AdventHealth

POLICY

Policy # CW F 50.1	**Policy Name** Financial Assistance
Policy Location Corporate Headquarters	**Responsible Department** Patient Financial Services
Policy Owner/Executive Owner Katie Munsey	**Original Creation Date** March 2006
Policy Effective Date January 1, 2024	**Policy Review Date** September 12, 2024

Revisions to this policy are effective January 1, 2024. This policy also applies to any patient accounts with dates of service from January 1, 2024, through current date if the patient has submitted an application that is on file.

I. **SCOPE:** This Financial Assistance Policy (Policy) applies to all entities within AdventHealth. Refer to the AdventHealth website for Policy details, forms, and instructions. This Policy applies to any patient who submitted a Financial Assistance Application (Application). Applications can be re-processed retrospectively within eighteen (18) months of application date.

II. **PURPOSE:** AdventHealth is committed to excellence in providing high quality health care while serving the diverse needs of those living within our service area. AdventHealth is dedicated to the belief that medically necessary care should be accessible to all, regardless of race, color, sex, national origin, age, gender, gender identity, sexual orientation, geographic location, religion, cultural background, disability, physical mobility, ability to pay, or whether payment for services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). AdventHealth is committed to providing health care services and acknowledges that in some cases an individual will not be financially able to pay for the services received. This Policy is intended to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder, and shall be interpreted and applied in accordance with such regulations. This Policy has been adopted by the governing body of AdventHealth in accordance with the regulations under Section 501(r).

AdventHealth provides emergent care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. Emergent care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to the health of a patient; b) serious impairment of any bodily functions; and c) serious dysfunction of any bodily organ or part. This is inclusive of care related to such conditions post initial treatment. If third-party coverage is not available, AdventHealth offers financial assistance for those who qualify. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of service by a hospital or other organization. AdventHealth or a related entity (a partnership providing emergent care or other medically necessary care in which AdventHealth has an ownership interest) will provide financial assistance to eligible patients receiving medically necessary care based on financial need.

The Policy provides guidelines for financial assistance, based on financial need, to eligible self-pay individual patients and eligible insured individual patients with balances remaining from emergent or other medically necessary services. This Policy also provides guidelines for discounted amounts that may be charged to all uninsured patients who receive medically necessary care.

Financial assistance is only available for emergent care or medically necessary care, except as may be determined in the sole discretion of AdventHealth on a case-by-case basis. Patients may apply for financial assistance in accordance with the guidelines set forth in this policy.

III. **POLICY:** Individuals receiving medically necessary care may be considered for financial assistance if the patient presents with any of the following:

- No third-party coverage is available.
- Medicare or Medicaid benefits have been exhausted or are considered not covered and the patient has no further ability to pay.
- Patient is insured but qualifies for assistance based upon financial need with respect to the individual's remaining balance after insurance, out-of-pocket, or all other payments from third parties.
- Patient meets local and/or state charity requirements.
- Patient is already eligible for assistance (e.g., Medicaid), but the services rendered are not covered.

A. The Policy, Application, and Plain Language Summary (Summary) of the Policy are transparent and available to the individuals served at any point in the care continuum in languages that are appropriate for the AdventHealth service area. In compliance with the Language Assistance Services Act, the documents are available in the primary languages of any populations with limited proficiency in English that constitute the lesser of 1,000 individuals or 5% of the members of the community served by the particular AdventHealth entity (limited proficiency in English populations meeting the criteria above will be referred to hereafter in this policy as the LEP-defined populations). Note: Translations may be available for organizations in communities with fewer than the above referenced populations if another organization had the requisite population.

- AdventHealth will prominently and conspicuously post complete and current versions of the following on their respective websites and provide paper copies to patients upon request:
    - Financial Assistance Policy (Policy)
    - Financial Assistance Application (Application) (including Patient/Applicant Financial Statement)
    - Plain Language Summary of the Financial Assistance Policy (Summary)
    - Methodology for calculating the maximum amount billed to uninsured patients for Amounts Generally Billed (AGB).
    - Physicians who do and do not participate in the AdventHealth Policy.
    - Contact information for AdventHealth Financial Assistance Representatives.
- The AdventHealth website will indicate that a copy of the Policy, Application, and

Summary is available and how to obtain such copies in the primary languages of the LEP-defined populations.

- Signage declaring the availability of financial assistance will be conspicuously displayed in public locations in AdventHealth, including all admission and registration areas and the Emergency Department. All signage denoting that financial assistance may be available will contain the following elements:
    - The applicable website address where the Policy, Summary, and Application can be accessed.
    - The telephone number and physical location individuals can call or visit to obtain copies of the Policy, Application, or Summary, or to obtain more information about these documents or the application process.
- Each AdventHealth entity will make paper copies of the Policy, Application, and the Summary available upon request and without charge, both in public locations in the hospital facility (including the Emergency Department and all admission and registration areas) and by mail. Paper copies will be available in English and in the primary languages of any LEP-defined populations. A paper copy of the plain language summary is available to patients as part of the intake or discharge process.
- Financial Assistance Representative Visits: Financial Assistance Representatives may, upon patient request, provide personal financial counseling to individuals admitted to an AdventHealth hospital who are classified as uninsured. Interpreters will be used, as indicated, to allow for meaningful communication with individuals who have limited English proficiency. Financial assistance eligibility criteria and discount information will be available in participating AHMG physician practices, urgent cares, and other settings.
- The Summary should be distributed in a reasonable manner to members of the community who are served by AdventHealth and are most likely to require financial assistance. An example would be the distribution of copies of the plain language summary to organizations in the community that address the health needs of low-income populations such as, but not limited to, Healthcare Navigators.

B. AdventHealth and the individuals served each hold accountability for the general processes related to the provision of financial assistance.

- AdventHealth Responsibilities:
    - AdventHealth has a Policy to evaluate and determine an individual's eligibility for financial assistance.
    - AdventHealth has a means of widely publicizing and communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.
    - AdventHealth workforce members in Patient Financial Services and Consumer

Access understand the AdventHealth financial assistance policy and can direct questions regarding the policy to the proper representatives.

- AdventHealth requires all contracts with third-party agencies who collect bills on behalf of AdventHealth to include legally binding written contract provisions that follow AdventHealth financial assistance policy.

- The AdventHealth Revenue Cycle Department provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance, billing, and collection processes.

- After receiving the individual's request for financial assistance, AdventHealth notifies the individual of the eligibility determination within a reasonable period.

- AdventHealth provides options for payment arrangements.

- AdventHealth upholds and honors individuals' right to appeal decisions and seek reconsideration.

- AdventHealth maintains (and requires billing contractors to maintain) documentation that supports the offer, an application, and provision of financial assistance for a minimum period of seven years.

- AdventHealth will periodically review and incorporate Federal Poverty Guidelines (FPG) published by the United States Department of Health and Human Services, where applicable.

- **For Colorado Facilities** – To determine if the patient can apply for Hospital Discounted Care (HDC), AdventHealth will first proactively screen for HDC for all uninsured patients for forty-five (45) days from the date of service or date of discharge, whichever is later, prior to billing a statement. If the patient's household income is at or below two hundred fifty percent (250%) of the FPG, the patient may qualify for discounts towards hospital-based care unless the patient declines screening prior to sending a statement. For insured patients, AdventHealth will screen upon request. If an uninsured patient does not want to be screened, the patient/guarantor must opt out of being screened each visit. We will continue to attempt to screen up to one hundred eighty (180) days post discharge. Our process will be to follow the requirements for HDC within our Colorado facilities.

- **For Illinois Facilities** – AdventHealth will proactively screen all uninsured patients for potential eligibility for coverage under Medicaid/public insurance programs and eligibility for financial assistance or other discounts under this Policy (unless the patient/guarantor declines to be screened). For insured patients, AdventHealth will screen upon request.

- Individual Patient Responsibilities

  - To be considered for a reduction in patient responsibility under the Policy, the individual must provide AdventHealth with the information and documentation

necessary to apply for other existing financial resources that may be available to pay for health care, such as Medicare, Medicaid, third-party liability,etc.

- To be considered for a reduction in patient responsibility under the Policy, the individual must provide AdventHealth with financial and other required information to determine eligibility. This may include completing the required application, provision of the requested supporting documentation, and cooperating fully with the information gathering and assessment process.

- An uninsured patient who is not eligible for a one hundred percent (100%) reduction in charges based upon financial need will be billed no more than the AGB to individuals who have insurance covering such care and will cooperate with the entity to establish a reasonable payment resolution.

- An uninsured patient who does not qualify for a one hundred percent (100%) reduction in charges based upon financial need must make good-faith efforts to resolve their outstanding balance(s). The individual is responsible to promptly notify AdventHealth of any change in financial situation so that the impact of this change may be evaluated against policies governing the provision of financial assistance, their bills, or payment plan provisions.

C. Financial assistance eligibility determinations and the process of applying for financial assistance will be equitable, consistent, and timely.

- ***Identification of Potentially Eligible Individuals***. Requests for financial assistance will be honored up to two hundred forty (240) days after the date of the first post-discharge billing statement, sent by mail or electronically to the patient, for the care provided.

  - Registration and pre-registration processes promote identification of individuals in need of financial assistance.

  - Financial Assistance Representatives will make best efforts to contact all uninsured inpatients during their stay or at time of discharge.

  - The AdventHealth Summary will be offered along with the Application form to every under-insured or uninsured individual upon intake or upon discharge from the hospital facility for emergent and/or inpatient care.

  - A conspicuous written notice will be included on all billing statements that notifies and informs recipients about the availability of financial assistance under the AdventHealth Policy and includes the following: 1) the telephone number of the AdventHealth Financial Assistance Department that can provide information about the Policy and the Application process; and 2) the website where copies of the Policy, the Application , and the Summary may be obtained.

  - Reasonable attempts will be made to notify individuals about the AdventHealth Policy and how the individual may obtain assistance with the Application. AdventHealth will use various resources to communicate with patients, including but not limited to, e-mail, statements, letters, phone calls, and face-to-face

interactions.

- The individual will be provided with at least one written notice, along with a copy of the plain language summary. These will notify and inform the individual that financial assistance is available for those who are eligible and that AdventHealth may engage in other specified extraordinary collection actions if the individual does not submit an Application or pay the amount due by a specified deadline. This deadline cannot be earlier than one hundred twenty (120) days from the date AdventHealth provides the first post-discharge billing statement for the care. The notice must be provided to the individual at least thirty (30) days before the deadline specified in the notice.

- Every effort will be made to screen all uninsured patients receiving medically necessary care in our Illinois and Colorado hospital facilities for financial assistance unless they have declined to be screened.

- ***Requests for Financial Assistance.*** Requests or applications for financial assistance may be received from multiple sources, including the patient, a family member, a community organization, church, a collection agency, caregiver, Administration, etc.

  - Requests received from third parties will be directed to a Financial Assistance Representative.

  - The Financial Assistance Representative will work with the third party to provide resources to assist the individual in the application process.

- ***Eligibility Criteria***

  - AdventHealth offers different types of discounts to uninsured patients receiving medically necessary care. Uninsured patients reporting incomes above four hundred percent (400%) of the Federal Poverty Guidelines, or for whom no income information is available, are eligible for a discount that reduces the balance to the AGB similar to individuals who have insurance coverage. This percentage will vary based on the specific entity or location and shall be updated annually in **Attachment 1**. Patients qualifying for this discount may receive greater discounts if they are determined to be eligible for other financial assistance under this policy.

  - To be eligible for a one hundred percent (100%) reduction on applicable balances (i.e. full write-off for uninsured patients and full write-off of the patient responsibility portion of balances after insurance) the individual's household income must be at or below two hundred fifty percent (250%) of the current Federal Poverty Guidelines for the prior twelve (12) months or full year preceding the date of service or the date a Financial Assistance Application is submitted, whichever is later. Alternatively, a patient may also qualify for a one hundred percent (100%) reduction on applicable balances when the unpaid portion of the patient's balance exceeds twenty-five percent (25%) of the annual family income, but only where the total annual family income is less than four hundred percent

(400%) for our entities outside of Illinois.

- **For Illinois entities,** a patient may also qualify for a one hundred percent (100%) reduction on the applicable balances when the unpaid portion of the patient's balance exceeds twenty percent (20%) of the annual family income, where the patient has qualified for financial assistance under the current Federal Poverty Guidelines within a twelve (12)-month period, and the patient's household income does not exceed six hundred percent (600%) of FPG for uninsured and four hundred percent (400%) for insured.

- Patients with household incomes that exceed two hundred fifty percent (250%) of the current Federal Poverty Guidelines but are less than four hundred one percent (401%) shall be granted the below discounts:
  - Uninsured patients with household incomes between two hundred fifty-one percent (251%) and four hundred percent (400%) of Federal Poverty Guidelines would be granted a ninety-eight percent (98%) discount on applicable balances.
  - Insured patients with household incomes between two hundred fifty-one percent (251%) and four hundred percent (400%) of the Federal Poverty Guidelines and who possess out-of-pocket remaining balances may, at the discretion of the Financial Assistance Review Committee, receive a seventy-five percent (75 %) discount off ONLY the remaining patient out-of-pocket balance, which represents the remaining balance after all other third-party payers have paid. The seventy-five percent (75%) reduction in out-of-pocket balance for these patients shall be considered financial assistance.

- Patients with household incomes that exceed four hundred one percent (401%) of the Federal Poverty Guidelines shall be granted the below discounts:
  - **For Illinois facilities** –Uninsured patients with household incomes between four hundred one percent (401%) and six hundred percent (600%) of Federal Poverty Guidelines would be granted an eighty-five percent (85%) discount on applicable balances.
  - For all other facilities, in the event the uninsured patient needs an elective service and has income greater than four hundred percent (400%) of Federal Poverty Guidelines, or for whom no income information is made available, they will be offered the consumer shoppable discount in accordance with CWF 50.5 Self Pay Discount policy, which is facility specific, updated annually, and published in the online shoppable estimator per CMS Price Transparency guidelines. For urgent and emergent services, uninsured patients with income greater than four hundred percent (400%) will receive the AGB discount.

- For urgent care visits in our CentraCare clinics, financial assistance would apply only to sick visits to which a hospital admission was experienced within a thirty (30)-day window after the urgent care visit. Assistance would also not apply to any self-pay balance related to a corporate agreement

type of visit, any wellness visit, or vaccine visit for CentraCare.

- The amount charged to any uninsured patient for non-elective care will not exceed Amounts Generally Billed (AGB) to individuals who have insurance covering such care at each specific AdventHealth hospital. AdventHealth will determine its AGB by determining an AGB percentage and multiplying that percentage by the gross charges for the services provided to the individual. AdventHealth utilizes one of the five unique AGB Calculation types described in §1.501(r)-5(b)(3) and listed below:
    i. Lookback method Medicare only
    ii. Lookback method Medicare and private insurance
    iii. Lookback method Medicaid only OR Medicaid and private insurance
    iv. Prospective method Medicaid only
    v. Prospective method Medicare only

    - Each AdventHealth entity shall elect one of the five methods and calculate a discount annually, accordingly listed on **Attachment 1**. A document detailing AdventHealth's methodology for calculating AGB can also be found on the AdventHealth website or can be requested in person, by phone, or mail.

- Balances billed to an individual eligible for financial assistance under the AdventHealth financial assistance policy for any medical services will always be less than the gross charges for that service.

- In addition to evaluation of income level outlined above, an asset means test may also be applied to Medicare recipients only. This asset evaluation's purpose is to determine eligibility for financial assistance for applicants who are retired with fixed incomes less than or equal to two hundred fifty percent (250%) of the Federal Poverty Guidelines up to the max asset limits provided by the Center's for Medicare and Medicaid Services (CMS). An asset for the purposes of this policy evaluation shall represent any cash or cash-equivalents the applicant possesses in his or her bank(s) along with the value of certain non-retirement investment accounts (i.e., stocks, bonds, and real estate). However, the home applicants live in and one vehicle, including motor home or motorcycles, are excluded from the asset test. Furthermore, any household items are excluded from the calculation of assets. Notably, retirement accounts such as but not limited to 401(k), 401(a), 403(b) and/or 457(b) are not considered assets for purposes of the financial assistance asset test. These guidelines mirror the Medicare Savings Program and may be revised accordingly by the CMS. The specific details are found at Medicare Savings Programs | Medicare (www.medicare.gov/medicare-savings-programs).

    - The asset limit, if exceeded, shall disqualify an applicant from total write-off, at which point, less discount shall be applied for applicants with an FPL between two hundred fifty-one percent (251%) and four hundred percent (400%). The asset limits are included in **Attachment 2** – Asset limit.

- Income can be verified by using a personal financial statement or by obtaining copies of that applicant's most recent Form W-2, the most recently filed 1040 Tax Form, tax transcripts, bank statements or any other form of documentation that supports reported income. Income is defined as any of the following: a) wages and salary; b) child support; c) alimony; d) unemployment compensation; e) worker's compensation; f) veteran's pension; g) social security; h) pensions or annuities; i) dividends; j) interest on savings or bonds; k) income from estates or trusts; l) net rental income or royalties; m) net income from self- employment; n) contributions from any source, including any amount contributed toward the support of any individuals in the household as defined above.

- Documentation supporting income verification and available assets shall be maintained in patient files for future reference.

- In addition to relying on information obtained from the patient's Application and/or Patient/Applicant Financial Statement and any other documentation provided by the patient to support the patient's resources, AdventHealth may also rely on an additional Independent Eligibility Assessment (IEA) to substantiate the patient's resources, or may rely on third-party information to verify information supplied by the patient. That information may include documentation from credit reports available through the credit reporting bureaus and information regarding prior full year's income as reflected on Internal Revenue Service (IRS) tax transcript for verification of income through databases that organizations can use to verify employment and income information. These databases consist of large central repositories of payroll information in the United States, with millions of employers contributing payroll records. The income information from these tools assists in developing a full understanding of the individual's financial circumstances.

    - IEA tools may be used to justify financial assistance eligibility. An IEA may use publicly available information consistent with applicable legal requirements, such as estimated household size and income amounts for the basis of determining financial assistance eligibility when a patient does not provide an assistance application or supporting documentation, or is otherwise uncooperative in providing financial assistance determination documentation. These tools include but are not limited to credit reports, other third-party asset information, and income verification which may be used to demonstrate financial need on the part of an uninsured patient without the completion of a financial assistance application.

        - Applications will be considered up to two hundred forty (240) days after the date the first post-discharge billing statement for the care provided.

- **Presumptive Eligibility**: Individuals who are uninsured and demonstrate one or more of the following will be deemed eligible for the most generous financial assistance without further scrutiny by AdventHealth, even in the absence of a

completed Application:

- Individual is self-identified as homeless.
- Individual is deceased and has no known estate or spouse able to pay hospital balance or debt.
- Individual is incarcerated for a felony.
- Individual is mentally incapacitated with no one to act on the individual's behalf.
- Individual is currently eligible for Medicaid but was not at the date of service.
- Individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act.
- Individual has via IEA been deemed to have a payment capability score of low or unknown. The IEA consists of algorithms that incorporate data from credit bureaus, demographic databases, and hospital specific data. The third-party credit report data and other publicly available data sources utilize a healthcare industry-recognized predictive model that is based on public record databases to calculate a socio-economic and financial capability score. Information gleaned from this IEA will constitute adequate documentation of financial need under this Policy to infer and classify individuals into respective economic means categories irrespective of whether complete documentation has been voluntarily provided.
- Individual was previously approved for financial assistance and service date falls within twelve (12) months prior or twelve (12) months after original application approval date.
- Additional eligibility criteria for Illinois facilities is required for enrollment in any of the following assistance programs:
    - Women, Infants and Children Nutrition Program
    - Supplemental Nutrition Program
    - Illinois Free Lunch and Breakfast Program
    - Low Income Home Energy Assistance Program
    - Organized community-based programs providing access to medical care that assess and document limited low-income financial status as a criterion for membership
    - Receipt of grant assistance for medical services

- For any individual presumed to be eligible for Financial Assistance in accordance with this policy, the same actions described in this Section C and throughout this policy would apply as if the individual had submitted a completed Application. However, some of the patient population may not engage in the traditional financial assistance application process. If the patient does not submit the Application, AdventHealth may choose to provide financial assistance in lieu of sending the patient to collections based upon the above referenced IEA.

- Every reasonable effort will be used to secure written income information, and if

not provided, we will use the patient's attestation and stated income to determine eligibility if unable to verify through IEA.

- ***Method for Applying for Financial Assistance***

  - To apply for Financial Assistance, the individual must complete the AdventHealth Financial Assistance Application. Except as otherwise provided in this Policy, the individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income. Acceptable forms of income verification include, but are not limited to, the most recent Form W-2, the most recently filed 1040 Tax Form, Tax Transcripts related to 4506-T requests, bank statements, and signed letters of support when household income is zero. If documents verifying an applicant's income are included, an approved financial assistance application will apply to dates of service twelve (12) months prior and twelve (12) months after approval date and will not have to be repeated. Service dates outside this window will require a new application for assistance.

  - An individual can obtain a copy of the AdventHealth Financial Assistance Application form by accessing it on the AdventHealth website, by requesting a free copy by mail, from the Financial Assistance Department, or by requesting a copy in person at any AdventHealth admission/registration location.

  - A completed AdventHealth Financial Assistance Application will be submitted to Patient Financial Services for processing. Proof of income (POI) may be required from the individual. In addition, Medicare beneficiaries are subject to an additional asset test in accordance with federal law. A review is completed to determine individual eligibility based on the individual's total resources, including but not limited to family income level, assets as required for Medicare patients and other pertinent information. POI is required for balances greater than $25,000 for insured patients. Written attestation will be accepted on uninsured patients and for balances under $25,000.

- **Actions that may be taken in the event of non-payment:**

  - One hundred twenty (120) days from the date the entity provides the first post-discharge billing statement for the care provided, AdventHealth may engage in ECAs including but not limited to selling debt to a third party (see section D of this policy for more information regarding debt sale) only after the following notifications have been provided to the individual at least thirty (30) days before initiating any ECAs: 1) a written notice, along with the plain language summary, is provided to the individual indicating that financial assistance is available for eligible individuals and stating the specific ECAs that may be initiated after a stipulated deadline (the deadline may not be earlier than thirty (30) days after the written notice is provided), and 2) a reasonable attempt is made to notify an individual about the AdventHealth financial assistance policy and how the individual may obtain assistance with the financial assistance application process.

  - If no Application has been submitted within one hundred twenty (120) days from the

date the entity provides the first post-discharge billing statement for the care provided, and the stipulated deadline in the written notice has passed, AdventHealth may initiate ECAs. AdventHealth may still elect to provide financial assistance in absence of a Financial Assistance Application submitted if third-party sources, based on the Independent Eligibility Assessment, indicate credible evidence that the patient is eligible.

- If an individual submits an incomplete Application within two hundred forty (240) days after the date of the first post-discharge billing statement for which the care is provided (application period), AdventHealth must take the following actions:

    - Suspend any ECAs.
    - Provide the individual with a written notice that describes the additional information and/or documentation required under the Policy or Application that the individual must submit within a reasonable time. The notice will contain contact information including the telephone number and physical location of the AdventHealth entity or department that can provide information about the Policy, as well as contact information of individuals who can provide assistance with the Application process or, alternatively, a non-profit organization or governmental agency that can provide assistance with the Application process.
    - If the Application is not completed by the deadline discussed above, the hospital may initiate or resume ECAs.
    - Liens attached to insurance (auto, liability, life, and health) that represent potential proceeds owed because of an individual's claim for which AdventHealth provided care are permitted in connection with the collection process. No other personal judgments or liens will be filed against financial assistance eligible individuals.
    - AdventHealth will make a minimum of two contact attempts to facilitate completion of an incomplete application before the normal collection cycle resumes.

- **Complete Financial Assistance Application Received:**

    - If an individual submits a complete Application during the application period of two hundred forty (240) days after the date of the first post-discharge billing statement for the care provided, AdventHealth must take the following actions:

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    - Make and document the determination as to an individual's eligibility for Financial Assistance.
    - Notify the individual in writing in a timely manner, generally within sixty (60) days after receiving a completed Application of the eligibility determination and the basis for the determination.
    - Provide the individual with a billing statement (not required for a $0 balance billing statement) that indicates the amount owed as a financial assistance policy-eligible individual; describes how the individual can get information regarding the AGB for care; and how

AdventHealth determined the amount the individual owes.

- Refund any excess payments to the individual, provided no other balances are due after applying financial assistance.
- Take all available measures to reverse any ECAs against the individual.
- Provide a written notification of denial to any individual determined ineligible for Financial Assistance and include both a reason for denial and the process and contact information for filing an appeal. If an individual disagrees with the denial, the individual may request an appeal in writing within forty-five (45) days of the denial. The appeal must include any additional relevant information that may assist in the appeal evaluation. A request for an appeal to overturn a denial will be reviewed monthly by the Financial Assistance Committee. Decisions reached by the Financial Assistance Committee will be communicated to the individual within sixty (60) days of the Financial Assistance Committee's review and will reflect the Committee's final decision.
- Upon receipt of a complete Application, AdventHealth may postpone determination of an individual's eligibility under its Policy if the individual has submitted an application for Medicaid assistance until such time as Medicaid eligibility has been determined.

D. Patient Financial Services Responsibilities

- Financial Assistance Committee: Patient applications for financial assistance are reviewed by one or more members of the Financial Assistance Committee, which consists of a Financial Coordinator/Counselor, a Supervisor or Manager of Financial Assistance, a Director, and a Vice President or higher. The Financial Assistance Committee reviews borderline and non-routine financial assistance recommendations that require case-by-case review.

- Financial Assistance that exceeds $25,000 per account must be approved by the Finance Review Committee.

- Following review and approval by the Financial Assistance Committee, the approved Financial Assistance will be applied to the individual's account by Patient Financial Services.

- Patient Financial Services has the responsibility to determine if AdventHealth has made reasonable efforts to evaluate whether an individual is eligible under the Policy and whether the hospital may take action to engage in any ECAs.

- Billing agencies that contract with AdventHealth for collection services will follow this Policy with respect to all billing and collection matters.

- Selling an individual's debt to another party (other than a non-Extraordinary Collection Activity (Non-ECA) sale as described below) is considered an Extraordinary Collection ECA and should not be initiated until the required steps outlined above in Section C have been completed. With any proposed sale of debt, the master service agreement must be approved by the AdventHealth Senior Finance Council and submitted to the

AdventHealth Contract Review Process before execution. Certain sales of debt are not considered ECAs. Non-ECA debt sales require that AdventHealth enter into a legally binding written agreement with the purchaser of the debt that stipulates the following:

- The purchaser may not engage in any ECAs.
- The purchaser is prohibited from charging interest on the debt over an IRS established rate.
- The debt is returnable or recallable by AdventHealth upon a determination that the individual is financial assistance policy eligible.
- If the debt is not recalled or returned, the purchaser must ensure that the individual does not pay more than he or she is personally responsible for as an eligible individual under the financial assistance policy.

E. Individual Payment Plans

- Reasonable payment plans will be offered to all patients. All collection activities will be conducted in accordance with federal and state laws governing debt collection practices. No interest will accrue to account balances while payments are being made unless the individual has voluntarily chosen to participate in a payment arrangement that bears interest applied by a third-party consumer financing lender.

- If an individual complies with the terms of his or her individually developed payment plan, no collection action will be taken.

F. Record-Keeping

- A paper or electronic record will be maintained reflecting authorization of financial assistance along with copies of all application and worksheet forms.

- Summary information regarding applications processed and financial assistance provided will be maintained in accordance with the records retention policy. Summary information includes the number of patients who applied for financial assistance at AdventHealth, how many patients received financial assistance, the amount of financial assistance provided to each patient, and the total bill for each patient.

- The cost of financial assistance will be reported annually in the Community Benefit Report. Financial Assistance (Charity Care) will be reported as the cost of care provided (not charges) using the most recently available operating costs and the associated cost-to-charge ratio.

G. Subordinate to Law: The provision of financial assistance may now or in the future be subject to federal, state, or local law. Such law governs to the extent it imposes more stringent requirements than this policy.

IV. DEFINITION(S):

- **Participating Physician Providers:** See addendum to this policy for a listing of all physician providers who deliver emergent-related care at AdventHealth hospital facilities. The addendum specifies which providers are covered by this financial assistance policy and which are not. The listing of providers contained in addendum to the policy can be accessed online at the AdventHealth website. The provider listing is updated quarterly on the website to add new or missing information, correct erroneous information, and delete obsolete information. The date of the most recent update is included on the provider listing. AdventHealth may list names of individual doctors, practice groups, or any other entities that provide emergency or medically necessary care by the name used either to contract with the hospital or to bill patients for care provided.

- **Federal Poverty Level (FPL)**: Federal Poverty levels are issued every year by the Department of Health and Human Services (HHS) and are used to determine eligibility for programs and benefits provided by the federal government, such as but not limited to marketplace health insurance, Medicaid, or CHIP coverage. These income thresholds can be found here: https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

- **Federal Poverty Guidelines (FPG)**: the U.S Department of Health and Human Services (HHS) sets the poverty guidelines. The guidelines are a simpler version of the thresholds set with the official poverty measure, mostly used by federal agencies to determine eligibility for public programs.

- **Amounts Generally Billed (AGB):** AdventHealth will determine its AGB by determining an AGB percentage and multiplying that percentage by the gross charges for the services provided to the individual. AdventHealth hospitals utilize one of the five unique AGB Calculation types described in §1.501(r)-5(b)(3) and listed below:
  - Lookback method Medicare only
  - Lookback method Medicare and private insurance
  - Lookback method Medicaid only OR Medicaid and private insurance
  - Prospective method Medicaid only
  - Prospective method Medicare only

- **Discount:** A reduction made from the gross amount or value of something.

- **Extraordinary Collection Actions (ECA):** Defined as actions taken by an entity against an individual related to obtaining payment of a bill for care covered under the entity's financial assistance policy that involve selling an individual's debt to another party, etc.

- **Gross Charges**: The total invoice amounts before insurance and other adjustments.

- **Medically Necessary:** 'Medically necessary' means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A medically necessary service does not include any of the following: (1) non-medical services such as social and vocational services; (2) Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.

- **Household:** One or more persons residing together in the same household whose needs, income, and assets are included in the household budget, excluding roomers and boarders. Members include the applicant, legal spouse, dependent children, stepchildren, adopted children and blood relatives under twenty-five (25) years of age, unrelated minor children for whom the applicant or the applicant's spouse has legal guardianship or custody; legal guardian or parents of minor children, and minor siblings' children under the age of twenty-five (25). Students over twenty-five (25) years of age who are dependent on the family for over fifty percent (50%) support are also included in the household size.

- **Independent Eligibility Assessment (IEA):** Tools used to determine an individual's income.

- **Emergent:** Emergent care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to the health of a patient; b) serious impairment of any bodily functions; and c) serious dysfunction of any bodily organ or part. This is inclusive of care related to such conditions post initial treatment.

- **Elective**: Elective care is defined as a non-life threatening, non-emergent visit for both inpatient and outpatient levels of care. Typically, it is scheduled care that has been arranged in advance.

- **Urgent**: Admissions that do not go through the emergency room, where the patient's condition is stable enough to not require emergent care, but could become an emergency if not diagnosed or treated in a timely manner.

- **Limited English Proficient (LEP):** Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

V. EXCEPTION(S):

A. AdventHealth Retail Pharmacy

B. RxPlus / Expedien Rx Pharmacy

C. Non-AdventHealth Physicians

D. Non-AdventHealth Facilities

VI. REFERENCE(S):

VII. RELATED DOCUMENT(S) / ATTACHMENT(S):

Attachment 1: Self-Pay Discount/AGB Calculation

Attachment 2: Asset Test

Attachment 1 – 2024 Self Pay Discount / AGB Calculation Method:

2024 - AdventHealth Self-Pay Discount Calculations 12-Month Look-Back Method	2024 Requested Self Pay Discount % (501r)	AGB Calculation Method
Southeast Region Hospitals		
AdventHealth Hendersonville	72%	12-Month Comm+Mcare Lookback Method
AdventHealth Murray	90%	12-Month Comm+Mcare Lookback Method
AdventHealth Manchester	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Gordon	90%	12-Month Comm+Mcare Lookback Method
AdventHealth Redmond	90%	12-Month Comm+Mcare Lookback Method
Great Lakes Region Hospitals		
UCM AdventHealth Hinsdale	74%	12-Month Comm+Mcare Lookback Method
UCM AdventHealth La Grange	77%	12-Month Comm+Mcare Lookback Method
UCM AdventHealth Bolingbrook	75%	12-Month Comm+Mcare Lookback Method
UCM AdventHealth GlenOaks	73%	12-Month Comm+Mcare Lookback Method
Rocky Mountain Region Hospitals		
AdventHealth Porter	77%	12-Month Comm+Mcare Lookback Method
AdventHealth Avista	77%	12-Month Comm+Mcare Lookback Method
AdventHealth Castle Rock	77%	12-Month Comm+Mcare Lookback Method
AdventHealth Littleton	77%	12-Month Comm+Mcare Lookback Method
AdventHealth Parker	77%	12-Month Comm+Mcare Lookback Method
Southwest Region Hospitals		
Texas Health Huguley	80%	12-Month Comm+Mcare Lookback Method
Texas Health Mansfield	80%	12-Month Comm+Mcare Lookback Method
AdventHealth Central Texas	80%	12-Month Comm+Mcare Lookback Method
AdventHealth Rollins Brook	80%	12-Month Comm+Mcare Lookback Method
Mid America Region Hospitals		
AdventHealth Shawnee Mission	83%	12-Month Comm+Mcare Lookback Method
AdventHealth Durand	39%	12-Month Comm+Mcare Lookback Method
AdventHealth South Overland Park	83%	12-Month Comm+Mcare Lookback Method
AdventHealth Ottawa	83%	12-Month Comm+Mcare Lookback Method
Central Florida Division Hospitals		
AdventHealth Orlando (includes: Altamonte, Apopka, Celebration, East Orlando, Kissimmee, Winter Garden, Winter Park)	88%	12-Month Comm+Mcare Lookback Method
West Florida Division Hospitals		
AdventHealth Tampa/Pepin	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Zephyrhills	87%	12-Month Comm+Mcare Lookback Method

AdventHealth Carrollwood	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Connerton	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Wesley Chapel	87%	12-Month Comm+Mcare Lookback Method
AdventHealth North Pinellas	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Dade City	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Ocala	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Sebring	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Heart of Florida	87%	12-Month Comm+Mcare Lookback Method
AdventHealth Lake Wales	87%	12-Month Comm+Mcare Lookback Method
East Florida Division Hospitals		
AdventHealth Deland	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Fish	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Palm Coast	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Palm Coast Parkway	81%	12-Month Comm+Mcare Lookback Method for Palm Coast
AdventHealth New Smyrna	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Daytona Beach	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Waterman	81%	12-Month Comm+Mcare Lookback Method
AdventHealth Professional Billing		
AHMG/PCP+/AHIC/AHCC	Varies	12-Month Mcare Lookback Method

Attachment 2 – Asset Test

Note: the below limits are 2024 Medicare Shared Savings Program resource limits and may be updated annually at Medicare Savings Programs \| Medicare (www.medicare.gov/medicare-savings-programs)

Situation/Applicant	*Resource Limit*
Individual	***$9,430***
Married couple	***$14,130***