YUMA REGIONAL MEDICAL CENTER

Title: Financial Assistance Policy (FAP)	
Department: Revenue Cycle	Category: System-Wide
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I. Policy

In keeping with our mission as a not-for-profit charitable organization committed to providing quality health care to all those we serve in a manner that responds to the needs of our communities, Yuma Regional Medical Center (YRMC) will provide emergency or other medically necessary care to all of our patients, regardless of their ability to pay for all or part of that care.

This Financial Assistance Policy (FAP) applies to YRMC and its affiliated clinics and is intended to meet the requirements of applicable federal, state and local laws including, without limitation, section 501(r) of the Internal Revenue Code and the regulations thereunder.

Accordingly, this written policy:

- Describes services eligible under this FAP
- Describes eligibility criteria for financial assistance, free and discounted care
- Describes the method by which patients may apply for financial assistance
- Describes eligibility criteria and amounts charged to patients
- Affirms FAP-eligible patients will not be billed more than amounts generally billed to other patients who have insurance covering such care
- Affirms this FAP is widely publicized within the community that we serve
- Affirms YRMC will not engage in extraordinary collection actions prior to making reasonable efforts to determine the patient's eligibility under this FAP

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with YRMC's procedures for obtaining financial assistance, and to contribute to the cost of their care based on their ability to pay.

The guiding principles behind this policy are to treat all patients and individuals responsible equally, with dignity and respect, and to ensure appropriate billing and collection procedures are uniformly followed and that reasonable efforts are undertaken to determine whether an individual is eligible for financial assistance before engaging in any extraordinary collection actions.

The principal beneficiaries of the FAP are intended for patients whose annual household income does not exceed 200% of the Federal Poverty Income Guidelines (FPG) published by the U.S. Department of Health and Human Services.

Additional financial assistance may be available for uninsured and other patients with annual household income up to 400% of FPG.

No FAP eligible individual will be charged more for emergency or other medically necessary care than the amounts generally billed (AGB) for emergency or other medical necessary services provided to individuals with insurance covering such care. YRMC is required to comply with the Emergency Medical Treatment and Labor Act (EMTALA) law and all Federal regulations and interpretive guidelines concerning this law. YRMC reserves the right to make financial assistance decisions outside of this policy.

II. Definitions

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

Emergency Care: Services, including examination and stabilization, provided to treat a medical condition (1) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be reasonably expected by a prudent layperson to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or (2) with respect to a woman who is having contractions, that (a) there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Federal Poverty Guidelines (FPG): Income thresholds used mainly for statistical purposes to estimate the number of Americans in poverty each year. These guidelines are updated each year by the U.S. Department of Health & Human Services and are also used to determine who receives federal subsidies or aid such as food stamps, Medicaid, the Affordable Care Act and other welfare programs.

Gross Charges: The amount charged for an individual item or service, absent any discounts.

Guarantor: An adult receiving medical service or the parent of a minor child (under age 18) receiving services who sign the consent for medical treatment on their behalf (not the subscriber of insurance).

Households (Family vs Nonfamily): A household is composed of one or more people who occupy a housing unit. Not all households contain families. Under the U.S. Census Bureau definition, family households consist of two or more individuals who are related by birth, marriage, or adoption, although they also may include other unrelated people. Nonfamily households consist of people who live alone or who share their residence with unrelated individuals.

Households that consist of unmarried couples living together would be counted as nonfamily households. If these couples live with children from their current or a previous relationship, the household moves into the family category.

Household Income: Household income consists of:

- 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, and other miscellaneous sources
- Noncash benefits (such as food stamps and housing subsidies) do not count
- Determined on a before-tax basis

- If a person lives within a family household, includes the income of all household members

Liquid Assets: Any asset that is cash or can be easily converted to cash such as checking and savings accounts, money markets, stocks, bonds, or Certificates of Deposit (CDs).

Medically Necessary Care: Services, based upon an assessment of the eligible individual's medical needs, that are reasonable and required to identify, diagnose, treat, correct, cure, palliate or prevent a disease, illness, injury, disability, or other medical condition including pregnancy, and which are consistent with the determination of "Medical Necessity" as defined by Arizona's Medicaid Program. Such services must be clinically appropriate and within generally-accepted standards of good medical practice. Further, such services must be provided in the most appropriate location where, for practical purposes, they may be safely and effectively rendered. Medically Necessary Care does not include any care provided primarily for the convenience of the individual, the individual's caregiver or healthcare provider, or for cosmetic reasons.

Plain Language Summary (PLS): A written document that describes the YRMC financial assistance programs available, the eligibility requirements, how to apply, and how to obtain more information including free copies of the FAP and application.

Resident: A Resident shall mean a person who is a legal resident of the United States.

Uninsured Patient: Individuals who do not have government, private health insurance or third party coverage; whose insurance benefits have been exhausted; whose insurance benefits do not cover the Medically Necessary Care the patient is seeking

III. Procedures

A. Services Eligible under this Policy. For purposes of this policy, financial assistance refers to healthcare services provided by YRMC for free or at a discounted rate to qualifying patients. The following healthcare services are eligible under this FAP:

- Emergency medical services provided in an emergency room setting
- Medically necessary services as defined above

Discounts under this policy do not apply to YRMC cash based services or services where other discounts have already been applied to total billed charges. Insured individuals who fail to reasonably comply with insurance requirements, such as coordination of benefits, completing accident details, or obtaining authorizations, are excluded from this FAP.

Services provided by non-employed YRMC providers are excluded from the YRMC FAP. These providers include but are not limited to emergency physicians, neonatologists, cardiologists, and/or ambulance services or air-ambulance services. A list of providers covered under FAP is maintained in a separate document and can be provided upon request. It is also located on our website at www.yumaregional.org.

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

Financial Assistance may be applied to the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts and other liabilities for medically necessary hospital services, except for the Medicaid (called "Medi-Cal" in California) Share of Cost (SOC) amounts. States require patients to pay the SOC as a condition of receiving Medicaid/Medi-Cal covered services.

The following must also apply:

- Individuals must submit documented proof of residency.
  - Acceptable proof of residency may include the following:
    - Copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year)
    - Copy of lease and record of most recent rent payment
    - Current utility bill
- Arizona and California residents, whose household income is lower than the current Medicaid eligibility threshold, must apply for Medicaid coverage. If the patient does not meet the Medicaid eligibility requirements, a copy of the determination status from Medicaid must be submitted as documentation for FAP
- All insurances, to include worker's compensation, third party liability and motor vehicle claims must have been billed and benefits paid to YRMC; all insurance guidelines/plan provisions must have been followed
- Proof of household income and family size is required along with a completed application. Eligibility must meet the FAP criteria based on household income, family size and asset calculations
  - Examples of required documentation include Social Security or Disability benefit statement, Unemployment or Pension/Annuity benefits, 30 days of the most recent pay stubs at time of application, most recent Federal or Business tax returns, SSI, bank statements showing liquid assets and any other extenuating information to show special circumstances
  - Individuals included in household size need to be a dependent on the federal tax return provided
  - Examples of liquid assets include cash, savings, checking and CD's
- Eligibility for assistance under this FAP for past services is no guarantee that future services will be eligible
- Patients annual household income does not exceed 400% of the FPG

Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance care discounts, but there is no financial assistance form on file and/or a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance.

YRMC may use outside agencies or other sources in determining estimated income and assets for presumptive financial assistance eligibility. Once determined, due to the inherent nature of the circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include, but not limited to:

- State-funded prescription programs
- Homeless or received care from a homeless clinic
- Participation in Women, Infants and Children programs (WIC)
- Food stamp eligibility
- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
- Patient is deceased with no known estate
- Patient is incarcerated

Non-covered and denied services provided to Medicaid eligible beneficiaries may be considered a form of financial assistance. Medicaid beneficiaries are not responsible for any forms of patient financial liability besides the Share of Cost (SOC) and all charges related to services that are not covered, including all denials, may be considered financial assistance.

Examples may include, but not limited to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
- Medicaid-pending accounts
- Medicaid of other indigent care program denials
- Charges related to days exceeding a length-of-stay limit
- Medicaid claims (including out of state Medicaid claims) with "no payments"
    - Any service provided to a Medicaid eligible patient with no coverage and no payment

C. Method by Which Patients May Apply for Financial Assistance. It is the patient's responsibility to submit a completed application prior to the Application Period which is 240 days after the first post discharge statement was sent to the patient.

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may:

- Include an application process, in which the patient or the patient's guarantor is required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need
- Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring)
- Include reasonable efforts by YRMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs take into account the patient's available assets, and all other financial resources available to the patient
- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history
- Patients will be asked to certify all information provided is true. If any information is determined to be false or the patient fails to cooperate with any alternative source of payment all discounts afforded to the patient may be revoked, making the patient or patient's guarantor responsible for the full charges for services rendered. If there is a discrepancy between sources of information, YRMC reserves the right to request additional information to support annual household income
- Patients will be notified of information missing from the Financial Assistance Application and given reasonable opportunity to provide additional documentation. If missing information is not provided, YRMC will notify the patient by letter that the application has been closed until requested information is supplied

Once YRMC has determined that a patient is eligible for financial assistance, that determination is valid for 180 days (6 months) from the date of application.

YRMC's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of FAP. Requests for financial assistance shall be processed promptly and YRMC shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D. Eligibility Criteria and Amounts Charged to Patients. Services eligible under this policy will be made available to the patient based on family size and income, in accordance with financial need, as determined in reference to Federal Poverty Guidelines (FPG) in effect at the time of the determination.

The basis for the amounts YRMC will charge qualifying patients is as follows:

- Patients whose annual household income is at or below 200% of the FPG are eligible for financial assistance care and will not be charged
- Patients whose household income is above 200% but not more than 400% of the FPG are eligible for financial assistance and will receive services at a discounted rate. Once financial assistance eligibility status has been determined, the patient will not be charged more than the "amounts generally billed" (AGB) for emergency or other medical necessary services provided to individuals with insurance covering such care
    - YRMC utilizes the "look-back' method to determine the AGB. The AGB percentage is calculated by using all claims allowed by commercially insured and Medicare patients for services with a discharge date from the previous fiscal year (October – September). For these claims, the sum of all allowable reimbursement amounts is divided by the associated gross charges. The AGB percentage is applicable as of October 1st of each year or more often if determined necessary by YRMC
    - Information detailing the AGB percentages used by YRMC, and how they are calculated, can be obtained by visiting the following website: www.yumaregional.org
- Allowances may be made for extenuating circumstances based on each person's unique life situation and mitigating factors. The amount of assistance provided by YRMC may be more than outlined in the YRMC FPL Grid for the current year, but not less.

E. Communication of the Financial Assistance Policy. Community outreach and communication regarding the YRMC FAP is achieved through the following methods, including but not limited to:

- Paper copies of YRMC FAP, financial assistance application and a Plain Language Summary (PLS) of the FAP are available upon request and without charge in YRMC emergency departments and all admissions areas. Patients may alternatively request that copies of these documents be sent to them electronically.
- The FAP, PLS and financial assistance applications are posted on the YRMC website to view, download and print free of charge. The PLS will contain the website address where these documents can be found online, in addition to the physical location in the hospital where paper copies may be obtained.
- The PLS is offered to all patients at registration or prior to discharge as part of the YRMC Condition of Admission process.
- All billing statements include a statement on the availability of financial assistance, including a telephone number for YRMC hospital staff that provide assistance with the application process and the website address where the FAP, PLS and financial assistance application can be found.
- The FAP, PLS and financial assistance application are available in the primary languages of significant patient populations with Limited English Proficiency (LEP).

F. Extraordinary Collection Actions (ECA). YRMC will not impose ECA's such as wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for discounts under this FAP. Reasonable efforts shall include:

- Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the hospital

- Documentation that YRMC has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the hospital's application requirements
- Documentation that the patient has been offered a payment plan but has not honored the terms of that plan

For patients who fail to apply for financial assistance under FAP or fail to resolve their account balance or set up an agreed upon payment plan within 120 days after the first post discharge statement and have received a final notice, YRMC may utilize a collection agency. A patient may apply for financial assistance within the application period, even after the patient's unpaid balance has been referred to a collection agency.

Collection agencies representing YRMC have the ability to pursue collection for up to 18 months from the point when the balance was sent to the collection agency. YRMC and its collection agencies do not report to credit bureaus nor do they pursue wage garnishments or similar collection actions.

G. Regulatory Requirements. In implementing this Policy, YRMC's management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

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