Current Status: *Active*

PolicyStat ID: *4580832*

Origination:	*4/3/2017*
Last Approved:	*3/2/2018*
Last Revised:	*3/2/2018*
Next Review:	*3/2/2019*
Owner:	*Lorrie Haden: Director of Patient Financial Services*
Department:	*Administration*
Category:	*Patient Financial Services*
Applicability:	*Lake Regional Hospital*

Financial Assistance

POLICY

To identify patients that qualify for Financial Assistance for services provided at Lake Regional Health System (LRHS). LRHS is committed to providing quality health care to all patients. As a charitable non-profit institution exempt from taxation under Section 501(c)(3) of the Internal Revenue code, LRHS cares for the medically indigent by waiving fees for service based upon the patient's ability to pay.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility is based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date. The need for financial assistance can be re-evaluated at the following times:

- Income change
- Family size change
- When an account that is closed is to be reopened
- When the financial evaluation was completed more than six months before

To be considered for financial assistance, the patient must provide information and documentation necessary to apply or for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients who otherwise qualify for subsidized insurance under the Affordable Care Act, Mo. Medicaid or any other insurance, but choose to forgo it, will not be considered financial assistance provided by LRHS. Patients are responsible for completing an application form and providing necessary information, in order to determine eligibility. Signage will be visible at all points of registration in order to create awareness of the financial assistance program. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the emergency room, the admission/patient registration areas and all clinic facilities. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for LRHS service in accordance with the state's Language Assistance Services Act. This policy will be made available in Spanish. The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

PURPOSE

To identify circumstances where LRHS may provide care at a discount or without charge for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies to services provided by Lake Regional Health System and Lake Regional Medical Group. This policy does not apply to independent physicians such as Lake Regional Imaging Partners, or independent physician groups billing for Anesthesia, Radiology interpretations or emergency services from other physician groups. A list of these groups is available upon request. The provisions of free and discounted care through the LRHS financial assistance program are consistent, appropriate, and essential to the execution of our Mission Statement, and are consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the LRHS resources are used on those patients who are most in need and least able to pay, rather than those who choose not to pay. Financial assistance will not be made available for elective or cosmetic services. Specifically, Wellness visits, Phase Three Cardiac Rehab services, and Aquatic services will not be eligible for financial assistance. The patient's physician will have the final decision on the medical necessity of the service in question and its coverage under the LRHS Financial Assistance policy.

Financial assessments and the review of patient's financial information are intended for the purpose of assessing need as well as gaining a holistic view of the patient's circumstances. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, assets (identified as those convertible to cash and not necessary for the patient's daily living expense) and family/household income.

- Communicating to patients so they can more fully and freely participate in providing the necessary information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoid seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

SPECIAL INSTRUCTIONS

I. Definitions

   A. **Assets:** LRHS will not utilize exempt assets in the determination of financial assistance.

   B. **Bad Debt Expense:** Uncollectible accounts that were expected to result in cash inflows (i.e., the patient did not meet the Financial Assistance eligibility criteria for LRHS).They are defined as the provision for actual or expected uncollectable resulting from the extension of credit.

   C. **Catastrophic:** Incurred medical expenses that result in patient responsibility exceeding 25% of the gross family income.

   D. **Exempt Income:** Retirement Benefits listed in Missouri Exemption Statues, Public Assistance, Railroad Retirement benefits, and Black Lung benefits.

   E. **Exempt Assets:** Life Insurance Benefits, Household Goods & Furnishings, Clothing, Appliances, Books, etc., Jewelry, Tools of Trade, One Motor Vehicle, Mobile Home, Life

Insurance, Health Aids, Other exempt property as outlined by Missouri Revised Statues 513.430 – 513.440.

F. **Financial Assistance:** Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

G. **Financial Assistance Authorizers:** Persons consisting of staff and leadership that review financial assistance applications. This includes applications that warrant special consideration. Authorized persons have the authority to approve/reject any application for financial assistance. All decisions, whether approved or rejected, must be documented formally.

   a. LRHS Financial Assistance Authorizers consist of the Chief Financial Officer, Director of Revenue Cycle, Director of Resource Management, Patient Financial Services Collection Manager or a mix of these individuals.

H. **Disposable Income:** Annual family income after paying required taxes divided by 12 months, less monthly expenses as requested on the application.

I. **Family:** The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

J. **Family Income:** Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, and trusts. In order to provide consideration for any patient with: veteran stipends, high monthly pharmacy costs (exceeding $500), disability income (exceeding $15,000 annually) or Chapter 13 bankruptcy, patients falling into any of the categories above will be able to appeal their Financial Assistance for adjustments to the Family Income.

K. **Documentation:** Income should be included for all patients applying for financial assistance. All forms of income verification should be pursued to satisfy that the income represented is accurate. If documentation is limited, then the following forms may be acceptable,

   a. Prior year Federal tax return

   b. Current Pay Stubs

   c. Letter of Support/Recommendation

   d. Any of the above documentation will be sufficient

   e. Documentation of household expenses may be required if not easily determined.

Bank statements will be requested for review of assets. However, when considering services provided in the primary care clinics (RHC's) only paycheck stubs and tax returns will be used as proof of income and not bank statements.

L. **Qualified Patient :**

   a. Financially Needy: A person who is uninsured or under insured

   b. Catastrophically Needy: A person who does not qualify as financially needy, but whose

patient responsibility after payment by third-party payers, exceed 25% of their gross annual income will be recognized as having a catastrophic medical expense.

II. Financial Assistance Guidelines and Eligibility Criteria

A. To be eligible for a 100 percent reduction from charges (i.e., full write- off) the patient's household income must be at or below 200 percent of the current Federal Poverty Guidelines. Incomes between 200and 400% of the Federal Poverty Guidelines (FPG), will be eligible for a Financial Assistance adjustment based on income and family size. Incomes above 400% of the FPG, will receive a 35% self-pay discount, based on the hospital's Amount Generally Billed (AGB).

B. Financial Assistance will be considered on catastrophically needy patients on a case-by-case basis. Out of pocket responsibilities will be capped at 25% of the patient's gross annual income. Eligibility for financial assistance due to a catastrophic situation is available in accordance with all other criteria contained in the LRHS Financial Assistance policy.

C. Financial assistance applications will be considered as long as an account is open (even if in bad debt collection process) or when a change in financial status is determined. A financial assistance application will not need to be repeated for dates of service incurred up to six (6) months after and (12) months prior the date of application approval.
After the financial assistance adjustment has been computed the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of the LRHS Self-Pay Payment Schedule Policy.

D. If the patient is unable to meet the guidelines of the application a recommended acceptance of payments can be made to reduce the account balance. This also applies to payments made through a collection agency.

E. Once financial assistance is approved, a letter will go out to the patient confirming the terms of the financial assistance acceptance. Any account during this twelve (12) month period that was classified as bad debt will be written off as financial assistance.

III. Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance discounts, but the financial assistance form on file fails due to a lack of supporting documentation. Once the determination can be made and can be proven due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

A. Homeless or receiving care from a homeless clinic

B. Participation in Women's Infants, and Children's programs (WIC)

C. Food stamp eligibility

D. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)

E. Low income/subsidized housing (Section 8) is provided as a valid address

F. Patient is deceased with no known estate

G. Incarcerated prisoners not expected to be released soon

H. Mentally incapacitated

LRHS may use outside agencies or vendors to determine eligibility for financial assistance. Documentation from the outside agency or vendor will serve as the supporting documentation for financial assistance.

PROCEDURE

I. **Identification of Potentially Eligible Patients**

A. Where possible, prior to the admission or pre-registration of the patient, LRHS will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre- admission/pre-registration interview is not possible, this interview should be conducted upon admission or registration or as soon as possible thereafter. In the case of an emergency admission, the evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial patient interview, the following information should be gathered:

a. Demographic data review.

b. Complete information regarding any third party coverage.

B. Identification of a potentially eligible patient can take place at any time during the rendering of services or during the collection process (including bad debt).

C. Patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

D. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved.

II. **Determination of Eligibility**

A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the hospital, or in the case of outpatients or emergency patients, a financial assistance application will be mailed to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information.

B. Requests for financial assistance may be received from:

a. The patient or guarantor.

b. Church sponsored programs.

c. Physicians or other caregivers.

d. Various intake departments of the hospital or clinics.

e. Administration and/or other approved programs that provide primary care of the indigent patient.

C. The patient should receive and complete a written application and provide all supporting data required to verify eligibility.

a. In the evaluation of an application for financial assistance, a patient's family income and medical expenses will be the determining factor for eligibility. If a patient qualifies as

medically needy, then the application should be referred to the Financial Assistance office for review and determination.

b. The Credit/Collection Manager should approve financial assistance for amounts up to $5,000. Amounts greater than $5,000 but lower than $10,000 should be approved by the Director of PFS, amounts $10,000 and greater but lower than $25,000 should be approved by the Director of Revenue Cycle, amounts $25,000 and greater but lower than $100,000 should be approved by the CFO, and amounts $100,000 and greater should be approved by the CEO.

D. After appropriate approvals are complete a record, paper or electronic, should be maintained reflecting authorization of financial assistance. These documents shall be kept for a period of six (6) years.

III. **Notification of Eligibility Determination**

A. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides reasons(s) for denial (if appropriate) will be provided, generally within 30 days of the determination. Patients will be notified in the denial letter they may appeal this decision and will be provided contact information to do so.

B. If a patient disagrees with the decision, the patient may request an appeal process in writing within 30 days of the date of denial. The application will be reviewed and a decision reached will then be communicated to the patient within 30 days of the date of the appeal request.

C. Collection activity will be suspended during the consideration of a completed application for any other healthcare bracket (i.e. Medicare, Medicaid, etc.) a note will be entered into the patient's account. If the account has been placed with a collection agency, the agency will return the account to us for write off and this notification will be documented in the patients account.

All revision dates:	5/1/2016, 6/9/2015, 5/13/2014, 7/12/2013, 5/8/2012, 4/26/2011, 4/20/2010, 4/13/2009, 4/15/2008, 4/1/2008, 4/17/2007, 5/2/2006, 5/2/2005, 3/1/2005, 5/14/2001, 4/10/2000

All revision dates:	3/2/2018, 6/5/2017, 4/3/2017, 12/2/2016
Attachments:	FY18 Financial Assistance Guidelines

Approval Signatures

Step Description	Approver	Date
Board of Directors	Dane Henry: Chief Executive Officer	5/3/2018
Board of Directors	Kathy Hoemeyer: Administrative Executive Assistant	5/1/2018
	Tom Williams: Vice President of Employee and Community Developme	4/25/2018
	Dane Henry: Chief Executive Officer	4/24/2018
	Melissa Hunter: Senior Vice President - Clinical Services	4/9/2018
	David Halsell: Chief Financial Officer	4/9/2018

Step Description	Approver	Date
	Kevin McRoberts: Senior Vice President of Operations	4/5/2018
	Patrick O'Neil: VP of Medical Staff Affairs	4/4/2018
	Michael Burcham: Vice President of Physician Practices	4/4/2018
	Scott Poest: Chief Information Officer	4/4/2018
	Fred Goecker: Director of Revenue Cycle	4/3/2018
	Lorrie Haden: Director of Patient Financial Services	4/2/2018