POLICY CLASSIFICATION: TMC Hospital	POLICY TYPE: Revenue Cycle - PFS Patient Customer Service	PAGE: **1** of **12**
DOCUMENT ID: RC-05-01	VERSION: A	EFFECTIVE: 9/21/2022
TITLE: **Financial Assistance Policy**		

Purpose:	This document will explain the financial assistance policy that is used to assist patients with financial obligations owed to Tucson Medical Center. This document is also designed to further the Tucson Medical Center mission to the communities it serves. TMC will provide financial assistance for Medically Necessary healthcare in a fair, consistent, respectful, and objective manner to low income patients who do not have insurance coverage or are underinsured.
Definitions:	Look Back Method: Calculation of all claims paid in a 12 month period by Medicare fee for service and Insurance Companies. This amount calculated is then divided by the full total charges of those claims in order to get the calculated number for the "Amount Generally Billed" (AGB). Medically Necessary: Refers to inpatient or outpatient healthcare services provided for the purpose of evaluation, diagnosis and/ or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated would pose a threat to the patient's ongoing health status. Services must be clinically appropriate and within generally accepted medical practice standards, represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available at Tucson Medical Center with a primary purpose other than patient or provider convenience. Expressly excluded from medically necessary services are: healthcare services that are cosmetic, experimental, part of a clinical research program, private and/or non- TMC medical or physician professional fees, or services and/or treatments not provided at a TMC. Uninsured: Those who are not eligible for coverage that would otherwise pay for medical services (whether through employer-based coverage, commercial insurance, government-sponsored coverage, or third-party liability coverage.) Underinsured: Those who have health insurance (including employer and individual exchange plans) but face deductibles and health care costs that are high in relation to their income.
Keywords:	Financial Assistance, 501 (r)
Applicability:	TMC
Statement of Policy:	**Community Care and Financial Assistance Process** is in keeping with TMC Healthcare's commitment and our mission to deliver caring, personalized, quality healthcare, services will be made available to all patients regardless of

ability to pay. True self pay patients, those denied for preexisting conditions, not eligible on dates of service or non-covered benefits with the exception of elective package pricing, automatically receive a discount. When appropriate TMC Healthcare staff should determine if a patient account qualifies for community care.

Services provided to patients when payment is not anticipated because of an inability to pay. Financial Assistance is available through Tucson Medical Center's (TMC'S) "Financial Assistance Policy" (FAP) program. This policy is also known as our Community Care Policy. The FAP is separate and distinct from Bad Debts, which are accounts in which credit has been extended and payment is anticipated, but not received. Following the determination of FAP-eligibility, a FAP-eligible individual will not be charged more for emergency or other medically necessary care than the "Amounts Generally Billed" (AGB) to individuals who have insurance covering such care. The methodology used by Tucson Medical Center to calculate AGB is the Look-Back Method. Members of the public may readily obtain the current AGB percentage and a description of how it is calculated by contacting TMC's Patient Financial Services at 520-324-1310.

Consistent with its Mission statement, Tucson Medical Center (TMC) will provide available and necessary healthcare services, including emergency medical conditions, to patients regardless of their: disability, sexual orientation, age, sex, race, religion, creed, national origin, or ability to pay.

TMC assists eligible persons without insurance coverage or who are underinsured by waiving all or part of the charges for services provided by TMC.

Services Covered: Hospital Based Services
This policy covers the hospital technical services provided in the hospital and other freestanding Outpatient Departments, including but not limited to:

- Tucson Medical Center-hospital services (emergency care, medical/surgical services, intensive care, mother/baby, pediatrics and outpatient departments within the hospital)

- TMC for Women Breast Center
- Adult and Pediatric Therapy
- Infusion Center
- Sleep Lab
- Pain Clinic
- Wound Center
- Diabetic Education

Services Not Covered: Physician Fees Not Covered

This Policy does not cover physician fees (also known as "professional fees") for emergency, and other medically necessary care provided by physicians and certain other medical providers who treat patients seen at Tucson Medical Center

More specifically, this policy does not cover professional fees for emergency and other medically necessary care provided by the following types of physicians:

- Emergency Department physicians
- Hospitalists/Laborists
- Internists
- Radiologists and Radiology groups
- Anesthesiologists and Anesthesia groups
- Pathology

These health care providers bill separately from Tucson Medical Center, and this Policy does not apply to their charges. Payment for professional fees billed by these health care providers is the patient's responsibility and does not qualify for a discount or charity care adjustment under this Policy. This Policy only applies to the technical and facility fees for emergency and other medically necessary care provided at a Tucson Medical Center or hospital-based clinic.

Additional Services Not Covered:

Cosmetic surgeries are generally considered to be elective procedures that are non-emergent and not Medically Necessary Care (as defined below) and are excluded from this policy.

1. Application Financial Assistance Determination and Payment

1.1. Completion of the Community Care Application

(a) Patients wishing to apply for financial assistance must complete a Community Care application within 30 days of discharge. Otherwise, a patient will continue to be billed.

(b) A copy of the Community Care application may be obtained on the hospital's website at www.tmcaz.com/about-my-visit-to-tmc/about-your-bill/financial-assistance/community-care-policy, by calling the business office anytime at (520) 324-1310, by mail to TMC Business Office, PO Box 42195 Tucson, Az 87533 or in person at 1400 N Wilmot, Tucson, AZ 85712

(c) Completion includes filling out and submitting a Community Care application, along with all requested documentation of income and assets, to P.O. Box 42195, Tucson, AZ 85733 or by Fax (520) 324-3004.

(d) Documentation provided with the completed Community Care application must include, as applicable: copies of social security cards, proof of residency, bank or credit union statements for the last three months, investment statements for the last three months, W-2s or other wage or income information such as three months of payroll stubs, social security checks, or unemployment checks, self-employment business records, income award letters/grant of education benefits, or other documents showing income and assets, a copy of the current IRS tax return, mortgage statements and annual property tax statements, and documents evidencing the relationships of household members, including birth or

baptismal certificates, adoption papers, marriage license, divorce decree or legal separation documents. TMC may request additional documentation during its application

1.2. Incomplete Applications - Incomplete financial assistance applications may denied until or unless they are completed. TMC will retain the incomplete application for six months and send a letter to the patient outlining the information needed and how to submit the necessary paperwork.

1.3. Confidentiality - TMC keeps all Community Care applications and supporting documentation confidential.

1.4. Eligibility Determinations - The TMC Business Office will review the patient applications and inform patients via mail of the results within 30 days of receiving a completed application and all requested documentation. Final determination for financial assistance is provided to the patient in a written "Notice of Determination" (NOD). Assignment to a collection agency for follow-up will not occur during the assistance determination process.

1.5. Payment arrangements after financial assistance determination - TMC will continue to work with patients to resolve the remainder of their balance after a financial assistance determination has been made. Patients are responsible to make mutually acceptable payment plan arrangements with TMC within 30 days of their NOD (See payment plans).

1.6. Patient default notification - of transfer to a collection agency after payment plan arrangements - TMC will send a minimum of two monthly statements to patients who have failed to make payment arrangements after NOD or who do not comply with mutually agreed payment plans. The notice will alert the patient of their balance, and if their financial situation has changed, they may have the opportunity for a new payment plan. The notice will also alert the patient that the matter may be sent to a collection agency if it is not resolved. This communication will take place prior to transfer to a collection agency.

1.7. Collection activities - Patients who have completed an application and are under review will have collection activity on hold pending the decision.

1.8. Late completion of an application - Patients may apply for financial assistance at any time.

2. Eligibility Criteria for Patient Financial Assistance under the FAP

2.1. The Community Care Policy employs a sliding scale discount that takes into consideration a patient's household income and assets.

2.2. Eligible patients are uninsured or underinsured persons who receive inpatient or outpatient medically necessary services from any TMC locations.

(a) Are not eligible for coverage that would otherwise pay for these services (whether through employer-based coverage, commercial insurance, government-sponsored coverage, or third-party liability coverage.)

(b) Have Household Incomes (as defined below) below 400% of the Federal Poverty Level (See FPL Grid) for the 12 months preceding the date of services

2.3. Financial assistance determinations will be consistent among patients regardless of their age, sex, race, religion, creed, disability, sexual orientation, national origin, or immigration status.

2.4. Financial assistance is generally secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability, and Qualified Assets.

2.5. Individuals with access to health insurance, third party reimbursement for health services, or governmental assistance who refuse to enroll, fail to take advantage of, or fail to maintain eligibility for such coverage may be excluded from receiving financial assistance.

2.6. Hospital Community Care application information may be used for a period of six months for qualification. After six months, a new application may be required to qualify new services for charity.

2.7. Community Care applications will be reviewed and approved within the limits stated as follows:

Patient Financial Services Rep.	$0 - $3,000
Supervisor	$3,001 - $10,000
Patient Financial Services Manager	$10,001 - $25,000
Director of Revenue Cycle Services	$25,0001 - and over

3. Financial Assistance Determination Process

3.1. The qualifying level of assistance for patients eligible for Community Care will be based on TMC's billed charges. Patients that qualify under the Community Care Policy will not be charged more than the amounts generally billed (AGB) for services rendered. AGB is calculated annually by determining the average percentage paid for services rendered to Medicare and private insurance payers. A copy of this calculation is available upon request by calling the business office at (520) 324-1310. Thereafter, financial assistance will be determined using a sliding-fee scale based upon Household Income as compared to the Federal Poverty Level (FPL) and subject to a reduction based on Qualifying Assets. Financial assistance discounts will be applied to the amounts generally billed (AGB).

3.2. In order to obtain financial assistance, the patient must establish (through completion of a FAP application and submission of required documentation) that the patient's Household Income is below 400% Federal Poverty Level (FPL).

3.3. Allowances may be made for extenuating circumstances based on each person's unique life situation and mitigating factors. The

amount of assistance provided by TMC may be more than outlined in the TMC FPL Grid for the current year but not less.

3.4. Documents used for income and assets verification for the household include but are not limited to: copies of the most recent 90 days of payroll stubs, Social Security checks, or unemployment checks; copy of the current IRS tax return filed; current bank, trust fund statements, mortgage statements and annual property tax statements. In the absence of income, a letter of support from individuals providing for the patient's basic living needs may be provided. Upon request TMC may require additional verification of income and assets.

4. Payment Plans for Financial Assistance Patients

4.1. Guidelines for payment plan amounts are outlined below:

Amount Owed	Months to Pay
$75-250	3
$251-500	5
$501-1,000	7
$1,001-2,000	13
$2,001-3,000	18
$3,001-4,000	22
$4,001-5000+	24

4.2. If a Payment Plan needs further extension the Business Office must be Contacted at 520-324-1310

4.3. Community Care patients meeting an agreed upon monthly payment plan will not be assigned to a collection agency.

4.4. Patients are responsible for communicating to the business office anytime an agreed upon payment plan may be broken. Lack of communication from the patient may result in further account collection action after appropriate patient notification.

	4.5. Payment plans extending beyond the recommended time frame are accepted based on supporting documentation or adequate security with manager approval. 4.6. Payment plans extending beyond the recommended time frame with no supporting documentation may be forwarded to the collection agency for extended payments. These may be interest-free with no legal action pursued as long as the payment plan is maintained. **5. Appeals of Assistance Determinations** 5.1. Patients or their representatives may appeal a financial assistance determination by providing additional information demonstrating eligibility, such as income verification or an explanation of extenuating circumstances, to the business office within 30 days of receiving the NOD. The Patient Financial Services Manager and the Director of Patient Financial Services will review all appeals. The responsible party will be notified of the outcome.
Procedure:	**1. Collection Practices for Community Care Patients** 1.1. If a patient does not make payment and fails to initiate the financial assistance process, TMC will continue to bill the patient for at least 120 days and may elect to begin collection activity including possible transfer to a collection agency. Prior to transferring to a collection agency, TMC will send a minimum of three statements every 30 days or make two phone calls on accounts with returned mail in an attempt to contact the patient at the address and phone numbers provided by the patient and to ensure the account has reached at least 241 days in delinquency. Statements and communications will inform the patient of the amount due, of the opportunity to complete a FAP application, and that the completion of the application may qualify the patient for free or reduced cost care. 1.2. Accounts older than 241 days from discharge and that have been

referred to a collection agency may be reported to a Credit Bureau agency.

1.3. Agencies contracted with TMC will provide patients the TMC 24-hour phone number that patients may call to request financial assistance if financial assistance is requested by the patient while in collections

1.4. Patients whose accounts have been transferred to a collection agency may request TMC financial assistance, submit a Community Care application with requested documentation and be considered for reduction of their bill. These patients will be subject to a stay of collection activities described in the preceding paragraph.

1.5. Patients sent to collections and are making payments will not be reported to the Credit Bureau

2. Accounting for Charity Care

2.1. A separate file will be maintained for accounts written off as Charity Care and retained in the Business Office for a minimum of two years.

2.2. Staff will use the "Approval of Application for Charity Care" form when the receivable is approved for write-off.

3. Communication To Patients

3.1. TMC is committed to making the people in the communities it serves aware of the availability of financial assistance through the Community Care Policy. TMC will provide financial counseling to patients upon request and assist those who are eligible through the Community Care application process.

3.2. TMC communicates the availability of financial assistance in appropriate acute care settings such as Emergency Departments, registration areas, and on the hospital website.

3.3. All billing statements and statements of services will inform patients that financial assistance is available.

3.4. Signs are posted in hospital registration areas informing patients that financial assistance is available for qualifying patients who complete an assistance application. These signs inform patients that free or reduced cost care may be available to qualifying patients who complete an application.

3.5. Materials describing the Community Car Policy, including cards and brochures, are available in English and Spanish on the hospital website, in admitting areas, and at the business office.

3.6. Financial counseling and business office personnel are available at the hospital or at the business office to assist patients in understanding and applying for local, state, and federal healthcare programs and the TMC Community Care.

3.7. Reasonable efforts are made to ensure that all TMC employees are informed about how to refer patients to apply for the TMC Community Care application. Annual staff education programs are provided to all business office and admitting staff.

3.8. Patients can request financial assistance information or a copy of this policy or the Community Care application by calling the Business Office phone line on a 24-hour basis at (520) 324-1310. Voicemail is available and calls will be followed up within two working days.

3.9. Patients are provided information regarding the availability of financial assistance upon registration or admission to TMC's acute facility areas.

3.10. This policy and the Community Care application for assistance in the form of the TMC FAP are available on the TMC website at www.tmcaz.com/about-my-visit-to-tmc/about-your-bill/financial-assistance

	3.11. in acute care inpatient registration areas, or via mail from the Business Office. The Community Care application documents include instructions on how to complete the application form and the kinds of supporting documentation that are necessary to complete the application process. Instructions for return of the form are also provided. 3.12. Individuals other than the patient, such as the patient's physician, family members, community or religious groups, social services, or hospital personnel, may make requests for financial assistance on a patient's behalf. 3.13. Non-covered charges for Medicaid patients are considered charity allowances.
Standard Work:	TMCH has not adopted Standard Work for this Policy.
References:	Policy created in compliance with 501 (r) in order to maintain Not for Profit status for Tucson Medical Center.
Policy Creator:	Director of the Revenue Cycle & HIM
Executive Sponsor:	Chief Financial Officer
Review:	This Policy shall be reviewed as needed per changes in applicable laws, regulations, and accreditation or operational requirements, but no less often than every 3 years.

Approved: /s/ Maria Persons 09/21/2022
Maria Persons Date
Director, Revenue Cycle & HIM