

POLICY AND PROCEDURE

EFFECTIVE DATE: 06/01/2017

SUPERSEDES POLICY DATED: 12/95; 3/98; 2/01; 4/04; 12/04; 7/05; 1/07; 11/11; 2/1/13; 7/10/14; 1/1/2016; 2/15/16; 9/7/16

SECTION: A (1)

SUBJECT: FINANCIAL ASSISTANCE POLICY; COLLECTIONS ACTIVITIES

**PURPOSE:**

To provide free or discounted healthcare services to residents of the community who are determined by Ashland Hospital Corporation d/b/a King's Daughters Medical Center ("Medical Center") to have inadequate financial resources to pay for necessary healthcare services provided by Medical Center and to ensure that no extraordinary collection actions are taken against any individual until Medical Center makes reasonable efforts to determine whether the individual is eligible for free or discounted services.

**POLICY:**

**1. Emergency and Medically Necessary Care.**

Medical Center's policy is to provide emergency and other medically necessary care, excluding certain services that are deemed to be elective, to patients without regard to race, creed, gender, color, age, religion, disability, national origin or ability to pay. Subject to the provisions of this Financial Assistance policy, patients without the means to pay for services provided at Medical Center may request to be considered for awards of Financial Assistance under this policy.

Medical Center will provide, without discrimination, care for individuals with emergency medical conditions (within the meaning of the Emergency Medical Treatment & Active Labor Act) (42 U.S.C. §1395dd) ("EMTALA") regardless of their eligibility under this policy and in accordance with Medical Center's EMTALA/Inter-facility Patient Transfer Policy. For emergency medical conditions, team members shall not delay appropriate treatment or the provision of an appropriate medical screening to inquire about the individual's method of payment or insurance coverage.

Medical Center prohibits any actions that would discourage individuals from seeking emergency medical care, such as demanding that Emergency Department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

All patients will be treated with respect and fairness regardless of their ability to pay.

**2. \*Publicizing Financial Assistance Policy.**

This policy will be widely publicized within the community served by Medical Center, including providing a copy of the policy to any patient or patient representative who requests a copy of the policy and posting signage visible at all patient intake areas including, without limitation, the emergency department and patient registration areas at all Medical Center locations. A copy of this policy will be provided to any member of the

public or governmental entity upon request. This policy will be made available on Medical Center's website. In addition, the following language will be included on all patient invoices: "All or a portion of your bill may be eligible for forgiveness under our Financial Assistance Policy. For more information about our financial assistance program, please call (606) 408-4118 or visit Medical Center's website [www.kingsdaughtershealth.com](http://www.kingsdaughtershealth.com)."

### 3. \*Definitions

For the purpose of this policy, the terms below are defined as follows:

- A. **\*Amounts Generally Billed (AGB):** The maximum amount billable to a patient who is eligible for Financial Assistance under this policy. This amount is determined using the "look back" method described in 26 C.F.R. §1.501(r)-5(b)(3) of the applicable regulation. Medical Center calculates this amount as described in the FRC policy, *Limitation on Charges*, available online at [www.kingsdaughterhealth.com](http://www.kingsdaughterhealth.com).
- B. **Application Period:** The period during which a patient may apply for financial assistance with his or her outstanding balance. This period may begin prior to the patient receiving services and will end on the 240<sup>th</sup> day after the date of the first post discharge billing statement.
- C. **Family:** Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for financial assistance purposes.
- D. **Family Income:** Family Income will be based on average earnings for the six months prior to date of application and projected earnings for the six month period following the application. It is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
  - 1. Earnings, unemployment compensation, Workers' Compensation, Social Security, Supplemental Security Income (SSI), 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 source. Annual Family Income will be based on at least a three-month period immediately preceding the first date of service on the application;
  - 2. Noncash benefits (such as food stamps and housing subsidies) do not count;
  - 3. Determined on a before-tax basis;
  - 4. Excludes capital gains or losses; and
  - 5. If a person lives with a family, includes the income of all family members
  - 6. Non-relatives, such as housemates, do not count.
  - 7. The most recent Federal Income Tax Return as of February of each year will be required for taxable wages.
- E. **Financial Assistance:** Healthcare services that will be, or have already been provided which are never expected to result in payment. Financial Assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.
- F. **Gross Charges:** The total amount billed by Medical Center for the services provided before any payments or discounts are applied.
- G. **Medically Necessary Care:** Those services reasonable and necessary to diagnose and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care generally accepted at the time services are provided.
- H. **Notification Period:** The 120 days immediately following the patient's first post discharge billing statement. During this period Medical Center will make reasonable efforts to inform the patient that he or she may be

eligible for assistance under the guidelines of this policy and it will not engage in any extraordinary collection activities.

- I. **Patient:** The person who received health care services, or the person who is financially responsible for the person receiving those services, such as in the case of minors and the mentally impaired.
- J. **Uninsured:** When a patient who has no level of insurance or third-party assistance to assist in meeting his/her payment obligations and is not covered by Medicare, Medicaid or Tricare or any other health insurance program of any nation, state, territory or commonwealth, or under any other government or privately sponsored health or accident insurance or benefit program including, without exclusion, workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

**4. \*Which service providers are covered by this financial assistance policy?**

Emergency and medically necessary services provided and billed by Medical Center, services provided at King's Daughters Family Care and Urgent Care Centers, as well as services provided by the emergency department physicians are covered by this program.

Additionally, services and supplies rendered by or through King's Daughters Home Health and King's Daughters Home Medical Equipment are managed under the guidelines established in this policy.

**5. What service providers are NOT covered by this financial assistance policy?**

- A. Surgeons providing surgical services
- B. Physicians employed as members of King's Daughter Medical Specialties, which includes Hospitalists who complete rounds for patients receiving Inpatient and Observation levels of care
- C. Anesthesia services
- D. Reading and interpretation of radiological testing such as X-rays, CT scans, etc.
- E. Pathology services supplied on select laboratory samples
- F. Medical transport/ambulance services
- G. Pharmacy services
- H. Kingsbrook Lifecare Center

The groups listed above are not covered by this financial assistance policy, but they may each have their own assistance plans available.

**6. When is Financial Assistance available?**

A. General Eligibility

Patients will be considered for assistance under the following circumstances:

- 1. The patient has no insurance or has exhausted coverage and meets the other guidelines established in this policy;
- 2. The patient qualifies for limited Medicaid coverage;
- 3. The patient has Medicare or other insurance and meets the guidelines established in this policy, may be eligible for assistance with deductibles, co-insurance and co-pays;
- 4. Medical Center receives a completed application and supporting documents within the Application Period;

#### B. Catastrophic Circumstance Eligibility

Medical Center understands that circumstances may come up when a patient needs assistance that is outside the general guidelines of this policy. The patient may be eligible for discounts on emergency and medically necessary services if:

1. Other payment options including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties have been exhausted,
2. The patient's has out-of-pocket obligations that exceed 20% of the patient's family income, and
3. The patient does not have significant assets.

This process is further described within Medical Center's FRC policy, *Catastrophic Circumstance Determination*.

#### C. Presumptive Eligibility

There are instances when a patient may appear eligible for financial assistance discounts, but there is no completed financial assistance application on file due to a lack of supporting documentation. Adequate information may be available through other sources, which could provide sufficient evidence to support the patient being considered eligible for financial assistance. If a patient does not or cannot provide the required documentation to make an eligibility determination, Medical Center may use outside agencies to determine estimated family income and assess eligibility for financial assistance. Due to the inherent nature of the presumptive circumstances, the only discount granted in these circumstances will be a 100% write off of the account balance. The following criteria may be used to make presumptive eligibility determinations and may be used in place of the documentation described in Section 8(D) of this policy:

1. The patient is eligible for State-funded prescription programs;
2. The patient is homeless or received care from a homeless clinic;
3. The patient is eligible for assistance through the Women, Infants and Children program (WIC);
4. The patient is eligible for assistance through the Supplemental Nutrition Assistance Program (SNAP);
5. The patient is eligible for subsidized school lunch programs;
6. The patient is eligible for other state or local assistance programs that are unfunded (e.g. Medicaid spend-down);
7. The patient is eligible for assistance through low income/subsidized housing; or
8. The patient is deceased with no known estate.

#### D. The following are NOT considered to be medically necessary and are therefore not covered by this policy:

1. Elective cosmetic surgery (but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity);
2. Surgical weight loss procedures;
3. Experimental procedures, including non-FDA approved procedures and devices or implants;
4. Services for which prior authorization is denied by the patient's insurance carrier;
5. Cost of specialty replacement lenses;
6. Hearing aids and hearing aid repair;
7. Fertility treatment; and
8. Services or procedures for which there is a reasonable substitute or if the patient's insurance company will provide a service or procedure that is a covered service or procedure.

If we determine a patient has the ability to pay all or a portion of a bill, that determination does not prevent the patient from submitting a new application in the future.

## 7. Self-pay Discount

All Uninsured patients, as defined in Section 2 of this Policy, will receive a Self-pay Discount as described in FRC policy *Self-pay Discount for Uninsured Patients*.

## 8. How does a patient apply for Financial Assistance?

A. Patients may apply for financial assistance at any time during the application period, which begins when the patient begins seeking treatment and ends on the 120<sup>th</sup> day after those charges are referred to a collection agency for action, but not sooner than the 240<sup>th</sup> day after the date of the first post discharge statement.

B. \*Applications for financial assistance may be obtained:

- i. Medical Center's website at [www.kingsdaughtershealth.com](http://www.kingsdaughtershealth.com),
- ii. e-mailing the FRC team at [FinancialAssistanceTeam@kdmc.kdhs.us](mailto:FinancialAssistanceTeam@kdmc.kdhs.us),
- iii. calling the FRC team at (606) 408 - 4118 or (866) 408 - 6466,
- iv. sending a fax to (606) 408-6049, or
- v. mailing a request to the FRC team at:  
King's Daughters Medical Center  
Attn: Financial Resource Center  
P.O. Box 151  
Ashland, KY 41105

Anyone contacting Medical Center's FRC team may request that the applications be mailed, faxed, or e-mailed to them.

C. Members of Medical Center's FRC team are available to assist patients in completing the application or reviewing a completed application with the patient. Members of the FRC team are available within the Main Patient Registration area at the hospital facility in Ashland, Kentucky between the hours of 8 am and 4 pm Monday through Friday, except for observed holidays. Appointments are not required, and individuals will be assisted in the order in which they arrive.

D. To be considered for financial assistance, patients must:

- i. Cooperate with Medical Center and respond to requests for information or documentation in timely manner;
- ii. Make a good faith effort to honor the terms of any reasonable payment plan if the patient qualifies only for a partial discount;
- iii. Notify Medical Center promptly of any change in financial situation so that Medical Center can assess the change's impact on the individual's eligibility for financial assistance or payment plan;
- iv. Agree to apply for any state, federal or local assistance for which the patient may be eligible to help pay for his or her hospital bill;
- v. Complete the required application form truthfully and submit all applicable documentation listed below, as applicable:
  - i. Copies of pay check stubs for the most recent past three (3) months, copy of the most recent pay stub showing year-to-date earnings, or a signed letter from the patient's or dependent's employer which verifies his or her gross income;

- ii. Copies of benefit award letters or 1099 form showing Social Security†, Disability, Worker’s Compensation, or Veteran’s Administration benefits;
- iii. Copies of benefit award letters or 1099 form showing Unemployment, Retirement†, or Pension benefits†;
- iv. Verification of Child Support, Alimony, or Kinship payments;
- v. Verification of rental income received
  - 1. rental contract,
  - 2. signed Federal income taxes from most recent filing year which include Schedule E showing rental incomes,
  - 3. receipts, or
  - 4. a signed letter from the tenant stating monthly rents paid to the applicant;
- vi. Verification of Self-employment status and income received:
  - 1. receipts from clients,
  - 2. signed Federal income taxes from the most recent filing year which include the appropriate schedule showing income from self-employment, S-corp, or other such entity;
- vii. Copies of bank statements (checking and savings) from the past three (3) months, noting next to each deposit the source of funds for that deposit;
- viii. NO INCOME FORM, included with the application packet, signed by the person providing the patient’s daily living expenses in the case that the patient and patient’s family have no other source of income;
- ix. STATEMENT OF SEPARATION, included with the application packet, signed by a non-family member if the patient is married but maintaining a separate residence and expenses from their spouse;
- x. A copy of **ALL** forms filed with your Federal Income Taxes signed and filed for the most recent tax year, including W2’s and all applicable Schedules, or completed 4506T form to request IRS transcripts of taxes if copies are not available from the applicant;
- xi. Documentation of other resources (certificates of deposit, stocks, 401k/IRA, or real estate) are requested based on the responses provided by the applicant during either in person or phone contact or provided as answers to application questions.

*†In the case of Social Security Income, Retirement, and Pension benefits, since these income sources do not typically fluctuate throughout the year, the Financial Counselor has the option to use documents provided on a previous application within the previous 12 months.*

- E. If a patient’s and/or a dependent’s income is self-reported (such as self-employment, S-corporations, partnerships, farm income, etc.), then Medical Center will use a signed federal income tax return for the most recent filing year to determine that patient’s and/or dependent’s income for financial eligibility purposes.
- F. Generally, the amount of an applicant’s assets not required for his or her daily living may be considered when determining eligibility for financial assistance and may alter or eliminate any discount. The following factors, among others, may be considered in determining available assets, particularly when the patient does not or cannot participate in completing the financial assistance application:
  - 1. The local cost of living;
  - 2. Patient’s income, assets, and expenses;
  - 3. Patient’s family size (including the patient, spouse, and legal dependants according to Internal Revenue Service rules);
  - 4. Scope and extent of patient’s medical bills;
  - 5. Patient’s available medical insurance coverage;

6. Size of medical bill in relation to financial resources.

- G. Before being considered for assistance under this policy, patients who do not have insurance coverage must also cooperate with Medical Center's Medicaid Eligibility vendor. If the patient already applied for and was denied Medicaid benefits within the past 90 days, he or she may present that documentation instead.

Patients who have insurance coverage may also be asked to cooperate with Medical Center's Medicaid Eligibility vendor if there is reason to believe the patient may be eligible for some benefits under an available program.

Failure to complete applications or provide requested documentation to Medical Center's Medicaid Eligibility vendor will be considered non-cooperative. Patients found to be non-cooperative by Medical Center's Medicaid Eligibility vendor will not be considered for assistance under this policy.

- H. Medical Center will assess the applicant's eligibility for assistance once a complete application, with supporting documentation, is received. The applicant will receive a letter explaining Medical Center's assessment of their eligibility and amount of financial assistance they will be provided.

Medical Center will advise the applicant that he or she has the option to establish a monthly payment plan on any balances that remain after discounts are applied, so long as the remaining balances are in good standing.

Medical Center will direct applicants wishing to establish a monthly payment plan to call Medical Center's Patient Accounts toll free at (855) 253 – 5426.

- I. All applicants determined to be eligible and who will receive less than \$1,000 in applicable adjustments at the time of review may be approved by the Financial Counselor. Applicants determined to be eligible who will receive applicable adjustments between \$1,000 and \$10,000 will also be reviewed and approved by a Supervisor within the Revenue Cycle. Applicants determined to be eligible who will receive applicable adjustments in excess of \$10,000 will be reviewed and approved by both a Supervisor a Director within the Revenue Cycle. All approvals will be made in accordance with the standards set forth in this policy.
- J. If the patient does not, or cannot, cooperate in completing the financial assistance application, financial assistance may be granted based on considerations contained in this policy, and other considerations that evaluate the individual's family income and resources compared to the medical expenses incurred.
- K. A new application, along with updated income verifications, will be required every 90 days.

9. \*Limitation on Patient Responsibility:

For emergency and medically necessary care, the charges to patients who are eligible under this policy are limited to the Amounts Generally Billed (AGB) for such services to patients that have insurance coverage for such care. Such amounts are determined in accordance with the look-back method set forth in IRS regulations and documented in Medical Center's Financial Resource Center departmental policy on *Limitations on Charges*.

Additional information about how Medical Center calculates the AGB and how it is applied to a patient’s bill may be found at [www.kingsdaughtershealth.com](http://www.kingsdaughtershealth.com). In addition, copies of this Limitation on Charges Policy are available by request from the Financial Resource Center team by contacting them using the information found in Section 8(B) of this policy (pg. 5).

For services not eligible for discount under this policy, as described in Section (6)(D) of this policy, the patient will not be responsible for more than the Gross Charges for the service or procedure being performed.

**10. How is the level of Financial Assistance calculated?**

A. Except where exceptions are defined elsewhere in this policy, a “Sliding Scale Methodology”, shown below, will be used to calculate amounts charged to patients who are eligible for assistance under this policy. The sliding scale is based on the Federal Poverty Guidelines, which are updated annually by United States Department of Health and Human Services. This scale does not apply to certain elective procedures and those deemed not medically necessary. The sliding scale discount is based on the Family Income as follows:

<b>Family Income as a percent of Federal Poverty Guidelines (FPG)</b>	<b>Applicable Discount to Patient Responsible Balance</b>
Up to 200% of FPG	100%
201 – 250% of FPG	80%
251 – 300% of FPG	65%

1. A patient having a family income at or below 200% of the Federal Poverty Guidelines effective at the time the application is under review will be eligible for a 100% reduction of the patient responsible balance (i.e., a full write-off).
2. A patient with a family income in excess of 200% but equal to or less than 250% of the Federal Poverty Guidelines effective at the time the application is under review will be eligible for an 80% reduction of the patient responsible balance (i.e. balance after insurance discounts and payments are applied, or the balance after the Self-pay Discount is applied).
3. A patient with a family income in excess of 250% but equal to or less than 300% of the Federal Poverty Guidelines effective at the time the application is under review will be eligible for a 65% reduction of the patient responsible balance (i.e. balance after insurance discounts and payments are applied, or the balance after the Self-pay Discount is applied).

B. The discounts described above are applied to the patient responsible balances after insurance payments and discounts or self-pay adjustments.

**11. Request for Eligibility Reconsideration**

Patients may experience a change of circumstances after the application for assistance has been reviewed and a determination has been made. In this case, or if a patient indicates there was an error with the application or supporting documents provided, the patient may request a reconsideration. The process for the reconsideration is covered by the FRC policy *Request for Eligibility Reconsideration*.

## 12. Billing and Collections

A. In General: No extraordinary collection actions will be pursued against any patient until 120-days after the first post discharge bill is issued or Medical Center has made reasonable efforts, described below, to determine if the individual is eligible for financial assistance under this policy.

B. Actions in the Event of Non-payment:

Medical Center has the right to pursue collections directly or working with a third-party collection agency. Medical Center will pursue collection actions against individuals determined to be ineligible for assistance, individuals determined to be eligible who have received discounted but not free care, or individuals who failed to cooperate with Medical Center and are not making payments in accordance with established payment plans.

Medical Center may take the actions described below if a patient does not pay his or her medical bill, including collection actions:

*Note: The following section memorializes a change in billing process that began 03/15/2014.*

1. Medical Center is contracted with a Medicaid eligibility vendor to contact each self-pay patient in person, by mail, by phone, or a combination of these approaches. The vendor will assist the patient in determining whether Medicaid or other government funds are available to assist the patient in paying his or her medical bill.
2. Patients with valid mailing addresses who are provided services by Medical Center will receive statements on a regular basis over a minimum 120 day period.
3. If Medicaid or other governmental funding is unavailable, disputes have been reviewed and resolved, and payment arrangements are not made with the patient for paying the bill during the 120-day billing cycle, then Medical Center may refer patient files to an outside collection agency for processing and collection efforts.
4. Medical Center may extend the period of time patients receive statements beyond the standard 120 days at the discretion of Medical Center leadership.
5. Once the patient's account is referred, the agency is authorized to contact the patient to establish a plan for resolving the patient's debt. The agency is also authorized to report the negative status of the debt to credit bureaus.
6. Medical Center may defer or deny (or require a payment before providing) medically necessary care, but not emergency care, because of a patient's non-payment of prior care. Medical Center does not need to provide the ECA Initiation Notice before deferring or denying (or requiring a payment before providing) care based on past non-payment. Medical Center will, however, provide separate written and oral notice, described below, after which I may defer or deny (or request payment before providing) care immediately. The notification requirement specific to this collection action will be satisfied if Medical Center provides a copy of its FAP application form to the patient, notifies him or her that financial assistance is available, and provides the deadline after which it will not accept a FAP application for the previously provided care. Medical Center must also provide a plain language summary of this policy to the patient and orally notify the patient about this policy and how the patient can obtain help with completing the application. The deadline to submit a FAP application must be no earlier than the later of 30 days from the date of the written notification or 240 days from the date of the first post-discharge

billing statement for the previously provided care. If a FAP application is timely submitted, then Medical Center will process in on an expedited basis to minimize any risk to the patient's health.

C. Reasonable Efforts to Determine Eligibility

Patients may submit an application throughout the Application Period, as defined in Section 3(B) above, which will be a minimum of 240 days from the date on which Medical Center, or its subcontractor, issued its first, post-discharge billing statement. If an individual has not submitted an application within the first 120 days from the date on which Medical Center issues its first, post-discharge billing statement, then Medical Center may begin engaging in the collection actions described above.

If Medical Center receives an incomplete application form, Medical Center will suspend any collection activities being undertaken against the patient and provide the patient or his or her legal representative with a list of the missing information or documentation and give the patient 30 days to provide the missing information. The notice concerning missing information will include contact information for Medical Center and FRC team which can help the patient with completing his or her application. If the patient does not provide the missing information within this period, Medical Center may commence (or resume) collection actions assuming it has provided the ECA Initiation Notice described above.

If Medical Center receives a complete application form, Medical Center will make and document eligibility determinations in a timely manner. If the patient is eligible for financial assistance, Medical Center will provide the patient with a billing statement showing the amount owed, how the amount was determined, and describe how the individual can learn more about how Medical Center calculates AGB. Medical Center must issue refunds to the patient if the patient previously paid an amount exceeding what he or she is personally responsible to pay, unless such amount is less than \$5 (indexed for inflation), or such amount determined by the IRS. If the applicant is eligible for financial assistance, Medical Center will take all reasonable measures to reverse any collection actions taken against his or her account (with the exception of deferring or denying care for non-payment of amounts for previous care).

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