FACILITY: Phoenixville Hospital	
MANUAL: Organizational (Administrative)	**FOLDER:** Rights and Responsibilities of the Individual
TITLE: Patient Financial Assistance	**DOCUMENT OWNER:** Patient Access Director
DOCUMENT ADMINISTRATOR: Sr. Vice President, Revenue Cycle	**KEYWORDS:**
ORIGINAL DATE: September 2017	**REVISION DATE(S):** 10/20, 02/25

SCOPE:
Phoenixville Hospital

PURPOSE:
To ensure standard procedures are established and practiced throughout Phoenixville Hospital in reference to identifying and consistently assisting patients in need of financial assistance. Phoenixville Hospital is designated as a charitable organization under Internal Revenue Code (IRC) Section 501(c) (3). In compliance with IRC Section 501(r), it is required to establish and widely publicize the organization's financial assistance policy. The intention of the policy is to identify and serve patients in financial need, as well as to create an increased awareness of the availability of financial assistance throughout the Health System and community.

POLICY:
As part of the Phoenixville Hospital mission of providing compassionate, accessible, high-quality, cost-effective healthcare to the community, there is recognition that not all patients have an equal ability to pay for medical services. Phoenixville Hospital shall widely publicize the availability of financial assistance to the community through the hospital website, brochures and engagement with community advocacy groups. Financial counselors will educate patients and families in reference to available resources and will provide assistance with the financial assistance application and approval process to ensure all patients continue to have the opportunity to access the care they need.

DEFINITIONS:
Amounts Generally Billed (AGB): Section 501(r)(5)(A) requires a hospital organization to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization's FAP (FAP-eligible individuals) to not more than the amounts generally billed to individuals who have insurance covering such care. AGB is calculated using the prospective method based on Medicare fee for service rates.

EMTALA (the Emergency Medical Treatment and Labor Act): Federal regulatory requirement which states any hospital that accepts payments from Medicare to provide care to any patient who arrives in its emergency department for treatment, regardless of the patient's citizenship, legal status in the United States or ability to pay for the services.

Federal Poverty Guidelines (FPL): These guidelines are published annually in the Federal register and are utilized to determine a baseline for the poverty level. The Department of Health and Human Services publishes this statistical information.

Financial Assistance: Healthcare provided to patients without the expectation of payment for services, in whole or in part, as determined by a patient's financial inability to pay.

Guarantor: The individual who is legally and financially responsible for payment of a patient's bill.

High dollar services: For purposes of this policy, high dollar services are defined but not limited to services being generated by high-cost departments, such as high-end imaging, cardiology, perioperative services, scheduled admissions, and respiratory services, as well as outpatient therapy services.

Household composition: Defined as: Patient/Spouse, any biological or adopted children under the age of 18 years old.

Household income: Income of those residing in the household, includes but not limited to wages, interest, dividends, social security benefits, veterans' benefits, pensions and spousal income. For the purpose of eligibility of financial assistance, examples of income which are excluded are temporary assistance for needy families (TANF) benefits, supplemental nutrition assistance program (SNAP) benefits, low income home energy assistance program (LIHEAP) benefits, and weatherization benefits.

Medicaid: A joint federal and state program that assists with medical costs for some people who have limited income and resources.

Medically necessary services: Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Presumptively eligible patients: Patients who are presumed to be eligible for financial assistance based on life circumstances such as homelessness, zero income, or previous eligibility for financial assistance programs.

Underinsured patients: Patients who have insurance coverage which results in high patient financial responsibility toward payment of their medical bills.

Uninsured patients: Patients who have no insurance coverage available for their medical needs.

PROCEDURE:

1) Creating awareness of the Patient Financial Assistance option

a) The current Financial Assistance policy and applications for financial assistance, in English and Spanish, are accessible at https://towerhealth.org/locations/phoenixville-hospital/billing/financial-assistance. Additionally, Tower Health maintains, and updates on at least a quarterly basis, a list of all providers (identified by name, practice group/entity, hospital department or type of service) delivering emergency or other medically necessary care at Phoenixville Hospital specifying which providers are and are not covered by this Patient Financial Assistance policy. This provider list is available online at the following Phoenixville Hospital website address: https://www.towerhealth.org/providers/. Fees for services provided by physicians who are not employed by Phoenixville Hospital are excluded from the financial assistance policy.

b) Pamphlets titled Understanding Billing & Payment include the plain language summary of the Financial Assistance policy. The pamphlets, printed in English and Spanish, will be available

in lobbies and waiting areas throughout Phoenixville Hospital. These pamphlets provide an easy-to-read summary of the financial assistance program, with contact information of Phoenixville Hospital employees who will assist the patients with the application process. These pamphlets are also distributed to patients at the points of registration throughout Phoenixville Hospital. Patients who are uninsured or who express the inability to pay at point of service are provided with the pamphlet. Emergency patients in these situations are provided with the pamphlet at the time of discharge.

c) Patient billing statements for Phoenixville Hospital services contain guidance and direction on the availability of the financial assistance program. In addition, the back of the billing statement is a financial assistance application.

d) Phoenixville Hospital will work closely with advocacy programs in the community. The availability of Phoenixville Hospital financial assistance policy is shared with those agencies.

2) Identifying patients in need of Financial Assistance for medically necessary services:

a) As a result of the Phoenixville Hospital patient financial services verification-of-coverage process, there will be the opportunity to identify uninsured patients and underinsured patients. Phoenixville Hospital financial counseling resources will assist these patients with the Medicaid application process.

b) Patients who are denied Medicaid coverage, or who are screened and determined to not meet the Medicaid coverage criteria, will be considered for the Patient Financial Assistance program.

c) Phoenixville Hospital patient financial services will utilize available eligibility resources to determine insurance coverage and benefits available to all patients. For scheduled patients, the verification of coverage will take place prior to patient's arrival for all high dollar services (ex. MRI, CT Scan, surgical procedures, cardiology services). Scheduled patients receiving services that are not defined as high dollar, as well as unscheduled patients, will have coverage verified at the time of check in. As a result of the verification of coverage process, patients may be requested to pay their confirmed patient liability amount prior to check in. Emergency medicine patients will have coverage verified after the point-of-medical screening exam, as required by EMTALA guidelines.

d) Phoenixville Hospital billing and collection policy outlines the process by which Phoenixville Hospital will charge and bill uninsured patients and pursue the collections of outstanding balances. The uninsured rate is 25% of AGB and is applied at the time of billing. This separate Phoenixville Hospital billing and collection policy is available online on the Phoenixville Hospital website, and a paper copy can be obtained, free of charge, by e-mailing call.center@towerhealth.org or by calling 484-628-5683.

- Cosmetic procedures have an established self-pay fee schedule and are not subject to the Uninsured payment rates.

3) Determining eligibility for Financial Assistance

a) Patients who are seeking, or have received any emergency or medically necessary services and who demonstrate the inability to pay for services, will be considered for the financial

assistance policy.

b) Patients visiting from out of the country and requiring emergency services are eligible for consideration of financial assistance. However, patients visiting the United States with the intent of receiving non-emergent care are not generally eligible for financial assistance.

a) Patients will be requested to provide verification of household income along with the names of people residing in the household, as a requirement of the application process. Application listing income and assets. Must provide the following for income verification:

- Current pay stubs or written verification from employer.
- W-2's and/or 1099's.
- Form approving or denying unemployment or worker's compensation.
- Written verification from public welfare agencies or any governmental agency of the patient's income.
- Self-employed provide complete tax forms from most recent filing, including schedule C.
- Most recent bank statements for all open accounts (for asset verification only).

c) An allowance amount is assigned to each FPL category and is calculated using the assigned percentage of the Medicare-Fee For-Service Rate. For patients above 400% of the FPL, the uninsured rate applies.

FPL Category	Allowance	Maximum patient payment per encounter/visit
= < 200% FPL	100% financial assistance allowance	$0
between 201% up to 250% FPL	90% allowance on MCR FFS rate	$300
between 251% up to 300% FPL	80% allowance on MCR FFS rate	$500
between 301% up to 350% FPL	70% allowance on MCR FFS rate	$1,000
between 351% up to 400% FPL	50% allowance on MCR FFS rate	$2,000

b) While it is ideal to initiate the process as soon as possible, patients are eligible to request consideration of financial assistance within 240 days from first patient statement date.

c) Patients determined eligible for financial assistance will be charged less than gross charges for any non-emergent and non-medically necessary care provided by the hospital.

d) Decisions pertaining to eligibility for financial assistance will be made within 14 days of receipt of a complete financial assistance application. Incomplete applications will be reviewed and attempt to contact the patient/guarantor for additional information will be made. A confirmation letter will be sent to the patient describing the outcome of the decision. The revised billing statement will take into consideration any excess payments made by the patient in determining the amount due.

When financial assistance is approved, the confirmation letter will also serve as a means of specifying the timeframe covered by the financial assistance determination. Approved financial assistance applications are good for one (1) year from the initial date of service.

e) If financial assistance is not approved, letters will be sent describing the reasons for the decision, as well as information for who should be contacted for other payment options. Should patients wish to appeal the decision, directions regarding the appeals process will also be provided.

f) Patients or guarantors who disagree with the outcome of the financial assistance eligibility decisions will have the opportunity to appeal the decision. Review of the appeal request will be the responsibility of the Public Benefits Department.

2) <u>Presumptive Eligibility</u>

Patients may be eligible for a discount of the full unpaid balance in the absence of a completed financial assistance application form if the patient meets one of the following:

- Is homeless or resides in low-income subsidized housing.
- Is deceased.
- Is currently eligible for Medicaid (as primary insurance) but was not at date of service OR
- Medicaid benefits are exhausted or charges for services that are non-covered by Medicaid.
- Is currently eligible for Rx assistance, SNAP/Food stamps or WIC.
- Is eligible to receive benefits from a governmental agency as the victim of a violent crime or sexual assault and the treatment is related to the violent crime or sexual assault.
- A demonstrated inability to pay for services based on all available assets. Patients receiving care in or from the emergency department who are without financial resources may be eligible for the financial assistance policy if they are unemployed or self-employed and cannot provide income an income tax statement, are indigent without access to the required application documentation.

GUIDELINE:

PROVIDER PROTOCOL:

EDUCATION AND TRAINING:
Patient Access Management team will be responsible for annual education on expectations covered in this policy. New patient access employees will be educated as part of their initial orientation.

REFERENCES:

COMMITTEE/COUNCIL APPROVALS:

CANCELLATION:
The content of this document supersedes all previous policies/procedures/protocols/guidelines, memoranda, and/or other communications pertaining to this document.