INTRODUCTION

It is the policy of Ellis Medicine to provide financial assistance to every patient residing in the communities we serve for medically necessary health services, regardless of their ability to pay. This policy applies to those individuals who: (1) have a financial responsibility for services provided by Ellis Medicine, (2) have exhausted all insurance benefits, (3) may qualify for a governmental program, (4) have limited insurance benefits, and/or (5) meet the income levels as set in this policy.

PURPOSE OF POLICY

A. To establish criteria and procedures to assist patients who are unable to pay their financial obligation.

B. To define the level of expected payment from patients who have a financial obligation.

C. To balance the financial obligations of patients with the broader fiscal responsibilities of Ellis Medicine.

D. This policy outlines the eligibility procedures for Financial Assistance in accordance with federal, state and local laws.

E. Patients seeking emergency medical care will be treated regardless of their ability to pay and in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

DEFINITION OF TERMS

A. Financial Assistance – reduced cost of medical care for services provided by Ellis Medicine that are medically necessary and where the patient does not qualify for Medicaid or some form of governmental insurance program and is underinsured or uninsured. This would include instances in which benefits have exhausted and/or where services rendered are non-covered. Financial Assistance is available for anyone seeking emergency hospital services, including emergency transfers as established under EMTALA. Financial Assistance is not available for admission(s) to our Skilled Nursing
Facility and non-emergent elective services such as cosmetic or dental procedures. Some bariatric procedures are also excluded. Patient must be a legal resident of the US.

B. **Medically Necessary Services** - are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.

C. **Financial Assistance Fee Schedule** - a fee schedule developed to determine a patient’s financial obligation when their income falls between 0% and 300% of the most recent Federal Poverty Guidelines. The Federal Poverty Guidelines and Financial Assistance Guidelines can be found in *Exhibit B*. This is revised yearly as the Federal Poverty Guidelines change.

D. **Patient Financial Obligation** is the amount owed by the patient after all other sources of third party coverage, including but not limited to private health insurance, medical savings accounts, federal and state government programs, workers’ compensation insurance or other responsible insurance, such as automobile or third party liability insurance. Amounts covered by this policy do not include physician professional charges not billed by Ellis Medicine. Deductibles, co-payments or co-insurance amounts may be covered under this policy if the patient meets the criteria outlined in this policy.

E. **Urgent/Emergent Services** - defined as conditions in which the life or limb of the patient is in immediate danger and in which any delay in administering treatment or care would significantly increase such danger.

F. **Non-Urgent/Elective Services** - defined as a condition in which the next available date for scheduled admission or visit/procedure is not considered to cause an adverse effect on the patient’s health or welfare, including dental, cosmetic and bariatric surgeries/procedures, although certain of these procedures could possibly be considered urgent/emergent based on specific circumstances.

G. **Presumptive Financial Assistance** is a determination that the patient is eligible for assistance when adequate information is provided by the patient or through other sources which allows Ellis Medicine to determine that the patient meets the Financial Assistance guidelines for coverage.
PROCEDURES AND GUIDELINES

General Guidelines

A. Identification of potentially eligible patients can take place at any time during the rendering of non-emergent services or during the collection process.

B. Financial Assistance is a program that is available at any time within 240 days of the first post discharge bill or service date.

C. Any patient payments for services provided by Ellis Medicine prior to approval of Financial Assistance will be evaluated to determine patient financial responsibility. If it is determined the patient financial responsibility is less than what the patient paid, a refund will be provided to the patient within a reasonable amount of time.

D. Only completed Financial Assistance applications will be reviewed. If an application is incomplete, Ellis will make a good faith effort to contact the patient to obtain the missing information.

E. Financial Assistance applications will be reviewed within two weeks of receipt of a complete application or after reasonable follow-up efforts have been taken to collect missing information. Determination of application will be sent in writing to the patient within two weeks of a decision (total of 30 days).

F. Those patients who may qualify for a governmental program (Medicaid or other governmental program) will be referred to the appropriate program. They will sign a release stating such programs may contact them to start the approval process. This will not suspend the processing or possible approval of Financial Assistance.

G. Financial Assistance determinations will be periodically reviewed by Corporate Compliance to ensure adherence to the policy and external regulations.

H. Information from the applicant’s Financial Assistance application and supporting documentation will be applied to the Financial Assistance guidelines for determination.

I. Verification will include one of the following: the applicant’s most current pay statement, Social Security benefit form, Worker’s Compensation or others as listed on the Financial Assistance application.

J. Non-payment will result in account being sent to a collection agency after standard billing cycle is complete.

K. Financial Assistance application will be maintained within the Department.

L. Any patient identified as homeless will be awarded Financial Assistance at Tier 1 (100%)
Identifying Patients Eligible for Financial Assistance

A. Ellis Medicine will attempt to identify patient’s eligible for Financial Assistance as soon as possible, either prior to services being provided, during or after.

B. Attempts at determining Financial Assistance eligibility will cease no later than 240 days from the first post discharge bill or service date if unable to make determination.

Presumptive Financial Assistance

Presumptive Financial Assistance determinations will be made by using publically available data and financial information provided by the patient to determine eligibility for self-pay patients.

A. Patient’s account will be placed with self-pay vendor to determine the patient’s ability to meet their financial responsibility.

B. The patient’s Social Security number is helpful in determining their Financial Assistance coverage but is not required.

C. The self-pay vendor will score each patient based on publically available data that will then be used to place them in the corresponding Federal Poverty Level.
   
   a. The scoring will not be used to deny Financial Assistance.

D. 100% Assistance for households up to 300% of Federal Poverty Levels

E. If the account is eligible for presumptive assistance the self-pay vendor will close the account and notify Ellis where the patients income puts them on the Federal Poverty Scale.

F. The appropriate adjustment, if approved, will be made on the account.

Emergent/Urgent Services

A. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial patient interview, the following information should be gathered:
   
   1. Routine and comprehensive demographic data.
   2. Complete information regarding all existing third party coverage.
   3. Family size and income.

B. For patients treated in the Emergency Room, no discussion of their financial obligation will occur until the checkout process following their treatment.
Financial Assistance Appeals Process if Application is Denied

A patient may be determined ineligible for Financial Assistance based on the guidelines of this policy. If it is determined the patient is ineligible for Financial Assistance the patient can appeal in writing to the Patient Financial Services Department.

Reasons for Potential Denial of Financial Assistance

1. Patient does not complete or provide needed documentation to appropriately make determination.
2. Sufficient income, not meeting the income guidelines based on the Federal Poverty Level.
3. Uncooperative, despite reasonable efforts to work with the patient. (i.e. providing additional documentation)
4. Incomplete Financial Assistance application, despite reasonable efforts to work with the patient.
5. Withholding insurance payment and/or insurance settlement funds.
6. Failure to participate and cooperate with outside collection agencies.

Appeals Process

1. A formal letter written to the Patient Financial Services department for reconsideration MUST be received within 2 weeks of denial notification.
2. Consideration of change in wages that would provide a different result than the current paystub or other proof of income. Proof of change in wages MUST be received in this case.
3. A review of prior payment history will be conducted.
4. All cases need to be below 400% of the Federal Poverty level to be considered.
5. Within 14 days of receiving the letter, review of the supporting documentation will take place and the Director will inform the Manager of Self Pay/Customer Service of the decision made and advise to uphold or overturn the original denial decision.

If approved, it will be in effect for up to 3 months. After that point in time, a new letter requesting Hardship consideration will be required along with the additional income documentation to support the request.

Non-Urgent/Elective Services

Non-urgent or elective services will not be covered by Financial Assistance. Financial Advocates are available to discuss various programs and services available to patients to assist them in meeting their financial obligation for services requested.
Communication of Policy with Patients and the Public

A. Ellis will post notices regarding the availability of Financial Assistance throughout the organization in both English and Spanish. These notices and the Financial Assistance application will be posted and available in both languages in all service areas throughout the facility including patient access/registration, the cashier/billing office, emergency department and other appropriate settings including the Ellis Medicine website.

B. If English is not your primary language, Ellis Medicine has a translation service available.

C. A list of all providers that are included in this policy can be found on the Ellis Medicine Website (www.ellismedicine.org).

D. Every posted notice regarding Financial Assistance will contain a statement indicating that the facility has a Financial Assistance policy for low-income patients who may not be able to pay their bill and brief instructions regarding how to apply. The notices will include a telephone number that can be used by a patient or family member who is requesting information.

E. Ellis will ensure that staff members in the patient access/registration areas and in the Billing Office are knowledgeable about the existence of Financial Assistance policies. In communication with patients and families regarding Financial Assistance, Ellis will attempt to communicate in the primary language of the patient, or his/her family, if reasonably possible. This will be done in a manner consistent with all applicable federal and state laws and regulations.

F. A written notice on the billing statement will inform the patient that financial assistance may be available either from a government program or through the Financial Assistance policy along with a contact.

Billing and Collection Practices

Current billing and collections policies can be found in the Patient Financial Obligations Policy, Credit and Collections Policy, Referral to Bad Debt Collection Policy, and the Self-pay Discount Policy.

A. At the time of billing, Ellis will provide to all uninsured patients the same information on services and charges that is provided to all other patients receiving care.

B. If the account has been placed at a collection agency, the agency will be notified to suspend collection efforts until a determination is made.

   a. All collection agencies will comply with Ellis Medicine’s FAP and provide information to patients on how to apply.
Communication of Policy with Patients and the Public (continued)

C. Charges from *private doctors* that Ellis Medicine does not bill for who provide services in the hospital are not covered by this policy. You should talk with your private doctor(s) to see if they offer a discount, financial assistance or payment plan for services they provide. A list of providers covered by this policy can be found on the Ellis Medicine website.

D. **Hospital Billing** – For those approved for Financial Assistance, the full balance owed will be written off and the account balance brought to zero.

E. **Physician Billing** – For those approved for Financial Assistance, the full balance owed will be written off and the account balance brought to zero.

F. **Dental Billing** – Rates will be determined by the current highest volume managed Medicaid payer.

**Exhibits**

A. Uninsured Discount

B. 2019/2020 Federal Poverty and Ellis Financial Assistance Guidelines
   - The grid is updated yearly – expected release dates are January or February of the current year.

C. Financial Assistance Tier Summary

**ORIGINAL IMPLEMENTATION DATE:** 05/01/06  
**REVIEW DATE:** 03/07, 05/10, 07/14, 1/20  
**REVISED DATE:** 10/08, 11/09, 05/10, 03/12, 07/13, 12/15, 2/16, 3/18, 1/19, 3/19, 1/20

**REVIEWED BY:**
Board Finance and Planning Committee  
Director, Patient Financial Services  
Director, Reimbursement  
Manager, Patient Financial Services  
Corporate Compliance Officer

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Patient Financial Obligations and Financial Assistance  
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Exhibit A. Uninsured Discount (Self Pay discount)

<table>
<thead>
<tr>
<th>Service</th>
<th>Self-Pay Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Technical/Professional</td>
<td>$250.00 per Visit as initial down payment and billed for remaining balance. An uninsured discount equal to 50% will be applied to the total charges on the account and the initial payment will be credited towards the discounted total. The uninsured discount is not applied to copay, deductible, or coinsurance amounts.</td>
</tr>
<tr>
<td>Emergent Technical/Professional</td>
<td>$150.00 per Visit as initial down payment and billed for remaining balance. An uninsured discount equal to 50% will be applied to the total charges on the account and the initial payment will be credited towards the discounted total. The uninsured discount is not applied to copay, deductible, or coinsurance amounts.</td>
</tr>
<tr>
<td>Outpatient/Inpatient</td>
<td>An uninsured discount equal to 50% will be applied to the total charges on the account and any initial payment will be credited towards the discounted total. The uninsured discount is not applied to copay, deductible, or coinsurance amounts.</td>
</tr>
<tr>
<td>Clinic / Professional</td>
<td>An uninsured discount equal to 50% will be applied to the total charges on the account and any initial payment will be credited towards the discounted total. The uninsured discount is not applied to copay, deductible, or coinsurance amounts.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Household/ Family Size</th>
<th><em>100%</em></th>
<th>200%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,490</td>
<td>24,980</td>
<td>37,470</td>
<td>49,960</td>
</tr>
<tr>
<td>2</td>
<td>$16,910</td>
<td>33,820</td>
<td>50,730</td>
<td>67,640</td>
</tr>
<tr>
<td>3</td>
<td>$21,330</td>
<td>42,660</td>
<td>63,990</td>
<td>85,320</td>
</tr>
<tr>
<td>4</td>
<td>$25,750</td>
<td>51,500</td>
<td>77,250</td>
<td>103,000</td>
</tr>
<tr>
<td>5</td>
<td>$30,170</td>
<td>60,340</td>
<td>90,510</td>
<td>120,680</td>
</tr>
<tr>
<td>6</td>
<td>$34,590</td>
<td>69,180</td>
<td>103,770</td>
<td>138,360</td>
</tr>
<tr>
<td>7</td>
<td>$39,010</td>
<td>78,020</td>
<td>117,030</td>
<td>156,040</td>
</tr>
<tr>
<td>8</td>
<td>$43,430</td>
<td>86,860</td>
<td>130,290</td>
<td>173,720</td>
</tr>
<tr>
<td>9</td>
<td>$47,850</td>
<td>95,700</td>
<td>143,550</td>
<td>191,400</td>
</tr>
<tr>
<td>10</td>
<td>$52,270</td>
<td>104,540</td>
<td>156,810</td>
<td>209,080</td>
</tr>
</tbody>
</table>

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Exhibit C. Financial Assistance Tier Summary
(Dental Services are indexed off the Highest Volume Managed Medicaid Payer Rate)

<table>
<thead>
<tr>
<th>Income Tier*</th>
<th>% of FPL</th>
<th>Financial Assistance Award</th>
<th>Dental Financial Assistance Award</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(highest vol. payer rates)</td>
</tr>
<tr>
<td>1</td>
<td>0% - 300%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>0% - 200%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Tiers 2 & 3 were removed with the 2018 policy update. Tier 4 remains for consistency in the Tier category and description.

Example of Financial Assistance
A Patient is provided services that total $1,500 in Hospital charges for a Magnetic Resonance Imaging (MRI) test. The chart below depicts how Financial Assistance would apply to eligible patients receiving this MRI test who fall into each of Ellis' Financial Assistance tiers.

<table>
<thead>
<tr>
<th>Tier</th>
<th>% of FPL</th>
<th>Total Net MRI Charge (50% discount applied)</th>
<th>Financial Assistance Award of Medicare-equivalent rate</th>
<th>Patient's Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0-300%</td>
<td>$750 ($1500 @ 50%)</td>
<td>100%</td>
<td>$0</td>
</tr>
</tbody>
</table>

For comparison purposes, a self-pay patient with income exceeding 300% of Federal Poverty Guidelines would be charged $750 for this MRI test, as the uninsured discount would be applied to the total charges on the account.