Title: Financial Assistance Policy (FAP) - Hospital and Clinics

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SCOPE:
The intent of King's Daughters Medical Center's ("KDMC") Financial Assistance Program ("FAP") is to identify indigent patients and provide Financial Assistance ("Charity Care") to qualifying individuals consistent with community needs. In accordance with applicable federal (IRS 501 (r)) and state laws, financial assistance is offered to hospital and clinic patients and/or their guarantor(s) who receive emergent or medically necessary health care services.

STATEMENT OF PURPOSE:
The purpose of this policy is to establish clear, consistent guidelines for the identification, evaluation and administration of the financial assistance program for patients and/or their guarantor(s) who exhibit a need for financial assistance. This policy serves as part of our overall Community Benefit Program.

DEFINITIONS:

A. **Amount Generally Billed ("AGB")**: The amount generally billed is calculated based upon a one-year lookback period of the sum of the total amounts allowed by health insurers divided by the sum of total charges for those claims. The AGB includes the full amount allowed by insurers, including the total amount paid by insurers and the total amount owed by patients. The AGB differs between the hospital and clinic. The AGB percentage is 30% for hospital claims and 55% for clinic claims.
B. **Charity**: Emergent or medically necessary services provided for free to patients who qualify based upon KDMC's established criteria;
C. **Discounted Services**: Emergent or medically necessary services provided at a reduced cost to patients who are uninsured and do not qualify for financial assistance. Uninsured patients are eligible for the standard uninsured discount as stated herein;
D. **Extraordinary Collections Actions ("ECAs")**: Actions taken by a hospital against an individual related to obtaining payment of a bill for care, which may include credit reporting, garnishment of wages, property liens, or other civil legal action.
E. **Family/Household**: A group of 2 or more people residing together who are related by blood, marriage or adoption.
F. **Financial Assistance Policy ("FAP")**: The KDMC FAP defines guidelines for determination of a patient and/or guarantor(s) eligibility for free and/or discounted healthcare and the process of allocation of financial assistance.
G. **Gross Charges**: The full, undiscounted price of medical services uniformly billed to all patients prior to any discounts, deductions, or contractual allowances.
H. **Income**: Any household income, which includes but is not limited to income from employment, unemployment, disability, social security, retirement, pension, annuity, investment, life insurance proceeds, third-party settlements, inheritances, or any other income of cash value will be considered income for purposes of determining financial assistance. Non-cash benefits (food stamps, housing subsidies, etc.) are not considered income.
I. **Medically Necessary**: Health care services or supplies necessary and appropriate to diagnose, treat, cure or provide relief of a health condition, illness, injury, disease or its symptoms that are within the generally accepted standards of medical care in the community and are not rendered solely for convenience, or for experimental, investigational or cosmetic purposes.
J. **Presumptive Eligibility**: The process by which KDMC may use previous eligibility determinations and/or information from outside sources to make financial assistance determinations.
K. **Third-Party Claims**: Any financial responsibility owed by another individual, insurer, or entity for the patient's healthcare services.

L. **Underinsured**: Patients who have insurance or third-party coverage but still experience out-of-pocket amounts for their care which exceeds their financial abilities.
M. **Uninsured**: Patients who do not possess insurance or third-party coverage to assist with financial obligations for their healthcare.

POLICY:
King's Daughters Medical Center is committed to providing financial assistance to eligible patients who are uninsured or underinsured in our community who are in need of emergent or medically necessary healthcare services. Patients who have a household income of ≤150% of the Federal Poverty Guidelines (FPG) are eligible for free care. Patients with a household income up to 250% of the FPG will be eligible for discounted care on a sliding scale basis:

Percent of FPG	Charity Allowance
0 – 150%	100%
151-200%	90%
201-250%	80%

King's Daughters Medical Center patients who do not qualify for financial assistance based upon the guidelines above are still eligible for the standard uninsured discount rate of **70%**. KDMC Physician Clinic patients who do not qualify for financial assistance based upon the guidelines above are still eligible for the standard uninsured discount rate of **45%**.

The annual financial assistance amounts and eligibility requirements will be reviewed and adjusted annually, subject to approval by the KDMC Finance Committee. Once a person is determined to be eligible for financial assistance, the person will not be charged more than the AGB for emergent or necessary care.

I. **ELIGIBILITY**

A. Criteria to be considered in determining eligibility will include, but are not limited to, the following:
   i. Annual gross household income meets poverty guidelines as established by the Federal Government Services Agency ("GSA") and published annually in the Federal Register;
   ii. Employment status and capacity for earnings;
   iii. Catastrophic illnesses where the medical bill exceed the annual gross household income;
   iv. Information provided during interviews with Financial Counselor.

II. **COVERED SERVICES**

A. Emergent and Medically Necessary inpatient and outpatient services are considered "Covered" Services for the purpose of Financial Assistance. These services are defined as *Health care services or supplies necessary and appropriate to diagnose, treat, cure or provide relief of a health condition, illness, injury, disease or its symptoms that are within the generally accepted standards of medical care in the community and are not rendered solely for convenience, or for experimental, investigational or cosmetic purposes.*
B. Services rendered by healthcare Providers for which KDMC performs billing are included under this policy. These include:
   i. Inpatient hospital services
   ii. Outpatient hospital services

iii. Services rendered in any of the KDMC Physician Clinic Locations:
- KDMC Medical Clinic
- KDMC Primary Care Clinic
- KDMC Pediatric & Adolescent Clinic
- KDMC Orthopedic Clinic
- KDMC Behavioral Wellness Clinic
- KDMC Vision Clinic

iv. Professional claims for Providers who render inpatient or outpatient services, and are employed or contracted by KDMC, and for whom KDMC performs billing (for a listing of excluded providers, see section IV "Exclusions")

III. PRESUMPTIVE ELIGIBILITY

KDMC reserves the right to apply presumptive eligibility to individuals without submission of a completed financial assistance application based on actual information received and the amount owed by the patient. KDMC also reserves the right to utilize third-party software, including scoring systems, to assist in the prediction of an individual's propensity to pay and eligibility for financial assistance.

Additional circumstances placing an individual eligible for 100% charity include homelessness; eligibility for state or federal assistance programs such as food stamps, Women, Infant and Children ("WIC") program, state funded prescription programs, or limited or reduced Medicaid coverage (Qualified Medicare Beneficiaries; Specified Low-Income Medicare Beneficiaries; Qualified Individuals; Family Planning Waiver; Healthier Mississippi Waiver).

Individuals who have active Medicaid coverage in another state where KDMC does not have an active provider number are automatically eligible for a 100% charity adjustment.

Individuals qualifying for financial assistance are considered presumptively eligible for 180 days following the initial approval. Services rendered after 180 days of the initial approval will require submission of a new financial assistance application.

IV. EXCLUSIONS

The KDMC FAP does not provide coverage for charges for the following conditions:

A. Elective inpatient, outpatient, or observation admissions;
B. Cosmetic procedures;
C. Services determined by an insurance payer to be considered "not medically necessary", requiring issuance of an Advanced Beneficiary Notice ("ABN") or Commercial Notice of Non-Coverage;
D. Retail purchases;
E. Charges resulting from an auto accident, unless there is proof of no third-party coverage;
F. Charges resulting from a work-related accident, unless there is proof of no third-party coverage;
G. Charges incurred by an individual with healthcare insurance, unless that individual is determined to be underinsured based on the individual's capacity to pay;
H. Household relatives of any KDMC-employed or contracted Physician;
I. The patient is currently the recipient of or qualifies for financial assistance under another city, county, state, federal or other assistance program superseding the FAP;
J. The patient is currently in the custody of a correctional facility;
K. The patient is not a United States citizen;

L. Charges incurred in the following departments, as a non-inclusive list:
   i. Anesthesia, radiology, surgical, oncology professional services;
   ii. Professional services rendered in the following locations or by the following Providers: KDMC Vein Clinic; KDMC Wound Care Clinic; Dr. Wade at the KDMC Sleep and Pulmonology Clinic; Brookhaven OB-GYN Providers; Brookhaven Surgery Providers; Brookhaven Surgical Associates Providers; Brookhaven Urology Providers; Anointed Nephrology Providers; Brookhaven Nephrology Clinic Providers; Brookhaven Ear, Nose & Throat Providers; KDMC Pediatric Dentistry Providers; Capital Ortho Providers.

V. **EXCEPTIONS**

KDMC reserves the right to grant financial assistance in extraordinary circumstances at its sole discretion. KDMC also reserves the right to deny financial assistance to any individuals who refuse to participate or provide information for confirmation of eligibility or provide false information.

PROCEDURE:

I. Application Process
   A. All patients presenting to KDMC for care will be offered a copy of the FAP Plain Language Summary upon admission with paper copies will be available upon request. Copies of the financial assistance application form are available at the Patient Financial Services office, by calling 601-823-5294 or on our website: https://www.kdmc.org/patients-visitors/billing/patient-financial-resources/. Financial assistance information is provided in the initial billing statement for all patient bills.
   B. A request for determination of financial assistance may be processed at any point in the collection cycle, up to 240 days from the date of the first post-discharge billing statement.
   C. KDMC will notify individuals with open self-pay accounts of the FAP application period for at least 120 days after first notice of bill. KDMC will not engage in any extraordinary collection practices (“ECPs”) until sufficient time and notification periods have passed. KDMC will provide individuals written notification 30 days prior to the end of the Financial Assistance Application period.
   D. In the event an individual applies for financial assistance after the initial 120-day period, reasonable measures will be taken to vacate any ECPs.

II. Determination of Eligibility
   A. Individuals requesting financial assistance should provide one of the following forms/documents to substantiate income:
      i. Most recent W-2 form
      ii. Most recent paycheck stubs
      iii. Most recent Federal income tax return
      iv. Third-party Propensity to Pay documentation
   B. If the individual is unemployed and has not filed Federal income taxes, the third-party Income Determination Statement Attestation documentation and a credit report may be utilized in lieu of wage documentation to determine eligibility for financial assistance.
   C. The family of a deceased individual must submit a death certificate, and a Financial Counselor must verify on the deceased patient’s county of residence County Clerk’s office website that a deceased patient has no estate. The death certificate and estate information are scanned onto the patient account before the adjustment is posted.
   D. Written documentation regarding all eligibility determinations, whether approved or denied, will be maintained by the Patient Financial Services department.

III. Review and Approval
   A. Applications will be reviewed by Patient Financial Services staff to determine whether eligibility criteria are met.
   B. Individuals will be notified in writing if a submitted application is considered incomplete. The individual will have until the expiration of the application period to supply additional information.
   C. Applications meeting criteria will be submitted to the Patient Financial Services Director and Chief Financial Officer for review and approval.
   D. Once eligibility determinations have been made, the individual will be notified in writing of the decision. For approved applications, the determination letter will identify the discount percentage approved and any remaining patient responsibility.
   E. For FAP approved accounts, the patient responsibility amount will be determined based upon the current outstanding account balance. The patient will not be refunded any net overpayments.
   F. KDMC reserves the right to reverse financial assistance decisions based upon newly discovered information, such as active insurance coverage, third-party liability, or intentional falsification of information submitted. In these instances, KDMC will reverse any financial assistance adjustments made to the account(s) and resume appropriate reimbursement and/or collections processes.
   G. Any individual found to have intentionally falsified financial assistance documents will not be eligible for financial assistance for 12 months.