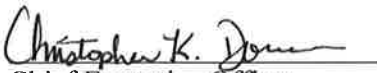



Tift Regional Health System System Policies and Procedures

<p>TITLE: Financial Assistance</p> <p>Effective Date: March 1, 2019</p> <p> Chief Executive Officer</p>	<p>FACILITIES:</p> <p><input checked="" type="checkbox"/> Tift Regional Medical Center</p> <p><input checked="" type="checkbox"/> Cook Medical Center</p> <p><input type="checkbox"/> Cook Senior Living Center</p>	<p>SYSTEM POLICY NUMBER:</p> <p>FUNCTION:</p> <p>Finance</p> <p> SVP, Chief Financial Officer</p>
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Application:

This Policy applies to the selected facilities above. Such facilities are referred to as a "TRHS Facility" in the singular and collectively as "TRHS Facilities".

Definitions:

- “CMC” means Cook Medical Center.
- “CSLC” means Cook Senior Living Center.
- “TRHS” means Tift Regional Health System.
- “TRMC” means Tift Regional Medical Center.

I. PURPOSE

Tift Regional Health System (“TRHS”) is a not-for-profit charitable corporation and is committed to providing financial assistance and community services to improve access to care.

II. POLICY

TRHS is committed to providing indigent and charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, TRHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. TRHS will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance – free or discounted (partial charity) care

- Includes a list specifying which providers delivering emergency and/or other medically necessary care in the hospitals that are covered by this policy and which are not (Appendix A)
- 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 the method by which patients may be presumptively determined to qualify for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the hospital for commercially insured or Medicare patients

In order to manage its resources responsibly and to allow TRHS to provide the appropriate level of assistance to the greatest number of persons in need, the following guidelines have been established for the provision of patient indigent and charity assistance.

III. DEFINITIONS

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

Tift Regional Health System (“TRHS”): This includes hospital campuses, Tift Regional Medical Center and Cook Medical Center and hospital based physician services to include Emergency Room Physicians, Anesthesiologists, Hospitalists, Critical Care Physicians, Oncology, and Cardiovascular Surgery. Community physicians and independent specialists who are not employed by TRHS will not be subject to this policy.

Indigent Care: Indigent Care results from a provider’s policy to provide healthcare services free to individuals with family income less than or equal to 125% of the U.S. Federal Poverty Guidelines.

Charity Care: Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals with family income at least 126% but less than or equal to 225% of the U.S. Federal Poverty Guidelines.

Application Period: The 240-day period beginning with the first post-discharge billing statement reflecting the patient’s liability.

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 purposes of the provision of financial assistance. A dependent attestation form may be completed if the income tax returns are not available.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, 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 sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

IV. PROCEDURES

A. **Services Eligible Under This Policy.** For purposes of this policy, "indigent" "charity" or "financial assistance" refers to healthcare services provided by TRHS without charge or at a discount to qualifying patients. The following healthcare services are eligible for indigent and charity:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening

circumstances in a non-emergency room setting; and

4. Medically necessary services as defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

B. Services Not Eligible Under this Policy. Generally, the following services are not eligible for indigent or charity:

1. Elective or cosmetic procedures. For purposes of this Policy an “elective or cosmetic procedure” is a procedure which the Georgia Medicaid Program would not cover if the patient was a Medicaid beneficiary.
2. Reoccurring outpatient therapies which exceed the number of visits that would customarily be covered by a private insurer.
3. Services required while the patient is incarcerated or in the custody of law enforcement when law enforcement is responsible for the cost of the service.
4. Accounts that are covered under liability or workers’ compensation with no proof of denial of coverage.

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

D. Method by Which Patients May Apply for Charity Care.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
 - a. Include an application process, in which the patient or the patient’s guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
 - b. Include the use of external publically available data sources that provide information on a patient’s or a patient’s guarantor’s ability to pay (such as credit scoring);
 - c. Include reasonable efforts by TRHS to explore appropriate

alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs; and

- d. Take into account the patient's available assets, and all other financial resources available to the patient (only if the total verified income is more than 125% but less than or equal to 225% of the Federal Poverty Guidelines for the specified family size).
2. It is preferred but not required that a request for a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the application period. The application period begins with the receipt of the first post-discharge patient statement and concludes after 240 days. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.
 3. TRHS values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and TRHS shall notify the patient or applicant in writing within 30 days of receipt of a completed application.
 4. Every determination is documented in the Health Information System. The Financial Counselor maintains the application, along with all accompanying financial documentation, in the patient's record.
 5. If approved for assistance, the patient's account is adjusted appropriately using proper adjustment codes.
 6. If an application is denied, the reasons for the denial are included in the written notice.
 7. If an application is denied or if the charges are only reduced, the written notice also includes instructions as to how the patient may seek reconsideration if he/she disagrees with the decision. The instructions for reconsideration include the title/name and contact information of a TRHS Facility personnel member who will handle the reconsideration.
 8. Each written determination contains the toll free number for the Georgia Department of Community Health, which the patient may contact if he/she disagrees with the TRHS Facility determination regarding eligibility for assistance.

E. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for charity care discounts, but there 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, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, TRHS could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address; and
8. Patient is deceased with no known estate.

F. **Eligibility Criteria and Amounts Charged to Patients.** Services eligible under this Policy will be made available to the patient in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by TRHS to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts TRHS will charge patients qualifying for financial assistance is as follows:

1. Patients whose family income is at or below 225% of the FPL are eligible to receive free care (discount of 100% of patient liability);
2. Patients whose family income exceeds 225% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of TRHS; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital for) Medicare patients.

- G. **Communication of the Financial Assistance Program to Patients and Within the Community.** Notification about financial assistance available from TRHS, which shall include a contact number, shall be disseminated by TRHS by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, admitting and registration departments, and patient financial services offices that are located on facility campuses, and at other public places as TRHS may elect. TRHS also shall publish and widely publicize a summary of this financial assistance policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital as TRHS may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by TRHS. Referral of patients for financial assistance may be made by any member of the TRHS staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
- H. **Relationship to Collection Policies.** TRHS management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from TRHS, and a patient's good faith effort to comply with his or her payment agreements with TRHS. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, TRHS may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. TRHS will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:
1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital;
 2. Documentation that TRHS has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements;
 3. Documentation that the patient does not qualify for financial assistance on a presumptive basis;
 4. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

- I. **Regulatory Requirements.** In implementing this Policy, TRHS management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.
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Original Effective Date: March 1, 2019

Revise/Review History:

Replaces “*Indigent/Charity Care Assistance*” policy

Please Note: A printed copy of this Policy may not be the most recent version. The official current version of this Policy is maintained in the TRHS electronic policy system.