Decatur Health
Policy & Procedure

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SUBJECT: Patient Financial Assistance

PURPOSE: Establish a means for providing financially disadvantaged or other qualified patients with the ability to apply for and receive free or discounted care consistent with the Internal Revenue Code and implementing regulations.

POLICY: It is the policy of Decatur Health to provide quality care to all patients regardless of their financial situation.

DOCUMENTATION:

I. Eligibility Criteria

A. Financially Indigent

Financially Indigent qualifications are those who have a household income of equal to or less than 150% of the Federal Poverty Level for their household size. The following definitions explain in further detail:

Household: A household is considered all individuals living together at the same residence, provided they have a legal (or voluntarily accepted) responsibility for providing the necessities of life for each other. Temporary absences from the household (i.e. college attendance, military leave) do not disqualify an individual from being counted as a member of the household. Joint or shared custody situations of children will be considered a member of the household who provides the majority of support for the child. If situation of who provides the majority of support is unclear, then the child will be considered a member of the household where a majority of his/her time is spent. Independent adults who choose to share a residence with one or more individual adults will generally be considered as a single household without counting the presence or income of the other adults. Decatur Health will generally leave the discretion of an individuals' relationship up to the individual when determining who to be counted in the household.

Household Income: Total income from all members considered to be in the patient's household over the twelve months prior to application for assistance.

B. Medically Indigent

Medically Indigent qualifications are those who have medical bills and related debt from Decatur Health in excess of a percent of the greater of the patient's household income or net worth following the table below. The following definitions explain in further detail:

Net Worth: Net asset value (assets – liabilities (excluding hospital liabilities)) of all members living in the patient's household over the twelve months prior to application of assistance.

Assets to Include: 1 – liquid assets such as cash, bank balances, marketable investments, annuities outside of a qualified retirement account; 2 – equity in a primary or secondary residence or other property; 3 – equity in personal automobiles in relation to the number of automobiles and licensed drivers in the household; 4 – equity in business assets of a self-employed persons including trade tools and equipment, real estate, business vehicles and farm ground; 5 – equity in business assets of a passive active (i.e. leased real estate, etc); 6 – equity in business assets of a business type hobby or secondary occupation; & - luxury/collectable personal property (i.e. jewelry, watercrafts, etc).

Assets to Exclude: 1 – household personal property (i.e. furnishing, appliance, etc); 2 – pensions, IRA's, 401(k)s, 403(b)s, 457's, education savings accounts and section 529 accounts.

Table 1 – Patient's liability will be no more than the greater of ___% of income or net worth and as limited by amounts generally billed:

FPL	% of Income	% of Net Worth
151-300%	10%	5%
301-500%	15%	7.5%
501% +	20%	10%

C. Failure to Apply for Medicaid

Patients who may be eligible for Medicaid and fail to apply for the benefit within forty days of the request of Decatur Health will disqualify him/her from being eligible for assistance under this policy.

D. Care Eligible for Assistance

Dependent on the qualifying of the patient as either financially or medically indigent, all medically necessary care including emergency medical care are classifications for eligibility under the financial assistance policy. Cosmetic procedures do not qualify for assistance regardless of eligibility.

II. Covered Providers

Care provided by the Hospital and Hospital-employed physicians and practitioners is covered by this policy.

Care provided by independent providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance.

The list of current providers is as follows:

Providers whose services and fees are subject to this policy include:
Craig Bartruff, MD
Charles Krysl, PA-C
Sean Conroy, PA-C
Lillian Kaltenbaeck, PA-C
Jeffery McKinley, DO
Richard Akromis, PA-C
Melissa Mathews, APRN

Providers whose services and fees are NOT subject to this policy include:
Walter Eskildsen, MD (professional fees only)
Daniel McGowan, MD (professional fees only),
Sean Denney MD (professional fees only)
Richard Markowicz, MD (professional fees only)

III. Limitation on Charges and Calculation of Amount Owed

Patients eligible for assistance under this policy will not be charged more than those individuals who have health insurance covering the same care. Discounts granted to eligible patients under this policy will be taken from gross charges.

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Hospital determines its AGB utilizing the method detailed below.

The Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is the Hospital's gross charges multiplied by the AGB Percentage. The Hospital's current AGB Percentage is 100%. The AGB Percentage is calculated by dividing the total of all claims allowed by health insurers during the prior 12-month period by the total gross charges for those claims, limited to 100%. Claims are considered to be "allowed" not based upon when the care was provided, but when the insurer determines the allowable amount of the claim. The amount "allowed" includes the amount the insurer will pay plus the amount for which the individual is personally responsible (including co-pays and deductibles). Allowed claims are included in the AGB Percentage calculation regardless of whether they have been paid or collected. "Health insurers" for purposes of this definition are Medicare fee-for-service and all private health insurers.

The Hospital calculates its AGB Percentage on an annual basis at the end of each fiscal year. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.]

B. Amount of Financial Assistance/Discount

Patients are eligible for assistance at 100% if they qualify as Financially Indigent.

Patients are eligible for assistance based on Table 1 which is the percentage of the greater of their household income or net worth if they qualify as Medically Indigent and will be responsible for their medical bills up to that percentage.

Applications are active for six months and any care received during that time frame will be subject to the assistance decided upon when the application was submitted and approved.

If financial assistance provided to the patient results in a charge of greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

IV. Application Process & Determination

Patients will be required to submit an application on the appropriate financial assistance form if they believe that they may qualify for assistance under this policy. Completed applications must be returned during the application period (defined below) to:

Decatur Health
Attn: Business Office Director
PO Box 268
Oberlin, KS 67749

Application Period: This period begins on the date that care is provided to the patient and ends on the later of the 240th day after the date that the first post-discharge billing statement is provided to the patient (whether inpatient or outpatient) OR not less than 30 days after the date the facility provides the patient the required final notice to commence extraordinary collection actions (ECA's).

This policy, summary and application may be obtained by mail by calling 785-475-2208, downloaded from decaturhealthsystems.org, or in person at the Business office or emergency room.

A. Completed Applications

Upon receipt, Decatur Health will suspend any ECA's being taken against the patient and will review and make a decision on the completed financial assistance application that are submitted during the application period.

Determination of eligibility for assistance will be made by the: Business Office Director with approval from the COO or CFO.

Unless otherwise delayed, a decision shall be made within 30 days of submission of a timely completed application. Patients will be notified of the decision by mail.

To be considered "complete" an application must include all information requested on the form and in the instructions of the form.

Decatur Health will not consider an application incomplete or deny financial assistance based upon the failure to provide information that was not requested. Decatur Health may take into account any information provided by the patient that was not requested in the application.

If it is determined that a patient may be eligible for participation in the Medicaid program after submission of an application during the application period, Decatur Health will notify the patient in writing of such potential eligibility and request that the patient take the necessary steps to enroll in the program. In such circumstances, Decatur Health will delay the processing of the assistance application until the patient has completed the Medicaid application, submitted it to the program and received a decision from such program. If the patient fails to submit an application to Medicaid within forty days of the request, the patient's assistance application will be processed and denied due to the failure to meet the eligibility criteria.

For questions and/or assistance with filling out the assistance application, the patient may contact the Business Office Director or Billing Clerk in person at Decatur Health, 810 W Columbia, Oberlin, KS or by calling 785-475-2208.

B. Incomplete Applications

Incomplete applications will not be reviewed by Decatur Health. If a patient submits an incomplete application, Decatur Health will suspend ECA's and provide the patient in writing of the additional information or documentation required to complete the application. The notice will provide the patient with thirty days to submit the required information/documentation.

C. Presumptive Eligibility

Decatur Health reserves the right to provide financial assistance even though an application has not been submitted, in which case the patient will be provided the maximum possible level of assistance.

V. Collection Actions

Patients will be provided a plain language summary of the policy upon admission to the hospital, along with contact information where patients may obtain further information about the financial assistance documents.

Decatur Health may refer a patient's bill to a third party collection agency or take any or all of the following extraordinary collection actions in the event of non-payment of outstanding bills:

a. Reporting to credit bureaus
b. Legal suit
c. Selling the account to a third party
d. Garnishment of wages

Decatur Health may refer a patient's bill to a collection agency 120 days from the date the first bill for care was provided to the patient. Decatur Health will not take ECA's against a patient or any other individual who has

accepted or is required to accept financial responsibility for a patient unless and until the facility has made "reasonable efforts" to determine whether the patient is eligible for financial assistance.

A. No Application Submitted

If a patient has not submitted an application, the facility has taken "reasonable efforts" so long as it:

1. Does not take ECA's against the patient for at least 120 days from the date the facility provides the patient with the first bill for care; and

2. Provides at least thirty days' notice to the patient that:

   a. Notifies the patient of the availability of financial assistance;

   b. Identifies the specific ECA's the facility intends to initiate against the patient;

   c. States a deadline after which ECA's may be initiated that is no earlier than thirty days after the date the notice is provided to the patient.

3. Provides a plain language summary of the assistance policy with the aforementioned notice; and

4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least thirty days prior to initiating ECA's against the patient describing how the individual may obtain assistance with the application process.

B. Incomplete Applications

If a patient submits an incomplete application during the application period, "reasonable efforts" will have been satisfied if the facility:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information of the department that can provide the application and assistance with the application process. The notice shall provide the patient with at least thirty days to submit the required information; and

2. Suspends ECA's that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECA's may resume; provided, however, that if the patient submits the requested information during the application period, the facility must suspend ECA's and make a determination on the application.

C. Completed Applications

If a patient submits a completed application, "reasonable efforts" will have been made if the facility does the following:

1. Suspends all ECA's taken against the individual, if any.

2. Makes a determination as to eligibility for assistance as set forth in the financial assistance policy.

3. Provides the patient with a written notice either (i) setting forth the assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If the facility has requested that the patient apply for Medicaid, the facility will suspend any ECA's it has taken against the patient until the patient's Medicaid application has been processed or the patient's application is denied due to the failure to timely apply for Medicaid coverage.

If the patient is eligible for assistance other than free care, the facility will;

1. Provide the patient with a revised summary setting forth: (i) the amount the patient owes for care provided after assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the AGB for the care provided.

2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to Decatur Health.

3. Take reasonable measures to reverse any ECA's taken against the patient.

VI. Emergency Medical Care

Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under this policy. Refer to the EMTALA policy for further information. Decatur Health will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with the facility policies governing and implementing the Emergency Medical Treatment and Active Labor Act.