GRAND LAKE HEALTH SYSTEM	**POLICY AND PROCEDURE** **GRAND LAKE HEALTH SYSTEM**
SUBJECT: FINANCIAL ASSISTANCE	
DEPARTMENT: Patient Accounts	**Policy Number: Patient Accounts - 010**
APPROVED BY: Board of Directors	**Page: 1 of 9**

SCOPE

Joint Township District Memorial Hospital (JTDMH) is a 501(c)3 tax exempt charitable organization, established to meet the health care needs of residents in Auglaize and Mercer County and its surrounding communities. JTDMH is committed to providing both "Emergency Care" and "Medically Necessary Care" on a non-profit basis to patients regardless of race, creed, or ability to pay while managing JTDMH's limited resources to appropriately provide necessary health care.

The principal beneficiaries of the Financial Assistance Policy are intended to be patients whose Annual Family Income does not exceed 100% of the Federal Poverty Income Guidelines (FPG) published from time to time by the U.S. Department of Health & Human Services and are in effect at the date service is rendered.

Financial Assistance under this policy may also be available for patients with Annual Family Income up to 200% of the FPG and for patients with significant outstanding patient balances in exceptional circumstances.

Various providers provide emergency and medically necessary care in the Hospital facility. Appendix A to this policy lists which providers are covered by this policy and which are not.

This policy is effective for admissions after January 1, 2016.

POLICY

In fulfilling the Hospital's Mission, we recognize that we will not receive payment from certain individuals for emergency and medically necessary care that has been rendered. The following eligibility requirements, application process, and basis for amounts charged to patients will be followed in determining the financial assistance levels of these patients.

JTDMH is a participant in Ohio's Hospital Care Assurance Program (HCAP). All HCAP services are governed by JTDMH's HCAP policy, and nothing in this Policy is intended or should be interpreted to limit an HCAP-eligible person's assistance under HCAP. HCAP covers only basic, medically necessary hospital level services, and in some cases, qualified HCAP recipients may be eligible for financial assistance under this policy, for medically necessary services (not covered by HCAP).

ELIGIBILITY REQUIREMENTS:

Patients or their responsible party(s) will be eligible for Charity Care if they meet all of the

following guidelines:

1. The patient is voluntarily living in the state of Ohio. (See Definition of Resident)

2. The patient is seeking Emergency Care or Medically Necessary Care for inpatient and outpatient hospital and physician services. Non-Emergency and Non-Medically Necessary care are not covered under this Financial Assistance Policy.

3. The patient or the responsible party will provide proof or demonstrate that all available coverage by a third party insurer or governmental program (Medicaid, Disability Assistance, etc.) has been exhausted.

4. The patient or the responsible party will complete an application and provide the requested supporting documentation to determine eligibility.

5. The patient's and/or responsible party's annual family income does not exceed 200% of the Federal Poverty Guidelines (FPG), as established by the U.S. Department of Health and Human Services, for the year in which the date the services were provided.

6. The deductible and coinsurance on a Medicare patient's account that qualifies for both Medicare Bad Debt and Financial Assistance cannot be recorded as both Bad Debt and Financial Assistance. The account will be removed from the Medicare Bad Debt listing and will qualify only for Charity Care or a Charitable Care Write Off.

7. Uninsured Patients who potentially are eligible for Medicaid insurance are required to seek Medicaid coverage for future visits. The Financial Counselor is available to assist if needed.

8. Any Insured Patient or Uninsured Patient may qualify for financial assistance under exceptional circumstances. They will be considered for assistance if 100% of the patient's balance due for services provided during the calendar year is greater than 25% of their annual family income for the same calendar year. Both internal and external healthcare outstanding patient responsibilities will be considered for evaluation of the balance as a % of their annual family income. Accounts cannot be in legal status with the collection agency.

9. Specific Circumstances
    a. Insured Patients who are billed for residual amounts may be eligible for assistance under this Policy. They also may be eligible for assistance under the HCAP program.

b. Only non-covered services provided to a patient who is covered under a Medicaid plan will be eligible for Financial Assistance.
c. Pregnant patients with insurance that does not provide maternity benefits are eligible for assistance under this policy.
d. JTDMH will attempt to collect per visit co-payments at point of service in compliance with the insurance benefit terms. Patients not eligible for financial assistance and not making per visit co-payments are subject to cancellation of non-emergent appointments.
e. Patients who are under arrest or are under detention at the time of service are not eligible for charity care, as the city or county is required to arrange for medical care for persons that they have under arrest or are detaining. If a patient was with an officer, but not yet under arrest, or was released from detention for sole purpose to receive medical care, then they are eligible to apply for charity care. However, the hospital must still follow the charity care guidelines as set forth in this policy in determining eligibility.

10. In order to assess the responsible party's eligibility for Financial Assistance, the responsible party must cooperate with JTDMH and provide the necessary information.

11. In extenuating circumstances, it may be the judgment of the Chief Executive Officer, Chief Financial Officer or their designee to deviate from these eligibility requirements if it is in the best interest of the Hospital.

12. If a patient has sufficient insurance coverage or assets to pay for care, the Chief Executive Officer, Chief Financial Officer or their designee may deem the patient ineligible for financial assistance.

METHOD OF APPLYING FOR FINANCIAL ASSISTANCE:

1. To receive financial assistance under this Policy, individuals must;
    a. Meet the eligibility criteria for financial assistance set forth above
    b. Complete the Financial Assistance Application including the patient or responsible party's signature
    c. Provide reliable evidence documenting the family income on the Financial Assistance Application. Examples of reliable evidence include but are not limited to;
        i. Paystubs
        ii. Self Employment Form
        iii. Documentation from state or federal agency
        iv. If these are not available, the patient may call the Patient Accounts

Department to discuss other evidence they may provide.

d. Applicants of working age who state they have no income must provide a letter of support identifying how they maintained their day-to-day lifestyle for the time frame corresponding to the period in which they have no income and charity care is sought.
e. If there is discrepancy between two sources of information, a hospital representative may request additional information to support the application.
f. Statements must be provided to support outstanding patient responsibilities from external healthcare organizations.
g. If the patient is a member of a HealthSharing plan, the patient will be required to provide a copy of their EOB or other proof of payment amount from their HealthSharing plan prior to the Financial Assistance application being processed.

2. Time guidelines
    a. Applications for financial assistance will be accepted until one year has elapsed from the date of the first follow-up bill/notice for a given date of service.
    b. Incomplete applications will be returned to the patient or guarantor for completion. The applicant has 30 days to provide a complete application. If a complete application is not submitted within 30 days, normal collection processes will continue.
    c. Each inpatient admission and outpatient procedure represents a separate financial encounter and will be evaluated with new data to determine if a change has taken place.
        i. An eligibility review will be conducted and a new application will be requested for each inpatient admission and every 90 days for outpatient services.
        ii. If an inpatient is readmitted within 45 days of a discharge approved for financial assistance, the initial financial assistance application will be used for both inpatient stays.
        iii. An inpatient application can also be used to cover related outpatient services for the patient in the 90 day period immediately following the first day of the inpatient admission.
3. The patient will be notified of their qualification for assistance and the level of assistance provided or their ineligibility for assistance.

BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS

1. Patients eligible for awards of financial assistance under the Policy will receive assistance in the form of a discount from gross charges according to the following sliding scale

Annual Family Income	Amount of Discount
<121% FPG	100%
121 – 140% FPG	80%
141 – 160% FPG	60%
161 – 180% FPG	40%
181 – 200% FPG	25%

2. Patients eligible for financial assistance due to exceptional circumstances (100% of the patient's balance due is greater than 25% of their annual family income) will receive assistance in the form of a 75% discount from the patient's balance due at Grand Lake Health System.

3. Notwithstanding the sliding scale described above, where there is an award of financial assistance that does not cover 100% of gross charges for the service, the amounts charged to patients eligible under this Policy for discounted care will not be more than the amount JTDMH generally bills patients having insurance for such care under Medicare fee-for-service or private health insurers. As used herein, the "amount generally billed" has the meaning set forth in IRC Section 501(r)(5) and any regulations or other guidance issued by the Treasury Department or the Internal Revenue Service defining that term. See Appendix B for an "Explanation of Amounts Generally Billed" at JTDMH.

ACTIONS UNDER COLLECTION POLICY IN THE EVENT OF NONPAYMENT

The actions JTDMH may take with regard to non-payment by a patient who is able to pay for services, including collection actions and reporting to credit agencies, are set forth in the Collection Policy, Patient Accounts - 006.

DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE PRIOR TO COLLECTION ACTION

JTDMH will not engage in extraordinary collection actions before it makes reasonable efforts to determine whether an individual is eligible for financial assistance under this policy. As used in this policy

- "Extraordinary collection actions" include lawsuits, liens on residences, arrests, body attachments or other similar collection processes, and will include such other actions as may be set forth in guidance from the United States Department of Treasury or the Internal Revenue Service.
- "Reasonable efforts" includes notification to the patient of the policy upon admission and in written and oral communications with the patient regarding the patient's bill, including

invoices, telephone calls, and such other communication as may be set forth in guidance from the United States Department of Treasury or the Internal Revenue Service.

PUBLICATION OF FINANCIAL ASSISTANCE POLICY

JTDMH is committed to publicizing this Policy widely within the communities we serve. To that end, JTDMH will take the following steps to ensure that members of the communities to be served are aware of the Policy and have access to the Policy.

1. A copy of the policy will be available to the community by posting a plain language summary of the Policy and the Policy on its webpage.
2. A plain language summary of the Policy will be available in locations throughout its facilities.
3. Patient Accounts Representatives will make a plain language summary of the Policy available to all patients with whom they meet and will provide any person who requests it a copy of the Policy.

DEFINITIONS:

Annual Family Income includes wages, salaries and cash receipts before taxes. Deductions for reasonable business expenses supported by receipts will be deducted in determining eligibility for self-employed applicants. Other sources of income include, but are not limited to: alimony, child support, veteran's benefits, social security/disability income, unemployment/worker's compensation, interest, dividends, and monthly or lump-sum distributions for a retirement account. Child support and SSI payments for children would only be included as income when determining eligibility if the applicant is the child who is receiving the support payments. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information. Annual Family Income determination should be based on either the three-month period immediately preceding the date of service on the application or eligibility review multiplied by four or the twelve month period immediately preceding the date of service on the application or eligibility review. The time period most beneficial for the patient to support eligibility for charity care will be used as the final determination.

Emergency Care shall mean the care or treatment for an Emergency Medical Condition as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 U.S.C. SS 1395dd).

Family as defined by OAC rule 5101:3-2-07.17(B1) shall include the patient, the patient's spouse (regardless of whether they live in the home, and all of the patient's children, natural or

adoptive under the age of 18 who live in the home. If the patient is under the age of 18, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive under the age of 18 who live in the home. If the patient is of a minor parent residing in the patient's grandparents' home, the "family" shall include the patient, the parent(s) and any of the parent(s)' children, natural or adoptive who reside in the home.

Medically Necessary Care at JTDMH shall mean "basic, medically necessary hospital level services" at the inpatient, outpatient and emergency levels of care covered under the Medicaid program as defined by the Ohio Administrative Code (OAC), Chapter 5101:3-2 "with the exception of transplant services and services associated with transplant. This definition does not include:

- Routine Non-Medically necessary pharmacy orders
- Prostheses Replacement Costs
- Late Fees
- Patient Convenience Items

Resident shall mean a person who is a legal resident of the United States and voluntarily living in Ohio. Patients voluntarily living in Ohio include temporary residents, such as students or migrant workers, and patients who are temporarily residing with in-state relatives. This status does not include out of state patients who are on vacation or patients who come to Ohio solely to receive medical care.

Uninsured Patients are individuals who do not have governmental or private health insurance, who insurance benefits have been exhausted, or who do not have governmental or private health insurance other than benefits under the Ohio Medicaid and Ohio Job and Family Services Covered Family Planning – Related Services program.

APPENDIX A
PROVIDERS

The following providers provide emergency or medically necessary care in the hospital facility and are covered under this Financial Assistance Policy.

- Anesthesia services provided by JTDMH providers
- Occupational Health services provided by JTDMH providers
- Emergency services provided by Emergency Professional Services, Inc
- Urgent Care services provided by Emergency Professional Services, Inc
- Hospitalist services provided by Chalasani, MD Inc or FEP Acute, LLC
- Sleep Center services provided by Mercy Health Physicians Lima, LLC
- Pathology services provided by Lima Pathology Associates, Inc.
- Wound Care services provided by JTDMH providers
- Cardiology services provided by Rajendra P. Kakarla, Inc.
- Pulmonary Rehab services provided by Jason Stienecker, DO.

The following providers performing services on behalf of JTDMH and are exempted from coverage under this Financial Assistance Policy

- Radiology services provided by West Ohio X-Ray or Columbus Radiology
- Cardiology services provided by Mercy Health St. Rita's Cardiology or Cardio Terra, LTD
- Pain Management services provided by Pain Management Group
- Inpatient Psychiatric Services provided by Amita Patel MD, Inc, DBA Dayton Psychiatric Associates

APPENDIX B
AMOUNTS GENERALLY BILLED

Following a determination of financial assistance eligibility under this policy, an individual will not be charged more than the amounts generally billed (AGB) for emergency or other medical care provided to individuals with insurance covering that care.

At JTDMH, the AGB is determined using the "Look-back method" which is calculated as follows:

1. The AGB is calculated by reviewing all past claims that have been paid in full to the hospital facility for medically necessary care by Medicare fee-for-service together with all private health insurers in a prior 12 month period. This amount can include co-insurance, copayments and deductibles.
2. The AGB for emergency or medically necessary care provided to a financial assistance eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages")
    a. The percentages are calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.
    b. Multiple AGB percentages may be calculated for separate categories of care (for example, inpatient versus outpatient care, or care provided by different departments) or for separate items or services.
    c. The percentages are applied by the 45th day after the end of the 12 month period the hospital facility used in calculating the AGB percentages.

Each account eligible for Financial Assistance will be evaluated to ensure the patient is not charged more than the AGB percent of Gross Charges. The AGB percentages will be updated January 1 of each year.

Reference Patient Accounts - 027, Amounts Generally Billed for current AGB percentages.