

## Financial Assistance

- I. Policy: Uninsured Individuals receiving medically necessary care and exhibit financial need according to the Federal Poverty Guideline are eligible to receive financial assistance.
- II. Purpose: The Financial Assistance Program policy, in accordance with federal and state regulatory guidelines, ensures financial assistance is available for Individuals unable to meet their financial obligations based upon their care need.
  - a. Definitions:
    - i. Amounts generally billed (AGB): For each hospital, the AGB Percentage is a percentage derived by dividing the sum of all claims for Medically Necessary services provided at such Hospital paid during the Relevant Period by all private health insurers as primary payors, together with any associated portions of these claims paid by insured individuals in the form of co-pays, co-insurance or deductibles. The AGB Percentage is calculated by January 31 and is effective until the next annual calculation. The calculation shall comply with the "look-back method" described in Treasury Regulation §1-501(r)-5(b) (1) (B).
    - ii. Bad Debt: A balance no longer deemed collectable.
    - iii. Elective: Service deemed by a physician to be non-emergent and safe for delay.
    - iv. Federal Poverty Level (FPL): The minimum amount of gross income required to sustain a family as determined by the United States Department of health and Human Services.
    - v. Medically Necessary Services: Medical care required to ensure the well-being of the patient as defined by generally accepted medical practice. TGC's Flat Rate: TGC's provides flat rate self-pay fees for specific services to uninsured Individuals.
- III. Eligibility: To be eligible for consideration, an applicant must be an uninsured patient receiving medically necessary care and exhibit financial need in accordance to the Federal Poverty Guideline (FPL) are eligible to receive financial assistance.
  - a. To be eligible for consideration, an applicant must be:
    - i. Ineligible for Medicaid;
    - ii. Approved for Medicaid postdate of service;
    - iii. Medicaid eligible but service is not a covered benefit;
    - iv. Less than 400% of the FPL.
  - b. TGC's flat rate fees and co-pays are not eligible for consideration.
  - c. Eligible balances will be adjusted according to the FPL calculation based upon household number and income. In the event that the patient receives a tiered discount under this policy, the patient will not be billed more than the amounts generally billed for care, calculated using the Amounts Generally Billed method as described in applicable IRS regulations.
  - d. This policy is communicated via the following:
    - i. TGC's website;
    - ii. The guarantor billing statement;
    - iii. Available throughout the covered facilities and upon request without charge via mail;
    - iv. Customer Service team members.

Procedures:

1. Charges for all emergency or other medically necessary services provided by entities covered by this policy are eligible for financial assistance consideration, excluding elective care. Care provided by physicians not employed by The Guidance Center are not eligible for financial assistance consideration under this policy.
2. Encounters for which a third party is liable for care are not eligible for consideration. If the third party does not accept liability for the cost of the services, the applicant may reapply.
3. The Financial Assistance Applications are not processed if received after the 240th day after the first bill to the individual for the most recent episode of care. If an application is received within that time but after the encounter has been sent to bad debt, the account will be recalled to the hospital to review and act on the application in accordance with this policy.
4. Financial Clearance (FC) can be done prospectively, concurrently, and retrospectively.
  - a. Prospective and Concurrent Review:
    - i. Individuals are reviewed for the ability to pay by Patient Access Services (PAS) after confirmation from clinical staff that the patient has received an appropriate medical screening examination by a qualified medical professional, and either
      - o no emergency medical condition exists or;
      - o if an emergency medical condition exists, such condition has been stabilized as defined by the Emergency Medical Treatment and Active Labor Act. The hospital will not delay or deny emergency medical care to an individual on the condition that an individual submit information to determine whether the individual qualifies for third-party coverage or financial assistance for the care being delayed or denied.
    - ii. The financial clearance process will be performed in accordance with the procedural requirements outlined in the job aids indicated in the reference section of this policy.
  - b. Retrospectively, the Revenue Cycle staff review requests for assistance submitted post discharge.
  - c. If the patient is unable to meet his or her financial obligation for care, the FC reviews the patient for eligibility for Arizona Medicaid (AHCCCS).
    - i. Individuals that do not provide the necessary documentation to determine eligibility for AHCCCS will not be considered for financial assistance.
    - ii. If the proof of income indicates it is in excess of the limits for AHCCCS eligibility, the financial assistance process may continue without completing the AHCCCS application.
    - iii. If the patient has AHCCCS or other insurance coverage, the financial class is changed on the encounter and financial clearance is concluded.
    - iv. If the patient does not have AHCCCS or other insurance coverage, and proof of income indicates possible eligibility, the FC engages the patient in the AHCCCS application process (see MECS AHCCCS eligibility procedure):

- o If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance (see Presumed Financial Assistance);
  - o If the patient is denied coverage, the FC will provide the patient with the Financial Assistance Application.
- d. The Financial Assistance Application is completed by the patient/guarantor. The application supporting documents include the following:
  - i. Complete copy of the signed prior year federal tax returns;
  - ii. Determination letter from AHCCCS (valid denial or acceptance of a completed final application for AHCCCS) or other government-funded program for the patient's individual state, such as Medicaid or proof of ineligibility based upon FPL calculator;
  - iii. The patient/guarantor must prove total household income as defined below:
    - o Household income is required for all adults (18 years or older or full times students under 24);
    - o 3 months of personal bank statements for all account types (savings, checking, etc.);
    - o Proof of employed patient/guarantor income;
      - Employed applicants: 3 consecutive check stubs or a letter from the applicants Human Resources Dept.
      - Self-employed applicants: A copy of the federal tax form schedule C.
    - o Unemployed applicant: Copies of Unemployment payments or statement for means of support;
    - o A copy of the SSA 1099 form if retired and/or on Social Security;
    - o Copy of any pension benefit letters;
    - o Other income to include rent, alimony, child support or other source.
  - iv. Eligibility for charitable assistance will be based on the income and family size of the patient/guarantor.
    - o Income levels are based on the FPL published by the Federal Register annually (Financial Assistance Scale).
      - Household members are defined as all dependents and adults residing with the patient.
      - Applicants with household income of 400% of FPL or lower may receive financial assistance based upon a tiered discount (Financial Assistance Scale).
  - v. Financial Assistance Applications are processed within 5 business days of receipt :
    - o Incomplete applications will be returned to the patient/guarantor, along with written notice identifying the missing information or documentation needed to process the application. This notice must describe the collection activities that may occur if the individual does not provide

the missing documentation or make arrangements to pay the bill within the later to occur of (i) 30 days from the date of notice or (ii) 120 days after the first bill to the individual for the most recent episode of care.

- Patient/Guarantor has 30 days to provide missing information or documentation;
  - Failure to respond to missing information or documentation request within 30 days may result in denial.
- vi. Under no circumstances will a determination that an individual is not eligible for assistance under this policy be based on information that there is reason to believe is unreliable, incorrect or obtained from the individual under duress.
  - vii. The patient/guarantor is notified of approval or denial of application in writing:
    - o Financial Assistance less than 100% requires an established payment plan to remain in good standing;
    - o Assistance is applicable to all current outstanding balances excluding elective cosmetic procedures for 6 month postdate of approval;
    - o The patient/guarantor is responsible to notify the Central Business Office of new balances eligible for approved financial assistance adjustment.
- e. Presumed Financial Assistance
- i. Eligibility:
    - o If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance;
    - o Patient had AHCCCS coverage the month preceding and the month post services;
    - o Indigent based upon residency validation;
    - o Patient's services are covered under a grant that has exhausted funding;
    - o Patient is incarcerated and the care is not the financial responsibility of the local, state, or federal institution;
    - o Patient provides an invalid social security number;
    - o AHCCCS covered Individuals who exceed maximum allowable days;
    - o Deceased;
    - o Bankruptcy.
  - ii. Presumed Financial Assistance is by encounter only and cannot be used for future balances.
- f. Exception/Financial Assistance Committee:
- i. Individuals/Guarantors requesting exceptions can appeal an outcome by escalation to the Financial Assistance Committee.
  - ii. The Financial Assistance Committee is comprised of the Executive Director of Revenue Cycle, Controller, Director of

Patient Financial Services, and Clinical Department Director for the affected areas of care.

- iii. Committee findings are documented and mailed to the patient/guarantor.
- iv. Remaining balances after committee findings require an established payment plan to remain in good standing.

Poverty Level*	0 - 100 %		101 - 125 %		126 - 150 %		151 - 175 %		176 - 200 %	
Percent Discount	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
Family Size	Minimum Fee		20% Pay		40% Pay		60% Pay		80% Pay	
1	\$0	\$13,590	\$13,591	\$16,988	\$16,989	\$20,385	\$20,386	\$23,783	\$23,784	\$27,180
2	\$0	\$18,310	\$18,311	\$22,888	\$22,889	\$27,465	\$27,466	\$32,043	\$32,044	\$36,620
3	\$0	\$23,030	\$23,031	\$28,788	\$28,789	\$34,545	\$34,546	\$40,303	\$40,304	\$46,060
4	\$0	\$27,750	\$27,751	\$34,688	\$34,689	\$41,625	\$41,626	\$48,563	\$48,564	\$55,500
5	\$0	\$32,470	\$32,471	\$40,588	\$40,589	\$48,705	\$48,706	\$56,823	\$56,824	\$64,940
6	\$0	\$37,190	\$37,191	\$46,488	\$46,489	\$55,785	\$55,786	\$65,083	\$65,084	\$74,380
7	\$0	\$41,910	\$41,911	\$52,388	\$52,389	\$62,865	\$62,866	\$73,343	\$73,344	\$83,820
8	\$0	\$46,630	\$46,631	\$58,288	\$58,289	\$69,945	\$69,946	\$81,603	\$81,604	\$93,260
For Each Additional person, add	\$4,720									

\*Based on 2022 HHS Poverty Level Guidelines (<https://aspe.hhs.gov/povertyguidelines>)