The Medical Debt Crisis in Indianapolis: A Closer Look
Part Two- Financial Assistance Policies

A Report by the Hospital Accountability Project
An Initiative of
Citizens Action Coalition Education Fund
And
Indiana Legal Services
With support from Community Catalyst

EMBARGOED UNTIL WEDNESDAY, JUNE 22 AT 2:00PM
About the Indianapolis Hospital Accountability Project

The Citizens Action Coalition Education Fund (CACEF) was established in 1976. CACEF’s mission is “To improve the quality of life of all inhabitants of the State of Indiana by conducting research, public education and development efforts to conserve natural resources, protect the environment and provide affordable access to essential human services.” CACEF is a 501(c)3 organization. Often CACEF partners with the Citizens Action Coalition of Indiana (CAC), a 501(c)4 membership organization that works statewide on consumer, health and environmental issues. Over the last thirty years these organizations have contributed measurably to improving the lives of Hoosiers from all socioeconomic spheres.

Incorporated more than forty years ago, Indiana Legal Services, Inc. (ILS) is the largest poverty law firm in Indiana, serving clients in all 92 Hoosier counties. Its mission is to provide poor people with a wide variety of aggressive, quality legal services which will effectively help them to gain equal access to the courts; empower them to control their lives; and impact on the major causes of poverty. ILS attorneys provide free legal counsel on a wide range of civil legal matters; however, consumer law, income maintenance (public benefits) and health care are among the most often raised.

Community Catalyst is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society. Community Catalyst’s Hospital Accountability Project works with advocates across the country to implement state and local hospital practices that regularly involve the community in health planning, protect families from financial devastation due to medical debt, and allow the uninsured and underinsured to seek and receive needed health care services. The Indianapolis Hospital Accountability Project is funded by Community Catalyst. For more information, visit www.communitycatalyst.org.

The Indianapolis Hospital Accountability Project is a collaborative effort of the Citizens Action Coalition Education Fund and Indiana Legal Services. This is a second report following an initial report, which examined the impact of hospital debt and the strength of the hospital safety net in Indianapolis. This report will focus on the nonprofit hospitals’ financial assistance policies, how well they are complying with the new provisions under the PPACA, and best practices they could engage in to better serve the underinsured and uninsured citizens of Indianapolis.

Hospital Accountability Project: Working to ensure that nonprofit hospitals in Indianapolis earn the tax breaks they receive by providing an adequate amount of charity care to underinsured and uninsured citizens.
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Executive Summary and Recommendations

Summary

The Citizens Action Coalition Education Fund (CACEF) and Indiana Legal Services (ILS) began work on the Hospital Accountability Project (HAP) in 2008 to focus on the issue of medical debt within Marion County. The goal of the project is to ensure that the four Marion County nonprofit hospitals earn the tax breaks they receive by providing an adequate amount of free and/or reduced cost care, often referred to as charity care, to uninsured and underinsured citizens.

Hospital debt is a key element of the medical debt problem facing Marion County residents. Over the past two years, HAP has worked to improve Indianapolis nonprofit hospitals’ financial assistance policies to ensure that uninsured and underinsured citizens can access hospital care without incurring large amounts of debt by: a) identifying residents with significant hospital debt; b) conducting community meetings to educate these residents of their legal rights and responsibilities as medical consumers; c) dialoguing and negotiating with the hospitals to improve their written financial assistance policies and to increase public awareness about these policies. The Medical Debt Crisis Report, the first issued by HAP, examined how well Marion County nonprofit hospitals are fulfilling their charitable mission. HAP conducted a study from September 2009 through June 2010 and found that health insurance does not necessarily protect one from hospital debt and that half of people surveyed were unaware of financial assistance programs available. These findings support much of what has been reported nationally: in Indiana, hospital charity care is a secret to many patients who are truly in need of safety net services. This demonstrated that improvements must be made and Indianapolis nonprofit hospital financial assistance programs should not be a “best kept secret.”

To challenge the “best kept secret,” over the past 18 months, the Hospital Accountability Project has partnered with community organizations and conducted neighborhood meetings where an ILS attorney educated people on their rights and responsibilities as medical consumers. These instructional forums have produced scenarios where people have discovered significant errors in their hospital bills, negotiated arrangements to repay the outstanding debt without aggressive collection actions taken, and in several cases, received financial assistance after attending one of our meetings and knowing what to ask. The HAP staff has also met with key administrators at the county’s nonprofit hospitals to share consumer stories collected at our community meetings and to discuss their financial assistance policies. The Patient Protection and Affordable Care Act (PPACA) made some important changes to laws regarding financial assistance/community benefits and while regulations and details have yet to be issued, this presented an opportune time to provide feedback to hospitals and encourage them to comply with the new law in a way that will most help consumers.

While the hospitals shared their well-intentioned practices and procedures, the lack of knowledge among the public about available help raises the issue of this glaring disconnect between a hospital’s written policy and how that policy is implemented. This is a critically important issue.

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1 HAP recommendations from the initial report are provided in Appendix I.
since failure to adequately notify the public and implement the law could lead to revocation of nonprofit hospitals’ tax-exempt status.

Overall, these initial meetings were constructive, positive, and were usually met by hospital administrators with open attitudes and a desire to learn more about ways they may be able to improve their policies and procedures to better protect vulnerable consumers. From information received in our face-to-face meetings with hospital administrators and after carefully analyzing the financial assistance policies, our review indicates that IU Health has the most comprehensive written financial assistance policy.

St. Francis Hospital has the dubious distinction of having the least comprehensive financial assistance policy. This is troubling because our interactions with St. Francis Hospital representatives have been disappointing. Perhaps it is because their corporate headquarters are located in Northern Indiana, but our initial meeting with them yielded few answers and little willingness to engage in dialogue about improving their charity care and financial assistance policies. Much of our consumer outreach has been focused on the south side of Indianapolis, St. Francis’ main service area, so we have heard numerous horror stories about their harsh collection practices and failure to provide information about financial assistance to those in need. We are concerned that a lack of local decision-making is preventing St. Francis patients in Indianapolis from getting the help they need.

This second report will examine in detail the four nonprofit Indianapolis hospitals’ (St. Vincent Health, Sister of St. Francis Health Services, Community Health Network, and IU Health) financial assistance policies by looking for compliance with the basic provisions under the PPACA and using Community Catalyst’s Patient Financial Assistance Model Act as a guide for best practices that will most benefit vulnerable consumers.

Recommendations

The language in the PPACA regarding hospital financial assistance policies is vague and needs further clarification through rulemaking. In the meantime though, hospitals are reworking policies and we encourage them to take this opportunity to build a stronger safety net that will protect more Hoosiers. Along with the initial recommendations presented in our first report regarding notification, billing practices and measures to publicize financial assistance programs outside the hospital walls; HAP has further recommendations.

Eligibility Categories:

1. The financial assistance policies should include full free care, partial free care, and medical hardship categories.
   A. Full Free Care- Provided for those with incomes at or below 200% FPL with no asset test
   B. Partial Free Care- Provided for those with incomes at 201%-400% FPL with no asset test, based on a sliding fee scale.
   C. Medical Hardship- Provided for those whose hospital bills exceed 25% of the family’s annual income with assets that cannot cover the amount. Primary home and vehicle may not be considered.
Notification and Application Process:
1. Staff working in the relevant areas such as admissions, billing departments, emergency rooms, and neighborhood clinics should be consistently and regularly trained on the hospital’s financial assistance policy. They should be able to explain information about the programs and assistance the hospital offers and direct the patient to someone who will further assist them with questions. There should also be financial assistance applications available at each of these areas for staff to provide.
2. Screening for the uninsured and underinsured should occur at the point of service or at the front end of the hospital experience.
3. The policy must state how hospitals provide assistance in the application process.
   A. Documentation- Social Security Numbers should not be required. Assets should not be considered for full and partial free care.
   B. Timing-Once an application has been submitted, hospitals should determine eligibility within 14 days. The patient’s account should be placed on hold during this period.

Limiting Charges:
1. The amount owed by the uninsured should be calculated at the lowest rate paid by Medicare or Medicaid or the actual unreimbursed cost to the hospital for that particular service determined by the cost-charge ratio.

Debt Collection:
1. Payment plans should only be offered after determining that a government assistance program and/or financial assistance do not apply.
2. Those who qualify for government programs or financial assistance should be exempt from debt collection activity.
3. Accounts submitted to collection agencies that are later found to be eligible for financial assistance should be given the appropriate level of financial assistance. The hospital should also be required to refund any money the patient may have already paid on the account.
4. If collection actions are taken, the highest levels of hospital leadership should be engaged.
5. Any third party the hospital contracts with or uses in the collection process should abide by the same collection policy the hospital has in place.
Overview of Hospital Meetings

HAP began meeting with the nonprofit hospitals in September 2010 to initiate a dialogue about their financial assistance policies as well as share the findings from our first report and offer suggestions and recommendations to better address the medical debt crisis in Indianapolis. To help provide a face to this problem, HAP also shared numerous consumer stories collected at our community meetings. They all included a common theme: people without the means to pay their hospital bills were never informed by hospital personnel of any financial assistance programs. This lack of information is a critically important issue since failure to adequately notify the public and implement the law could lead to revocation of nonprofit hospitals’ tax-exempt status.

The initial meetings also provided HAP with an opportunity to hear from the hospitals about their current practices and focused mainly on areas of notification within the hospital, eligibility requirements, assistance in applying for financial assistance, billing and debt collection practices, as well as efforts to publicize their policies to the communities they serve. While the hospitals shared their well-intentioned practices and procedures, the lack of knowledge among the public about available help raises the issue of this glaring disconnect between a hospital’s written policy and how that policy is implemented. Overall these initial meetings were constructive, positive, and were usually met by hospital administrators with open attitudes and a desire to learn more about ways they may be able to improve their policies and procedures to better protect vulnerable consumers.

In advance of scheduling follow-up meetings, HAP requested the financial assistance policies from each of the four nonprofit hospitals, in order to determine how well their policy matches up with our recommendations. We were disappointed in the length of time it took the hospitals to fulfill our request. The lack of response by St. Francis to a number of communications made it necessary to send a certified letter asking for the policy, which hospital representatives had initially agreed to provide. However St. Vincent, IU Health, and St. Francis all stated the delay was due to revisions and updates being made to their policies as a result of the new law. HAP appreciates the hospitals’ efforts to comply with the new federal provisions and the open lines of communication put forth by Community, St. Vincent, and IU Health. Community Hospital was the first to send their policy and thus the first to begin meeting with HAP to answer specific questions. IU Health was next, followed by St. Vincent and finally St. Francis. For the purpose of this report, the analysis will be based on the current hospital policies and a separate section will be provided discussing what updates and revisions the hospitals say they are in the process of making.

From information received in our face-to-face meetings with hospital administrators and after carefully analyzing the financial assistance policies they provided to us upon request, our review indicates that IU Health has the most comprehensive written financial assistance policy.

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policies. Much of our consumer outreach has been focused on the south side of Indianapolis, St. Francis’ main service area, so we have heard numerous horror stories about their harsh collection practices and failure to provide information about financial assistance to those in need. We are concerned that a lack of local decision-making is preventing St. Francis patients in Indianapolis from getting the help they need.

Charles’ Story

Charles Melton went in for two surgeries at St. Francis Hospital on April 14, 2010. Charles, 62, and his wife, 70, started receiving the bills a month later. Due to their inability to pay the bill, Charles called the 1-800 number listed on the bill for help. He received the application for financial assistance in the mail from Hammond, Indiana and sent in the correct documentation including income and assets. Charles did not receive any word from St. Francis until the end of July 2010. Instead of informing him about his eligibility for charity care, he got a bill demanding payment, stamped FINAL NOTICE. His wife called to set up a payment plan of $226 per month and despite their earlier application for financial assistance, the billing agent never mentioned the possibility of any help. Charles and his wife paid $226 monthly until January 2011, when ill health forced Charles to retire and their already modest income plunged. They never got any response to their April 2010 request for financial assistance.

Charles and his wife first learned about the hospital’s legal responsibility to provide financial assistance/charity care at the Hospital Accountability Project community meeting in April 2011. They were able to learn more about their rights and responsibilities as medical consumers and felt better equipped and educated to know what to ask for when talking with St. Francis. Charles called the hospital back informing them of his presence at the community meeting and asked for information on charity care. Even then, Charles was continually pressured to set up another payment plan, but remained persistent in asking about charity care. The billing representative finally stated that papers would be mailed to his house, but he informed her that he had already filled out an application. After going back and forth, he agreed to have the papers mailed to him again, but after about a week there was still nothing in Charles’ mailbox. He called back and talked with a different representative. This representative, after asking a supervisor, told Charles another of set of papers would be mailed to him and that his previous application had been destroyed after six months. Charles was also asked to send in a payment. The application arrived three days later and Charles promptly returned it with all the information requested.

Three weeks later St. Francis notified Charles via mail about a missing signature on his application. He was told to resubmit a copy of all the original tax forms. These were included in the first application sent, but Charles was told to mail those back in by June 17th. No explanation was given as to why he needs to repeat this, and he is getting frustrated.
Overview of State and Federal Law Requirements

Both Indiana and federal law set requirements for nonprofit hospitals to provide financial assistance. For example, Indiana’s law (IC 16-21-9) sets parameters and requirements that nonprofit hospitals must meet for providing free and/or reduced cost care to patients, conducting community assessments to identify health care needs, creating community benefit plans for meeting those needs, evaluating the effectiveness of the community benefit plan, and also providing public notification through prominent postings within the hospital including the emergency room, waiting area, and the admission office waiting area.

In addition to state law, the recently passed PPACA adds new standardized IRS reporting requirements that nonprofit hospitals must meet to keep their federal tax-exempt status. The new reporting standards and financial assistance provisions serve as another important step towards cracking open “the best kept secret.” Through the IRS and new Schedule H that hospitals will be required to complete beginning next year, important information will now be made available to the public giving communities better insight on hospital budgeting and finance, policies on billing and debt collection, and financial assistance. The Secretary of the Treasury will receive audited financial statements from the hospitals along with the Schedule H where hospitals must report information on levels of bad debt, charity care and unreimbursed costs from government programs for all hospitals as well as community benefit costs borne by private nonprofit hospitals. These reports will be reviewed and given to Congress every year. The Secretary of the Treasury will be charged with reviewing each hospital’s community benefit activities every three years.

Specifically, Section 9007 of PPACA amends section 501(c)3 of the Internal Revenue Code by adding four new conditions hospitals must meet to qualify as tax-exempt under the federal tax code. The hospitals must:

1. Develop written financial assistance policies, which must state:
   o Whether they offer free or discounted care
   o Eligibility criteria for receiving financial assistance
   o The basis used to decide how much patients are charged for care
   o A description of how to apply for financial assistance

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2 Financial assistance is commonly referred to as Charity Care and Community Benefits. For the purpose of this report, financial assistance will be substituted for both.
Steps the hospital might take to collect payments, unless the hospital already has a separate billing/debt collection policy in place
- Measures to publicize the policy widely in the community the hospital serves

2. Limit what they charge for services:
   - Hospitals are prohibited from using “gross charges.” The term “gross charges” is not defined by law but is generally accepted to mean the hospital’s list price for services without any negotiated discounts.
   - If a patient qualifies for financial assistance and is in need of emergency or other medically necessary care, he or she may only be charged the “amounts generally billed” to insured patients for the same services.

3. Observe fair billing and debt collection practices.
   - Nonprofit hospitals need to make a “reasonable effort” to determine if a patient qualifies for financial assistance before pursuing “extraordinary” debt collection activities.

4. Conduct regular community needs assessment at least every three years, seek input from community members, make the assessments available to the public, and adopt strategies for meeting needs identified.\(^6\)

\(^6\) Unlike the other requirements that were effective March 23, 2010, the Community needs assessment will be effective after March 23, 2012.
What Are the Hospitals Doing?

Financial Assistance Policies:

IU Health (IUH)
- Full free care is available to patients with income levels at or below 200% of the FPG.
- Partial free care is available to patients with income levels between 201%-400% of the FPG, based on a sliding fee scale.
- Partial free care ends at 400% of the FPG for insured patients.
- Partial free care is available for uninsured patients above 400% of the FPG, based on a sliding fee scale. This ends once the amount has exceeded the uninsured discount of 40% already given by IUH.
- Eligibility for financial assistance is based on income and family size.
- A description of how to apply for assistance is provided along with necessary documentation to complete an application.
- Patients are responsible for initiating the financial assistance process. After receiving the application, the patient has 21 calendar days to return it.
- IUH allows 90 days to issue a determination.
- A written request may be submitted, along with supporting documentation, if a patient wants to appeal the financial assistance determination.
- There is no detail regarding billing and debt collections, unless IUH has a separate billing and debt collection policy in place. HAP has asked, but does not know the current status on this policy.
- There are no measures stated in the financial assistance policy to publicize the policy widely in the community.

Community Health Network (CHN)
- Full Free Care is available to those with income levels at or below 200% of the FPG.
- Eligibility for Full Free Care is based on family size, income, and whether the patient has other financial resources.
- Partial Free Care will be considered for those above 200% with medical bills that exceed 25% of family income.
- The discount may be given depending on the patient’s circumstance and a financial assistance representative will determine the amount.
- The policy describes how to apply for financial assistance.
- Efforts to determine eligibility are made on the front-end of patient’s hospital stay.
- Patients are given 15 calendar days from the initial date of request to submit a financial assistance application. A 15-day extension is offered.
- CHN allows 30 business days to issue a determination.
- Patients may appeal the decision in writing and include the basis for the appeal.
- There is very little detail about billing and debt collection in the CHN policy, but it is unclear whether or not CHN has a separate billing and debt collection policy.
- CHN also fails to describe any measures they are taking to publicize the policy widely in the community.
St. Vincent Health (SVH)- After some initial confusion about what information we were requesting, SVH shared their corporate parent’s Billing and Collection for the Uninsured Policy with us. The policy given does address financial assistance, but its wording leads us to believe it is limited to uninsured patients only. HAP is waiting on clarification as to whether this policy extends to patients with health coverage. SVH stated they are continuing to make revisions and will have an updated policy out by the first of their fiscal year, July 1, 2011.

- Full Free Care is available to those with income levels at or below 200% of the FPG.
- Partial Free Care is available to those with income levels between 200%-300% of the FPG, based on a sliding fee scale.
- The amount of financial assistance given is based on income and may be adjusted by the hospital for the cost of living in that particular area.
- Patients above 300% of the FPG will be eligible for a medical hardship discount.
- This is based on their ability to pay, issuing a “Means Test” which considers income, medical bill obligations, mortgage payments, utility payments, number of family members, and disability considerations.
- A description of how to apply for financial assistance is lacking in the policy.
- As this policy is specifically for billing and collections, this analysis will be picked up in following section.
- Measures taken by SVH to publicize the policy widely in the community is also lacking in the policy.

Sisters of St Francis Health Services (SSFHS)

- Full Free Care is available to those with incomes at or below 200% of the FPG.
- Partial Free Care is available to those with incomes between 201%-300% of the FPG, based on a sliding fee scale.
- The amount of financial assistance given is based on family income and available assets.
- Patients may apply for financial assistance by calling the number provided on posted notices throughout the hospital or going onto the website.
- In a separate Patient Financial Policy, SFH states the registrar will screen the patient for insurance and then against the Medicaid database.
- For uninsured patients, the registrar discusses possible payment arrangements. The registrar, at their discretion, first discusses bank loan information and then whether the patient qualifies for Medicaid. Financial assistance is offered once those options have been exhausted.
- Uninsured patient accounts under $2000 are not screened for possible coverage by government programs.
- The billing process is briefly outlined in the CBO Patient Financial Policy.
- There is no mention of measures the hospital is taking to publicize the policy widely in the community.
Limiting Charges for Self-Pay: Under the PPACA, hospitals are uniformly prohibited from using “gross charges” and may only charge patients the “amounts generally billed” to insured patients for the same services.7

IUH
- IUH has a separate Adjustment for Uninsured Patients Policy that does prohibit the hospital from using gross charges for uninsured patients.
- The policy determines the adjustment by averaging the “three best negotiated Managed Care rates.”8 This is calculated annually. For 2011 the amount comes to 40% of gross charges.

CHN
- Patients are given a discount from gross charges with varying percentages according to the facility and service. Discounts for the uninsured at the hospital are 30%. However, the policy does not describe the basis for the charge or how discounts are calculated.

SVH
- SVH offers uninsured patients with the ability to pay a discount based on the discount provided to the highest-paying private payer.
- If the highest-paying private payer does not account for at least 3% of the hospital’s business for that given year, more than one payer contract will be averaged to reach 3% of hospital business.

SSFHS
- SFH offers a 20% discount of billed charges to eligible uninsured patients.
- It is unclear what constitutes eligibility in this section.
- What the discount is based on is also unknown.

Billing and Debt Collection Practices: The new law prohibits hospitals from engaging in “extraordinary collection actions” before making a “reasonable effort” to determine whether a person qualifies for financial assistance.9

IUH
- IUH policy states it will make reasonable attempts to determine eligibility for financial assistance before assigning the account to a collection agency or before engaging in “extraordinary collection actions.”
- If IUH finds it necessary to pursue further collection actions Section V(e) reads, “…IUH, and its contractors, will engage in fair, respectful and transparent collection activities.”10

7 “Protecting Consumers…” page 3.
9 “Protecting Consumers…” page 4.
- Regarding financial assistance applications, IUH may include a description of the policy with all patient bills and statements and may suspend collections activities on that account while an application is being processed.
- Payment plans are not offered for bills below $240, regardless of income.
- HAP did inquire about a separate billing and collection policy and is waiting for a response from IUH on the status of that policy.

CHN
- CHN does not have adequate detail in the written policy regarding whether the hospital engages in “fair” billing and debt collection practices.
- If a patient’s account is sent to collections and later found to be eligible for financial assistance, the amount will be written off to charity care. If the collection agency has incurred attorney fees, the patient will be held responsible for those charges.
- However, if a patient has made a payment on an account and qualifies for free care, CHN “is not obligated” to refund the payments already made.
- It is unclear, at this time, whether or not CHN has a separate billing and debt collection policy in place.

SVH
- SVH’s Billing and Collection for the Uninsured Policy states, “All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good…”¹¹
- SVH further states that outstanding balances “are pursued fairly and consistently.”¹²
- SVH does permit liens to be taken out on personal residences if the patient is not making payments on the payment arrangement and did not qualify for financial assistance.
- Liens are not permitted if they will result in foreclosure.
- Wage garnishments are permitted if a person did not qualify for financial assistance and a court determines that wages are sufficient.
- The executive management of the hospital must approve the lien as well garnishments pursued by a collection agency or other representative of the hospital.
- There are also assessments for interest charges on outstanding balances.

SSFHS
- Payment options include cash, check, money order, credit card, bank financing, and payment plans up to 12 months.
- An account is turned over to collection after four sent statements.
- Patients can still apply for financial assistance once the account has gone to collections.
- If a patient account has been turned over to SSFHS’s collection agencies and thought to be bad debt, but after review is eligible for free care, the patient may be asked to provide some documentation for the financial assistance process.

¹² Ascension Health… page 2.
- Documentation they may request is not outlined in the policy.
- There is no further information on SSFHS’s billing and debt collection policy and whether they comply with “fair” practices.

**Our Concerns:** Our review of the financial assistance policies indicates a number of areas where hospitals need improvement to comply with the PPACA. The St. Vincent Billing and Collections policy does address important issues regarding billing and debt collection, but does not adequately meet the language of the PPACA, failing to mention safety net services for those who are insured and/or underinsured. Failing to develop a policy for these patients, who constitute a large percentage of those with hospital debt, leaves them exposed to unnecessary financial hardship. All four nonprofit hospitals should describe how the hospital publicizes its policy in the community. With the exception of St. Vincent, it appears the hospitals need to develop a billing and debt collection policy if they do not intend to include it in their financial assistance policy. In our meetings with Community, they did inform us that the discount of the charge to the uninsured is based on an average of all commercial payers. However, Community and St. Francis should indicate in their policy the basis for the charge that is being discounted. New language and detail are needed in St. Francis’ and St. Vincent’s policy with regard to the application process.
Best Practices

The new requirements and reporting standards in the PPACA are an important first step towards addressing the unmet needs of underinsured and uninsured citizens with hospital debt. With increased oversight of their financial assistance policies and billing and collection practices, the new regulations provide a level of accountability that has been lacking for nonprofit hospitals. The new requirements also add an important level of transparency to an inconsistent, complex system that has exposed millions of vulnerable consumers to unnecessary harm. With commitment and a collaborative effort toward implementing these basic provisions, nonprofit hospitals will fulfill their role and responsibility as charitable organizations and as a vital actor in an ever-changing health care system. Safety-net services will remain important for those who, even with future health policy changes, may find services unaffordable.13

However, while the new requirements are welcome, more must be done to ensure hospitals are effectively serving patients in need. HAP has several recommendations or best practices that hospitals should implement to provide vulnerable consumers with the most meaningful protections.

ELIGIBILITY CATEGORIES:
Full Free Care, Partial Free Care, Medical Hardship Eligibility

It is important that eligibility for financial assistance be based on family income and not the amount of a bill. The financial eligibility criteria based on the FPG should be used as floors only. Hospitals should take into account the area served and cost of living. Anyone whose income falls at or below 200% of FPG should be given full discharge of debt and a sliding fee scale should be applied to those whose income is from 201%-400% of FPG. For full and partial free care, hospitals should only look at family income and not take assets into account. People at this income typically don’t have many assets and it can be inefficient for hospitals to pursue this action since it is unlikely to be successful. Medical hardship should be available for those above 400% of FPG and whose medical bills threaten the patient’s financial stability. A patient’s medical bills must exceed 25% of family income and have insufficient assets to cover the amount in order to be eligible. Primary home and vehicle valuation should not be included in an assets test as this can create an unnecessary burden on the family leaving them with no financial cushion.14

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## Analysis of Eligibility Categories by Hospital

### IU HEALTH

<table>
<thead>
<tr>
<th>PRO</th>
<th>CON</th>
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<tbody>
<tr>
<td>Full free care is available to patients at or below 200% of the FPG.</td>
<td>Medical hardship is not available to insured patients above 400% of the FPG.</td>
</tr>
<tr>
<td>Partial free care is available to patients with incomes that exceed 400% of the FPG.</td>
<td>Regardless of income, for accounts in excess of $60,000, a credit and asset test may be used to determine eligibility and amount.</td>
</tr>
<tr>
<td>Medical hardship is available to uninsured patients with incomes that exceed 400% of the FPG.</td>
<td>The valuation of home and real estate is included in an assets test.</td>
</tr>
<tr>
<td>Eligibility for financial assistance is based upon income and family size.</td>
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</tr>
<tr>
<td>During our meetings, IUH did state they will be updating their medical hardship policy and will consider not looking at primary home in an assets test.</td>
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### COMMUNITY HEALTH NETWORK

<table>
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<tr>
<th>PRO</th>
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<tbody>
<tr>
<td>Full free care is available to patients at or below 200% of the FPG.</td>
<td>Assets are looked at to determine eligibility for full free care.</td>
</tr>
<tr>
<td>Eligibility for financial assistance is based on family size and income.</td>
<td>There is no mention of partial free care for patients with incomes between 201%-400% of the FPG.</td>
</tr>
<tr>
<td>Medical Hardship may be available for patients who do not qualify for full free care and have debts equal to or greater than 25% of family income.</td>
<td>For medical hardship, the patient may be given a discount, which is at the discretion of the financial assistant representative.</td>
</tr>
<tr>
<td></td>
<td>Assets evaluated for this section are unclear.</td>
</tr>
<tr>
<td></td>
<td>There is no detail as to guidelines the financial assistance representative follows to determine eligibility for medical hardship.</td>
</tr>
</tbody>
</table>
**ST. VINCENT HEALTH**

SVH policy is specific to uninsured patients only.

<table>
<thead>
<tr>
<th><strong>PRO</strong></th>
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| - Full free care is available to patients at or below 200% of the FPG.  
- Full and partial free care is based on income and may be adjusted by the hospital for that area’s cost of living.  
- They are in the process of updating and revising their policy, piloting programs such as a catastrophic/medical hardship category. | - Partial free care is only available to patients with incomes up to 300% of the FPG, based on a sliding fee scale.  
- For those above 300% of the FPG, partial free care is only available to uninsured patients. Eligibility is determined by assessing a patient’s ability to pay based on eligible assets and eligible income. Little detail is provided. |

**SISTERS OF ST. FRANCIS HEALTH SERVICES**

<table>
<thead>
<tr>
<th><strong>PRO</strong></th>
<th><strong>CON</strong></th>
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</table>
| - Full free care is available to patients at or below 200% of the FPG.  
- Full and partial free care is based on income.  | - Partial free care is only available for patients with incomes up to 300% of the FPG, based on a sliding fee scale.  
- Full and partial free care is based on available assets.  
- Medical hardship is mentioned but not detailed in the policy. |
NOTIFICATION AND APPLICATION PROCESS

Our research and conversations with consumers indicate that public notification about financial assistance within the hospitals is insufficient. Information about financial assistance should be provided at multiple points and times during a patient’s visit. Along with visible and easy to read signage in prominent locations inside the hospital and all outpatient clinics and postings on the website, it is even more impactful when staff is properly trained and informs a patient of the hospital’s financial assistance policy and programs. Also, signs in the hospital, information on the website, and applications should be available in multiple languages.\(^\text{15}\)

Unfortunately, our research has found that notwithstanding their written policies regarding notification and signage, the nonprofit hospitals in Indianapolis are not doing an adequate job of posting information about charity care and financial assistance. It is disappointing they have not improved these practices since our first report, because notification within the hospital and on a website is the easiest way to provide the information. While hospitals must improve their community outreach as well, better signage and brochures and more accessible websites should be the first step taken to better inform patients in need of help. We have identified numerous consumers through our meetings and surveys who have avoided seeking needed care because of fear about not being able to pay the bill; this situation would be significantly reduced if hospitals did a better job of informing patients about the availability of financial assistance.

Screening uninsured and underinsured patients for financial assistance should occur at point of service or the front end of the hospital experience. The process should first check for eligibility for public or private enrollment in a health plan. This will help avoid patients from being embroiled in the collection process only to find out they were eligible for assistance.

When a patient is eligible for financial assistance or some other form of coverage the hospital should provide assistance in the application process. In order not to deter those from seeking necessary medical care, especially undocumented immigrants, documentation such as social security numbers should not be required and for those receiving full or partial free care, no assets should be reviewed. Once applications are submitted, hospitals should make timely decisions, within 14 days, of approval or denial and place the patients account on hold while the application is being processed.\(^\text{16}\) Overall, hospitals need to assume a larger share of responsibility for aggressively promoting financial assistance programs. Through front-end screening, aggressive notification and implementation, and assistance with the application process hospitals will become more efficient with their resources and patients will avoid unnecessary hardship.

\(^{15}\) “The Patient Financial…” page 29.
Analysis of Notification and Application Process by Hospital

**IU HEALTH**

<table>
<thead>
<tr>
<th>PRO</th>
<th>CON</th>
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<tbody>
<tr>
<td>• Financial assistance notification, the policy, and application are available on the website.</td>
<td>• Signage and notification are not prominent throughout the hospital.</td>
</tr>
<tr>
<td>• After a significant rebranding transformation IUH has new documents, brochures, and signs that will be implemented soon to better promote their financial assistance programs. They are also working to have the information available in Spanish.</td>
<td>• Alternative language availability and simplicity of language are an issue.</td>
</tr>
<tr>
<td>• Every uninsured person will be mailed a financial assistance application.</td>
<td>• A description of the policy <em>may</em> be included with all patient’s bills.</td>
</tr>
<tr>
<td></td>
<td>• The onus remains on the insured and underinsured to ask for assistance.</td>
</tr>
<tr>
<td></td>
<td>• A patient is given 21 days to submit an application while the hospital has 90 days to make a determination on the financial assistance application.</td>
</tr>
<tr>
<td></td>
<td>• The application takes into account assets such as the primary home and vehicle.</td>
</tr>
<tr>
<td></td>
<td>• The policy does not state if an account is placed on hold during this period.</td>
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</tbody>
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### COMMUNITY HEALTH NETWORK

**PRO**
- In the three past due notices sent to patients, financial assistance is mentioned.
- Patients who are “likely to qualify” for financial assistance, determined through a third-party vendor, automatically receive the appropriate level of financial assistance.
- Patients are given 15 calendar days and may ask for an extension of another 15 days to submit an application.

**CON**
- Signage and notification are not prominent throughout the hospital.
- Alternative language availability and simplicity of language are an issue.
- Brochures and posters should include a contact person or number for patients to call for assistance.
- There is no information on the website about financial assistance.
- Financial assistance applications are not sent with the three past due notices.
- Financial assistance application is the most rigorous and extensive of the four hospitals.
- The policy does not state if an account is placed on hold during this period.
- CHN has 30 business days to make a determination on the financial assistance application.

### ST. VINCENT HEALTH

**PRO**
- Brochures do provide detail on financial assistance and include an application.
- At our meeting, determining eligibility at the point of service was stressed along with staff training and an openness to discuss and exchange ideas on signage.
- SVH is in the process of issuing policy updates regarding point of service counseling, inpatient evaluation of need for financial assistance, and increasing patient engagement.

**CON**
- Signage and notification are not prominent throughout the hospital.
- Alternative language availability and simplicity of language are an issue.
- Financial assistance information is not available on the website.
- There is no detail on the application process.
SISTERS OF ST. FRANCIS HEALTH SERVICES

<table>
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<th>PRO</th>
<th>CON</th>
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<tbody>
<tr>
<td>▪ Financial assistance information along with an application are provided on the website.</td>
<td>▪ Implementation concerns are similar to the other hospitals regarding signage and notification.</td>
</tr>
<tr>
<td>▪ SSFHS does not ask for documentation of the primary home and vehicle in determining assets in the financial assistance application.</td>
<td>▪ Alternative language availability and simplicity of language are an issue.</td>
</tr>
<tr>
<td>▪ According to email correspondence, an account is placed on hold for 30 days while being processed and will remain on hold until a determination is made.</td>
<td>▪ Only uninsured patient accounts over $2000 are screened for possible coverage by State or Federal programs.</td>
</tr>
<tr>
<td></td>
<td>▪ There are no further details with the application process.</td>
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</table>

LIMITING CHARGES:

In the new law, further clarification on specific terms like “gross charges” and “amounts generally billed” have yet to be defined. Therefore, this part of the law fails to ensure what the law intended; that uninsured hospital patients are charged at the lowest rate. It is recommended that hospitals calculate the amount owed by uninsured patients at either the lowest rate that would be paid by Medicare or Medicaid, or the actual unreimbursed cost to the hospital for that particular service determined by the cost-to-charge ratio. ¹⁷ While the Marion County nonprofit hospitals are giving discounts to the uninsured, none of the hospitals calculate the amount at the lowest rate that is paid to the hospital.

BILLING AND DEBT COLLECTION

Best practices for this section are intended to preserve the right of hospitals to pursue payment for services while at the same time protecting consumers from unfair practices. Two important parts of this section are debt collection practices that are prohibited and whether third party vendors are held to the same restrictions as the hospitals with which they contract. Patients who

qualify for financial assistance, are eligible for government programs, or have pending financial assistance applications should be exempt from debt collection activity. If a hospital does engage in aggressive collection action on a patient’s account, the highest levels of leadership at the hospital should be fully engaged and required to sign off on the collection. Accounts that are already involved in collection actions, but are found to be eligible for free care should receive a refund for any money they may have already paid.

For billing payment plans, pressure should not be applied to a patient to enter into a plan before eligibility for a government program or determination of financial assistance. If a patient does enter into a payment plan, arrangements should take into account a patient’s income and other financial responsibilities. Hospitals should also inform patients about general information on the difference between the interest rate it charges and the rate charged by credit card companies and banks that finance consumer debt.\textsuperscript{18}

\textbf{Analysis of Billing and Debt Collection Policy by Hospital}

\textbf{IU Health}

\begin{tabular}{ll}
\textbf{PRO} & \textbf{CON} \\
\begin{itemize}
\item IUH has a new consolidated statement plan, combining billing for hospital services and physician practices/groups with one phone number to call for questions. \\
\item According to our meetings, a total of 7 notifications are made via mail and phone about payment on a bill before the account is sent to collections. \\
\end{itemize} & \begin{itemize}
\item A description of the policy \textit{may} be included with all patient bills and statements. \\
\item Payment plans are not offered for bills below $240. \\
\item There is no mention of an account being placed on hold while a determination is being made for financial assistance. \\
\item At this time, a separate billing and debt collection policy does not exist to clarify and further explain these issues. \\
\end{itemize} \\
\end{tabular}

\textsuperscript{18} “The Patient Financial…” page 13-14.
### COMMUNITY HEALTH NETWORK

#### PRO
- In order to comment more on billing and debt collections for CHN, a separate policy or more information in the financial assistance policy is needed.

#### CON
- The financial assistance policy provides little detail about billing and debt collection.
- It is unclear whether CHN has a separate billing and debt collection policy.
- CHN has no obligation to refund payments made on an account to patients who later qualify for financial assistance.

### ST. VINCENT HEALTH

#### PRO
- The language in the policy about pursuing outstanding balances adheres to the PPACA.
- Payment arrangements are offered to uninsured patients who do not qualify for financial assistance.
- Information about the difference in interest charges is addressed in certain situations.
- In the meetings, SVH stated they have interest free payment plans up to 120 months.
- Upper level management must sign off on collection practices that include lien and wage garnishments.
- Collection agency agreements must be signed by contractors for compliance of SVH billing and debt collection practices.

#### CON
- The policy only extends to the uninsured and offers no protection for the insured and underinsured.
- Collection practices do include lien and wage garnishments.
**SISTERS OF ST. FRANCIS HEALTH SERVICES**

<table>
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<th>PRO</th>
<th>CON</th>
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| - A written notice will be provided on the billing statement about the availability of financial assistance.  
- Through email correspondence SSFHS stated that all patients are offered interest free payment plans up to one year.  
- Patients can apply for financial assistance once the account has gone to collections.  
- Accounts sent to collection agencies will be reviewed to identify amounts originally thought to be bad debt, but that qualify for financial assistance. | - There is no detail or explanation about what is included on the statement or a financial assistance application attached.  
- Uninsured patients are offered financial assistance only after other possible payment arrangements are discussed including bank loan information.  
- 4 options are given to patients paying. Financial assistance is not included.  
- Patients receive a total of 4 statements before an account is sent to collections.  
- Patients with accounts sent to collections that are later found eligible for financial assistance may be requested to provide documentation. No details are provided. |
CONCLUSION

It is encouraging to see that the nonprofit hospitals are including some of the “best practices” in their financial assistance policies. However, from our research and conversation with consumers, it is clear there is a disconnect between the policies and the implementation of those policies. From our ongoing dialogues with the hospitals, we are hopeful that improved and updated policies will include medical hardship programs; more consistency and adherence to the law regarding signage and public notification; details about and assistance with the application process and fairer debt collection practices.

Our primary concern with nonprofit hospitals and financial assistance has not changed since our first report: They are not doing an adequate job in informing their patients, or the public, about charity care and financial assistance. While the new requirements under the PPACA are well intentioned, in order for consumers to really benefit they have to be informed about these programs. Additionally, hospitals tend to focus their charity care outreach on the uninsured, leaving many underinsured consumers vulnerable. Our research indicates the majority of consumers with hospital debt had insurance, so this focus is misplaced and must be re-examined.

At best, the inadequacies in the Marion County nonprofit hospitals’ charity care programs prevent them from completely fulfilling their charitable missions. At worst, they are disregarding the law and IRS regulations, cheating taxpayers and putting their nonprofit status at risk. We hope the hospitals will continue to work with us to improve their policies and increase public awareness about them to ultimately decrease the number of families in our community devastated by hospital debt.
Appendix I

HAP Recommendations from, “The Medical Debt Crisis in Indianapolis: A Snapshot”
HAP RECOMMENDATIONS

Public Notification
1. Information that services are available at no or reduced cost must be clearly posted in a variety of places throughout the hospital, on the hospital website, and throughout the community. This should include:
   a. Posted in all waiting rooms
   b. Provided verbally and in writing at the time an individual registers or pre-registers with the hospital.
   c. Provided verbally when an individual contacts the hospital requesting an appointment, and in any documents that are sent to the individual prior to the appointment.
   d. The hospital employee responsible for getting signatures on discharge papers should be required to remind the patient and/or their family that the hospital has a financial assistance program, and application papers should be provided in the discharge packet.
   e. Post-relevant information at local community organizations and/or faith based organizations and the township trustee.
   f. Prominently posted on the hospital website
   g. Include information on the types of discounts that are available and detailed information on eligibility guidelines.
   h. Posted notices should be large in size and use terms and words that are easy for all to understand.
2. Areas that have information posted on community benefit programs should also contain applications for all relevant government insurance programs such as Medicaid, Medicare, Healthy Indiana Plan and Hoosier Healthwise with assistance provided in filing for benefits as needed.
3. Information posted should be available in alternate languages as well as alternate formats for individuals with disabilities.
4. Staff working in areas such as hospital clinics, billing departments, emergency rooms and other relevant areas should be provided adequate information on the types of charity care and community benefits available at the hospital. These individuals should be able to explain the programs and services to anyone when asked and be able to answer questions or direct the patient to someone who can provide an accurate answer within a short period of time.
5. Detailed information and all applications should be available via the hospital’s website.

Billing/Payment Plans for Community Benefits – All billing must be clear, concise and easy to understand.
1. Upon discharge from care, the patient must be reminded that the hospital has a financial assistance program that may be able to help with payment of bills.
2. Any and all bills sent to a patient must include information on available payment plans as well as other assistance that may help with the payment of outstanding debt.
3. If there is no response following multiple written correspondences, protocol should be established for attempting to contact the individual in person or by phone prior to sending unpaid bills to a debt collection service.
4. Payment plans MUST be designed with cooperation between the hospital and the patient. Payments must be reasonable based on the individual income and expenses and not based on a rigid pre-determined income scale.
5. Individuals who have trouble paying for care should be provided applications to appropriate health insurance such as Medicaid, Medicare, HIP and Hoosier Healthwise. As appropriate these individuals should also be provided assistance in completing these application forms.
6. Establishing partnerships with local community and faith based organizations to help with providing education and information on payment plans and community benefits.

Additional items to consider:
1. At all “Health Fairs” and other community outreach events information should be available in the form of brochures or other written materials that inform attendees of financial assistance that is available from the hospital.
2. All staff who may answer the phone – whether in billing or general operators – must have information on who to contact when individuals call asking for financial assistance and/or community benefits and should have basic information on the type of financial assistance that may be available.
3. Financial assistance counselors/appropriate staff must be available at all times in the emergency room to provide information on financial assistance and to answer questions.
Appendix II

Financial Assistance Policies
FINANCIAL ASSISTANCE POLICY

I. PURPOSE

As part of its mission to improve the health of its patients and community through innovation and excellence in care, education, research and service, Indiana University Health (“IU Health”) values charity, equality and justice in healthcare. Indiana University Health is committed to serving the healthcare needs of all of its patients, regardless of their ability to pay for such services. To assist in meeting those needs, Indiana University Health has established this Financial Assistance Policy to provide financial relief to eligible patients receiving Emergency or Medically-Necessary Services. This policy was developed and is utilized to determine patients’ financial ability to pay for services.

II. SCOPE

This policy applies to charges for all hospital and emergency services provided by Indiana University Health Facilities (as defined below) and physician services processed by Indiana University Health Revenue Cycle Services.

III. EXCEPTIONS

Any exceptions to this policy must be approved in writing by the Financial Assistance Committee.

IV. DEFINITIONS

a. Adjustments for Uninsured Patients Policy – a policy that provides a reduction in charges billed for any patient/guarantor who at the time services are provided, has no insurance coverage for, or right to,
the payment of care, through employer-based insurance, government-sponsored coverage or third party liability coverage.

Title: Financial Assistance Policy
Policy #: 88

b. **Emergency Services** – an emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences.

c. **Facilities**— includes the following Indiana University Health hospitals and Indiana University Health affiliated surgery centers. This includes: Methodist Hospital, Indiana University Hospital, Riley Hospital for Children, Indiana University Health West, Indiana University Health North, Indiana University Health Arnett, Indiana University Health Ball Memorial and Indiana University Health Blackford Community Hospitals. The Indiana University Health surgery centers are: Eagle Highlands Surgery Center, Beltway Surgery Center, Springmill Surgical, Springmill Endoscopy, Indiana Endoscopy Center, Senate Street Surgery Center, Ball Outpatient Surgery Center, ROC Surgery Center and all other locations identified by Revenue Cycle Services.

d. **Financial Assistance** – a reduction in the amount of charges billed for patients who are eligible for relief under this policy.

e. **Financial Assistance Application** – an application to receive Financial Assistance.

f. **Financial Assistance Committee** – a committee appointed by the Indiana University Health Chief Financial Officer that meets routinely with the task of determining exceptions and making account approvals under this Financial Assistance Policy and the Adjustment for Uninsured Patients policy.

g. **Financial Assistance Determination** – a written decision indicating whether Financial Assistance will be provided to a patient/guarantor.

h. **Interest Free Payment Arrangements** -

- **Consolidated Patient Statements**: An invoice payment program that allows a patient up to twenty (20) months to pay an outstanding balance without accruing interest. Exceptions can be made at management discretion.

- **Non Consolidated Patient Statements**: An invoice payment program that allows a patient up to twelve (12) months to pay an outstanding balance without accruing interest.

i. **Limited Means**—an inability to pay full amounts due of the hospital/physician obligation and qualifies for partial assistance. The patient/guarantor must request assistance and have income between 200-400% of poverty guidelines for insured patients to qualify for partial assistance. For uninsured patients, limited means can extend beyond 400% and is based on a sliding scale which incorporates income, number in the household and provides the patient/guarantor relief beyond the 40% adjustment for uninsured patients.

j. **Medically-Necessary Services** – inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated, would pose a threat to the patient’s ongoing health status.
Services must:

- Be clinically appropriate and within generally accepted medical practice standards; and
- Represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available at a Indiana University Health hospital, with a primary purpose other than patient or provider's convenience.

V. POLICY STATEMENTS

i) General:
   (a) Indiana University Health will not refuse, delay or discourage services based on a patient’s ability to pay for the cost of such services.

   (b) Indiana University Health will actively promote all patients’ awareness of the availability of Financial Assistance. All patients will receive notification of Indiana University Health’s Financial Assistance Policy and all uninsured patients will receive an application to participate in the program.

   (c) Indiana University Health will make reasonable attempts to confirm that a patient is not eligible for Financial Assistance prior to assigning that patient’s account to an agency for collection or otherwise engaging in extraordinary collection actions.

   (d) Financial Assistance determinations will be made without regard to a patient’s age, sex, race, creed, disability, sexual orientation, or national origin.

   (e) When it is necessary to engage in such actions, Indiana University Health, and its contractors, will engage in fair, respectful and transparent collections activities.

ii) Eligibility:
   (a) Eligibility for Financial Assistance will be determined based upon a patient’s household income and number of members in the household. A patient is eligible for Financial Assistance, as described in Section V(ii), when the patient’s:
      (1) Household income is equal to or less than 400% of the Federal Poverty Guidelines; or
      (2) Household income is greater than 400% of the Federal Poverty Guidelines, the patient is an uninsured patient, and qualifies based on an established sliding scale.

   (b) Patients in the following categories are presumed to be eligible for Financial Assistance, without a determination of household income:
      (1) Patients whose financial need has been determined by the following third parties: Wishard, Project Health, Children’s Special Health Care Services (CSHCS), Medicaid, Out-of-State Medicaid;
      (2) Patients who are pending Medicaid approval;
      (3) Homeless patients; and
      (4) Patients who have a hospital bill with a maximum balance to be determined by the Executive Director of Revenue Cycle Services and who meet credit scoring and asset determination criteria.
(c) Additional Requirements:

1) For patients/guarantors who are otherwise eligible for Financial Assistance and whose hospital and/or physician liability is greater than $60,000 Indiana University Health may review available assets in determining eligibility and amount of Financial Assistance provided. This dollar threshold may be increased annually based on Indiana University Health price increases and at the discretion of Revenue Cycle Leadership.

2) Financial Assistance may be granted to patients/guarantors who qualify for government programs when funding has been delayed. If later government assistance is approved, the Financial Assistance awarded will be reversed. This includes but is not limited to when a patient’s account is pending Medicaid approval.

3) Financial Assistance may be granted to a deceased patient whose estate has been determined to be without valuable assets.

4) Financial Assistance will not be granted to non-Consolidated Patient Statements patients that have a physician bill with a balance less than $240.00.

5) Indiana University Health will deny Financial Assistance for any patient/guarantor who falsifies any portion of an application.

6) All third party resources and non-hospital financial aid programs, including public assistance available through Medicaid, must be exhausted before Financial Assistance will be awarded.

iii) Available Assistance

(a) When an insured or uninsured patient's household income is less than or equal to 200% of the Federal Poverty Guidelines or the patient meets one or more of the eligibility criteria identified in Section V(ii)(b), Indiana University Health will provide one hundred percent (100%) relief/financial assistance of allowable charges.

(b) When an insured or uninsured patient's household income exceeds 200% of the Federal Poverty Guidelines and is less than or equal to 400% of the Federal Poverty Guidelines, Indiana University Health will provide a limited means adjustment/relief of allowable charges based on household income and number in the family. This is calculated based on a sliding scale. For insured patients, the limited means/partial assistance ends at 400%.

(c) When an uninsured patient’s household income exceeds 400% of the Federal Poverty Guidelines, Indiana University Health will provide a limited means adjustment/partial assistance of allowable charges based on household income and number in the family. This is calculated based on a sliding scale. For uninsured patients, the limited means/partial assistance ends when their ability to pay reaches the uninsured discount already granted by Indiana University Health.

iv) Reporting:

(a) Indiana University Health will report on the amount of Financial Assistance provided to eligible patients, and on any modifications to this policy, on an annual basis in its Community Benefit Report.

VI. PROCEDURES

i) Communication:
(a) Indiana University Health will broadly communicate the availability of Financial Assistance within the communities it serves by posting a description of this policy in appropriate acute care settings such as emergency departments, registration areas, and on its website.

Title: Financial Assistance Policy  Policy #: 88  PAGE 5 of 6

• Signs will be posted in each of these areas describing the available assistance and directing interested patients to the Financial Assistance Application.
• Brochures and other materials describing the program may be available in languages other than English that are frequently spoken in the geographic vicinity of each respective Indiana University Health hospital.

(b) Indiana University Health may include a description of this policy with all patient bills and statements of services and will mail a Financial Assistance Application to each patient eligible under the Adjustment for Uninsured Patients Policy upon the conclusion of treatment, along with a summary of incurred charges.

(c) Indiana University Health Billing Services Center representatives will be available via telephone Monday through Friday from 8 a.m. to 5 pm to assist with questions and completion of financial assistance applications.

(d) Patients/guarantors may request a Financial Assistance Application using the Indiana University Health website or by calling the Billing Services Center.

(e) Each year, all Indiana University Health employees will be informed as to how to refer patients to apply for the Indiana University Health Financial Assistance Program.

ii) Application:

(a) Patients/guarantors wishing to apply for Financial Assistance are responsible for initiating the financial assistance process in a timely fashion and must return the Financial Assistance Application to Indiana University Health Revenue Cycle Services within twenty-one (21) calendar days of receipt. Indiana University Health will consider applications complete upon the submission of all requested documentation.

(b) Patients/guarantors must submit the following documentation with a completed application:
  • Income from all sources.
  • Copies of statements from savings and checking accounts, certificates of deposit, stocks, bonds, money markets accounts, etc.
  • Value of assets including home and real estate.
  • Monthly expenses.
  • Number of dependents.
  • Copies of most recent three months of pay stubs.
  • Copies of the most recent state and federal income tax forms including copies of:
    • W2s
    • Schedule C Profit or Loss from Business
    • Schedule D Capital Gains and Losses
    • Schedule E supplemental Income and Loss
    • Schedule F Profit or Loss from Farming

Title: Financial Assistance Policy  Policy #: 88  PAGE 6 of 6

• A signed copy of the Financial Assistance Application

• Any additional information requested by Indiana University Health to assist in the verification of household income and assets.

(c) Individuals other than the patient, such as the patient's physician, family members, community or religious groups, social services, or hospital
personnel may request a Financial Assistance Application to be mailed to a patient’s primary mailing address.

(d) The Financial Assistance Application and accompanying documentation must be submitted annually. It is the patient’s responsibility to notify Indiana University Health if the patient’s financial status has changed.

(e) Indiana University Health keeps all applications and supporting documentation confidential.

(f) Once Financial Assistance has been granted, the patient/guarantor will not be supplied with documentation required to bill insurance companies. This includes the UB, 1500 and/or detailed itemization bill forms.

iii) **Determination:**
(a) Indiana University Health will inform patients/guarantors of the results of their application by providing the patient/guarantor with a Financial Assistance Determination within ninety (90) days of receiving a completed application and all requested documentation.

(b) If a patient/guarantor is granted less than full assistance and the patient/guarantor provides additional information for reconsideration, Revenue Cycle Services staff may amend a prior Financial Assistance Determination.

(c) If a patient/guarantor seeks to appeal the Financial Assistance Determination further, a written request may be submitted, along with the supporting documentation, to the Financial Assistance Committee for additional review/reconsideration.

(d) Decisions of the Financial Assistance Committee are final.

iv) **Non-Payment/Collections:**
(a) Patients/guarantors who have not applied for Financial Assistance and whose accounts have been transferred to a collection agency may request Financial Assistance, complete an application with requested documentation and be considered for reduction of their bill. Indiana University Health may suspend collection activity on an account while an application is being processed and considered. For a patient/guarantor who chooses not to participate or is denied Financial Assistance, the full measure of collection activity will continue.

(b) Indiana University Health and its collection agencies will not provide assistance after an account has entered legal proceedings without first obtaining written consent from Revenue Cycle Services.
ADJUSTMENT FOR UNINSURED PATIENTS POLICY

I. PURPOSE

As part of our mission to improve the health of its patients and community through innovation and excellence in care, education, research and service, Indiana University Health (“IU Health”) values charity, equality, and justice in healthcare. As such, Indiana University Health is committed to serving the healthcare needs of all of its patients, including Uninsured Patients, regardless of their ability to pay for such services. In order to ensure transparency, consistency and fairness towards Uninsured Patients, this policy sets guidelines for providing a financial adjustment to any Uninsured Patient who obtains Medically-Necessary or Emergency Services from Indiana University Health. This policy ensures Indiana University Health’s compliance with the Patient Protection and Affordable Care Act, enacted March 23, 2010, Internal Revenue Code section 501 (r). This requires tax-exempt hospitals to limit amounts charged to uninsured patients for emergency and other medically necessary care to no more than those amounts generally charged to insured patients.

II. SCOPE

This policy applies to charges for uninsured patients and includes scheduled, unscheduled, and Emergency Services defined as Medically-Necessary provided by Indiana University Health Facilities, as defined below. Cosmetic and non-Medically-Necessary elective procedures are excluded.

III. EXCEPTIONS

Any exceptions to this policy must be approved in writing by the Financial Assistance Committee. No exception will be made that would permit Indiana University Health to bill an Uninsured Patient for gross charges incurred in connection with Medically-Necessary or Emergency Services.
IV. DEFINITIONS

a. **Emergency Services** – an emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences.

b. **Facility** – includes the following Indiana University Health hospitals and Indiana University Health affiliated surgery centers. This includes: Methodist Hospital, Indiana University Hospital, Riley Hospital for Children, Indiana University Health West, Indiana University Health North, Indiana University Health Arnett, Indiana University Health Ball Memorial and Indiana University Health Blackford Community Hospitals. The Indiana University Health surgery centers are: Eagle Highlands Surgery Center, Beltway Surgery Center, Springmill Surgical, Springmill Endoscopy, Indiana Endoscopy Center, Senate Street Surgery Center, Ball Outpatient Surgery Center, ROC Surgery Center and all other locations identified by Revenue Cycle Services.

c. **Financial Assistance Committee** – a committee appointed by the Indiana University Health Chief Financial Officer that meets routinely with the task of determining exceptions, and making account approvals under the Financial Assistance Policy and this Adjustment for Uninsured Patients policy.

d. **Financial Assistance Policy** – policy in accordance with which Indiana University Health provides financial relief to eligible patients.

e. **Medically-Necessary Services** - inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated, would pose a threat to the patient’s ongoing health status.

Services must:

- Be clinically appropriate and within generally accepted medical practice standards; and
- Represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available at an Indiana University Health facility, with a primary purpose other than patient or provider’s convenience.

f. **Uninsured Adjustment** – the reduction in usual and customary charges billed for Medically-Necessary or Emergency Services provided to Uninsured Patients.

g. **Uninsured Patient** – an Indiana University Health patient who at the time services are provided, has no insurance coverage for, or right to, the payment of care, whether through employer-based insurance, government sponsored coverage or third-party liability coverage.

V. POLICY STATEMENTS

a. Indiana University Health will not refuse, delay or discourage the provision of Medically-Necessary or Emergency Services based on a patient’s ability to pay for the cost of such services.
b. Indiana University Health assists Uninsured Patients by providing an Uninsured Adjustment based on the average rate of the three best negotiated Managed Care rates as calculated on an annual basis.

c. The Uninsured Adjustment applies to charges for Medically-Necessary hospital and emergency room services provided to Uninsured Patients by Indiana University Health. The adjusted amount for 2011 will be 40% of gross charges.

d. Indiana University Health will actively promote patients’ awareness of the availability of an Uninsured Adjustment.

e. If paying the remaining balance of the Indiana University Health medical bill creates a financial hardship, Uninsured Patients will be referred to the Financial Assistance Policy.

f. Provision of or eligibility for the Uninsured Adjustment has no bearing or impact on a patient’s ability to apply or qualify for assistance under the Financial Assistance Policy.

VI. PROCEDURES
A. Indiana University Health will identify Uninsured Patients during registration and/or admissions processes.

B. Indiana University Health Revenue Cycle Services department will automatically apply the Uninsured Adjustment to facility account balances at the time of billing. This adjustment will reduce the Uninsured Patient’s balance and shall be visible on the initial statement issued for the services.

C. If, at any time, Indiana University Health Revenue Cycle Services becomes aware that a previously identified Uninsured Patient was, in fact, covered by billable insurance at the time of service, it will revoke the Uninsured adjustment and issue a revised statement to the patient.

D. Indiana University Health will clearly and completely describe the availability of the Uninsured Adjustment on its website, in admission packets, with patient bills, and during other relevant points of contact, including when asked about such a discount by an Uninsured Patient.
TITLE:  FINANCIAL ASSISTANCE POLICY

EFFECTIVE DATE:  04/01/06

REPLACES: ADM B – 004
ADM B – 004A

TO BE READ WITH:  Net.Finance – 001: Definitions

PURPOSE:  To document the specific, Community Health Network, Financial Assistance Policy. To ensure policy and procedures exist for identifying those patients for whom service is to be rendered free of charge, or at a discount, based solely on ability to pay, financial condition and availability of third party funding. To clearly differentiate those patients eligible for Financial Assistance, based on established guidelines, from those patients with financial resources who are unwilling to pay.

PHILOSOPHY:  Community Health Network, in keeping with its mission, serves the medical needs of the community, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. We recognize the need to render care to the sick who do not possess the ability to pay. Medically Necessary health care services will be provided to these patients with no expected reimbursement, or at a reduced level of reimbursement, based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the Process. We expect all Responsible Parties with the ability to pay, to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies. The amount of free or discounted care considered will be reviewed and approved without jeopardizing our continued financial viability.

POLICY STATEMENT:

1.  POLICY:
1.1 Provision of Financial Assistance.

Annually, we will establish, a percentage of total consolidated operating expenses for Financial Assistance as a component of the larger category of Community Benefits. Further, we will monitor our ratio of Community Benefit cost to total consolidated operating expense and benchmark against pre-determined components of the applicable market with a goal of providing Community Benefits in total at a ratio better than average within the applicable market served.

1.2 Non-discrimination.

We will render services to our patients who are in need of Medically Necessary Services regardless of the ability of the Responsible Party to pay for such services. The determination of full or partial Financial Assistance will be based on the ability to pay and financial condition and will not be based on race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, or any other classification or characteristic.

1.3 Available Services.

All available Medically Necessary health care services, inpatient and outpatient, will be available to all individuals under this Policy.

1.4 Determination of Eligibility.

The determination of eligibility for Financial Assistance should be made before providing services. If complete information on the patient’s insurance or the Responsible Party’s financial situation is unavailable prior to rendering services or at the time of services, or if the Responsible Party’s financial condition changes, or if the patient requires Emergency Services, the determination of eligibility will be made after rendering services. All efforts will be made to establish eligibility for Financial Assistance before the patient leaves the facility/first patient visit concludes.

Notwithstanding the foregoing, in keeping with the Emergency Medical Treatment and Labor Act (EMTALA), as amended from time to time, no determination of eligibility will be attempted until after an appropriate medical screening examination and necessary stabilizing treatment have been provided.

1.5 Confidentiality:

The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this Policy and procedure will be guided by these values. No
information obtained in the Financial Assistance application may be released unless the patient/Responsible Party gives express written permission for such release.

1.6 Staff Information:

All employees in patient registration, Billing, collections, patient accounting, finance and Emergency Services areas will be fully versed in the Financial Assistance Policy, have access to the application forms, and be able to direct questions to the appropriate staff member(s).

1.7 Staff Training:

All staff with public and patient contact will be trained to understand the basic information related to the Financial Assistance Policy and will provide Responsible Parties with printed material explaining the Financial Assistance program.

1.8 Financial Assistance Representative:

Each corporation will designate an individual to approve Financial Assistance applications, coordinate outreach efforts and oversee Financial Assistance practices.

1.9 Financial Assistance Appeals Committee:

Each corporation will establish a Financial Assistance Appeals Committee or process that provides for at least three (3) members, excluding the Financial Assistance Representative, to review appeals from those whose applications have been denied or which do not provide for a level of Financial Assistance to which the Responsible Party believes he/she is eligible.

1.10 Physician Participation:

We will encourage and support physicians with admitting privileges and others who provide services to our patients to establish and implement Financial Assistance programs for the patients they see in connection with services rendered by us.

1.11 Notification:

1.11.1 Posters and Brochures:

A notice (Attachment A) of the availability of Financial Assistance will be posted in each patient registration and waiting area. Brochures (Attachment B) explaining the Financial Assistance program will be
placed in each patient registration and waiting area. In the case of services rendered in the home, the brochure will be provided to the Responsible Party during the first in-home visit. All publications and informational materials related to the Financial Assistance program will be translated into languages appropriate to the population in the service area.

1.11.2 Oral Notification:

Every Responsible Party will be told that we have a Financial Assistance program in the appropriate language during any pre-admission, registration, admission or discharge Process.

1.11.3 The front of each Past Due Notice (first, second and third) will substantially meet the contents and language in Attachments C through E.

1.11.4 “About Your Bill: Frequently Asked Questions.” One is for those with a Third Party Payer and one is for those without a Third Party Payer. Copies of these documents will be available in patient registration areas and through the Business Offices and Patient Financial Counselors. These documents will substantially meet the content and language set forth in Attachment F.

1.11.5 We will make available a notice titled “Registering For Services: What You Need To Know”. This notice will be available in patient registration areas and through the Business Offices and Patient Financial Counselors. This document will substantially meet the content and language set forth in Attachment G.

1.12 Uniformity:

This Policy applies to all Community Health Network corporations that provide health care items and services to patients as adopted by the applicable Boards of Directors.

1.13 Reporting:

Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations including Indiana Code 16-21-9-7, as amended and recodified from time to time. Such report will be made available to the public upon request.

1.14 Corporate Responsibility:

Each corporation’s principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, will certify in each annual report, that the signing officer has reviewed the report and based
on the officer’s knowledge, the report does not contain any untrue statements of a material fact or omits to state a material fact.

1.15 Accounting:

Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.

1.16 Internal Record Keeping:

1.16.1 Application for Financial Assistance:

The completed applications will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained in the patient’s financial file.

All debt discharged shall be recorded in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.

1.16.2 Automatic Discounts for the Uninsured:

All automatic discounts for the Uninsured will be coded specifically as an “automatic discount for the Uninsured” in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.

1.16.3 Prohibition on Medical Record Documentation:

No records will be placed in or notations made in a patient’s health (medical) record regarding financial matters, including whether the patient paid all or part of any medical Bill.

2. UNINSURED PATIENTS: CRITERIA TO BE ELIGIBLE FOR DISCOUNTS AND DISCOUNT AMOUNTS:

2.1 Patients who are Uninsured are automatically eligible for a discount from gross Charges. Such discount shall be applied to the patient’s Bill as early in the Billing Process as possible. The Responsible Party will be provided with a notice that such discount has been applied which will be sent with the Statement. (See Attachment F, “About Your Bill: Frequently Asked Questions for Self-pay Patients”)
2.2 Discounts from gross Charges for the Uninsured shall be as follows:

2.2.1 Gallahue Mental Health Center: In accordance with the Center’s sliding scale discount policy as a grant funded business unit.

2.2.2 Community Family Practice: In accordance with the Practice’s sliding scale discounts as a service partially funded by the Indiana Health Coverage Program (Medicaid) and Medicare.

2.2.3 Community Physicians of Indiana: Twenty percent (20%)

2.2.4 Hospitals: Thirty percent (30%), except/and as follows.

   2.2.4.1 Infertility/Related Services: Zero percent (0%) (1)
   2.2.4.2 Cosmetic Surgery/Related Services: Zero percent (0%) (1)
   2.2.4.3 Bariatric Surgery/Related Services: Zero percent (0%) (1)
   2.2.4.4 MedCheck Services: Twenty percent (20%) with payment at time of service.
   2.2.4.5 Maternity Care Center: Thirty percent (30%)
   2.2.4.6 Hook Rehabilitation Center: Thirty percent (30%)
   2.2.4.7 SNF Units: Thirty percent (30%)
   2.2.4.8 Community Health Network Employees Eligible for Discounts: in accordance with our Human Resources policies.
   2.2.4.9 Physicians’ Billing Service For Amounts Owned by Network: Twenty-percent (20%)
   2.2.4.10 Community Business Innovations: Zero percent (0%)
   2.2.4.11 Community Home Health Services: Thirty percent (30%)
   2.2.4.12 Community Long Term Care: Zero percent (0%) (2)

(1) This policy (2.2) does not apply to these services because these services are packaged priced which already includes a discount.

(2) This policy (2.2) does not apply to Community Long Term Care because it has its own Board adopted policy regarding patients without insurance.
2.3 When an Uninsured patient has been given a discount on an account(s) under this policy and the patient subsequently qualifies for free care for those accounts, total charges will be applied to the traditional charity care component of Community Benefit.

2.4 If we have extended a discount to the Uninsured patient and subsequently determine that third party funding is available, the discount may be reversed and the funding source Billed at full Billed Charges.

2.5 While this policy provides for discounts from Charges for services that are excluded services under a patient’s benefit plan and for Charges for services that are above the benefit limits of the patient’s benefit plan, we have no obligation to extend such discounts unless we know in advance of the provision of services or the Responsible Party contacts us following the provision of services regarding payment for those services.

3. **CRITERIA FOR ELIGIBILITY FOR FREE CARE:**

3.1 In order to be eligible for free care or discharge of debt under this Policy the patient must be a U.S. citizen or a legally residing non-citizen.

3.2 Requests for consideration of discharge of debt may be proposed by sources other than the Responsible Party, such as the patient’s physician(s), family members, community or religious groups, social services organizations, or Network personnel. We will inform the Responsible Party of such a request and it will be processed as any other such request.

3.2 The Responsible Party must complete an application (Attachment H), provide all requested information in a timely manner, fully participate in and cooperate with the Process and meet the eligibility requirements.

3.3 In an effort to screen 100% of patients for potential charity care eligibility, Community Hospital East, Community Hospital North, Community Hospital South and The Indiana Heart Hospital utilizes data from trusted third-party vendors to automatically estimate the financial condition of each patient. This data is collected from multiple sources using multiple methodologies including predictive modeling to maximize the accuracy of these financial estimates. To accomplish these tasks, the aforementioned hospitals use technology from MedeAnalytics; a leading provider of analytics software, based in Emeryville, CA. The MedeAnalytics platform enables the Community Health Network to automatically gather financial and demographic information for each patient from third-party data vendors including Acxiom Corporation and Equifax, Inc. Each of these vendors provides an estimation of household size and income required to calculate federal poverty level.
Acxiom Corporation aggregates census information, public records and self-reported information to estimate the financial conditions of consumer households. Equifax, Inc. uses a different methodology based on available credit balances and monthly credit obligations to estimate income and household size. Each of these data vendors use sophisticated predictive modeling techniques to increase the accuracy of these estimates based on millions of historical records.

On a daily basis, all accounts with balances due from the patient (Inpatient and Outpatient) are checked against these third-party databases automatically, and segmented based on Federal Poverty Level and the specific guidelines of the Community Health Network financial assistance program. This approach is consistently applied, leveraging automated analytics technology, in an unbiased fashion to all accounts.

Patients who are very likely to qualify for financial assistance, based on third-party Federal Poverty Level estimates, receive a charity care adjustment according to Community Health Network charity care guidelines. Patients at higher Federal Poverty Level thresholds have the opportunity to complete a financial assistance application and meet with a financial counselor to determine payment and assistance options. This approach enables the Community Health Network to efficiently serve the community while using a consistent approach to identifying all patients with a need for financial assistance.

3.4 A Responsible Party’s debt under this Policy includes gross or discounted Charges, and Charges for services not covered by a third party payer including deductible, co-payment and co-insurance amounts, and amounts for non-covered services including amounts for services beyond the benefit limits of the third party coverage.

3.5 For discharge of one-hundred percent (100%) of debt, the Responsible Party has a family income level at or less than two-hundred percent (200%) of the Federal Poverty Guidelines, as adjusted by the Federal Government from time to time, and no other financial resources from which to make payment. As of January 23, 2009, two-hundred percent (200%) of the Federal Poverty Guidelines is as follows.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Monthly Income</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,805</td>
<td>$21,660</td>
</tr>
<tr>
<td>2</td>
<td>2,428</td>
<td>29,140</td>
</tr>
<tr>
<td>3</td>
<td>3,052</td>
<td>36,620</td>
</tr>
<tr>
<td>4</td>
<td>3,675</td>
<td>44,100</td>
</tr>
<tr>
<td>5</td>
<td>4,298</td>
<td>51,580</td>
</tr>
<tr>
<td>6</td>
<td>4,922</td>
<td>59,060</td>
</tr>
<tr>
<td>7</td>
<td>5,545</td>
<td>66,540</td>
</tr>
<tr>
<td>8</td>
<td>6,168</td>
<td>74,020</td>
</tr>
</tbody>
</table>
For each additional person, add $7,480 annually.

3.6 Determining financial eligibility. We will determine eligibility using the Official Measure of Poverty published by the Census Bureau as adjusted from time to time.

3.6.1 Family Size is as follows:

3.6.1.1 When the patient is a non-emancipated minor: biological mother and father and/or step parent(s) if child is adopted and all persons on the tax return(s), filer(s) and dependents of same; or, in the event that that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

3.6.1.2 When the patient is not a minor or is an emancipated minor: the patient, the spouse and the dependents of same on the tax return(s) of the patient and/or spouse; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

3.6.2 Family Income is that of those listed in Section 3.6.1 above as applicable.

3.6.3 Income includes total annual cash receipts before taxes from the following sources. Money income including earnings, unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, 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, including that of the Responsible Party not residing with the patient, and other miscellaneous sources.

3.6.4 Income does not include the following: Non-cash benefits (such as food stamps and housing subsidies), and capital gains or losses.

3.6.5 Living expenses are not subtracted to determine income.

3.7 We will assume that a Responsible Party who has filed bankruptcy and whose debts to us have been fully or partially discharged by the Court have met the criteria necessary for us to write-off the discharged debt to Charity Care.

3.8 We will assume that a deceased patient with no estate and with no other Responsible Party for payment has met the criteria necessary for us to write-off the discharged debt to Charity Care.
3.9 We will assume a homeless patient, with no evidence of assets through communication with the patient, credit reports and other appropriate means and with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

3.10 We will assume a patient whom we know to be an illegal alien, with no evidence of assets through communication with the patient, credit reports and any other appropriate means, who refuses to cooperate with us in applying for governmental payment and/or with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

3.11 With the exception of accounts already submitted to a collection agency, current debt on accounts not yet submitted to a collection agency and debt incurred on and between the initial date of application and the date of approval and within ninety (90) days following the date of approval will be subject to the terms of the approval or denial.

With respect to accounts already submitted to a collection agency: If the collection agency has not yet incurred attorney fees and/or court costs, the charges will be written-off to Charity Care. If the collection agency has incurred attorney fees and/or court costs and the application has been approved, the amount payable by the Responsible Party for health care services will be written-off to Charity Care. The Responsible Party will remain financially responsible for payment of the attorney fees and/or court costs.

3.12 When a Medicaid patient is admitted for in or outpatient services and has unpaid accounts for dates of service within ninety (90) days prior to the patient’s Medicaid effective date; and to the best of our knowledge, there is no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write-off the discharged debt to Charity Care.

3.13 If a patient has made a payment(s) on his/her account(s) and subsequently qualifies for free care for those account(s), we are not obligated to refund the payments made because the patient demonstrated the ability to make payment as evidenced by the payment having been made.

4. OTHER DISCHARGE OF DEBT

4.1 Responsible Parties who do not qualify for Financial Assistance under 3 above, and have medical/dental debt equal to or greater than twenty-five percent (25%)
of annual income, as set forth on the Financial Assistance Application and determined through the Financial Assistance Application process, may be given a discount based on the totality of their circumstances. The amount of the discount will be at the discretion of the Financial Assistance Representative.

4.2 Responsible Parties who do not qualify for Financial Assistance under 3 and 4.1 above and whose debt to us exceeds their ability to pay, we may discount the Charges. The determination of ability to pay and the amount of the discount will be at the discretion of the Financial Assistance Representative.

Note: Sections 3.0 and 4.0 above are not applicable to Community Home Health Services and Community Long Term Care because they have their own Board adopted policies.

5. OTHER FINANCIAL ASSISTANCE

At the discretion of the Financial Assistance Representative we may pay health insurance premiums, including COBRA premiums, to assist the patient in maintaining health insurance coverage so long as the patient is receiving services from us which are covered services under the patient’s benefit plan.

6. SPECIFIC BUSINESS UNIT EXCEPTIONS:

Notwithstanding the foregoing, certain Business Units within the Network are exempted from the provisions of Sections 3, 4 and 5 herein above due to the unique nature of that Business Unit. Set forth below are the Business Units and their specific financial assistance policy.

6.1 MedChecks: MedCheck accounts subject to Financial Assistance shall be limited to those for services rendered by MedCheck which are reasonably related to the hospital services for which Financial Assistance has been granted.

7. APPLICATION AND APPEALS PROCESS

7.1 APPLICATION PROCESS

7.1.1 An application and financial statement for Financial Assistance will be provided to any requesting party. This may be done in person or by mail. (Attachments H and I)

7.1.2 Assistance in completing the application will be offered and provided to the Responsible Party.

7.1.3 The Responsible Party (“applicant”) will have fifteen (15) calendar days following the Initial Date of Request on the application to complete and
return the application. The applicant may request an extension of fifteen (15) calendar days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days will result in denial of the application and no discharge of debt.

7.1.4 Upon receipt of a complete application, it will be approved or denied within thirty (30) business days following the date of receipt and the applicant, and the physician if appropriate, will be notified, by telephone, certified mail or regular mail with an assumption of receipt five (5) days following the date mailed, of the result, including the amount of debt to be discharged and, if any, the amount of the remaining debt and due date, no later than the next business day.

7.1.5 With the exception of accounts already submitted to a collection agency, current debt on accounts not yet submitted to a collection agency and debt incurred on and between the initial date of application and the date of approval and within ninety (90) days following the date of approval will be subject to the terms of the approval or denial.

With respect to accounts already submitted to a collection agency: If the collection agency has not yet incurred attorney fees and/or court costs, the charges will be written-off to Charity Care. If the collection agency has incurred attorney fees and/or court costs and the application has been approved, the amount payable by the Responsible Party for health care services will be written-off to Charity Care. The Responsible Party will remain financially responsible for payment of the attorney fees and/or court costs.

7.1.6 The applicant will be given or mailed a copy of the application or a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.

7.1.7 The applicable accounts will be adjusted.

8. APPEALS PROCESS

8.1 If the application is denied or the amount of debt to be discharged is unsatisfactory, or financial conditions have changed, the applicant may appeal the decision.

8.2 The appeal must be in writing and include the basis for the appeal.

8.3 The appeal must be received within fifteen (15) business days following the date the applicant received the decision. For purposes of this process, submission of additional information does not require review by the appeals committee.
8.4 The appeals committee will convene and make a decision within fifteen (15) business days following receipt of the appeal.

8.5 No later than five (5) business days later, the applicant, and physician if appropriate, will be notified of the results by telephone and by certified mail or regular mail with an assumption of receipt five (5) days following the date mailed. If the debt to be discharged has changed, the notice will include the total debt to be discharged and, if any, the balance due and date due.

8.6 The decision of the appeals committee will be final but does not preclude the filing of a new application for debt not subject to the application that was under consideration.

Formulated By: Jacquelyn D. Johnson
Team Leader, Managed Care and Legal Projects

Approved By: ____________________________________________
Thomas P. Fischer, CFO

Date: _______________
SYSTEM POLICY #: 16  SUBJECT: Billing and Collection for the Uninsured

BOARD APPROVAL DATE: 12/10/03
EFFECTIVE DATE: 07/01/04
REVISION DATE: 06/08/06

President/CEO, Ascension Health

POLICY
It is the policy of Ascension Health to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HMs' patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within Ascension Health.

DEFINITIONS
For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at an Ascension Health hospital or medical center and the person who is financially responsible for the care of the patient.
- "Uninsured Patients" are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
  - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health Policy 9),
  - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay ("Means Test"), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES
1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship
2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does not apply to payment arrangements for elective procedures as defined by each hospital.

3. The application of this policy to International patients will be defined by each hospital.

4. Each hospital must ensure that:
   a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
   b. Patients receive prompt access to charge information for any item or service provided.
   c. Patients and their families are advised of the hospital’s applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
   d. Uninsured Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient’s financial status.
   e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
   f. Financial counselors are available to all Patients.
   g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
   h. Hospital programs that include nominal payments by Uninsured Patients designed to encourage Uninsured Patients to participate in their care are permissible.

5. Charity Care (Minimum Standards)
   a. At a minimum, Uninsured Patients with income less than or equal to 200% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
   b. At a minimum, Uninsured Patients with incomes above 200% of the FPL but not exceeding 300% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.
   c. Eligibility for charity care may be determined at any point in the revenue cycle.
6. Financial Assistance
   a. Uninsured Patients with income greater than 300% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
   b. The assessment of an Uninsured Patient’s ability to pay is termed a “Means Test” and will consider, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.
   c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
   d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
   e. Eligibility for financial assistance may be determined at any point in the revenue cycle.
   f. Eligibility for financial assistance must be determined for any balance for which the patient is responsible.

7. Uninsured Patients with the Ability to Pay
   a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
   b. The highest paying payor must account for at least 3% of the hospital’s population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
   c. A prompt pay discount must be provided to all of these Uninsured Patients, but can be in the form of an additional discount provided over the minimum required discount.

8. Collection Practices
   a. Liens on personal residences are permitted only in the following circumstances:
      i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
ii. The lien will not result in a foreclosure on a personal residence.

iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital

b. Garnishments of wages are permitted only if:
   i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, and a court determines that the Patient's wages are sufficient for garnishment.
   ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.

c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.

d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.

e. Interest charges on outstanding balances may only be assessed if:
   i. The financing plan offered is one of several options offered to the patient
   ii. The interest rate is fair (i.e., less than that charged by standard credit cards).
   iii. The amounts financed include only those amounts due after charity or financial assistance has been given.
   iv. The amount of interest anticipated to be charged by the financing entity must be netted against the balance the patient is deemed able to pay.

f. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

[Handwritten note: ]
Addendum To Collection Agency Services Agreement

[Health Ministry] and [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of ____________, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
   a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
   b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

<p>| | |</p>
<table>
<thead>
<tr>
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</table>

[Health Ministry]

<p>| | |</p>
<table>
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</table>

[Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.
SUBJECT: Charity Care And Uninsured Patient Discount Policy

PREFACE: Through the Sisters of St. Francis Health Services, Inc. (SSFHS), we continue the healing ministry of Christ in a Catholic healthcare system that upholds the moral values and teachings of the Catholic Church. Central concerns of this corporate ministry include compassion for those in need and respect for life and the dignity of persons.

We believe in the dignity, uniqueness, and worth of each individual and, within the limits of our resources, we offer a comprehensive range of healthcare services to all regardless of race, creed, color, sex, national origin or handicap. In light of this belief, we consider our healthcare services to be reaching out and responding, in a Christ-like manner, to those who are physically, materially, or spiritually in need.

DEFINITIONS

Charity - The action of reaching out and responding, in a Christ-like manner, to those who are physically, materially, or spiritually in need.

Charity Care - The cost of healthcare services, provided in accordance with the Charity Care and Uninsured Patient Discount Policy, for which no or partial reimbursement will be received because of the recipient’s inability to pay for those services.

Guarantor - The person who is financially responsible for payment of services provided by the facility.

Patient - The person who is the recipient of services provided by the facility.

Prompt Pay Discount - If applicable, a discount on the patient balance owed if paid in full and within a specified timeframe as may be established by SSFHS' facilities, if applicable.

Uninsured - Patients who do not have any insurance and are not eligible for federal, state, or local health insurance programs.
Uninsured Patient Discount or Discount - A discount provided to patients receiving medically necessary health care services who do not have any insurance and are not eligible for federal, state, or local health insurance programs.

**POLICY:** This policy is intended to address the financial assistance needs of patients:

A. Through the provision of Charity Care:

1. To patients whose level of income falls within or below a predetermined range of income (based upon a multiple of the U.S. Federal Poverty Level Guidelines); or

2. To patients who have limited financial means relative to their medical bills and are unable to pay, in part or in full, for medical services provided, without incurring undue financial hardship.

B. Through the provision of financial discounts to uninsured patients who have the means to pay for medical services provided.

This Policy is not intended to create any legal entitlement or to constitute a binding contract or agreement for or on behalf of any person, nor is the policy intended to cover elective cosmetic medical services or existing facility self-pay, flat-rate pricing arrangements.

**STATEMENT OF PURPOSE**

To best serve the community needs of each locality, this policy identifies the circumstances under which the facilities comprising SSFHS will extend Charity Care to patients whose financial status makes it impractical or impossible to pay for necessary medical services, and the circumstances under which SSFHS facilities will provide discounts to uninsured patients who have the means to pay for medical services provided. The necessity for medical treatment of any patient will be based on sound clinical judgment without regard to the financial status of the patient. SSFHS' Charity Care policy is designed primarily for those patients, whether employed or not, who do not have adequate private insurance, who do not qualify for Medicaid or other governmental or social service programs, and where no other person or entity is obligated to pay.

This policy is a vital component of SSFHS' Social Accountability agenda by which we hold ourselves accountable to our constituencies in those communities where we are privileged to serve.

**FINANCIAL ASSISTANCE**

*Charity Care*
Charity Care may be available to patients incurring emergency, urgent or emergent elective medical procedures and admissions. The level of Charity Care provided is based on U.S.
Federal Poverty Level Guidelines with a sliding adjustment scale starting from 200% and up to 300% of the U.S. Poverty Level Guidelines. See the Charity Care and Uninsured Patient Discount Procedures for eligibility and application provisions.

**Uninsured Patient Discount**

The minimum discount offered by SSFHS' facilities to eligible uninsured patients will be 20% of billed charges. Individual facilities may offer additional Discounts based on the facts and circumstances unique to their local markets. Any facility special package pricing in effect will not be impacted by this Policy. This Discount shall not be combined with other facility discounts, except for any Prompt Pay Discount as may be established by SSFHS' facilities. No Discount shall be provided that violates any laws or government regulations. See the Charity Care and Uninsured Patient Discount Procedures for eligibility and application provisions.

**PROCEDURAL CONSIDERATIONS**

Internal facility procedures for determining patient eligibility for Charity Care or Uninsured Patient Discounts will necessarily change over time and the then current facility procedures are to be referenced as appropriate.

**COMMUNICATION**

Each SSFHS facility shall post a notice regarding the availability of financial assistance for the payment of medical services provided to patients. Notices shall be posted in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration such as the emergency departments, billing offices, admitting offices, and outpatient service settings.

Posted notices shall contain the following:

A. A statement indicating that the facility has a financial assistance policy for patients who may not be able to pay their bill and that this policy provides for Charity Care and Discounts for medically necessary health care services; and

B. A contact phone number that a patient can call to obtain more information about the Charity Care and Uninsured Patient Discount Policy and about how to apply for such assistance or Discounts.

Oral and written communication to patients regarding the availability of and application process for financial assistance for the payment of medically necessary health care services shall be done in the primary language(s) of its service area and in a manner consistent with all applicable federal and state laws and regulations. In particular, the primary language(s) should be used on items such as: posted notices, the Financial Assistance Application Form, and the Uninsured Patient Discount Form, which is required to be filled out by the patient or the patient's guarantor, and the text of the Charity Care and Uninsured Patient Discount Policy. In addition, the facility shall provide, in the primary language(s), a written notice on the billing statement or via an
insert to the billing statement informing the patient that financial assistance may be available either from a government program or under the facility's own Charity Care and Uninsured Patient Discount Policy.

**MONITORING & REPORTING**

To facilitate timely monitoring and reporting of Charity Care, the patient accounting department will use appropriately identified transaction codes when writing off Charity Care allowances. Periodic reports will be prepared for management's use and discussions and presentation to SSFHS' leadership committees.

Uninsured Patient Discounts will be classified in the facilities’ financial statements in the Deductions from Revenue section in the account “Uninsured Patient Discounts”. The cost of medical services classified as Uninsured Patient Discount will be included in quarterly and annual Social Accountability and Community Benefit reports.

The patient accounting staff will review accounts which have been turned over to SSFHS' collection agencies in an effort to identify and report any amounts which were originally thought to be bad debts when, after further investigation, were found to be Charity Care allowances. If such accounts are identified, the patient or the patient's guarantor may be requested to provide some documentation for the Charity Care eligibility process. Under all circumstances, accounts falling into this category will be handled in a manner that fosters dignity and compassion for the patient.

**DISCLAIMER**

This document is intended to serve as a statement of policy and not as a contract or agreement with any patient or former patient. This document does not entitle any person to Charity Care or Uninsured Patient Discounts. This document does not create and is not intended to create any third party beneficiaries nor is it intended to create any legal rights with regard to any person or entity, including but not limited to any patient, former patient, governmental entity or agency, third-party payor or guarantor or anyone acting on behalf of such entity or administering benefits for such entity. This document does not create and is not intended to create any legal duties with regard to SSFHS or its facilities to any person or entity. All determinations of facility management or the Patient Financial Assistance Committee are final and are committed to the sound, unfettered discretion of such personnel or committee.

This policy replaces Corporate Charity Care Policy (300.03).
SISTERS OF ST. FRANCIS HEALTH SERVICES, INC.

MISHAWAKA, INDIANA

CORPORATE POLICY AND PROCEDURE

Number: CO 5070
Original Date: 07-15-2006
Latest Review/Revision: 04/05/2011

Subject: CBO Patient Financial Policy

Policy: It is the policy of Franciscan Alliance that necessary medical care will be rendered to all patients regardless of their ability to pay. We will first try to secure reimbursement coverage for the patient, but will then extend financial assistance for patients that can not pay for their services.

Procedure:

A. The registration staff is responsible for verifying insurance benefits via the electronic verification system. Patients that do not have insurance are also screened against the Medicaid database to see if they may have neglected to inform us of Medicaid Coverage.

B. If a patient presents with insurance that requires prior authorization, this is then also completed by the registration staff. Authorization approval is documented in the system.

C. If patient is not covered by insurance, the registrar first discusses possible payment arrangements. If patient seems eligible, the bank loan information is discussed. If patient may qualify for Medicaid, this is also discussed as an option. Patients that do not have the funds to pay for their services and cannot be covered by a government program are then offered financial assistance.

D. Financial Assistance can cover from 20% to 100% of the patient balance. The adjustment is based on family income and available assets.

E. Financial Assistance is offered to every person needing medical care and cannot afford to pay for the services. Patients that have insurance may also receive financial assistance for their portion to pay after the insurance payment.
F. All inpatient self pay accounts and all outpatient self pay accounts over $2000 are screened for possible coverage by State or Federal programs.

G. Patients that are making payments have the following options:
   
   1. Cash, check, or money order
   2. Visa, Master Card, Discover, American Express
   3. Bank financing
   4. Payment plans up to 12 months.

H. Charity information is posted at every registration site and the availability of charity is also noted on every patient statement. Patients receive a total of 4 statements before any account is referred to collection. The financial assistance application is also available on the website.

I. Prior to Early Out placement, all self pay accounts are again screened against the Medicaid data base to validate that Medicaid is still not available.

J. Patients can still apply for financial assistance once the account has gone to collection. The agency will send the patient the financial assistance application and the same approval review will take place.

ASSOCIATE (s)
RESPONSIBLE: ALL STAFF

____________________________
Executive Director CBO

____________________________
Vice President Revenue Cycle Management

____________________________
Date
Appendix III

Financial Assistance Adjustment Tables in relation to the Federal Poverty Guidelines
<table>
<thead>
<tr>
<th>Number in Family</th>
<th>Charity</th>
<th>Limited Means</th>
<th>Uninsured Financial Assistance Sliding Scale</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>200%</td>
<td>400%</td>
<td>400% - 425%</td>
</tr>
<tr>
<td>1</td>
<td>10390 - 21780</td>
<td>21781 - 43560</td>
<td>43561 - 48283</td>
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<tr>
<td>2</td>
<td>14710 - 29420</td>
<td>29421 - 58840</td>
<td>58841 - 62518</td>
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<tr>
<td>3</td>
<td>18530 - 37060</td>
<td>37061 - 74120</td>
<td>74121 - 78753</td>
</tr>
<tr>
<td>4</td>
<td>22360 - 44700</td>
<td>44701 - 89400</td>
<td>89401 - 94988</td>
</tr>
<tr>
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<td>26170 - 52340</td>
<td>52341 - 104680</td>
<td>104681 - 111223</td>
</tr>
<tr>
<td>6</td>
<td>29990 - 59980</td>
<td>59981 - 119960</td>
<td>119961 - 127458</td>
</tr>
<tr>
<td>7</td>
<td>33810 - 67620</td>
<td>67621 - 135240</td>
<td>135241 - 143093</td>
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<td>37630 - 75260</td>
<td>75261 - 150620</td>
<td>150621 - 158928</td>
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<tr>
<td>9</td>
<td>41450 - 82900</td>
<td>82901 - 165600</td>
<td>165601 - 176163</td>
</tr>
<tr>
<td>10</td>
<td>45270 - 90540</td>
<td>90541 - 181080</td>
<td>181081 - 192399</td>
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<tr>
<td>% of Discount</td>
<td>100%</td>
<td></td>
<td></td>
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<tr>
<td>% Family Owes</td>
<td>0%</td>
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<table>
<thead>
<tr>
<th>Uninsured Financial Assistance Sliding Scale</th>
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<td>450%-475%</td>
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<td>9</td>
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<td>10</td>
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Charity (available to Uninsured and Patients' Balances after Insurance)
Limited Means (available to Uninsured and Patients' Balances after Insurance)
Sliding Scale Financial Assistance (available to Uninsured ONLY)
<table>
<thead>
<tr>
<th>Household Size</th>
<th>Charity Care (100%)</th>
<th>Charity Care (101% to 160%)</th>
<th>Charity Care (161% to 200%)</th>
<th>Financial Assistance Program (to 250%)</th>
<th>Financial Assistance Program (to 300%)</th>
<th>Financial Assistance Program (to 350%)</th>
<th>Financial Assistance Program (to 400%)</th>
<th>Uninsured with Means to Pay</th>
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<tbody>
<tr>
<td>1</td>
<td>$10,830</td>
<td>$17,328</td>
<td>$21,660</td>
<td>$27,075</td>
<td>$32,490</td>
<td>$37,905</td>
<td>$43,320</td>
<td>&gt; 400%</td>
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<td>2</td>
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<td>5</td>
<td>$25,790</td>
<td>$41,264</td>
<td>$51,580</td>
<td>$64,475</td>
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<td>$111,030</td>
<td>$129,535</td>
<td>$148,040</td>
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**Classification**
- CC1
- CC2
- FAP3
- FAP4
- FAP5
- FAP6
- Self - Pay

**Discount**
- 100%
- 100%
- 100%
- 90%
- 70%
- 50%
- 30%
- 20%

**Discount Application**
1) Financial Assistance for the uninsured and Means to Pay discount is based on total charges.
2) Insured discount is based on patient liability or balance due.

### Other Services Minimum Co-Pay (Patient Liability) or Discount

| Emergency Room | $25 | $25 | $25 | $0 | $0 | $0 | $0 | 20% Discount |

<table>
<thead>
<tr>
<th>Employed or Participating Physician Services</th>
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</thead>
<tbody>
<tr>
<td>Office Visit</td>
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<tr>
<td>- 85% Discount</td>
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<tr>
<td>- 80% Discount</td>
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<td>- 70% Discount</td>
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<td>- 40% Discount</td>
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<td>- 40% Discount</td>
</tr>
<tr>
<td>- 30% Discount</td>
</tr>
<tr>
<td>- 20% Discount</td>
</tr>
<tr>
<td>- 20% Discount</td>
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</table>


** For each additional person at 100% poverty, add $3,740 (then, if necessary, multiply accordingly up to 400%).

*** Maximum owed by any patient per episode of care or account is 10% of gross household income.
Franciscan Alliance, Inc.  
(Sisters of St. Francis Health Services)  
2011 Charity/Financial Assistance Matrix

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100%</th>
<th>80%</th>
<th>60%</th>
<th>40%</th>
<th>20%</th>
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Family Size  
2011 Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2011 Federal Poverty Guidelines</th>
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<tr>
<td>1</td>
<td>$10,890</td>
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<td>7</td>
<td>$33,810</td>
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<tr>
<td>8</td>
<td>$37,630</td>
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each additional person | $3,820