300%FPL	Uninsured
Patient's Discount:	100%	95%	90%	80%	75%	35%
Patient Pays:	Co-Pay	Co-pay +5%	Co-pay+ 10%	Co-pay+ 20%	Co-pay+25%	65%
Co-pays						
Inpatient per stay	0	$300	$500	$ 750	$ 1,250	Medicare DRG
Observation Stays	0	$200	$300	$400	$ 500	65%
Outpatient	0	$50	$75	$100	$150	65%
Emergency	$50	$50	$50	$100	$100	65%
Surgery	0	$500	$1,000	$1,250	$1,800	65%
Therapy	$10	$10	$25	$50	$50	65%
Home-Health Visit	$ 10	$25	$50	$50	$50	65%
JMH Physician Visits	$10	$25	$25	$25	$50	MFS*
Phy. Surgery	$100	$300	$500	$750	$1,250	MFS*
Immediate Care Center	$10	$25	$25	$50	$50	$50

* Medicare Fee Schedule

VIII. NOTIFICATION OF FINANCIAL ASSISTANCE POLICY(FAP):

A reasonable effort will be made to inform patients and their Responsible Individual (if any) of the JMH FAP. The notifications will be: displayed in the registration areas of the hospital; on the hospital's website; and in all JMH Employed Physician Practices offices: on all bills submitted to the patient; and, other opportunities such as letters and telephone calls responding to billing inquiries.

IX. COLLECTION EFFORTS:

The timeliness of the collection practices for JMH will take into consideration the relationship of JMH's Financial Assistance and the potential that a patient may qualify for Financial Assistance. The manner in which a patient will be billed for any balance due for services rendered will be in the form of a statement summarizing the services provided and the amount due. Patients who are presumed FAP-eligible due to the lack of insurance will receive a pre-billed uninsured adjustment. Except in cases of return mail where no additional information is available for the correct address, no less than four notices will be submitted prior to a referral to an outside collection agency. If a valid telephone number was provided to JMH by the Patient or Responsible Individual, JMH will attempt to contact the individual by telephone no less than two times to ask for payment arrangements or if Financial Assistance is requested. After referral to a collection agency, consideration for Financial Assistance will be applicable for 120 days. If the patient or Responsible

Individual requests assistance during that period of time, the request for assistance will be handled in the same manner as prior to the referral.

See below tables for summary of Collection Efforts processes including Patient Statement Processing timelines and Financial Assistance Processing timelines.

	Patient Statement Processing:				
	Statement 1	Statement 2	Statement 3	Statement 4	Collection Agency Referral
Un-insured	After Uninsured discount applied	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
Insured	After insurance pays	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
	After insurance rejects	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
	No Insurance payment:	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
	Balances $100 or less- 45 days after 1st bill to insurance	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
	Balances $101-$1,000 45 days after 2nd bill to insurance	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
	Balances $1001 & up 45 days after 3rd bill to insurance	30 days 1st Statement	30 days 2nd Statement	30 days 3rd Statement	30 days 4th Statement
Ins Pays Full	**No Statement**				
Return mail	**if no additional information /new address located**	→			**Due to false information**

Financial Assistance Processing:					
	Statement 1	Statement 2	Statement 3	Statement 4	Collection Agency Referral
Financial Assistance Application sent; account placed on hold 120 days	30 days Reminder that application was sent	30 days Reminder that application was sent	30 days Reminder that application was sent	30 days Reminder that application was sent	@ approximately 145 days Referral due to balance
Financial Assistance Application received; Letter sent informing patient of assistance provided	Statement 1 30 days after letter sent	Statement 2 30 days letter sent	Statement 3 30 days 3rd Statement	Statement 4 30 days 4th Statement	Collection Agency Referral Referral due to balance due after assistance credit is applied
Payment arrangement established; failure to pay	Statement 1 30 days after default	Statement 2 30 days 1st Statement	Statement 3 30 days 2nd Statement	Statement 4 30 days 3rd Statement	referral due to default of promise (approximately 145 days)

X. Extraordinary Collection Actions:

JMH will not impose Extraordinary Collection Actions without first making reasonable efforts to determine whether that patient is eligible for Financial Assistance.

Documentation that reasonable actions have been taken is defined as:

a.) Validating that the patient owes the unpaid bill and that all insurance sources have been billed by JMH subject to timely filing of insurance information by the patient;

b.) Documentation that JMH has offered or attempted to offer the patient the opportunity to apply for assistance and that the patient has not complied with JMH's application requirements;

c.) Documentation that the patient does not qualify for Financial Assistance on a presumptive basis;

d.) Documentation that the patient has been offered a payment plan but has not honored the terms of that plan or has refused the payment plan option.

XI. ADDITIONAL PROCEDURAL INFORMATION:

A. Medically Necessary: To be evaluated on a case-by-case basis at the discretion of JMH. Cases that are not clearly defined by the signs/symptoms and outcome diagnosis will be evaluated by clinically trained persons to assist with the final determination.

B. Emergency Services: Services treated in the emergency setting defined as:
   1.) Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
   2.) Elective services provided in response to life-threatening circumstances in a non-emergency room setting.

C. Application for Financial Assistance must be completed by the patient or family member who is designated as the healthcare representative or Responsible Individual.

D. Application must be completed in full and must be received within the designated time frame.

E. Applicants must allow JMH to share financial status with other parties involved with their care.

F. Applicants must assist JMH in the application of Federal or State programs that provide assistance for medical care.

G. It is preferred, but not required, that a request for Financial Assistance and a determination of financial need occur prior to the rendering of non-emergent medically necessary services. However the determination may be done at any point in the collection cycle. The need for Financial Assistance must be updated annually.

H. Presumptive Financial Assistance Eligibility may be determined in cases when a patient may appear eligible for Financial Assistance discounts, but here is no Financial Assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide the patient with Financial Assistance. JMH may use outside assistance to validate the income amounts for the basis of determining eligibility and the only discount that can be granted is 100% Financial Assistance.

Regulatory Requirements: In implementing this Policy, JMH management and facilities shall use reasonable efforts to comply with all federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this Policy. (Federal Register Vol. 79, N0. 250, December 31, 2014; Department of Treasury 26 CFR part 1, 53, and 602 Additional Requirements for Charitable Hospitals; Purposed Rule.; REG 130266-11)

REFERENCES:	
RELATED POLICIES/FORMS:	
REGULATORY / ACCREDITATION STANDARDS ADDRESSED:	Federal Register Vol. 79, N0. 250, December 31, 2014; Department of Treasury 26 CFR part 1, 53, and 602 Additional Requirements for Charitable Hospitals; Purposed Rule.; REG 130266-11

REVIEWED BY:	CFO; Director of Revenue Cycle
OWNER:	CFO