FACILITY: Tower Health at Home		
MANUAL: Organizational (Administrative)		**FOLDER:** Rights and Responsibilities of the Individual
TITLE: Patient Financial Assistance		**DOCUMENT OWNER:** Revenue Cycle Manager
DOCUMENT ADMINISTRATOR: Chief Operating Officer		**KEYWORDS:**
ORIGINAL DATE: August 2019	**REVISION DATE(S):**	

SCOPE:
Tower Health at Home

PURPOSE:
To ensure standard procedures are established and practiced throughout Tower Health at Home in reference to identifying and consistently assisting patients in need of financial assistance. Tower Health at Home 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 Tower Health at Home's 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. Tower Health at Home shall widely publicize the availability of financial assistance to the community through the agency website, brochures and engagement with community advocacy groups. Agency staff 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 the organization to limit amounts charged for 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.

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 hospice and therapy services.

Household composition: Determined by the tax household size. Household size includes but not limited to tax filer, tax filer's spouse and other tax dependents.

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://towerhealthathome.org/.

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 Tower Health at Home patient admission packets and upon request. These pamphlets provide an easy-to-read summary of the financial assistance program, with contact information of Tower Health at Home employees who will assist the patients with the application process. These pamphlets are also distributed to patients at the points of registration throughout Tower Health at Home. Patients who are uninsured or who express the inability to pay at point of service are provided with the pamphlet..

c) Patient billing statements for Tower Health at Home 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) Tower Health at Home will work closely with advocacy programs in the community. The availability of Tower Health at Home financial assistance policy is shared with those agencies.

Examples are Berks Western Clinic, Opportunity House, Berks Encore, Berks Community Health Center and Daniel Torres Hispanic Center, as well as the County Assistance Office.

2) <u>Identifying patients in need of Financial Assistance for medically necessary services</u>:

a) As a result of the Tower Health at Home patient financial services verification-of-coverage process, there will be the opportunity to identify uninsured patients and underinsured patients. Tower Health at Home 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) Tower Health at Home 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.

d) Tower Health at Home billing and collection policy outlines the process by which Tower Health at Home will charge and bill uninsured patients and pursue the collections of outstanding balances. The uninsured rate is 70% of AGB and is applied at the time an initial payment is made. This separate billing and collection policy is available online at https://towerhealthathome.org, and a paper copy can be obtained, free of charge, by calling 610-378-0481.

3) <u>Determining eligibility for Financial Assistance</u>

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

b) The assistance can be used for direct patient care services only, except for Hospice medical supplies when no other reimbursement source is available.

c) The maximum number of approved visits per client per month should not exceed 12 visits. Services are capped at 20 visits total. Any request which exceeds monthly or total visit caps must approved by the Chief Operating Officer & Revenue Cycle Manager

d) Patients visiting the United States with the intent of receiving non-emergent care are not generally eligible for financial assistance.

e) 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. This information is utilized in determining where the household falls within the Federal Poverty Level Guidelines (FPL). The FPL category will determine the patient or guarantor contribution amount toward their medical bill as indicated by the chart below.

f) 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

g) Patients can also be determined to be presumptively eligible for financial assistance based on their current circumstances. Tower Health at Home will utilize all available resources to verify presumptive eligibility. For example: electronic verification resources, management letters from family members or shelters, and/or the patient's own description of their current life circumstance will be taken into consideration. Patients qualifying for presumptive eligibility will receive 100% financial assistance.

h) Patients are encouraged to begin applying for financial assistance as early as possible in the process of accessing medical care. The sooner Tower Health at Home becomes aware of the financial need, the greater the opportunity exists to successfully connect the patient with potential resources such as Medicaid or other assistance or insurance programs. While it is ideal to initiate the process as soon as possible, patients are eligible to request consideration of financial assistance at any point in the billing and collection cycle. If the financial assistance application is initiated while the account is in the collection's process, collection activity will cease until determination of eligibility has been made.

i) Patients determined eligible for financial assistance will be charged less than gross charges for any non-medically necessary care provided by Tower Health at Home.

j) At start of care, when the financial assistance visits are approved, they will be entered as authorized visits in the electronic health record system. The authorization for visits will include all disciplines and will be tracked to ensure that visit caps are not exceeded.

k) Decisions pertaining to eligibility for financial assistance will be made within 7 days of receipt of a complete financial assistance application. Incomplete applications will be reviewed and attempts to contact the patient/guarantor for additional information will be made. A confirmation letter in English and Spanish, and a revised patient billing statement, 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 time frame covered by the financial assistance determination. The confirmation letter will contain a contact name for the patient to retain as a reference and resource for additional questions.

l) If financial assistance is not approved, letters in English and Spanish will be sent describing the reasons for the decision, as well as information on other payment options. Should patients wish to appeal the decision made, directions on the appeals process will also be provided.

m) Patients or guarantors who disagree with the outcome of the financial assistance eligibility decision will have the opportunity to appeal the decision. Review of the appeal request will be the responsibility of the Revenue Cycle Manager and Chief Operating Officer.

GUIDELINE:

PROVIDER PROTOCOL:

EDUCATION AND TRAINING:
Revenue Cycle team will be responsible for annual education on expectations covered in this policy. New employees will be educated as appropriate during 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.