West Volusia Hospital Authority
BOARD OF COMMISSIONERS FUTURE HOSPITAL FUNDING
March 18, 2021 4:00 p.m.
DeLand City Hall
120 S. Florida Ave., DeLand, FL
And via Conference Call #1-339-209-4657

WORKSHOP OBJECTIVE:

To discuss with all interested stakeholders a long-term funding solution for hospital-based health care that could include emergency department (ED) services starting October 1, 2021.

AGENDA

1. Call to order
2. Approval of Proposed Agenda
3. Citizens Comments
4. Facilitation of Workshop Presentations by Jim Vertino, CEO, EBMS
    a. Recap of workshop objective (5 min)
    b. Introduction of stakeholder proposals
        i. AdventHealth (3 min)
        ii. EM Pros (3 min)
        iii. Halifax Health (3 min)
    c. Discussion on charitable care programs/Financial Assistance Policy related to hospital-based health care (15 min)
    d. Discussion on annual budgeted funding for hospital-based services (25 min)
        i. Annual funding limit
        ii. Options for when funding has been exhausted
        iii. Rate of reimbursement
        iv. Categories of services included
    e. Wrap up (5 min)
5. Adjourn

Tanner Andrews,
1027 W. Euclid Ave.,
P.O. Box 1208,
DeLand, FLA 32721.

West Volusia Hospital Authority,
% DRT CPA,
1006 N. Woodland Blvd., #A,
P.O. Box 940,
DeLand, FLA 32721.

04-Mar-2021

To the Board:

I write with some thoughts before the workshop regarding emergency room contracts. Please accept this letter in place of a spoken presentation.

- i -

Before we even consider the question of paying the hospitals to perform their EMTALA obligations, I should point out a risk. At the last meeting, we heard from Sundria Ridgley about her recent experience in the emergency room. Remember that she is a successful corporate executive, more familiar than the average person with the way things work and thus more likely to get results. I have no reason to doubt her report, and from that can only extrapolate to what our Health Card members are likely to see.

We are serving the most vulnerable population. That does not mean that none of them will ever find counsel after an unfortunate encounter. The Authority will represent a deep pocket, and whether or not we prevail, the taxpayers will be required to pay money to defend the indefensible actions of Adventist.

Before proceeding at all, I should like to have some explanation from Adventist as to (1) why the events recounted by Ms. Ridgley occurred, (2) who has been sacked, and (3) what other steps have been taken to prevent recurrence. Alternatively, I suppose they could explain that no one has been sacked because the entire situation is their standard and accepted practice. I hope that this alternative possibility is not reality.

- ii -

It could be that there is some overload at the ER. The problem with such an excuse is that Adventist have long been advertising the speed of the ERs, and even reporting speed to the Authority.

It could be that the advertising, and reports are misleading. They could be deceptively promoting themselves before a captive market of traffic stuck on I-4. But, in any event, it would probably be unwise for the Authority to encourage traffic to them if they are so overloaded that Ms. Ridgley's experience is deemed acceptable.

- iii -

I should also point out that the practice of unbundling the doctors from the emergency room is patently misleading. The hospital bills for emergency treatment, generally at an eye-popping rate that bears little connection to the rest of the world. Once that is paid, the patient then gets another bill for the doctors.

It is as if I paid a filing fee in court, but once the case ended I find out that the judge is extra. In some states, yes, the judge is extra, but that is expected to be handled quietly and before the decision. But this is as though I go to the opera, and on the way out they inform me that I need to pay extra for the tenor.

The hospital's view is obvious: it allows them to evade a substantial portion of the cost of EMTALA obligations. If they avoid the cost of providing care, it certainly reduces the cost of providing care. However, it does not reflect well upon the doctors that they acquiesce in such a scheme.

As an Authority taxpayer, however, I must view it differently. Even assuming we contracted with the hospitals to pay for their Federal obligations, they cannot speak for the ER docs. Emergency medicine has been corporately excised from the provision of emergency care, and is billed separately.

Unbundling may allow the hospitals to dodge at least part of their EMTALA obligations. Now, they seek to have taxpayers step up and pay for the rest. I cannot endorse taking that step.

Paying for their EMTALA obligations is an expected cost of being a not-for-profit. As a not-for-profit, they also receive significant advantages: they pay no property tax, and no sales tax, and no income tax.

The Authority has historically paid for the indigent care they provide our members, despite the fact that their own policies would make every one of our health card members eligible for hospital-provided charity. Last year, we codified the policy and EBMS has been able to make it work.

I could just say, "why mess with success", or even "if it works, don't fix it". But as a matter of policy, I think we managed to strike an appropriate balance. We pay for those things the hospitals ought to do but are not required to do. That is a benefit to the community, in that we have fewer sick people spreading illness among us. They ought to do the things which are required of them.

Finally, I have to come back to the optics. The hospitals have threatened not to deal with the authority for indigent payment. As I said a few meetings ago, they have two options: deal with the Authority, and get paid; alternatively, seek blood from the turnips that are our members. Part of the deal, as codified in the resolution, is that they are expected to fulfill their Federally-mandated obligations.

I have heard no reason that the taxpayers of West Volusia should be saddled with an obligation every other not-for-profit hospital in the country is expected to shoulder. Neither do anticipate that the Board will hear such a reason in the near future. It follows that we ought not amend the policy which we adopted last year and which appears to be working.

Yours,

Tanner Andrews

Eileen Long

From: Andrew G. Murray <amurray@ebms.com>
Sent: Wednesday, March 10, 2021 9:54 AM
To: elong@westvolusiahospitalauthority.org
Cc: tsmall@westvolusiahospitalauthority.org; Ron Cantlay; James Vertino; Darik J. Croft; Rose Alberts; Pepper Schafer
Subject: WVHA Hospital Funding strategy -- recommended framework

Eileen and WVHA team,

I was pleased to review the RFP submissions from AdventHealth, Halifax Health and EM Pros proposing key terms for a future multi-year, hospital funding strategy. As is to be expected from such a public consultation process, each organization thinks about this topic in a slightly different way but I'm pleased to report that there seems to be broad alignment on the desire to find a sustainable, affordable win-win-win solution that considers the needs of our patients, our tax payers and our healthcare Provider partners.

I am therefore confident that we would be able to achieve a mutually-agreeable outcome but would counsel the Board to only change the current arrangements (Resolution 2020-007) if this is replaced with a better, comprehensive, long term solution. I detail below a recommended approach that may allow us to finalize such a solution in the coming weeks.

Recommended Process

- I would counsel the Board to refrain from focusing on technical details as a first step. Rather align around a set of high-level principles that will then serve as guardrails when we develop the technical solution – I propose below such a framework that may structure the Board's deliberations on these topics.
- I would secondly recommend that the Board prioritize establishing it's longer-term strategy (i.e. define the approach for the next program year commencing on 10/1/2021) and then determine whether this longer term strategy may also work for the current program year.

Recommended Framework

1. **Coverage Policy** – While any WVHA coverage policy is completely discretionary, an affordable reimbursement strategy that also include coverage for ED services and does not expose patients to potential surprise medical bills would be desirable – the current 'carve-out' for ED is confusing to members, may expose them to surprise medical bills and is tough to administer. Importantly, an expanded, integrated hospital funding approach that includes cover for ED services would enable formal contracting with both hospital systems for care in all settings.
2. **Network Strategy**:
    a. Include both hospital systems to improve access, allow patient choice and avoid unhealthy market dynamics (e.g. unnecessary transfers from a non-partner hospital a partnered hospital).
    b. Expanding coverage to include additional access points (Urgent Care at Advent; Behavioral Health at Halifax) would be beneficial as long as this is done within the same budget to avoid increasing costs.
3. **Budgeted Hospital Funding**:
    a. Keep things simple – avoid an unnecessarily complex (and costly) actuarial process; continue using an annual budget cap for hospital services.
    b. Determine a reasonable budget cap that can be sustained for a 3 – 5 years period of time without increasing taxes. A logical range seems to $3.0M – $4.5M which respectively represents the current budgeted funding and the expanded level proposed by Advent. Consider a lower budgeted amount

(e.g., the current $3.0M level) paired with the constraint that only non-elective care will be offered by hospitals when the budgeted funding is exhausted (the Halifax proposal). The Board would have the option to make additional funds available on a discretionary basis to ensure that elective care is not delayed.

c. A reimbursement rate equal to 85% of Medicare seems to be fair and agreeable to all stakeholders; this is consistent with the current reimbursement level pursuant to Resolution 2020-007.
d. Consider expanding access to hospital funding to also include ED services, Urgent Care services and ASCs (out-patient surgery centers).
e. Consider a 'sub-limit' for ED services and Urgent Care services so "urgent" care does not prematurely exhausted funding for discretionary care.
f. Update relevant benefit design parameters (e.g. differentiated ED / Urgent Care co-pays) to encourage appropriate utilization by members.

4. **Protect members against surprise medical billing** – Hospital, ED and Urgent Care providers must contractually agree to not balance bill members, even when budgeted hospital funding has been exhausted.
5. **Long-term stability** – A formal multi-year provider agreement with all stakeholders will be critical to ensure stability of the proposed arrangement.

The EBMS team and I look forward to assisting the Board in working towards such a sustainable, affordable win-win-win solution.

Best regards,

Andrew

Dr. Andrew G. Murray

Chief Medical Officer | **EBMS** | www.ebms.com
President | **miCare Health Centers** | www.micarehealthcenter.com
President | **miRx Pharmacy** | www.mirxpharmacy.com

t: 800.777.3575 | **p**: 406.245.3575 | **e-mail**: amurray@ebms.com
2075 Overland Avenue | PO Box 21367 | Billings, MT 59104-1367

The benefit of balance is greater wellbeing

This is not a guarantee of benefits. All charges are subject to plan provisions, including exclusions, IRS regulations, and eligibility at the time charges are incurred.

Summary of key terms proposed pursuant to RFP relating to future Health Card program hospital funding

Compiled on March 10th, 2021 to facilitate easier comparison of stakeholder responses. Summary based on written submissions received from interested stakeholders – please refer to these original submissions for details.

	AdventHealth	EM Pros	Halifax Health
HOSPITAL SERVICES FUNDING PROPOSALS			
Proposed scope of services	• All facility-based settings: IP[i] + OP[ii] + observation + ED[iii] (facility only) • Introduce Centra Care as a new Urgent Care access points offered by AdventHealth	• ED Physician staffing at AdventHealth DeLand and Fish Memorial Hospitals (plus other facilities in Flagler Co.)	• All facility-based settings: IP + OP + observation + ED (facility & professional) • Physician services rendered by Halifax-employed physicians • Introduce coverage for Behavioral Health services offered by Halifax Health
Subcontracting of key services	• AdventHealth does not employ ED physicians but subcontracts to EM Pros • AdventHealth owns a separate multi-specialty medical group (AdventHealth Medical Group) that employs certain specialists; Advent Health Medical Group is contracted separately as part of EBMS' network	• AdventHealth contracts with EM Pros to provide ED physician staffing in its facilities; without such coverage ED's can't operate • All providers (Physicians and Advanced Practice Clinicians such as NPs or PAs) are employed by EM Pros who bills on their behalf (including pursuing collections)	• Halifax employs its ED Physicians directly • Halifax partners with UF to operate the new Deltona Medical Center • UF is contracted separately as part of EBMS' network
Principles for use of budgeted funding	• Any willing provider (all hospitals in taxing district share the hospital budget) • Funds follow the patient (the provider who renders care bills for services) • Claims to be reimbursed, subject to budget availability, on a first-come-first served basis	• Propose that ED Physicians access the Specialist budget (vs. the Hospital budget) • Any willing provider (i.e. all physicians collectively access the Specialist budget) • Cap funding by specialty on pro-rata basis by specialty	• Any willing provider (all hospitals in taxing district share the hospital budget) • Retain current referral process • Deploy ED diversion strategies to decrease avoidable ED encounters • Cap funding for ED (facility & professional) as a % of total available hospital budget
Rate of reimbursement	• 85% of Medicare in all settings • No balance billing of members	• 85% of Medicare for ED Physician services • No balance billing of members	• 75% of Medicare for ED services (facility fees & professional fees) • 85% of Medicare in all other settings • No balance billing of members
Proposed annual budget and adjustment mechanism	• Expand hospital funding to $4.5MM in 2021/22 • Future year budgets may decrease if ED utilization decrease through ED diversion programs implemented by miCare	• No specific budget level proposed	• No specific budget level proposed • Consider an actuarially based program, including capitation and/or stop-loss (this implies a formulaic budgeting process based on changes in demographic and utilization trends over time) • Consider generating new revenue streams to cross-subsidize tax funding by allowing opening access to WVHA's clinics and network beyond the Health Card program

Proposed mechanism when budgeted funding is exhausted	• AdventHealth will continue providing care once budgeted funds had been exhausted in any program year (with no balance billing of members)	• Delivery of ED care (including Physician services) form part of AdventHealth's non-negotiable EMTALA obligation • EM Pros will continue providing such ED care to members even when the budget is exhausted (with no balance billing to members)	• Halifax will continue providing care limited to "life or limb procedures" once budgeted funding had been exhausted in any program year (with no balance billing of members); this practically means that ED and urgent IP care will be offered but that OP care and/or elective procedures will be delayed until the next program year • WVHA, at its sole discretion, can decide to make additional funding available so elective care does not have to be delayed
Proposed relationship	• Formally contracted provider agreement • 3–5 years term	• Formally contracted provider agreement • 5 years term	• Formally contracted provider agreement • 3–5 years term with 90-day break clause
FINANCIAL ASSISTANCE POLICY			
Financial Assistance Policy	• Generally applies to income levels up to 200% FPL (adjusted up for larger families) • Financial assistance applies only to "non-elective, medically necessary service" (ED, ED admissions, IP/OP follow-ups related to ED care); elective services may be approved on a case-by-case basis • Financial assistance may be for a full write-off ("a 100% reduction in billed charges") or for a partial subsidy	• EM Pros does not have tax-exempt status and IRS Section 501(r) does not apply • EM Pros does not have a published Financial Assistance Policy but may choose to offer accommodations such as payment plans, write-offs, etc. on a case-by-case basis • Patient to engage with third-party billing company to negotiate such accommodation	• Generally applies to income levels up to 200% FPL (or 400% FPL for a family of 4); however, services approved on a case-by-case basis • Financial assistance applies only to ED and IP care (i.e. "life or limb procedures") • Eligibility is "residency" based – it appears that patients who reside in WVHA's taxing district may not qualify for the same level of financial assistance as those who live in Halifax's district
"Pass-down" of Financial Assistance Policy	• AdventHealth's Financial Assistance Policy does not apply to EM Pros or other independent providers	• *Not applicable – see above*	• Halifax Health's Financial Assistance Policy applies to employed physicians only; independent providers are not bound by this policy
Practical application of policy	• Complex and involved application process (multiple forms + supporting documents) • Onus is on patient pursue financial assistance and then to navigate process • Not fully aligned with WVHA eligibility but broadly similar	• Onus is on patient to contact EM Pros' third-party billing company and negotiate accommodation	• Complex and involved application process (multiple forms + supporting documents) • Onus is on patient pursue financial assistance and then to navigate process • Not fully aligned with WVHA eligibility but broadly similar

[i] IP = In-patient care

[ii] OP = Out-patient care

[iii] ED = Emergency Department (a.k.a. "ER" or "Emergency Services"); this is currently not a covered benefit for the Health Card program

AdventHealth

March 8, 2021

Dear West Volusia Hospital Authority (WVHA) commissioners:

For the past 20 years, AdventHealth has enjoyed a meaningful partnership with the WVHA, working together to care for those in the community who need us most. As we move on from our 20-year contract, we are excited about the opportunity to build on this relationship and collaborate with the WVHA on ways to strengthen care for the residents of West Volusia.

Over the years, AdventHealth has invested millions in the West Volusia community, bringing new technology and physicians to residents ahd expanding the footprints of both AdventHealth DeLand and AdventHealth Fish Memorial. Construction is underway in Orange City for a $100 million patient tower and expansion, and we've opened an outpatient facility and an emergency department in Deltona. We've also opened two AdventHealth Centra Care locations to create additional access points to care. These additional sites offer new, convenient locations for WVHA health card members to access world-class care. In addition to expanding our physical assets, we have also worked diligently to improve the quality of our care. Both AdventHealth DeLand and AdventHealth Fish Memorial have been continually ranked as Leapfrog Grade A hospitals which guarantees that the residents of West Volusia have access to high-quality care close to home.

As requested by the board during their February meeting, AdventHealth is submitting a contract proposal for discussion at the special workshop scheduled for March 18th, 2021. Below is an outline of the proposed contract structure we would be excited to work towards with the WVHA.

1. AdventHealth would provide inpatient, outpatient, observation, and emergency room care for all WVHA health card members.

2. Inpatient, outpatient, observation, and emergency room care would all be covered services under the contract.

3. AdventHealth would accept reimbursement for our services at a rate equal to 85% of Medicare.

4. AdventHealth would not balance bill WVHA health card members for any remaining balances after receiving payment from the WVHA.

5. AdventHealth would seek to establish a 3-5 year contract to create network stability for WVHA health card members, the WVHA board, and the hospital system.

6. AdventHealth would propose a $4,500,000 hospital care budget cap for year 1 of the contract. This cap would be adjusted in years 2 and 3 based on the performance of the WVHA network. We would propose that all parties agree on an acceptable ED utilization target for measuring this performance. The goal of this cap adjustment would be to allow

AdventHealth

for the WVHA to share in the reduced cost if their primary care network is successful in reducing the cost of care by reducing ED utilization in favor or lower cost settings of care. AdventHealth would propose that any savings from reductions in the cap reduce the overall WVHA budget and allow those savings to pass back to the taxpayers.

7. AdventHealth would continue to provide care for all WVHA health card members when the funding cap is reached in any given fiscal year. The cost of this care would be covered by AdventHealth; WVHA card members would not be billed when funding from the WVHA runs out.

8. AdventHealth is not requesting an exclusive agreement. Any other hospital systems that choose to participate should be able to share in the hospital care budget established by the WVHA.

9. AdventHealth would propose that the funding continues to follow the patient as it did in our prior agreement. The hospitals would bill the WVHA as care is provided. The WVHA would pay claims as there are received.

10. AdventHealth would propose including CentraCare as a lower cost option for urgent care as part of the contract.

The above list represents a foundation for discussion, and we recognize that any contract would have more precise and specific language.

Our current relationship with Emergency Medicine Professionals (EMPros) would not change as a result of this contract. EMPros is an independent group of specialty physicians who staff the emergency departments at our AdventHealth facilities within Volusia County. We do not contract with payors on their behalf. They provide world class care within our emergency rooms and bill for their services as do other specialty physicians in the community.

I have attached a copy of our financial assistance information as part of this submission. This information is readily accessible on our website as well.

AdventHealth is a proud member of this community and we feel blessed to serve the residents of West Volusia. We look forward to discussing our continued partnership together to improve the health of our community.

Sincerely,

Kyle Glass
West Volusia Market CFO
AdventHealth

AdventHealth

Submit financial assistance documents using the AdventHealth contact information below		
AdventHealth Financial Assistance Web Page Address: www.adventhealth.com/legal/financial-assistance		
SERVICE LOCATION	**MAILING INFORMATION**	**Phone / Fax**
Altamonte Springs	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Apopka	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Celebration	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
East Orlando	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Kissimmee	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Orlando	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Winter Garden	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Winter Park	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
For Children	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
For Women	Patient Financial Services PO BOX 538815 Orlando, FL 32853-9902	Phone: 407-303-0500 Fax: 407-200-4977
Heart of Florida	Patient Financial Services PO BOX 865839 Orlando, FL 32886-5839	Phone: 866-481-2553 Fax: 941-341-3717
Lake Wales	Patient Financial Services PO BOX 865836 Orlando, FL 32886-5836	Phone: 866-481-2553 Fax: 941-341-3717
Daytona Beach	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
DeLand	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Fish Memorial	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
New Smyrna Beach	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Palm Coast	Patient Financial Services 770 West Granada Blvd Ste 203 Ormond Beach, FL 32174	Phone: 888-676-2219 Fax: 386-676-2560
Waterman	Patient Financial Services 1000 Waterman Way Tavares, FL 32778	Phone: 352-253-3311 Fax: 352-253-3735

Carrollwood	Patient Financial Services PO Box 861372 Orlando, FL 32886-1372	Phone: 813-615-7848 Fax: 813-615-8182
Dade City	Patient Financial Services PO Box 865667 Orlando, FL 32886-5667	Phone: 813-615-7848 Fax: 813-615-8182
Lake Placid	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389
Connerton	Patient Financial Services PO Box 861372 Orlando, FL 32886-1372	Phone: 813-615-7848 Fax: 813-615-8182
North Pinellas	Patient Financial Services PO Box 862624 Orlando, FL 32886-2624	Phone: 813-615-7848 Fax: 813-615-8182
Ocala	Patient Financial Services PO Box 865696 Orlando, FL 32886-5696	Phone: 813-615-7848 Fax: 813-615-8182
Sebring	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389
Tampa	Patient Financial Services PO Box 861372 Orlando, FL 32886-1372	Phone: 813-615-7848 Fax: 813-615-8182
Wauchula	Patient Financial Services PO Box 9400 Sebring, FL 33871 Attn: MB 3	Phone: 863-386-7177 Fax: 863-402-3389
Wesley Chapel	Patient Financial Services PO Box 864855 Orlando, FL 32886-4855	Phone: 813-615-7848 Fax: 813-615-8182
Zephyrhills	Patient Financial Services PO Box 862310 Orlando, FL 32886-2310	Phone: 813-615-7848 Fax: 813-615-8182
Durand	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
Ottawa	Patient Financial Services PO Box 460 Ottawa, KS 66067	Phone: 785-229-3379 Fax: 785-229-3377
Shawnee Mission	Patient Financial Services 7315 E. Frontage Road, Suite 200 Shawnee Mission, KS 66204	Phone: 913-676-7558 Fax: 913-676-7571
Manchester	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Murray	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Gordon	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Hendersonville	Patient Financial Services 54 Brownsberger Circle Fletcher, NC 28732	Phone: 800-347-5281 Fax: 828-650-8080
Central Texas	Patient Financial Services 2201 S. Clear Creek Road Killeen, TX 76549	Phone: 254-519-8476 Fax: 254-519-8488
Rollins Brook	Patient Financial Services 608 N. Key Avenue Lampasas, TX 76550	Phone: 254-519-8476 Fax: 254-519-8488

Getting Help to Pay Your Bill

This information is for anyone who receives services from an AdventHealth facility or an affiliated health care provider. You can view a list of AdventHealth facilities at www.adventhealth.com. As a faith-based hospital system, we provide medical care to all patients, including those who have difficulty paying for services due to limited income. You can ask for help with your bill at any time during your hospital stay or billing process.

Qualifying for Help

If you receive emergency or medically necessary services and do not have medical coverage from a commercial insurer or governmental program, you may qualify for financial assistance. The amount of assistance depends on your annual income and family size. If your annual income is equal to or less than 200% of the current Federal Poverty Guidelines you will not have to pay your bill.

2021 Federal Poverty Guidelines	
Household Size	**200% of Poverty**
1	$25,760
2	$34,840
For each additional person in the household, add $9,080	

If your income does not meet the guidelines to have your entire bill paid, you may still qualify for help paying part of your bill. You may also qualify based on other factors on your application.

Applying for Help

You can apply for help with your bill in person, by mail or over the phone. To receive an application, call our Customer Service department, visit our website or go to the patient registration area at our hospital. Our phone number, website and address are located on the financial assistance section of our website and on the first page of this document when printed. This information is also available in other languages on our website or at the patient registration area.

Emergency and Medically-Necessary Care

If you qualify for help with your bill, you will not be billed more for emergency or medically-necessary care than people who have insurance coverage are billed. We compare the amount paid by insured patients and their insurance companies to determine how much you owe. You can view our charity policy on our website.

Supporting Documents

If you want to take part in our financial assistance program, you will be responsible for providing information and paperwork in a timely way. You will need to share all of the information about your health benefits, income, assets, and anything else that will help us determine whether you qualify for assistance. Paperwork might include bank statements, income tax forms and check stubs.

Collection Activities

Bills that are not paid 100 days after the first billing date may be reported to a collection agency. Bills that are not paid 120 days after the first billing date may be reported on your or your guarantor's credit history. You or the guarantor can apply for help with your bill at any time during the collection process by completing an application.

AdventHealth

FINANCIAL ASSISTANCE APPLICATION

(All fields must be completed unless noted otherwise)

Patient Last Name, First	Date of Birth	Social Security Number	*Number of People in Household	Last 12 Months Annual Household Income
				$

If Minor, Guarantor's Last Name, First	Date of Birth	Social Security Number	Guarantor's Source of Income

Vehicles in Household including Cars/Boats/RV's (Year/Make/Model)	Checking/Savings Account Balance	Properties Owned and Values	CD/Retirement/ Investment Account Balances	Other Assets
(Optional)	(Optional)	(Optional)	(Optional)	(Optional)

Patient Street Address	Home Phone Number	If income is $0, please check one:	
			Lives with Relative(s)
City, State, Zip Code	Alternate Phone Number		Lives with Friend(s)
			Retired
Number of children under age 21 in the home: _____			Unemployed
			Disabled
			Homeless

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will re-evaluate my financial status and take whatever action becomes appropriate. **To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.** *[State of Florida Applicants: Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083.]*

Signature of Applicant /Guarantor

Date Completed

* When calculating the number of people in the household, only the following people are counted: 1) Blood relatives living in the home, 2) Relatives by marriage living in the home, and 3) Relatives by legal adoption living in the home.

For Office Use Only				
Reason for Service	GAI	DOS	Family Size	Total Charges
☐ 1.0x $	☐ 1.5x $	☐ 2.0x $	☐ 25% Rule $	
Recommendation for account disposition				
Finance Committee Disposition				
Manager	Date	Director	Date	

AdventHealth

Company-Wide

Financial Assistance — CW F 50.1

Purpose

AdventHealth (AH) is committed to excellence in providing high quality health care while serving the diverse needs of those living within our service area. AH is dedicated to the view that emergency or other non-elective medically necessary care should be accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility, or ability to pay. AH 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 each AH hospital facility in accordance with the regulations under Section 501(r).

AH provides emergency or other non-elective medically necessary 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. In the event that third-party coverage is not available, an allocation is made each year for funds to be available for financial assistance. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of admission, by the financial counselor. This policy identifies those circumstances when an AH hospital organization or a substantially-related entity (a partnership providing emergency or other medically necessary care in which the AH hospital organization has an ownership interest) should provide care without charge based on the financial need of the individual.

The financial assistance policy provides guidelines for financial assistance to eligible self-pay individual patients and eligible individual patients with balances after insurance receiving emergency or other non-elective medically necessary services based on financial need. This financial assistance policy also provides guidelines for amounts that may be charged to all self-pay patients who receive medically necessary services. Financial assistance discounts based upon financial need will not be provided for elective procedures, except as may be determined in the sole discretion of the AH hospital facility on a case-by-case basis.

Non-elective services are defined as a medical condition that without immediate attention:

- Places the health of the individual in serious jeopardy
- Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.

Patients types assumed to be covered by this definition include, but are not limited to:

- Emergency Department Outpatients
- Emergency Department Admissions
- IP/OP follow-up related to previous Emergency visit.

Policy

Please see the Addendum to this Policy for a listing of all providers, other than the AH hospital facility, that deliver emergency or other medically necessary care at the AH hospital facility, and specifies which providers are covered by this Financial Assistance Policy and which are not. The listing of providers contained in the Addendum to the Policy can be accessed on-line at the AH hospital facility's website. A paper copy can be obtained free of charge from the AH hospital facility's Patient Financial Services Department.

The provider listing is updated quarterly 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.

An AH hospital facility may list names of individual doctors, practice groups, or any other entities that provide emergency or medically necessary care in the AH hospital facility by the name used either to contract with the hospital or to bill patients for care provided.

A. Emergency or non-elective medically necessary care may be considered for financial assistance if a patient presents with any of the following conditions:

1. No third-party coverage is available.

2. Patient is already eligible for assistance (e.g. Medicaid), but the particular services are not covered.

3. Medicare or Medicaid benefits have been exhausted and the patient has no further ability to pay.

4. Patient is insured but qualifies for assistance based upon financial need with respect to the individual's balance after insurance.

5. Patient meets local and/or state charity requirements.

6. Patients may apply for financial assistance in accordance with the guidelines set forth in this Policy.

B. Financial Assistance Policies, Financial Assistance Application Forms, and Plain Language Summaries of the Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in languages that are appropriate for the AH service area in compliance with the Language Assistance Services Act and 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 AH hospital facility (limited proficiency in English populations meeting the criteria above will be referred to hereafter in this policy as the LEP defined populations).

1. Website: AH hospital facilities will prominently and conspicuously post complete and current versions of the following on their respective websites:

    a. Financial Assistance Policy (FAP)

    b. Financial Assistance Application Form (FAA Form)

    c. Plain Language Summary of the Financial Assistance Policy (PLS)

    d. Contact information for AH facility Financial Counselors.

2. The website will indicate that a copy of the FAP, FAA Form, and PLS is available and how to obtain such copies in the primary languages of the LEP defined populations.

3. Signage will be conspicuously displayed in public locations in AH hospital facilities including all points of admission and registration areas, including the Emergency Department. All signage denoting that financial assistance may be available will contain the following elements:

    e. The hospital facility's website address where the FAP, PLS, and the FAA Form can be accessed

    f. The telephone number and physical location (room number) that individuals can call or visit to obtain copies of the FAP, FAA Form or PLS or to obtain more information about the FAP, PLS, or the application process.

4. Contact information for how and where individuals that are

    members of the LEP defined populations may obtain copies of the FAP, FAA Form, and PLS. Each AH hospital facility

will make paper copies of the FAP, FAA Form and the PLS 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 PLS will be offered to patients as part of the intake or discharge process.

5. Financial Counselor Visits: Financial counselors will seek to provide personal financial counseling to all individuals admitted to an AH hospital who are classified as self-pay. 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 made available.

6. The PLS should be distributed to members of the community served by the AH hospital facility in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. An example would be the distribution of copies of the PLS to organizations in the community that address the health needs of low-income populations.

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

1. AH Responsibilities:

   a. AH has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

   b. AH 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.

   c. AH workforce members in Patient Financial Services and Registration areas understand the AH financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

   d. AH requires all contracts with third party agents who collect bills on behalf of AH to include legally binding

written contract provisions that provide that these agents will follow AH financial assistance policies.

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

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

g. AH provides options for payment arrangements.

h. AH upholds and honors individuals' right to appeal decisions and seek reconsideration.

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

j. AH will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

2. Individual Patient Responsibilities

a. To be considered for a 100% reduction in charges under the financial assistance policy, the individual must cooperate with AH to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

b. To be considered for a 100% reduction in charges under the financial assistance policy, the individual must provide AH with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

c. A self-pay patient who is not eligible for a 100% reduction in charges based upon financial need will be billed no

more than the amount generally billed to individuals who have insurance covering such care and will cooperate with the hospital to establish a reasonable payment plan.

d. A self-pay patient who does not qualify for a 100% reduction in charges based upon financial need must make good faith efforts to honor the payment plans for their hospital bills. The individual is responsible to promptly notify AH of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance, their hospital bills or provisions of payment plans.

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

1. *Identification of Potentially Eligible Individuals.* Requests for financial assistance will be honored up to 240 days after the date the first post-discharge billing statement is remitted to the individual either by mail or electronic bill presentment.

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

b. Financial counselors will make best efforts to contact all self pay inpatients during the course of their stay or at time of discharge.

c. The AH hospital facility's PLS will be offered along with the FAA Form to every individual upon intake or upon discharge from the hospital facility.

d. A conspicuous written notice will be included on all billing statements that notifies and informs recipients about the availability of financial assistance under the AH hospital facility's FAP and includes the following: 1) the telephone number of the AH hospital facility's office or department that can provide information about the FAP and the financial assistance application process; and 2) the web-site address where copies of the FAP, FAA Form, and PLS may be obtained.

e. Reasonable attempts will be made to orally notify individuals about the AH hospital facility's FAP and how

the individual may obtain assistance with the FAA Form and process.

f. The individual will be provided with at least one written notice (notice of actions that may be taken), along with a copy of the PLS, that notifies and informs the individual that financial assistance is available for eligible individuals and states that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus or engage in other specified extraordinary collection actions if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first post-discharge billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

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

a. Requests received from third parties will be directed to a financial counselor.

b. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

c. Upon request, an estimated charges letter will be provided to individuals who request a written description of estimated charges.

3.*Eligibility Criteria*

a. To be eligible for a 100% reduction from applicable charges (i.e. full write-off for self-pay patients and full write-off of the patient responsibility portion of charges after insurance) the individual's household income must be at or below 200% of the current Federal Poverty Guidelines. Self-pay patients with household incomes that exceed 200% of the current Federal Poverty Guidelines will be charged no more than the amount generally billed to individuals who have insurance covering such care.

b. The amount charged to any FAP-eligible individual for emergency or all other medically necessary care will be based on amounts generally billed (AGB) to individuals who have insurance covering such care at each specific AH hospital. Each AH hospital facility will determine its AGB by determining an AGB percentage and multiplying that percentage by the gross charges for the services provided to the individual. All AH hospital facilities will utilize the look-back method as described in §1.501(r)-5(b)(3) to determine AGB. Individuals can contact a member of the relevant AH hospital's Patient Financial Services team at a telephone number shown on an attachment to this policy to obtain a free written information sheet stating the relevant AH hospital facility's AGB percentage and an explanation of how the AGB percentage was determined.

c. Charges to an individual eligible for financial assistance under the AH hospital facility's FAP for any medical services will be less than the gross charges for that care.

d. If the 200% maximum financial assistance threshold needs to be expanded for market-specific conditions (including competition and public relations), the entity's representative is to present the exception to the AdventHealth Senior Hospital Finance Group (SHFG) Committee for approval.

e. In addition to an income level evaluation as outlined above, an optional asset means test may also be applied to determine eligibility for financial assistance. An asset test is mandatory for Medicare patients only. An asset test for non-Medicare patients is optional. For the purposes of this policy, the amount of patient responsibility is 100% of the patient portion not to exceed the GREATER of: 1) Seven percent (7%) of Available Assets or 2) Required payment per the Financial Assistance Policy. "Available Assets" is defined as cash, cash equivalents and non-retirement investments.

f. When determining an individual's income, the following terms apply:

    i. Household size and income includes all members of the immediate family and other dependents in the household as follows:

1. An adult and, if married, a spouse.
2. Any natural or adopted minor children of the adult or spouse.
3. Any minor for whom the adult or spouse has been given the legal responsibility by a court.
4. Any student over 18 years old, dependent on the family for over 50% support (current tax return of the responsible adult is required).
5. Any other persons dependent on the family's income for over 50% support (current tax return of the responsible adult is required).

g. Income can be verified by using a personal financial statement or by obtaining copies of that applicant's most recent Form W-2, most recent Form 1040, bank statements or any other form of documentation that supports reported income.

h. Documentation supporting income verification and Available Assets is to be maintained in patient files for future reference.

i. A credit report may be generated for the purpose of identifying additional expense, obligations and income to assist in developing a full understanding of the individual's financial circumstances. A third party scoring tool may be used to justify financial assistance eligibility.

j. Financial assistance application forms will be considered up to 240 days after the first post-discharge billing statement is remitted to the patient or when a change in patient financial status is determined. A financial assistance application will not need to be repeated for dates of service incurred up to three (3) months after the last date of application approval.

k. Presumptive eligibility: Individuals who are uninsured and are represented by one or more of the following may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application Form:

- Individual is homeless;
- Individual is deceased and has no known estate able to pay hospital debts;
- Individual is incarcerated for a felony;

- 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 a payment risk score of "D" or "E" based on the Scorer® application. The Scorer application is a tool that is designed to classify individuals into groups of varying economic means. The scores consist of algorithms that incorporate data from credit bureaus, demographic databases, and hospital specific data to infer and classify individuals into respective economic means categories. In lieu of utilizing the Scorer application, credit bureau scores may also be used to determine presumptive eligibility at the hospital's discretion.
- Individual was determined to be eligible for financial assistance any time within the previous three-month period beginning after the date the last financial assistance application was approved.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in this Section D and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application Form.

4. *Method for Applying for Financial Assistance*

a. AH Financial Assistance Application Form. In order to apply for financial assistance, the individual will complete the AH Financial Assistance Application Form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income. See Financial Assistance Implementation Instructions for CWF 50.1 for acceptable forms of documentation.

b. An individual can obtain a copy of the AH Financial Assistance Application Form by accessing it on the AH hospitals' website, by requesting a free copy by mail, by contacting the AH hospitals' Patient Financial Services department, or by requesting a copy in person at any of the AH hospitals' patient admission/registration locations.

c. A completed AH Financial Assistance Application Form will be submitted to Patient Financial Services for processing. Proof of income and available assets will 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).

5. Actions that May be Taken in the Event of Non-Payment: After a 120-day period beginning with the date that the first post-discharge billing statement is sent to an individual, an AH facility may report outstanding debts for care provided to an individual to consumer credit reporting agencies or credit bureaus, or make a sale of debt that is considered an extraordinary collection action (ECA) (please see Section F. 6. of the Policy), or engage in any other specified ECA's only after the following notifications have been provided to the individual at least 30 days before initiating any ECA's: 1) a written notice , along with the PLS, is provided to the individual indicating that financial assistance is available for eligible individuals and stating the specific ECA's that may be initiated after a stipulated deadline (the deadline may not be earlier than 30 days after the written notice is provided), and 2) a reasonable attempt is made to orally notify an individual about the AH hospital facility's FAP and how the individual may obtain assistance with the financial assistance application process.

a. *No Financial Assistance Application Form Submitted:*
If no Financial Assistance Application Form has been submitted in the 120-day period following the date after the first post-discharge billing statement was sent to the individual and the stipulated deadline in the written notice has passed, the AH facility may initiate an ECA.

b. *Incomplete Financial Assistance Application Form Submitted:*
If an individual submits an incomplete Financial Assistance Application Form during the 240-day period following the date on which the first post-discharge billing statement was sent to the individual (the application period), the AH hospital must take the following actions:

i. Suspend any ECA's;

ii. Provide the individual with a written notice that describes the additional information and/or documentation required under the Financial Assistance Policy or Financial Assistance Application Form that the individual must submit within a reasonable time and that contains contact information including the telephone number and physical location of the AH hospital facility office or department that can provide information about the FAP, as well as contact information of a hospital facility office or department that can provide assistance with the financial assistance application process or, alternatively, a nonprofit organization or governmental agency that can provide assistance with the financial assistance application process if the AH hospital facility is unable to do so;

iii. If the Financial Assistance Application Form is not completed by the reasonable time deadline discussed above, the hospital may initiate or resume ECA's. Liens attached to insurance (auto, liability, life and health) that represent potential proceeds owed as a result of an individual's personal injuries for which the AH hospital facility provided care are permitted in connection with the collection process. No other personal judgments or liens will be filed against FAP-eligible individuals.

c. *Complete Financial Assistance Application Submitted:*

If an individual submits a complete Financial Assistance Application Form during the application period (240 days after the first post-discharge billing statement is sent), the AH hospital must take the following actions:

i. Suspend any ECA's.
ii. Suspend any collection activity during the consideration of a completed AH Financial Assistance Application Form. A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified to suspend collection efforts until a determination is made. This notification will be documented in the account notes.

iii. Make and document the determination as to an individual's eligibility for financial assistance.

iv. Notify the individual in writing in a timely manner, generally within 60 days, after receiving a completed Financial Assistance Application Form of the eligibility determination and the basis for the determination.

v. Provide the individual with a billing statement (not required for a $0 balance billing statement) that indicates the amount owed as a FAP-eligible individual and describes how the individual can get information regarding the AGB for care and how the AH hospital facility determined the amount the individual owes.

vi. Refund any excess payments to the individual.

vii. Take all reasonably available measures to reverse any ECA's that have been taken against the individual.

viii. Provide a written notification of denial to any individual determined to not be FAP-eligible and include both a reason for denial and a process and contact information for filing an appeal. If an individual disagrees with the decision to deny the provision of financial assistance, the individual may request an appeal in writing within 45 days of the denial. The appeal must include any additional relevant information that may assist in the appeal evaluation. Requests for denial appeal will be reviewed on a monthly basis by the Financial Assistance Committee. Decisions reached by the Financial Assistance Committee will be communicated to the individual within 60 days of the Committee's review and will reflect the Committee's final decision.

ix. Upon receipt of a complete FAA Form, the AH hospital facility may postpone its determination of an individual's eligibility under its FAP if the individual has submitted an application for Medicaid assistance until such time as Medicaid eligibility has been determined.

E. Patient Financial Services Responsibilities

1. Financial Assistance Committee: A summary of the financial assistance applications and resulting recommendations processed by Patient Financial Services will be reviewed monthly by the hospital's Financial Assistance Committee. The Financial Assistance Committee reviews all financial assistance recommendations, with a focused review on borderline or non-routine requests that require case-by-case review.

2. Provision of financial assistance that exceeds $10,000 must be approved by the Financial Assistance Committee.

3, 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.

4. Patient Financial Services has the responsibility for determining that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and whether the hospital may take action to engage in any ECA's.

5. Billing agencies that contract with AH for collection services will follow this financial assistance policy with respect to all billing and collections matters.

6. Selling an individual's debt to another party (other than a non-ECA sale as described below) is considered an ECA and should not be initiated until the required steps outlined above in Section D. have been completed. Any proposed sale of debt agreement must be approved by the relevant AH Regional CFO and submitted to the AH Contract Review Process before being executed.

Certain sales of debt are not considered ECA's. Non-ECA debt sales require that the AH hospital facility enter into a legally binding written agreement with the purchaser of the debt that stipulates the following:

a. The purchaser may not engage in any ECA's;
b. The purchaser is prohibited from charging interest on the debt in excess of an IRS established rate;
c. The debt is returnable or recallable by the AH hospital facility upon a determination that the individual is FAP-eligible; and
d. 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 a FAP-eligible individual.

F. Individual Payment Plans

1. Payment plans for self-pay patients who are charged AGB will be individually developed with the individual patient. All collection activities will be conducted in conformance with the 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 long term payment arrangement that bears interest applied by a third-party financing agent.

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

G. Record-Keeping

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

2. Summary information regarding applications processed and financial assistance provided will be maintained for a period of seven years. Summary information includes the number of patients who applied for financial assistance at AH, how many patients received financial assistance, the amount of financial assistance provided to each patient, and the total bill for each patient.

3. 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.

H. 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.

Donald L. Jernigan, President/CEO

November 13, 2015 (Effective January 1, 2016

Origination Date: March 2006

Revision Date: February 26, 2008

December 18, 2008

November 13, 2014

Reviewed and Affirmed: November 13, 2015

Submitted by: Emergency Medicine Professionals, P.A. (EMPros)

EMPros is a physician owned emergency medicine specialty practice contracted with AdventHealth to provide care in AdventHealth emergency departments in Volusia/Flagler counties including AdventHealth DeLand, AdventHealth Fish Memorial, and AdventHealth Deltona ER in West Volusia.

Request for Proposal (RFP) from interested stakeholders to inform the process of Budgeting and Managing future Hospital Funding for the West Volusia Hospital Authority's Health Card program.

1. The WVHA sets an annual budget (October through September of the subsequent year) for various service lines. With respect to the annual budgeted funding for the 2021/22 program year and subsequent program years:

a. Are you willing to share this annual budgeted funding with other providers?

Yes

b. What guidelines should be put in place to ensure that funding is drawn fairly by all participating providers?

EMPros proposes the pooled funds be divided by percentage of services provided to Health Card members. This ensures access to all entities eligible to bill from the pool of funds, and an appropriate pro-rata share of the funds will then be available to all physician practices of all specialties, including orthopedics, cardiology, emergency medicine, etc.

It is imperative that *professional services* provided by clinicians to Health Card members be distinctly separated and independent of any reimbursement arrangements the WVHA may have with hospitals/health systems regarding *facility services/fees*.

c. Will you continue offering care to all Health Card members once the budgeted annual funding has been exhausted for any budget year?

EMPros has provided care for 45 years in DeLand, 26 years in Orange City, and most recently in Deltona since December of 2019. Our clinicians have provided uncompensated care for West Volusia communities totaling over $400 million over this period of time. Emergency medicine physicians have always acted as the community's healthcare safety net by treating all comers, regardless of ability to pay, and EMPros will continue to provide this level of care reflective of our commitment to the West Volusia community.

d. Are you willing to partner with the WVHA on a multi-year basis (a 3 – 5 year period)?

Yes, we are very comfortable with a 5-year commitment containing mutually agreeable terms.

2. Detail on what basis you propose offering hospital-based services to Health Card members and at what rate of reimbursement – specify by service lines as indicated below. Please compare the proposed rate with your current rates for Medicaid, Medicare and any other social safety net programs you support.

a. In-patient Services

If a Health Card member were hospitalized and experienced cardiac or respiratory arrest, EMPros may be responsible for providing emergency assistance depending on the hour of the day/day of the week if a critical care specialist, cardiologist, pulmonologist, or other qualified specialist is not present in the hospital to attend to the needs of the patient. Responding to a "code blue" life-threatening emergency in the hospital, but outside of the emergency department, would result in delivery of emergency medicine professional services to the patient. (Historically, this occurs infrequently and is <1% of EMPros billable professional services delivered to Health Card members.)

b. Out-patient Services

If a Health Card member were hospitalized in an outpatient status (observation, outpatient in a bed, etc.) EMPros may be responsible for providing emergency assistance in the event of cardiac or respiratory arrest as noted above. Further, Emergency Department visits are considered outpatient status encounters. Therefore, EMPros provides professional services in an outpatient setting (please see below).

c. Professional Services (as is appliable for hospital-employed/contracted providers; hospital-owned specialist practices; any providers on whose behalf you do the billing)

EMPros is a private emergency medicine practice contracted with AdventHealth in Volusia/Flagler counties. EMPros ensures that physicians who are specialty-trained and board certified in emergency medicine provide high quality care to Health Card members at each of the AdventHealth Emergency Departments in West Volusia. EMPros has a reasonable expectation to be reimbursed at the same rate as other physician specialists providing care to Health Card members who are currently receiving 85% of Medicare rates from the WVHA.

d. Emergency Services

Please see inpatient, outpatient, and professional fee services detail above.

e. Any other service lines

N/A

3. Detail the operational and financial arrangement that exist between yourself and any Provider sub-contractors who provide patient care in the ED setting. Do those arrangements make such Provider subcontractors responsible to comply with the hospital's Financial Assistance Policy under IRS Section 501(r) or are they free to pursue billing and collections in a manner inconsistent with your hospital's Financial Assistance Policy?

All clinicians (physicians and advanced practice clinicians) employed by EMPros are paid directly by EMPros. As is customary for emergency physician practices throughout the United States, EMPros bills independently of AdventHealth for professional services rendered via a third-party billing company located in Volusia county, DuvaSawko. EMPros does not receive reimbursement or payments of any kind from the hospitals or health system for professional services rendered to patients. EMPros is contracted with AdventHealth (a not-for-profit entity), however, EMPros is an entirely separate corporation that does not have tax-exempt status; therefore, IRS Section 5019(r) requirements are not applicable. No clinical provider within EMPros is free to pursue billing and/or collections independently.

4. Describe your charity care and/or Financial Assistance Policy under IRS Section 501(r) with respect to the topics below:

a. What services qualify?

Under the Emergency Medicine Treatment and Labor Act (EMTALA), all patients are entitled to emergency medical screening exams and stabilization of emergent medical conditions. "Prudent Layperson Standard" also applies to any patient presenting to any Emergency Department seeking treatment, which allows each individual seeking care to initially decide for themselves if they believe their condition warrants emergency care.

As mentioned previously, emergency medicine physicians treat all comers, regardless of ability to pay. Government payers, individual payers/insurers, employers, and patients reimburse us accordingly for the services provided upon receiving a bill. All inquiries regarding bills received by patients or responsible parties may be discussed with our third-party billing company, DuvaSawko. Payment plans/arrangements including accommodations to allow for partial payment installments affording extra time to remit total payment are offered, if requested by the patient or responsible party.

b. Who qualifies and what are the criteria for qualification? How does this compare with the eligibility criteria for the WVHA Health Card program? Is there some eligibility criteria under your Financial Assistance Policy that will not allow your hospital to make WVHA Health Card members presumptively qualified for a complete write off for emergency services under that Policy?

No across-the-board policy is in place to presumptively qualify any group for a write-off of charges for professional services rendered by clinicians employed by EMPros. Emergency physician groups rely upon fair reimbursement for services provided in order to employ specialty trained emergency medicine board certified physicians and highly trained advanced practice clinicians at market competitive rates to serve all comers. Fair reimbursement for emergency medicine professional services by government payers, individual payers/insurers, employers, and patients ensures sustainability of the Emergency Department/healthcare safety net in our community. Emergency medical care is not available on a no cost basis. Emergency medicine physicians and advanced practice clinicians must be paid at market competitive hourly rates for their work in the Emergency Department to maintain the healthcare safety net for all citizens and taxpayers of West Volusia, including Health Card members.

The United States healthcare system operates on a cost-shifting standard, effectively burdening the privately insured patients with the majority of the costs. In order to make the provision of services possible, EMPros is entitled to receive reimbursement payments, from whatever coverage an individual may have, for professional services provided to patients. According to Center for Medicaid and Medicare Services (CMS), and the American College of Emergency Physicians (ACEP), approximately 60% of Emergency Department visits in the United States are uncompensated. ACEP estimates that every emergency physician in America provides between $135,000-$160,000 in charitable (uncompensated) care annually which far exceeds any other medical specialty. This is a tenuous business model for any business—to not be paid for the majority of the services you provide. *Clearly, emergency physician practices, including EMPros, are doing their part in caring for those who are uninsured/underinsured.*

c. How do you educate patients about their rights in terms of your Financial Assistance Policy?

Upon receipt of a bill from Emergency Medicine Professionals, P.A. (EMPros), patients or responsible parties are instructed to discuss the need for any payment arrangements with representatives at our third-party billing company, DuvaSawko. Charitable write-offs are determined on a case-by-case basis, at the discretion of the EMPros corporate management team, overseen by the EMPros Board of Directors.

d. What is the operational process for applying for your Financial Assistance Policy?

And how do you ensure that all patients who may qualify avail them of the

Financial Assistance Policy?

Please see 4(c) above.

5. The WVHA Health Card program is not an actuarially based primary health insurance

product but rather a taxpayer-subsidized, discretionary funding program that offers

"funding of last resort" (i.e., after other funding sources had been exhausted).

a. How should WVHA funding for hospital services relate to potential financial assistance already available to Health Card members in terms of your Financial Assistance Policy?

Funding for emergency care supports the healthcare safety net in Emergency Departments for all taxpayers and citizens of West Volusia including, but not limited to, Health Card members. Medicare rates of reimbursement for professional services does not cover the cost of paying emergency medicine clinicians to provide the care. Reimbursement to EMPros for services rendered at 85% of Medicare rates presents a significant value to WVHA, taxpayers, and Health Card members. Without WVHA discretionary funding for emergency services provided on behalf of Health Card members, these patients will be billed directly as patients who are uninsured are billed, and the process previously described in the response to questions 4(a), 4(b), and 4(c) above is undertaken to make arrangements for payment through our third-party billing company, DuvaSawko.

b. How do you propose that the WVHA Board set the annual budget for hospital care? How should this proposed level of funding relate to other budget categories e.g., Hospitals vs. Specialists vs. Primary Care vs. Pharmacy?

The WVHA Board of Commissioners have a fiduciary responsibility to set the budget, prioritizing "must-have needs" of Health Card members *before* other "nice to have" services. *Emergency medicine clinicians provide essential life-saving care every day.* Further, funding of emergency professional services improves access for the entire West Volusia community benefiting all taxpayers who contribute through their taxes to the funding of the program, as well as the Health Card members treated in the Emergency Department. Professional emergency services funding must be seen as an essential element of the West Volusia healthcare safety net and high priority budget item. Adequate access to primary care services such as through Mi-Care, access to affordable pharmaceuticals, etc. will reduce the need of Health Card members to seek care in the Emergency Department. However, when emergency medicine specialty care is needed, it is critical that this vital care is available for all comers in our community. *Ensuring availability of high-quality emergency medicine services to the citizens of West Volusia requires funding.*

c. If you propose an expansion on budgeted funding, how do you propose this gets funded (e.g., raising taxes, decreasing other funding categories, etc.)?

As noted above, the taxpayers have a reasonable expectation that elected WVHA Board members will act in accordance with their fiduciary responsibility to appropriately prioritize the needs of the indigent and uninsured population in our community. This prioritization for budgetary line items is to be accomplished by the WVHA Board within the existing constructs of the budgetary limitations based on the existing tax monies that are collected to fund the program. *Access to high-quality emergency care is undoubtedly in the top three priorities of both taxpayers and Health Card members with regards to "must have needs" for healthcare in West Volusia.*

6. What other special considerations should the WVHA Board be aware of as they consider the process of Budgeting and Managing for future hospital funding?

Please see the attached white paper from ACEP: The Impact of Unreimbursed Care on the Emergency Physician.

https://www.acep.org/administration/reimbursement/the-impact-of-unreimbursed-care-on-the-emergency-physician/#

As mentioned previously, emergency physicians are on the front lines of America's healthcare safety net, providing over $8 billion annually in uncompensated care to patients. *Since emergency physicians are already providing this level of uncompensated care, it is imperative that patients covered by any type of plan provide reimbursement to physicians at some level to keep this important safety net in place in our communities.*

Process and Deadline:

- The submission deadline is Monday 3/8/2021 at 12 noon ET.
- Please submit proposals, in writing, to the WVHA Program Administrator at elong@westvolusiahospitalauthority.org .
- All submissions will be consolidated by EBMS, for distribution and public discussion during the upcoming Hospital Funding workshop to be held on 3/18/2021 at 4pm ET.

Note: EMPros respectfully requests that our precise responses to this RFP be made available to the WVHA Board of Commissioners, in their entirety, so that they may glean a better understanding of the unique nature of emergency medicine as a specialty. Further, EMPros requests that our precise responses to this RFP be available to members of the public should the WVHA receive any inquiries or requests to share this information.

- Please refer to WVHA's current "Eligibility Guidelines" document for comprehensive details of the current eligibility criteria.
- Please address all appliable questions/items above in paragraph format with relevant supporting material (if needed) attached as an addendum. We anticipate that a comprehensive submission should be no longer than 2 – 3 pages excluding any relevant addendums.

The Impact of Unreimbursed Care on the Emergency Physician

Provision of emergency care to all patients who present to the emergency department regardless of their ability to pay is a longstanding commitment of emergency physicians and is the safety net of the nation's health care system. Emergency care provided to individuals who are uninsured or underinsured has been variously termed charity care, uninsured care, uncompensated care, indigent care, and bad debt. We will attempt to define and characterize these terms further and discuss the financial impact that this subset of patients has on emergency physicians.

Charity care was defined in the 1998 Lewin Group study for CMS (then HCFA) as care provided for free or at reduced fees due to financial need on the part of the patient. Many organizations have a defined policy and approach to characterize the financial management of this subset of patients. These policies generally state that no payment or reduced payment is expected on the part of the patient. The charity-based system has cared for the disadvantaged in the United States for more than 100 years, and the United States provides more charity care than any other industrialized nation in the world.1 Charity care generally is non-reimbursed care when the emergency physician provides it. However, it is not included in the definition of bad debt.

Uncompensated care or bad debt is defined as the provision of services for which payment was expected, but not received. Bad debt is not considered to include the difference between standard charges and reduced fees that have been negotiated with an insurer.2 Uncompensated care may result from patient non-payment of amounts not covered by insurance, uninsured patients expected to pay for services rendered, insurer denial of payment, insurer down-coding of claims, patients compensated directly from insurers but not forwarding this payment to the provider, and individuals who, in fact, have the resources and assets, but refuse to pay for services rendered for a variety of reasons. Some emergency departments deploy financial counseling systems to attempt recovery of a portion of the payment owed by an indigent patient. These debt-counseling interactions generally follow completion of the patient's emergency department care in an effort to avoid any risk of EMTALA noncompliance. All emergency medicine physicians provide service to patients who meet this economic classification.

In 2000, emergency physicians reported that 61% of their bad debt was related to EMTALA mandated care. For 27.7% of emergency physicians, EMTALA was the only source of bad debt. In utilizing the data from the Medical Expenditure Panel Survey from 1996-1998, it was determined that the percentage of total charges paid by Medicaid, Medicare, and the uninsured remained constant, while the mean reimbursement for privately insured patients declined from 77.7% to 65.7%.3 The MEPS data would suggest that the contribution of the commercial insurance companies to bad debt is increasing and that emergency physicians are less able to cost shift to offset the uncompensated care burden.

Indigent care and uninsured care are often inappropriately lumped together as a catchall term for those individuals lacking insurance. Indigent care is a term that defines those individuals without health insurance who live below the federal poverty level that may or may not be employed. Some uninsured individuals are employed and have means well above the federal poverty level. They cannot technically be classified as indigent. People with yearly incomes between 100%-200% of the federal poverty level comprised 48.9% of the uninsured. Current estimates put the number of uninsured at about 43,000,000. According to the U.S.

Census Data for 2001-2002, 74.7 million people under the age of 65 were without health insurance for all or part of that period. About 70.7% of the uninsured were employed at the time.

The fastest growing segment of the uninsured is comprised of middle income working families,1 not those who are unemployed or from families in which the head of household is unemployed, as is assumed by more than one-half of the American public.4 Many working Americans may not be offered health insurance through their employer, owing to the prohibitive cost of health insurance, or these people may be self-employed and choose not to purchase health care insurance for a variety of reasons.

Another significant group of patients who may qualify as being underinsured are those covered by the Medicaid program and other government supported programs such as Children's Health Insurance Programs (CHIPs) for children and families. In many circumstances, the program's institutional (hospital) reimbursement for services is reasonable and may even approximate Medicare payment schedules. However, emergency physician services are commonly under-compensated and frequently reimbursement does not cover the cost of providing services by emergency medicine physicians. In emergency medicine practice, this group of patients does not fall into the category of uncompensated care or bad debt because there is a contractual arrangement to accept the designated fee as payment in full; even though the Medicaid reimbursement rate in many states is well below the cost of providing the services.

Medicaid is a federally mandated program, jointly sponsored by federal and state governments. It is a program that offers health care coverage for select low-income families. Medicaid eligible patients also include people who are aged, blind, or disabled, along with certain people in families with dependent children. It is a common misconception that Medicaid is a program that is designed to cover medical costs for all poor persons. More correctly, Medicaid is the largest source of funding for medical and health-related services for people with limited income.5 Albeit a Federal program, Medicaid is administered by individual states. Each state determines-subject to federal approval-its own eligibility requirements, the range of health services offered, and the payment schedule for institutional and professional services provided. In 2002, 40,147,539 people were enrolled in Medicaid, up from 33,241,147 in 1996. Individual states either negotiate with providers or legislate the compensation for treating Medicaid patients. In New York State, emergency physicians received $17 for Medicaid patients that were cared for in emergency departments in 2003. In 2001, emergency physicians in Michigan received either $68.49 or $166.78 for similar services.7 Although physicians can expect a predictable payment for services rendered, the amount reimbursed in many circumstances and, depending on the state in question, may not cover emergency physician costs for providing service.

All emergency physicians are well acquainted with the provisions of EMTALA, the federal patient "anti-dumping law." It was created to eliminate the practice of hospital and physician refusal to provide emergency care to the medically indigent. Many have interpreted EMTALA as the U.S. government's declaration of universal emergency health care for all, creating a federally enforced right to emergency care for any individual in the United States.7 ACEP supports the unobstructed access to quality emergency care as a fundamental right for every American and all patients presenting to the emergency department. The government has created this safety net for the uninsured and indigent, but has provided no means of fiscal support for hospitals and physicians providing this federally mandated care. EMTALA has forced health care providers to assume the fiscal responsibility for providing care for all under the constant threat of fines, civil liability, and loss of provider participation in the Medicare and Medicaid programs.8 Emergency physicians bear the brunt of the financial impact of providing EMTALA mandated care, while maintaining access to care 24 hours a day seven days a week.

The cost of EMTALA mandated care is substantial for the emergency physician. According to a May 2003

American Medical Association (AMA) study, emergency physicians annually incur, on average, $138,300 of EMTALA-related bad debt. Approximately 95.2% of emergency physicians provide some EMTALA mandated care in a typical week and more than one-third of emergency physicians provide more than 30 hours of EMTALA-related care each week. Physicians in other specialties provide, on average, less than six hours per week of care mandated by EMTALA, and each incurred, on average, more than $25,000 of EMTALA-related bad debt in 2001.

According to the CDC's annual summary of hospital emergency visits--as prepared by the CDC's Center for Health Statistics, Americans made 110.2 million visits to emergency departments in the United States during 2002, a 23% increase over the 90 million visits made in 1992. This total represents 39 visits per 100 people and 61 visits per 100 individuals over 75 years of age. During the same period, the number of emergency departments has decreased by 15 %.9 According to The Centers for Medicare & Medicaid Services, 55% of an emergency physician's time is spent providing uncompensated care.10 Emergency physicians face the difficult challenges of increasing emergency department visits with fewer hospital inpatient beds, subsequent ED crowding, and eroding reimbursement.

Emergency departments across the country are essential to providing continuous 24/7 access for patients to physicians, specialty hospital services, advanced diagnostic technology, and when necessary, transfer of patients to appropriate centers of care for any problem with which a patient may present. ACEP has prioritized its efforts towards working for more reasonable reimbursement approaches that adequately address uncompensated care. Regardless of what practice structure an emergency physician finds him/herself in, the process for careful calculation and consideration of overhead costs, including the rising costs of malpractice insurance, must incorporate uncompensated care from uninsured or underinsured patient populations. In order to secure a healthy safety net and access for all, we must continue to lobby federal and state government for fair and equitable reimbursement to provide high quality emergency care.

Federal legislation to guarantee access to emergency medical care is commendable, but the substantial impact of uncompensated care needs to be considered as well. Realistic considerations and economic evaluation of the costs of providing emergency care is required to properly approach a solution to this problem. Understanding the economics and proposing a properly funded program of basic health care that includes unobstructed access to emergency care for financially challenged patients is a reasonable start.

Cetta MG, Asplin BR, Fields WW, Yeh CS. Emergency Medicine and the debate over the uninsured: a report from the Task Force on Health Care and the Uninsured. Annals of Emergency Medicine. Sep 2000;36:243-246.

Kane C. The Impact of EMTALA on Physician Practices. AMA PCPS Report from 2001. Feb. 2003.

Tsai A. Declining Payments for Emergency Department Care, 1996-1998. Annals of Emergency Medicine. March:2003:41(3)299-308.

Kaiser Family Foundation. National Survey on the Uninsured. The News Hour with Jim Lehrer, Menlo Park, CA: Kaiser Family Foundation; 2000.

http://www.cms.hhs.gov/medicaid/

Irvin AB, et al. Financial Impact on Emergency Physicians for Nonreimbursed Care for the Uninsured. Annals of Emergency Medicine. Oct 2003:42(4)571-576.

Bitterman R. Explaining the EMTALA Paradox. Annals of Emergency Medicine. Nov 2002:40(5)470-475.

Wanerman R. The EMTALA Paradox. Annals of Emergency Medicine. Nov 2002:40(5)464-469.

www.cdc.gov/nchs/pressroom/04facts/emergencydept.htm

Federal Register Vo. 67, No 251 Tuesday December 31, 2002.

HALIFAX HEALTH

March 8, 2021

West Volusia Hospital Authority
C/O Dreggors, Rigsby and Teal, P.A.,
1006 N. Woodland Blvd
Deland, FL 32720

RE: WVHA Provider Response to Request for Proposal

Dear Commissioners of the West Volusia Hospital Authority:

As a long standing community partner Halifax Health Medical Center (HHMC) along with Halifax Health | UF Health Medical Center of Deltona is submitting a response to the WVHA's request for proposal related to the process of Budgeting and Managing future Hospital Funding for the West Volusia Hospital Authority's Health Card program.

HHMC is interested in continuing to explore strategies to support WVHA's purpose of the district "to provide access to health care for indigent residents of the district".

We look forward to continued dialogue and supporting our share mission.

Sincerely,

Steve Mach
Director Patient Financial Services

PO Box 2830
Daytona Beach, FL 32120
T: 386.425.4000

halifaxhealth.org

Request for Proposal (RFP) from interested stakeholders to inform the process of Budgeting and Managing future Hospital Funding for the West Volusia Hospital Authority's Health Card program

1. The WVHA sets an annual budget (October through September of the subsequent year) for various service lines. With respect to the annual budgeted funding for the 2021/22 program year and subsequent program years:
    a. Are you willing to share this annual budgeted funding with other providers? *Halifax Health Medical Center (HHMC) recommends WVHA create a long range plan prioritized based on purpose of the district, "to provide access to health care for indigent residents of the district". HHMC believes traditional healthcare services and behavioral health meet the definition healthcare services.*

    In regards to Halifax budget, information is publicly available at https://www.halifaxhealthdistrict.org/

    b. What guidelines should be put in place to ensure that funding is drawn fairly by all participating providers?

    Halifax Health Medical Center (HHMC) proposes the following three components for consideration:

    - *For non-emergency outpatient services and inpatient services, care should be directed via referral and/or authorization for both hospital and specialty physician services. For inpatient services, retro-authorizations should be approved contingent on medical review from the TPA (as normal course of business with insurance payors).*
    - *It is expected that emergency services be included in the program. Healthcare programs need a full complement of traditional healthcare services, inclusive of emergency medicine. However, with budget constraints it is recommended that emergency services, both professional and facility be capped at a percent of total available spend. The board should monitor this expense and work with MiCare to ensure patients are not over-utilizing the emergency department.*
    - *Halifax recommends WVHA contract at consistent rates, creating a parody. Rates should be similar to Medicaid or HCRA programs. Emergency department may be funded at a lower rate due to utilization.*

    c. Will you continue offering care to all Health Card members once the budgeted annual funding has been exhausted for any budget year?

Halifax proposes the following: If funding is exhausted in a given budget year, hospital or specialist care should be limited to life or limb procedures. This can be mutually agreed during a contractual process. It will be expected that WVHA use reserves as necessary to offset cost and pay for non-life or limb procedures.

d. Are you willing to partner with the WVHA on a multi-year basis (a 3 – 5 year period)?

Yes, however, we request a 90 day termination clause at any time within the contracted period.

2. Detail on what basis you propose offering hospital-based services to Health Card members and at what rate of reimbursement – specify by service lines as indicated below. Please compare the proposed rate with your current rates for Medicaid, Medicare and any other social safety net programs you support.
   a. In-patient Services- Medicaid or 85% of Medicare
   b. Out-patient Services- Medicaid or 85% of Medicare
   c. Professional Services (as is applicable for hospital-employed/contracted providers; hospital-owned specialist practices; any providers on whose behalf you do the billing)- Medicaid or 85% of Medicare; emergency services 95% of Medicaid or 75% of Medicare
   d. Emergency Services- Medicaid or 75% of Medicare
   e. Any other service lines- Medicaid or 85% of Medicare

3. Detail the operational and financial arrangement that exist between yourself and any Provider sub-contractors who provide patient care in the ED setting. Do those arrangements make such Provider subcontractors responsible to comply with the hospital's Financial Assistance Policy under IRS Section 501(r) or are they free to pursue billing and collections in a manner inconsistent with your hospital's Financial Assistance Policy?

For Facility based services, Halifax Health Hospice Care, and employed providers, the hospital is the sole billing and contracting entity- These services follow an established financial assistance policy.

Independent providers on the medical staff, establish their own financial assistance policies and is not determined by the hospital.

PO Box 2830
Daytona Beach, FL 32120
T: 386.425.4000

halifaxhealth.org

4. Describe your charity care and/or Financial Assistance Policy under IRS Section 501(r) with respect to the topics below:

   a. What services qualify? *Services are approved on a case by case basis and may depend on the patient's district of residency. Patients living within the Halifax district may qualify for additional services.*

      Halifax assists patients in qualifying for available programs such as Medicaid or SSI disability. Charity is a payor of last resort and only available for patients willing to comply with application process.

   b. Who qualifies and what are the criteria for qualification? How does this compare with the eligibility criteria for the WVHA Health Card program? Is there some eligibility criteria under your Financial Assistance Policy that will not allow your hospital to make WVHA Health Card members presumptively qualified for a complete write off for emergency services under that Policy?

      - *Application and Policy attached.*
      - *HHMC charity program FPL limits are higher than WVHA charity program (200% or up to 400% of FPL for family of four). HHMC is consistent with AHCA's definition of charity care. HHMC also does not require an ACA ineligibility confirmation; other requirements are similar to WVHA district program.*
      - *In many cases, patients are non-compliant and fail to complete application. Charity programs serve as payor of last resort.*
      - *Hospital's goal is to keep patients out of hospital and into appropriate care setting.*
      - *Halifax will agree to qualify patients based on WVHA's policy. It is expected that qualified applicants receive a WVHA card.*
        - *If hospital amends financial assistance policy to mirror WVHA's, how does WVHA plan to accommodate patients in non-emergent settings? If hospital adopts the WVHA requirements is WVHA willing to migrate these patients to MiCare if they qualify?*

   c. How do you educate patients about their rights in terms of your Financial Assistance Policy? *Halifax provides the following resources: Posted on http://www.halifaxhealth.org, financial counseling office appointments, information included on statements, and patient education at time of service. Halifax would like complete and approve applications for the WVHA.*

d. What is the operational process for applying for your Financial Assistance Policy? And how do you ensure that all patients who may qualify avail them of the Financial Assistance Policy? *See above- patients have 10 days to complete post discharge. With consent, Halifax reserves the right to review for third party programs and charitable review based on policy.*

5. The WVHA Health Card program is not an actuarially based primary health insurance product but rather a taxpayer-subsidized, discretionary funding program that offers "funding of last resort" (i.e. after other funding sources had been exhausted).
   a. How should WVHA funding for hospital services relate to potential financial assistance already available to Health Card members in terms of your Financial Assistance Policy?

      - *Hospital's financial assistance options are also considered "funding of last resort". For non-district patients assistance may only be considered on a very limited basis. Without a program there will be significant care gaps in the community.*
      - *It is recommended the board determine the execution of its mission and prioritize the services included for cardholders. Foregoing mental health and traditional healthcare services will have an adverse impact to the community.*
      - *An experienced healthcare administrative team should be considered to facilitate the board's mission and assist with prioritization of services. Efficient and difficult medical decision making would be best facilitated by parties that understand the complexities of driving quality outcomes at a low cost and assist with determining which critical medical services should be covered.*

   b. How do you propose that the WVHA Board set the annual budget for hospital care? How should this proposed level of funding relate to other budget categories, e.g. Hospitals vs. Specialists vs. Primary Care vs. Pharmacy?

      - *Board should consider capitation arrangements, stop-loss insurance, or an actuarially based program to mitigate budget gaps. If not considered, WVHA should allow flexibility within budget line items and hire an experienced healthcare administrative team to manage the program. Halifax recommends traditional medical services (primary, specialty, and hospital) and, including mental health be a priority when considering healthcare services.*
      - *Has board considered?*

PO Box 2830
Daytona Beach, FL 32120
T: 386.425.4000

halifaxhealth.org

c. If you propose an expansion on budgeted funding, how do you propose this gets funded (e.g. raising taxes, decreasing other funding categories, etc.)?

- *As stated above Halifax believes traditional medical services mental health services serve as the primary responsibility as it relates to healthcare. Overhead and non-direct services are areas should be considered for decrease prior to reducing health services funding.*
- *Shift strategy and provide resources to fund healthcare exchange plans vs overseeing the delivery of healthcare.*
- *Halifax encourages WVHA to explore insurance to support budget overage.*
- *Halifax Health taxing district provides over $60M of uncompensated care and does so by cross-subsidization of paying healthcare services. WVHA should consider expanding MiCare to traditional payors and/or create a marketable product leveraging already created networks.*

6. What other special considerations should the WVHA Board be aware of as they consider the process of Budgeting and Managing for future hospital funding?

Process and Deadline:

- The submission deadline is **Monday 3/8/2021 at 12 noon ET**.
- Please submit proposals, in writing, to the WVHA Program Administrator at elong@westvolusiahospitalauthority.org .
- All submissions will be consolidated by EBMS, for distribution and public discussion during the upcoming Hospital Funding workshop to be held on 3/18/2021 at 4pm ET.
- Please refer to WVHA's current "Eligibility Guidelines" document for comprehensive details of the current eligibility criteria.
- Please address all applicable questions/items above in paragraph format with relevant supporting material (if needed) attached as an addendum. We anticipate that a comprehensive submission should be no longer than 2 – 3 pages excluding any relevant addendums.

HALIFAX HEALTH | UFHealth

MEDICAL CENTER OF DELTONA

Policy Title: Financial Assistance Programs		
Department: Patient Business Financial Services		TJC Chapter(s):
Title of Policy Owner: Director Patient Financial Services		Approved by: General Counsel
Effective Date: 2/04/20	Reviewed Date: 10/15/19	Revised Date: 10/15/19, 10/15/20

I. **PURPOSE**:

Halifax Health|UF Health Medical Center of Deltona is committed to providing financial assistance to uninsured or underinsured individuals, without discrimination, who are in need of emergent or medically necessary services regardless of the patient's ability to pay. The purpose of this policy is to provide a systematic method for identifying and providing financial assistance to the residents.

II. **SCOPE**:

This policy applies to all team members interacting with patients, authorized patient representatives, payers or other sources of financial remediation for outstanding balances. This may encompass the Financial Counseling, Billing, Customer Service, and Collections teams.

III. **DEFINITIONS:**

The following terms are meant to be interpreted as follows within this policy:

Extraordinary Collection Actions (ECAs) – A list of collection activities, as defined by the IRS and Treasury, which healthcare organizations may take against an individual to obtain payment for care only after Reasonable Efforts have been made to determine if the individual is eligible for financial assistance. These actions include reporting adverse information to credit bureaus/reporting agencies along with legal/judicial actions. Please reference the Patient Collections Policy for a more detailed description of how ECAs are employed.

Reasonable Efforts – In general, Reasonable Efforts may include; third-party proprietary data to determine a patient's financial status and/or the request and requirement of patient personal or professional financial information. The request and collection of this information will be for the intent of making determinations of eligibility and presumptive eligibility for full or partial assistance, evaluation for external coverage or assistance program qualification, financial reductions. Halifax Health|UF Health Medical Center of Deltona will make a Reasonable Effort to provide all patients with written and oral notifications about the Financial Assistance Program (FAP) and application process by posting FAP information on our website, providing this information in person, by mail or via email. FAP documents will also be available as hand-outs at Halifax Health|UF Health Medical Center of Deltona.

Financial Assistance Applications (FAA) – Refers to both Financial Assistance Assessment Self Declaration and Financial Assistance Assessment – Patience Assistance forms

Insured – Third party coverage for medical treatment

Underinsured – Third party coverage for medical treatment is insufficient to cover treatment based on income.

IV. POLICY:

This Financial Assistance Program applies to any patient who is not able to pay their financial obligation for medical care. Financial Assistance is provided to individuals when care is deemed medically necessary and after patients have been found to meet financial criteria. Halifax Health|UF Health Medical Center of Deltona offers both free care and discounted care, depending on individuals' family size and income.
Patients who are uninsured, underinsured, ineligible for government assistance programs, or unable to pay based on their individual financial situation may be eligible for charity care or discounted billing.
Halifax Health|UF Health Medical Center of Deltona will make every reasonable effort to assist patients in exploring alternative means of assistance, including Medicare, Medicaid or coverage through the Health Insurance Marketplace.
Patients will be considered for charity care if household family income does not exceed 200% of the current Federal Poverty Guidelines (FPG), unless the amount of the hospital charges exceeds 25% of the gross annual family income and meets HHPA or Catastrophic qualifications as outlined in this policy. However, in no case shall the hospital charges for a patient whose gross family income exceeds four (4) times the Federal Poverty Level for a family of four be considered charity. Patients with a family income between 200% to 400% of the current FPG may qualify for discounted billing or the catastrophic charity program. In order to determine eligibility for free care or discounted care, at minimum, one of the following forms must be submitted:

- W-2 withholding forms
- Paycheck stubs
- Income tax returns
- Forms approving or denying unemployment compensation or worker's compensation
- Written verification of wages from employer
- Written verification from public welfare agencies or any governmental agency which can attest to the patients income status for the past twelve (12) months
- A witness statement signed by patient or responsible party, as provided for in public law 770-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within the 48 hours of the patients' admission to the hospital as required by the Hill- Burton Act. The statement shall include an acknowledgement that, in accordance with Section 817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree (FAA).
- A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

MEASURES TO WIDELY PUBLICIZE THE FINANCIAL POLICY

Financial assistance-related documents include the full policy, plain language summary of the full policy, the application for financial assistance and directions for completion. All financial assistance documents will be available on the hospital facility's website (www.halifaxhealth.org), and from registration in both English and Spanish, upon request and at no charge through paper copies, by mail or electronically to the patient.

1. Financial assistance applications will be made available to anyone who requests them. The hospital will post notices, in English and Spanish, in all registration areas regarding the availability of charity assistance.
2. Patients will be advised of the availability of financial assistance during the registration, scheduling or collection process when they voice concerns over payment.
3. The financial assistance policy and application is available in both English and Spanish on our website (www.halifaxhealth.org).
4. Uninsured patients will receive information on applying for the financial assistance program with their bill and statement.

FINANCIAL ASSISTANCE PROGRAMS AND ELIGIBILITY

1. **Eligibility**
   a. Halifax Health|UF Health Medical Center of Deltona determines the need for financial assistance by reviewing the particular services requested or received, the individual's eligibility for other external programs (such as Medicaid or insurance through the Health Insurance Marketplace), or the individual's historical financial profile and current financial situation. Charity care or discounted billing will be granted based on the individual's ability to pay and the FPG issued and updated annually.
   b. Services eligible for financial assistance include: emergency or urgent care, inpatient, outpatient, elective and physician accounts as long as the services are deemed medically necessary. Financial assistance and discounts only apply to Halifax Health|UF Health Medical Center of Deltona bills. Independent, non-employed physicians may or may not honor financial assistance or discounts. At no time will any patient be denied emergency medical care based on any current or previous ineligibly for financial assistance.
   c. Balances payable by a third party insurance including but not limited to automobile insurance, worker's compensation, or liability insurance are subject to review and may not be eligible for financial assistance. Flat rate services or services due to complications from these services are not eligible for financial assistance. Prescription benefits are limited to the Patient Assistance Formulary. Patients are required to notify Halifax Health|UF Health Medical Center of Deltona Patient Assistance if they have a change in circumstance that may affect their eligibility.

2. **Programs**
   Halifax Health financial assistance programs are the payor of last resort. Uninsured patients who are not eligible for financial assistance under this policy may be eligible for a self-pay discount of 45% off gross charges. Any self-pay or financial assistance discount applied will be reversed if insurance, TPL, a settlement and/or other miscellaneous source is identified.

   The Patient Business & Financial Services Staff shall evaluate the patient's application and recommend one of the following financial assistance programs if the patient meets eligibility requirements. If deemed eligible for financial assistance, the patient's unpaid medical bills for the twelve (12) months prior to application date may be eligible under the program. Any unpaid medical services with dates of service prior to eligibility may be considered on a case by case basis for inclusion in the program.

   Halifax Health Patient Assistance Program (HHPA) – Patients that can demonstrate their family income is at or below 200% of the Federal Poverty Guideline or whose hospital-related expenses exceed 25% of the annual family income may be entitled to a full write off of charges. Upon completion of the required documentation, eligibility is effective for twelve (12) months from date of the application interview.

   Financial or Medical Hardship –If a patient's and/or responsible party's (i.e., parents, spouse) income exceeds 200% of the Federal Poverty Guideline, they may be considered for a Financial or Medical Hardship. Eligibility is determined based on available income and assets, acuity, and projected patient clinical outcomes. Patient must have medical bills that are greater than 25% of their gross annual family income.

   Halifax Health Uninsured Sliding Discount Program – Patients who are able to demonstrate that their family income is between 200% to 400% of the Federal Poverty Guideline may be eligible to receive services at the average rate of payment Halifax Health would receive from Medicare or a percentage thereof depending on the patient's gross income.

   Catastrophic Eligibility – Patients and/or responsible parties who have completed a FAA, may qualify for a catastrophic charity benefit. After services have been rendered, PBFS staff will use a combination of third-party systems and information from the FAA form to determine patient eligibility. The following guideline is used to determine eligibility:
   - Patients demonstrating income is at or below four (4) times the Federal Poverty Level for a family of four and medical bills within a twelve month period or greater than 25% of annual gross income (as reported in FAA documentation) may be eligible for catastrophic coverage up to 100% of charges
   - Halifax Health may supplement or confirm information given by patient using third party

information from other sources such as Transunion, Experian, Property Appraiser website
- If FAA is complete and a medical hardship is determined, catastrophic coverage may be granted if approved by Director, Patient Financial Services or Chief Revenue Officer
- Note, other assets will be considered prior to approval
- Patients with income greater than four (4) times the Federal Poverty Level for a family of four are excluded from catastrophic eligibility

Presumptive Eligibility
Halifax Health|UF Health Medical Center of Deltona may refer to or rely on external sources and/ or other program enrollment resources in the case of patients lacking documentation that supports eligibility or individual circumstance. It may provide free or discounted services when:
- Patient is eligible for state-funded prescription medication program
- Patient is homeless
- Patient does not apply for HHPA Assistance
- Patient participates in Women, Infants and Children programs (WIC)
- Patient is eligible for food stamps or subsidized school lunch program
- Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
- Patient is eligible for other state and local assistance programs that are unfunded
- Patient's valid address is considered low income or subsidized housing
- Patient is deceased with no known estate
- Patient files bankruptcy
- Patient is deemed to have minimal financial resources based on a proprietary third party tool utilized by the facility

3. **Basis for Calculating Discounts**
The patient's estimated annual household income, adjusted for family size, will be used to determine program eligibility. Patients that have qualified for full financial assistance will not be subject to any billing and/or collection actions with no expectation of payment. Patient is approved for partial financial assistance will be subject to billing and/or collection actions related to their determined amount. Expected payments for services covered under this policy will not exceed the Amounts Generally Billed (AGB) which is the average commercial payments for services. This is a sliding scale program so the maximum due would be 55% charges.

4. **Applying for Financial Assistance**
   1. Patients are requested to complete the financial assistance application, as well as submit as much of the requested information as possible. In addition to completing an application, required documentation may include: proof of identity, residency within the Halifax Health taxing district, income, and asset verification.
   2. Patients are requested to return the application and information as soon as possible or within 15 days. Collection activity will be placed on hold while patients are in the financial assistance application process.
   3. Consideration will be given to all applicants. Applications will be reviewed as soon as possible and notification of eligibility will be provided by mail or by email upon patient request.
   4. A patient may appeal a denial by phone, by email, or by letter with an explanation of their financial circumstances and documentation related to their extenuating circumstances.

5. **Applying for Catastrophic Eligibility**
   1. Patients are requested to complete the financial assistance application, as well as submit as much of the requested information as possible.
   2. Patients have completed consent form to allow Halifax Health|UF Health Medical Center of Deltona to submit information to third-party system.
   3. Patients are requested to return the application and information as soon as possible while in- house

or within 15 days upon discussion with PBFS team member.

4. Applications will be reviewed as soon as possible, patient may not be directly notified of approval.

6. **Relationship to Billing and Collection Policies**

Halifax Health|UF Health Medical Center of Deltona will not engage in, nor will it authorize its collection agency to engage in, extraordinary collection actions without verifying that patients have been given the opportunity to apply for HHPA financial assistance. Any external agency or business partner Halifax Health|UF Health Medical Center of Deltona contracts with for the purposes of debt servicing is required to adhere to and comply with the provisions of this FAP.

Halifax Health|UF Health Medical Center of Deltona will send the patient/guarantor monthly bills for any unpaid balances for up to 120 days after treatment. During this 120-day period, Halifax Health Credit & Collections will attempt to contact the patient/guarantor a minimum of three times

via statements, phone calls, and/or e-mails. During this period, the patient is expected to either:

- Apply for financial assistance
- Establish a payment plan for the balance – low/no interest options available
- Pay the outstanding bill in full

After the 120-day period, if the patient/guarantor does not take one of the three actions listed above, then the account will be referred to one of our contracted collection agencies. The patient's credit report may reflect the unpaid bill 60 days after collection agency placement.

The deadline for application of consideration for patient financial assistance is prior to 240 days following the issuance of the first post-discharge statement for the outstanding balance. If within that timeframe the patient is able to provide additional information to support determination of 100% financial assistance qualification, accounts within twelve months (12) of the patient's eligibility and placed with a collection agency will be closed, Halifax Health|UF Health Medical Center of Deltona will adjust the balance and request the agency recall adverse credit reporting action related to the eligible debt(s).
If the patient qualifies for partial (less than 100%) financial assistance, the account balance will be adjusted to reflect this discount, however placed accounts will not be returned from the collection agency and adverse credit action may still be reflected on the patient's credit report.

7. **Other Factors**
   Halifax Health patient assistance staff may request additional information to clarify inconsistencies or to make an accurate determination of income, assets and/or financial need.

REFERENCES

Patient Financial Assistance Plain Language Summary
N-HMC-408 Halifax Managed Healthcare Assistance (HHPA) Checklist
N-HMC-174 Halifax Health Patient Assistance Financial Assistance Assessment
Florida Agency for Health Care Administration - Florida Title XIX Inpatient Hospital Reimbursement Plan
Florida Statute 409.11 – Disproportionate Share Program

HALIFAX HEALTH

HALIFAX HEALTH – PATIENT ASSISTANCE CHECKLIST

REMEMBER YOU MUST HAVE AN APPOINTMENT TO SUBMIT YOUR APPLICATION FOR HALIFAX HEALTH – PATIENT ASSISTANCE (HHPA)

Applicants must return all required paperwork within 10 days of their scheduled appointment.
In most cases, HHPA coverage will go back 60 days and cover most services if received at Halifax Health.

CUSTOMER SERVICE (386) 425-4019 • APPOINTMENT LINE (386) 254-4000 EXT. 3238
303 N. CLYDE MORRIS BOULEVARD, DAYTONA BEACH, FL 32114

Required documentation for HHPA determination includes the following:

IDENTIFICATION

Every applicant must provide:

- Picture ID such as a Florida driver's license or passport, AND
- Social Security Card or Official document that includes name, address and Social Security Number.

If married (even if separated) – Picture ID or current Florida driver's license for applicant and spouse.
If dependent children in household – Social Security card(s).

RESIDENCY

Applicant must have lived within the Halifax Taxing District for a minimum of 3 previous months (90 days) prior to the date of service.

To show proof of residency any of the following can be submitted:

- Three months of consecutive mail, preferably different sources. Mail from Halifax Health will not be accepted.
- Drivers license with current address (issue date more than 3 months prior)
- Document showing residency for last 3 months
- Lease for last 3 months
- INS Papers from Immigration with current address
- Bank statements for last 3 months
- Utility bill for last 3 months – electric, water, phone, gas or other city or county utilities or other contracted service (pest control, cable service). Must have applicant's name and service address (not P.O. Box).
- Documentation of enrollment/participation in Volusia County Homeless Coalition.

HOUSEHOLD INCOME

The following is considered as Household Income and if applicable you must provide:

- Three months of bank statements and a current paycheck (within the last 30 days)
- A combination of tax return along with confirmation of filing of the Federal Tax Return, copy of W-2, declaration of support. If supported or claimed on another tax return, same data needed.

And, if applicable:

- Wages and salaries before deductions
- Self-employment income
- Social security benefits
- Pension and retirement benefits
- Unemployment compensation
- Strike benefits from union funds
- Worker's compensation
- Veteran's payments
- Public assistance payments
- Training stipends

HMC 408

(continued on page 2)

HALIFAX HEALTH

HALIFAX HALIFAX – PATIENT ASSISTANCE CHECKLIST

(CONTINUED)

HOUSEHOLD INCOME *(continued)*

- Alimony
- Child support
- Military family allotments
- Income from dividends, interest, rents, royalties
- Income or annuity payments
- Income from estates, trusts, and inheritance proceeds
- Income from student aid not subject to repayment
- Personal Injury or Worker's Compensation settlements
- Gifts (include donations from churches, other organizations and family members)

Please note: All sources of value including free rent and barter goods will be used to determine the income.

IF SELF EMPLOYED

- Bank statements of business accounts
- Self-employment income (Defined as the amount of Gross Income reported on Income Tax Return Schedule C)
- Schedule C of last income tax return

VA/VET

- DD 214 paperwork
- Letter showing that you have applied and been denied for medical VA benefits

IF EMPLOYED

- Letter from employer if insurance is offered, details of coverage

FULL TIME STUDENT

- Letter from college stating if medical insurance is offered, details of coverage
- Documentation showing classes currently enrolled in

DEPENDENT CHILDREN IN HOUSEHOLD

- Must have applied for Medicaid and be able to provide letter from DCF showing Medicaid determination

AUTO RELATED

- Need letter from attorney with status of case

Halifax Health Patient Assistance does not cover:

- Specialty services are not covered including ambulance transportation, cosmetic, bariatric, dental care, pain management, specialist office visits, vision care, home health care, chiropractic care, mental health care and hospice. Flat rate services, or services due to complications from these services, are not eligible for financial assistance.
- Halifax Anesthesiology Associates will write-off two-thirds of surgery charges. The adjusted amount after the HHPA write-off is the patient's responsibility. A payment plan can be set up with their office by calling (386) 255-1266.
- HHPA does not cover radiology or pathology bills.
- Obstetric services are usually covered under the Medicaid or our Obstetric Flat Rate Program and therefore do not generally qualify for financial assistance.
- Prescription benefits are limited to the Halifax Health Patient Assistance Formulary.

Services must be received at Halifax Health.
Abusive or disruptive behavior could result in termination from program.

HMC 408

HALIFAX HEALTH MEDICAL CENTER OF DAYTONA: 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
HALIFAX HEALTH MEDICAL CENTER OF PORT ORANGE: 1041 Dunlawton Ave., Port Orange, FL 32127
HALIFAX HEALTH | UF HEALTH MEDICAL CENTER OF DELTONA:
3300 Halifax Crossings Blvd., Deltona, FL 32725
TWIN LAKES SURGERY CENTER: 1890 LPGA Blvd., Daytona Beach, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

DALVANCE FINANCIAL DISCLOSURE FORM

Patient Name: _____

Visit Number: _____

Residence Address: _____

_____

Telephone: _____ Date of Birth: _____

Gross Income for the Past 12 months: _____ Household Size: _____

Insurance Coverage: None

PLEASE READ THE FOLLOWING:

1. I understand that providing false information to defraud a hospital to obtain goods or services is a second degree misdemeanor and punishable under the Florida Statute 817.50. Violators will be prosecuted.
2. I certify that the above information is true and correct to the best of my knowledge.
3. I will apply for any and all assistance which maybe available fore payment of my bill and will take any action reasonably necessary to obtain such assistance. Further, I will assign or pay to Halifax Health (HH), all amounts received towards my financial indebtedness until liquidated. I hereby grant permission and authorize such agencies (HRS, Social Security Administration, Etc.) to disclose the status of my application, approval, or reason for disapproval of such application.
4. I understand that information submitted is subjected to verification by HH, Federal and/or State agencies and others as required.
5. If I am deemed not eligible for assistance, I will pay for services rendered. I understand that payment arrangements can be reevaluated by HH at their request.
6. I certify the above address to be a true and accurate declaration of domicile/residence.
7. I certify that I have not been declared a dependent of my parents by virtue of Court Order and that my parents do not claim me as a dependent on their tax return. I understand that if I have been declared a dependent and that if my parents have claimed me as a tax deduction I must include my parents income in this assistance request.

HALIFAX HEALTH CHARITY GUIDELINES FY 2020

Family Members	Federal Poverty Level (FPL) Income	Charity 200% FPL 75% Write Off
1	$12,760	$25,520
2	$17,240	$34,480
3	$21,720	$43,440
4	$26,200	$52,400
5	$30,680	$61,360
6	$35,160	$70,320
7	$39,640	$79,280
8	$44,120	$88,240

SOURCE: Document Citation: 85FR **3060** Page: **3060–3061** Document Number: **2020–00858** Publication Date: **January 14 , 2020**

8. Authorization is determined by calculation of: 200% of the current Federal Poverty Guidelines.

Applicant Signature: X _____ Date: _____

Witness: _____ Date: _____

❑ Approved ❑ Not Approved

_____
(Resource Management / Financial Counselor)

LGL INS FORM

HALIFAX HEALTH MEDICAL CENTER OF DAYTONA: 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
HALIFAX HEALTH MEDICAL CENTER OF PORT ORANGE: 1041 Dunlawton Ave., Port Orange, FL 32127
HALIFAX HEALTH | UF HEALTH MEDICAL CENTER OF DELTONA:
3300 Halifax Crossings Blvd., Deltona, FL 32725
TWIN LAKES SURGERY CENTER: 1890 LPGA Blvd., Daytona Beach, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

PATIENT AUTHORIZATION FORM FOR MEDICATION ASSISTANCE PROGRAM

The Halifax Health Pharmacy Department is able to obtain reimbursement for some of your medications from the companies that manufacture them. Most of these programs require that you sign an authorization form. So that you do not have to sign this form for each medication, we are requesting that you sign this form once per calendar year.

This authorization appoints Brooke McMahon, MedSource Manager, a representative with Halifax Health Pharmacy Department, my representative for the sole and exclusive purpose of completing and signing in my name, the application forms required by the pharmaceutical manufacturers for Halifax Health to obtain reimbursement of my medications from the pharmaceutical manufacturers.

I understand that I may revoke this authorization at any time by sending a written request to the following address:

Halifax Health
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114

I understand that the revocation will not apply to information that has already been released in response to this authorization. I am aware that this authorization form is valid for one year from the date that I signed it, or a lesser time period as indicated here_____.

I understand that once the information has been released pursuant to this authorization, Halifax Health cannot prevent the re-disclosure of the information to another third party.

I understand that Halifax Health will not condition treatment on my signing this authorization.

This authorization shall be in full force from the date signed below.

Patient's Signature:_____ Date:_____

Personal Representative's Signature:_____ Date:_____

Witness' Signature: _____ Date:_____

LGL INS FORM

THIS FORM IS TO BE PLACED IN THE PATIENT'S MEDICAL RECORD AND A COPY PROVIDED TO THE PATIENT.

HALIFAX HEALTH – PATIENT ASSISTANCE
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
(386) 425-4019

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL ASSISTANCE ASSESSMENT

General Assessment

Date:_____

1. Do you have any dependent children living in the household? ☐ No ☐ Yes – _____
2. Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single
3. Do you have insurance? ☐ No ☐ Yes – _____
4. Were you ever a member of the US Military? ☐ No ☐ Yes – Did you apply for VA benefits? _____
5. Do you have any pending lawsuits? ☐ No ☐ Yes – _____

   Have you received any settlements? ☐ No ☐ Yes – _____
6. Do you have any stocks, bonds, pensions (401K or 403B), IRAs, CDs, inheritance or trust funds?

   ☐ No ☐ Yes – _____
7. Do you have a checking/savings account? ☐ No ☐ Yes – _____
8. Do you own any property? ☐ No ☐ Yes – _____
9. Are you self-employed? ☐ No ☐ Yes – _____
10. Is your injury due to being a victim of a crime or auto accident? ☐ No ☐ Yes – _____
11. Have you applied for Medicaid? ☐ No ☐ Yes – _____
12. Have you applied for Social Security Disability? ☐ No ☐ Yes – _____
13. Are you eligible for Cobra or insurance benefits from a current employer? ☐ No ☐ Yes – _____
14. Are you a natural born citizen? ☐ No ☐ Yes – Where were you born? _____
15. Have you sold or given away property or assets within the last 5 years? ☐ No ☐ Yes – _____
16. Current Medications – _____

    _____
17. Last Physician seen and when – _____
18. Are you fleeing the law due to a felony/probation/parole violation? ☐ No ☐ Yes – _____

Other Comments: _____

_____

_____

Patient Signature: _____ Date: _____

HMC 174

HALIFAX HEALTH – PATIENT ASSISTANCE
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
(386) 425-4019

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL ASSISTANCE ASSESSMENT

Financial Assessment

Address:_____ Phone: (_____)_____
Employer:_____ Phone: (_____)_____
Self Employed (Check one): ☐ No ☐ Yes – _____
Nearest Relative:_____ Phone: (_____)_____
Total in Household:_____ Total Dependents:_____
Gross Annual Income: $_____ Social Security #:_____
Bank Name:_____ Checking Acct. Balance: $_____ Savings Acct. Balance: $_____
Bank Name:_____ Checking Acct. Balance: $_____ Savings Acct. Balance: $_____
Family Automobile(s):
Make:_____ Model:_____ Year:_____
Make:_____ Model:_____ Year:_____

Monthly Expenses:

Rent / Mortgage: (specify which)	$_____	Amount of Mortgage:	$_____
Automobile: (if leased or financed)	$_____	Amount Financed:	$_____
Utilities:	$_____		
Loans:	$_____	Amount of Loan:	$_____
Credit Cards:	$_____		
Insurance: (car / home)	$_____		
Child Support / Alimony:	$_____		
Child Care:	$_____		
Food:	$_____		
Clothing:	$_____		
Transportation:	$_____		
Other:	$_____		
Total Monthly Expenses:	$_____		

THE INFORMATION CONTAINED IN THIS FINANCIAL ASSESSMENT IS SUBJECT TO VERIFICATION

I, the undersigned, do hereby swear and certify that the information contained herein is true and correct. Halifax Health may use my personal information, including my Social Security Number, to verify the accuracy of the information you provide, insurance and payment purposes, to help identify and prevent fraud or other criminal activity, to match, verify, or retrieve existing information, to help prevent medical errors, or for research activities. I hereby grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, or credit grantor of any kind to disclose to any authorized agent of Halifax Health, information of my past and present accounts and policies. I understand that providing false information to defraud Halifax Health for the purpose of obtaining goods or services is a misdemeanor in the second degree in accordance with s.817.50, Florida Statutes. I authorize this information be made available to all providers who participate in the Halifax Assistance program, should I be accepted. I agree to reimburse Halifax Health for the care and treatment in the event I recover any money for the injuries giving rise to the treatment. Any reimbursement shall be made at the rate found on the Halifax Health Charge Master at the time of service.

Patient Signature:_____ Date:_____

HMC 174

HALIFAX HEALTH – PATIENT ASSISTANCE
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
(386) 425-4019

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL ASSISTANCE ASSESSMENT

Verification Assessment (if applicable)

SELF-DECLARATION OF INCOME:

This is to certify that I, _____ (print Patient's name) at current address

_____ declare the following statements.

I made $_____ from the period of _____ to _____ as a

☐ Self-employed person, ☐ Doing odd jobs, or ☐ Jobs paid in cash/no paystubs given.

VERIFICATION OF SUPPORT:

_____ (print Patient's name), is presently residing at_____

_____ (print Address). I,_____

(print Party providing support name), am providing food and living expenses to Patient with an estimated monthly cost totaling

$_____,

Social Security Number of Party Providing Support: _____

I ☐ did ☐ did not declare _____ **as a dependent on my last tax return.**

Failure to provide complete and accurate information may result in the denial of benefits for the Patient.

Other Comments: _____

_____

_____

THE INFORMATION CONTAINED IN THIS FINANCIAL ASSESSMENT IS SUBJECT TO VERIFICATION

I, the undersigned, do hereby swear and certify that the information contained herein is true and correct. Halifax Health may use my personal information, including my Social Security Number, to verify the accuracy of the information you provide, insurance and payment purposes, to help identify and prevent fraud or other criminal activity, to match, verify, or retrieve existing information, to help prevent medical errors, or for research activities. I hereby grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, or credit grantor of any kind to disclose to any authorized agent of Halifax Health, information of my past and present accounts and policies. I understand that providing false information to defraud Halifax Health for the purpose of obtaining goods or services is a misdemeanor in the second degree in accordance with s.817.50, Florida Statutes. I authorize this information be made available to all providers who participate in the Halifax Assistance program, should I be accepted.

Signature of Party Providing Support:_____ Date:_____

Patient Signature:_____ Date:_____

HMC 174

HALIFAX HEALTH MEDICAL CENTER OF DAYTONA: 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
HALIFAX HEALTH MEDICAL CENTER OF PORT ORANGE: 1041 Dunlawton Ave., Port Orange, FL 32127
HALIFAX HEALTH | UF HEALTH MEDICAL CENTER OF DELTONA:
3300 Halifax Crossings Blvd., Deltona, FL 32738
TWIN LAKES SURGERY CENTER: 1890 LPGA Blvd., Daytona Beach, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL STATEMENT

PATIENT NAME: _____ D.O.B.: _____ SS #: _____

ADDRESS: _____ PHONE:(_____) _____

EMPLOYER: _____ PHONE:(_____) _____

SELF EMPLOYED (check one): ☐ YES ☐ NO

GROSS ANNUAL BUSINESS INCOME (if self employed): $ _____

NET ANNUAL BUSINESS INCOME: $ _____

NEAREST RELATIVE: _____ PHONE:(_____) _____

TOTAL IN HOUSEHOLD: _____ TOTAL DEPENDENTS: _____

GROSS ANNUAL PERSONAL INCOME
(Please include a copy of your most recent W2 tax form for all employment): $ _____

*CURRENT GROSS MONTHLY INCOME (Please include a copy of your most recent pay stub): $ _____

TOTAL NET MONTHLY INCOME: $ _____

BANK NAME: _____

CHECKING ACCOUNT BALANCE: $ _____ SAVINGS ACCOUNT BALANCE: $ _____

*** * A complete bank statement of all checking, savings, and/or inrvestment account(s) with transaction detail(s) MUST be provided with this Financial Statement in order to be considered for review.**

OTHER ASSETS / INCOME: $ _____ (Income type: weekly, monthly, quarterly, bi-annual, annual)
(e.g. stocks, bonds, 401K, rental income/properties, etc.)

PLEASE LIST THE TYPE OF OTHER ASSETS / INCOME: _____

_____

COMMENTS: _____

_____

ON THE FOLLOWING PAGE PLEASE LIST YOUR MONTHLY PAYMENT(S) AND BALANCE(S) DUE FOR THE EXPENSES LISTED:

HALIFAX HEALTH MEDICAL CENTER OF DAYTONA: 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
HALIFAX HEALTH MEDICAL CENTER OF PORT ORANGE: 1041 Dunlawton Ave., Port Orange, FL 32127
HALIFAX HEALTH | UF HEALTH MEDICAL CENTER OF DELTONA:
3300 Halifax Crossings Blvd., Deltona, FL 32738
TWIN LAKES SURGERY CENTER: 1890 LPGA Blvd., Daytona Beach, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

FINANCIAL STATEMENT

(continued)

MONTHLY EXPENSES:	PAYMENT:	BALANCE DUE:
RENT / MORTGAGE: (circle one)	$ _____	$ _____
AUTOMOBILE: (if leased or financed)	$ _____	$ _____
UTILITIES:	$ _____	$ _____
LOANS:	$ _____	$ _____
CREDIT CARDS:	$ _____	$ _____
INSURANCE: (car / home)	$ _____	$ _____
CHILD SUPPORT / ALIMONY:	$ _____	$ _____
CHILD CARE:	$ _____	$ _____
FOOD:	$ _____	$ _____
CLOTHING:	$ _____	$ _____
TRANSPORTATION:	$ _____	$ _____
OTHER MEDICAL:	$ _____	$ _____
OTHER:	$ _____	$ _____
TOTAL MONTHLY EXPENSES:	$ _____	$ _____

*** * Please provide copies of all statements, bills, and/or proof of payment for the debts listed above (e.g. cancelled checks, money orders, banking statements, current account statements reflecting payments and balances outstanding, utility bills, etc.) Failure to return all supporting documentation will exclude this document from being reviewed.**

STATEMENT AND FINAL CLEARANCE

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct. I hereby swear that I am unable to pay the entire amount of my medical bills in one payment, and am requesting monthly installment payments be made until the account is paid in full. Therefore, I grant permission and authorize any bank, building association, insurance company, real estate company, financial institution, and credit grantors of any kind or character to disclose to any authorized agent of Halifax Health of Daytona Beach, Florida, information as to my past and present bank accounts, insurance policies, property, credit experience, credit application and all pertinent information related thereto. I authorize this information to be made available to all providers who participate in the Halifax Health program, should I be accepted. I understand that providing false information to defraud a hospital to obtain goods or services is a second degree misdemeanor and punishable under the FL Statute 817.50. VIOLATORS WILL BE PROSECUTED.

_____ DATE	_____ DATE
_____ PRINT NAME	_____ WITNESS – PRINT NAME
_____ SIGNATURE	_____ WITNESS – SIGNATURE