Hospital
Fairview Range Health Services

Policy

Financial Assistance Policy—Range

Purpose

Fairview Range has a long history of providing quality health care to patients within our community regardless of their ability to pay. Fairview recognizes that some patients may be unable to pay all or a portion of the cost of medically necessary health care services received because they did not have health insurance coverage or because their health care costs exceed their ability to pay, such as a result of a catastrophic incident. In order to provide appropriate financial assistance to those who are truly in need, Fairview has a process to evaluate a patient's eligibility.

Definitions:

Federal Poverty Guidelines (FPG) - Income guidelines published annually by the U.S. Department of Health and Human Services that are used for determining financial eligibility for certain programs. Guidelines vary by family size. Fairview Range FAP income guidelines will be updated at the beginning of each fiscal year based upon the prevailing FPG.

Guarantor - A person who accepts the legal obligation to pay for medical services. The term patient in this policy includes the guarantor.

Household - A group of two (2) or more persons who reside together and are related by birth, marriage, adoption, civil union, domestic partnership or otherwise and are financially responsible for each other which is indicated by either (1) jointly filing or claiming the other person (s) as a dependent on the most recent federal tax return or (2) submission of some other legal documents to indicate joint financial responsibility for person expenses.

Household Income - Includes 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, education assistance, alimony, child support, assistance from outside the household and other miscellaneous sources:

1. Non cash benefits (such as food stamps and housing subsidies) do not count
2. Income is determine on a pre-tax basis
3. Excludes capital gains or losses

Medically Necessary Services - These include by are not limited to the following:

1. Trauma and emergency medical services
2. Any diagnostic study, procedure or treatment needed to prevent, diagnose, correct, cure, alleviate, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, or may result in overall illness or infirmity
3. Services defined under a patient's health insurance coverage as "covered items or services", including items and services covered by Medicare

4. Other services scheduled in advance, with physician orders, and assessed on a case-by-case basis and determined to be medically necessary by a physician may be approved at Fairview Range's discretion (see exclusions in Attachment A).

Most favored Insurer - A nongovernmental third-party payor that provided the most revenue to the provider during the previous calendar year.

Patient - The individual who received medical services and who is responsible for payment of the medical bill. If there is a guarantor that is separate from the patient, the term patient refers to the guarantor as well.

Presumptive Charity Care Eligibility - Process of proactively classifying charity care on the basis of limited financial information. A determination that a patient is presumed eligible for Charity Care when adequate information is provided by the patient or through other sources not provided directly by the patient, which allows Fairview to presume that the patient qualifies for Financial Assistance.

Uninsured Patient - An individual having no third-party payor coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program such as Medicare, Medicaid, Tricare and CHAMPUS, Worker's Compensation, third-party liability (e.g. auto), Medical Savings Accounts or other third-party assistance to assist with meeting their payment obligations.

Underinsured Patient - An individual with insurance coverage for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services. This would also include benefit exclusions in the insurance policy such as pre-existing conditions or mental health benefits.

Policy

Fairview will thoroughly and efficiently identify uninsured and underinsured patients and determine all third-party resources, non-hospital financial aid program and/or other government assistance programs. The Financial Assistance Policy is in effect to provide financial assistance to the eligible uninsured and underinsured patients who cannot afford to pay his/her medical bills for emergency and other medically necessary care. Fairview will not conduct any collection activities in its hospitals that would discourage patients from seeking the emergency care they need or delay emergency care [**as outlined in the Emergency Medical services** Policy]. Fairview Range shall inform patients about the Financial Assistance Policy prior to delivery of service, if feasible, during the registration or discharge process, and as appropriate and during the billing process. Fairview Range's Financial Assistance Policy consists of separate programs which are each detailed in the policy.

Procedure

I. Informing patients about financial assistance policy (FAP):

A. Fairview Range will make the FAP readily available and at no cost to the patient.
   i. The FAP documents (policy, plain language statement, application) will be available on the Fairview Range website http://www.range.fairview.org/QuickLinks/fap.aspx. Information and application

will be easily accessible. At a patient's request, the documents will be printed and provided at no charge at designated admission areas or by calling 218-362-6624.

ii. Notices on the availability of financial assistance will be conspicuously posted in the emergency room departments in all admission area.

iii. Postings and notices will be in English, and will also be translated into the primary language of any population in the communities served by the hospital facilities that constitutes more than 5% or 1000 individuals, whichever is less. Interpreter services will be used as needed to discuss the program further with patients or their guarantors.

iv. A plain language summary (PLS) of the Financial Assistance Policy will be offered to each patient prior to a hospital discharge.

v. Information about the FAP will be on all patient billing statements.

vi. FAP information will be made available to appropriate community health services agencies and other organizations that assist people in need.

B. Fairview Range has trained personnel available to provide information about the FAP and assist with the application process upon request.

II. Charity Care Program

A. Eligibility Criteria

i. Fairview is required to accept Charity Care applications for 240 days following the first post-discharge billing statement; however, Fairview currently accepts applications for all open accounts regardless of the timeframe.

ii. Only emergency and medically necessary services qualify for Charity Care. Fairview Range reserves the right to determine on a case-by-case basis whether services meet the definition of "medically necessary" for the purpose of eligibility for Charity Care (see Appendix A).

iii. To qualify for Charity Care, a patient must meet income and asset guidelines as follows:

a. Income Level: The patient's combined annual household income must be at or below 280% of the Federal Poverty Level (FPL):

Family income as % of FPL	**Discount**
>171% – 280%	50%
>121% – 170%	**75%**
≤120%	**Free**

b. Asset Level: The applicant's combined savings and checking accounts may not exceed $15,000 (household of one) or $25,000 (household of two or more). Combined retirement funds may not exceed $50,000 (household of one) or $100,000 (household of two or more).

c. Details regarding the required documentation to verify income and assets are found below under "Application Process".

B. Application Process

i. Patient Screening Process:

Accounts will only be considered for Charity Care after an exhaustive investigation of other funding sources indicates no additional coverage (i.e., Medicaid, state programs, Qualified Health Plans etc.) is available to cover the balance owed by the patient. All third-party resources and non-hospital financial aid programs, including public assistance available through Medicaid, must be exhausted before Charity Care may be considered.

ii. MNsure Application:
Prior to determining patient eligibility for the Charity Care Program during the patient screening process, Fairview shall assist the patient in applying through MNSure for Medical Assistance (MA), MinnesotaCare or Qualified Health Plans.

iii. Charity Care Application:
The patient will be required to complete a Fairview Charity Care application on which they will disclose their current assets and income levels (or that of his/her family if applicable) to determine eligibility for the Charity Care program. Fairview will make every attempt to assist with this process. The Charity Care application allows for the collection of information needed to complete the Charity Care approval process. If an application is received without sufficient documentation, the application will be considered "pending" and any extraordinary collection activities will cease until the application is approved or denied. The financial assistance application must be completed and documentation provided within thirty (30) days of receiving the application in order for eligibility to be considered. Failure to do so will result in a denial of the application.
Financial Assistance applications are to be submitted to the following office: Fairview Range, Patient Financial Services, 750 East 34th St Suite 1550 Hibbing, MN 55746.

a. Documenting, Verifying Income, Assets and Resources:
Income will be verified by using the most recent Federal Tax Returns and any of the following mechanisms: IRS Form W-2, Wages and Earnings Statement, Pay Check Remittance, Tax Returns, Proof of dependent Status, Social Security Disability Notification Letter, Workers' Compensation, Unemployment Compensation Determination letter, Experian tools or a letter from all of the applicant's employers indicating gross income before taxes. If the applicant cannot provide the requested document to prove household income, he or she may provide other reliable evidence of their earned and unearned income as determined by Fairview in order to make an accurate determination of income.

Other income or asset resources will be evaluated, including resources from savings, checking, retirement accounts, certificates of deposit (CD). Health Savings accounts (HSA) will be required to be used on their health care expenses before any Charity Care funding will be granted. If the applicant has not provided sufficient documentation of income and assets, Fairview will send the applicant a letter requesting additional documentation. If acceptation documentation is still not provided, Charity Care will be denied.

b. Calculation of Income:
For adults, the term "Total Yearly Income" on the Charity Care Application refers to the sum of yearly gross income of the applicant and the applicant's

spouse from all sources. If the applicant is a minor, the term "Total Yearly Income" refers to the combined gross income of the applicant and the applicant's parents' and/or legal guardian. The "Total Yearly Income" figure used on the Charity Care Application refers to the documented income annualized over 12 months. A minimum of the last 3 months of income verification will be requested. If the last 3 months verification is not available, the patient may provide the most recent amount of the documented total year income. Charity Care cannot be granted if the patient receives a third-party financial settlement associated with the care rendered by Fairview Health Services sufficient to cover the outstanding claims as such funds are expected to be used to satisfy the balance owed to Fairview Health Services by the patient.

A patient applying for Charity Care will report the number of people in their household to determine household size, income and assets:

Adults: In calculating the number of people in an adult applicant's household, Fairview will include the applicant, the applicant's spouse and any legal dependents.

Minors: In calculating the number of people in a minor applicant's household, will include the applicant, the applicant's father/guardian, mother/guardian and any dependents of the father, mother or minor.

Parents living in the home with their child will not count toward the household size or income of that child unless legal guardianship or conservatorship can be proven through official legal documentation.

iv. Processing of Charity Care Application

Financial representatives will review the applications using program guidelines and inform patients of their eligibility status within 14 business days from the date all required documentation is received.

a. Approved applications

An approved Charity Care application is valid for three months from the application acceptance date. For any dates of service after the three month time period, the patient must reapply for Charity Care and provide all required verification. Exceptions can be made to this with the appropriate management approval level.

The Financial Assistance Policy applies only to open account. If a patient is approved for Charity Care, any qualified prior balance in active accounts received or bad debt status will be written off to Charity Care. Any balances that have incurred legal costs are not eligible for Charity Care but may qualify for a financial exception.

Approved applications will require a case-by-case approval of the medically necessary services. If a patient is pre-approved for Charity Care this does not guarantee services unless those services are medically necessary and medically urgent. Medical necessity and urgency will be determined by the attending physician and, if the visit is not deemed necessary or urgent, the patient may be deferred. Patients may reapply if their status changes or additional documentation to support their application is obtained.

Fairview Range reserves the right to change its Charity Care determination if the applicant's financial circumstance has changed.

b. Denied Applications

Fairview Range reserves the right to deny an application for financial assistance if:

- income and asset verifications are not provided by the applicant;
- the applicant provides false information;
- the applicant does not fall within the Charity Care income or asset guidelines; or,
- the applicant does not choose to obtain coverage through MNsure or other means.

v. Falsification of Information:

Falsification of income information or a refusal to cooperate with Fairview through the application process will result in denial of the Charity Care Application. If, after an applicant is granted Charity Care, Fairview learns that a material provision of the Charity Care Application is untrue, the Charity Care Application and any Charity Care granted may be withdrawn as determined by Fairview's sole discretion.

vi. Cooperation:

Because the Charity Care Program is not a substitute for personal responsibility, persons seeking financial assistance through the program are expected to cooperate with the Fairview Range procedures for determining eligibility and to contribute to the cost of services to the extent of their individual ability and determined financial responsibility. Fairview Range encourages individuals who have the financial ability to purchase health insurance in order to assure their ongoing access to preventative health services and to protect individual assets. All patients must apply through MNSure for Medicaid, Minnesota Care, Qualified Health Plan or other acceptable form of healthcare coverage as outlined in the Affordable Care Act (ACA) to be considered cooperative, if eligible.

i. If a patient is potentially eligible for a third party funding source and does not cooperate due to extenuating circumstances beyond the patient's control, the patient will be required to submit a letter of explanation. The letter will be reviewed by Fairview management.

ii. A patient will not be eligible for Charity Care if a patient has a third party payor and does not submit the payer information to Fairview within a timely manner resulting in a denial to Fairview Range.

iii. If a patient elects not to bill his/her insurance for a particular procedure or date of service, that visit will not be eligible for Charity Care.

iv. Patients who have insurance and payment has not been received from the insurance company will be denied Charity Care if the applicant fails to cooperate with claims filing or collecting from potential third-party resources.

vii. Basis for determining discount amount:

The Federal Poverty Level (FPL) is published annually in the Federal Register and will be the basis for guidelines used to qualify Charity Care applicants.

Based on the financial application of the patient and the remaining balance for each account, a financial representative shall apply the discount which reflects the following considerations:

i. Discount Rate:

In order to direct Fairview Charity Care Program benefits toward the communities in which Fairview is located to the neediest patients, and to encourage patients to obtain health insurance coverage, the rate of discount shall be based on:

- Income Level: Patients determined to be eligible for Charity Care with a combined household income of up to 280% of the Federal Poverty level will qualify for a discount on their qualifying self-pay balance.

ii. In accordance with the IRS regulations under section 501(r), Fairview will limit the amounts charged for any emergency and other medically necessary hospital care provided to a patent determined to be eligible for assistance under the Financial Assistance Policy. Fairview will not charge these patients more than the Amount Generally Billed, or AGB.

a. The AGB was calculated for each hospital using the look-back method utilizing expected reimbursement on all commercial payors and Medicare discharged Spanning September 2014 through August 2015 as follows:
    i. Range Regional Health Services: 46.98% of gross charges
b. The AGB will be updated annually within the first 120 days of the new year
c. Individuals determined to be eligible for assistance under the Financial Assistance Policy will be refunded any payments made in excess of the AGB on FAP eligible accounts, unless that amount is under $5.00.

D. Exclusions

Fairview Range Charity Care Programs do not cover the following:

i. Patients who do not comply with the Charity Care application process
ii. Services considered non-covered by most insurance providers unless it is considered standard of care
iii. Services that would have qualified for insurance coverage if received at another facility or services not billed or received at Fairview Range
iv. Services rendered at our facilities by independent physicians, out-of-network services, Hospice, Greenview Alzheimer's, and foreign or out-of-state services (see Provider list - Appendix B). Provider list to be updated quarterly.

III. Other Charity and Discount Options

A. Financial Exceptions

If a patient does not qualify for Charity Care, a Financial Exception may be considered on a case by case basis for full or partial write-off of charges. Designated Fairview

Management shall evaluate all exceptions to determine the patient's ability to pay. Only exception cases pertaining to patients without the financial resources to pay shall be processed and reported as Charity Care. All other cases shall be processed and reported as administrative adjustments and not Charity Care or Bad Debt, as defined under state and federal guidelines.

Patients with significant medical debt who do not qualify for Charity Care and are unable to pay due to extenuating circumstances may apply for Charity Care through the Financial Exception process. Example: An applicant who exceeds FPL guidelines and has total outstanding medical debt which exceeds the gross household income for the past year.

B. Senior Partners:

Fairview Senior Partners is a partnership between Fairview and the Senior Community Services available to qualifying Minnesota residents on Medicare. Fairview has agreed to waive co-insurances and deductibles. Members of this program understand that they are responsible for any items not covered by Medicare, such as take-home drugs. The Financial Assistance Coordinator shall adjust accounts. Amounts collected from Medicare shall be offset against the charity care adjustment.

i. Applications for enrollment
   - All applications are sent to and processed by Senior Community Services or the outlying State offices. Patients may request an application or more information by calling 952-767-0665 or visiting www.seniorcommunity.org
   - There is an annual $42 fee for approved applications

ii. Eligibility Criteria
   - Patient must be enrolled in Medicare parts A and B and not on a replacement plan
   - Cannot have a Medicare supplement
   - Income cannot exceed 200% of the FPL
   - Assets cannot exceed $47,100 (excludes one home and one car)

C. Retro Charity Care:

Throughout the billing cycle, Fairview will identify patients who have current Medical Assistance (MA) or Minnesota Care and have previous dates of service which are not covered by MA/Minnesota Care. Charges incurred prior to the MA/MinnesotaCare coverage effective date may be eligible for Charity Care on a presumptive basis at Fairview's discretion. Any amounts approved for write off shall be offset against the medically indigent adjustment.

D. Uninsured Discount:

In addition to the programs available under the Financial Assistance policy, uninsured patients will be eligible for the uninsured discount for hospital services prior to the application of a Charity Care discount (See "Uninsured Discount Program Policy").

IV. Billing and Collections

A. Fairview has a separate Billing and Collections policy which is available via its website or by calling 218-362-6624. This policy includes more specific information about:

i. Billing Process: Fairview will issue billing statements in accordance with established timelines and will provide a minimum of 120 days from the first post-visit bill before initiating extraordinary collection actions on an account.

ii. Resolving Accounts: Fairview will provide a minimum of 240 days to resolve open accounts through vairious options, such as identifying eligible insurance or medical assistance, payment arragements, charity care or other means.
iii. Collection Actions: In the event of non-payment, Fairview may refer accounts to collection agencies and/or legal collection firms for follow up. Fairview will provide patient notification at least 30 days before initiaing extraordinary collection actions on an account.

Policy Owner:

Patient Financial Supervisor

Approved By:

Governing Board

Date(s):

Date Effective: 3/05
Date Reviewed: 7/09; 05/09; 03/08; Fairview Board Reviewed and Re-Approved: xx/15
Date Revised: 2/12; 8/10; 04/10; 10/14; 6/15; 11/15
Supercedes: