Banner Health

Policy and Procedure
Policy #: A1568
Status: Active
Version #: 2
Effective Date: 6/18/2005
Revised Date:
Scope: Banner Health
Population: All Employees

Title: *Financial Assistance Program for Uninsured Patients*

I. Purpose:

A. Banner Health (BH) is dedicated to providing quality healthcare to all patients regardless of age, sex, race, religion, disability, veteran status, national origin and/or ability to pay. BH makes every effort to complete a financial evaluation at the earliest possible point in the registration/accounting process for all patients indicating an inability to meet their financial obligation and will provide a Financial Assistance Program application once all other options for reimbursement have been exhausted. BH's Financial Assistance Program is intended to address the dual interests of providing access to care to those without the ability to pay (economic indigence) and to offer a discount from billed charges for those who are able to pay a portion of the costs of their care (medical indigence). BH reserves the right to maintain different discount percentages by region, reflecting the differences in charge levels, state assistance programs, and the specific dynamics of each marketplace.

B. This policy establishes two Financial Assistance programs, the **Basic Financial Assistance Program** and the **Enhanced Assistance Program**. Under the Basic Financial Assistance Program, uninsured persons having annual household incomes of $125,000 or less may, depending upon their assets and liabilities, qualify for Financial Assistance in the form of discounted pricing without having to apply for Medicaid assistance. Under the Enhanced Financial Assistance Program, uninsured persons having household incomes at or below 500% of the Federal Poverty Line and insufficient assets may, depending upon their assets, qualify for Financial Assistance in the form of substantial discounts or free care, subject to application for Medicaid assistance.

II. Policy:

A. Definitions.

1. Medicaid: The use of the term "Medicaid" throughout this document will refer to all State and Federal Programs which include (but is not limited to) Medicaid, Medi-Cal, AHCCCS, CICP, FES, etc.

2. Covered Services: Those inpatient and outpatient services provided by a BH hospital which are Medically Necessary in accordance with the standards of BH's Medicare fiscal intermediary.

3. Medically Necessary: Services required to identify or treat an illness or injury that is either diagnosed or reasonably suspected to be Medically Necessary. The most appropriate level of care, depending on a patient's medical condition, may be a home, a physician's office, an outpatient facility, or a long-term care, rehabilitation or hospital bed. A service must:
   a. Be required to treat an illness or injury or
   b. Be consistent with the diagnosis and treatment of the Patient's conditions; and
   c. Be in accordance with the standards of good medical practice; and
   d. Be not be for the convenience of the Patient or the Patient's physician; and
   e. Be performed at the most appropriate and readily available level of care or manner required by the
   f. Patient's medical condition; or
   g. Be that level of care most appropriate for the Patient as determined by the Patient's medical condition and not the Patient's financial or family situation.

4. Uninsured Patient: A patient without benefit of health insurance or government programs that may be billed for the care provided and who is not excluded from this policy under Section II. B below.

5. Usual and Customary Charges: The rates for Covered Services that are filed annually with the Arizona Department of Health Services or other applicable state agency. If rates are not required to be filed annually with any state agency by the relevant Banner facility, then the Usual and Customary Charges will be the rates for Covered Services as set forth in the chargemaster for that Banner facility at the time the services are rendered.

B. Exclusions. This policy applies solely to patients who have no third party coverage either for the Covered Services BH provides to them, through governmental sources or commercial insurance, or for physician services. It does not apply to the portion of charges an insured patient is personally responsible for, i.e., co-pays, co-insurance, and deductibles, and does not apply to non-Covered Services. This policy is not available to persons who have basic health insurance that excludes hospital inpatient or outpatient services, nor is it available to persons who have any contractual claim or right for reimbursement or indemnification from an insurer or other third party payor. Furthermore, this policy does not apply to charges for services from other providers whose services are coincident to those provided by BH, e.g., surgeons, anesthesiologists. The policy also does not apply to elective procedures except as may be determined in the sole discretion of Banner on a case-by-case basis. This policy applies to all facilities owned or leased by Banner; provided, however, that Fairbanks Memorial Hospital may opt out of this policy if a different policy for financial assistance for uninsured patients is adopted by the Greater Fairbanks Community Hospital Foundation and such policy is approved by Banner as being consistent with Banner's tax exempt status.

C. Reservation of Right to Seek Reimbursement of Charges from Third Parties. In the event that any first or third party payor is liable for any portion of an uninsured patient's bill, Banner will seek full reimbursement of all charges incurred by the patient at Banner's Usual and Customary Charges from such first or third party payors, including situations governed by the provisions of A.R.S. Section 33-931, et seq. (or the analogous provisions of the laws of other states as applicable) despite any financial assistance granted pursuant to this policy.

D. Basic Criteria for Financial Assistance Program. Uninsured patients are potential Financial Assistance Program patients. The criteria under which a patient will be considered for eligibility will be based upon the following:

1. Income (using poverty levels established annually by the Department of Health and Human Services);
2. Household size;
3. Assets and liabilities;
4. Estimated medical bill;
5. Other extenuating circumstances.

Household income is the primary criteria for determining eligibility. Banner reserves the right, however, to deny participation in either Financial Assistance Program for uninsured patients who, in the judgment of Banner, have sufficient net assets to pay for hospital services provided at Banner's charges.

E. Basic Financial Assistance Program. Uninsured patients may qualify for the Basic Financial Assistance Program if they have annual household incomes of less than $125,000. Participants in the Basic Financial Assistance Program will be charged for inpatient Covered Services at the percentage set forth in the table below of the expected DRG reimbursement that would be allowed for such services under the Medicare program, and will be charged for outpatient Covered Services at the percentage of Banner's Usual and Customary Charges set forth in the table below; provided, however, that the Basic Financial Assistance Program does not apply to Covered Services for which Banner has published a package price for procedures for self-pay patients (e.g., obstetric packages). In order to qualify for participation in the Basic Financial Assistance Program, uninsured patients must submit, at a minimum, an affidavit verifying annual household income, and such other information as may be reasonably requested by Banner with respect to annual income, assets and liabilities, but

are not required to apply for Medicaid. The Basic Financial Assistance Program does not apply to Banner facilities in Alaska.

Amount Payable Under Basic Financial Assistance Program	Arizona Facilities	Facilities in Colorado, Wyoming, Nebraska, Nevada, and California
Percentage of Expected Medicare DRG Reimbursement for Inpatient Covered Services	150%	225%
Percentage of Usual and Customary Charges for Outpatient Covered Services	28%	75%

F. Enhanced Financial Assistance Program. Uninsured patients may qualify for the Enhanced Financial Assistance Program if they have annual household incomes equal to 500% of the Federal Poverty Level or less. Participants in the Enhanced Financial Program will receive a discount from charges necessary to reduce them to a sliding scale percentage of the amount payable for such services under the Medicare program, the sliding scale dependent on income level. In order to qualify for participation in the Enhanced Financial Assistance Program, uninsured Arizona and Colorado patients must apply for Medicaid, fully cooperate in the Medicaid eligibility process, be denied Medicaid, complete a BH Financial Assistance Application and submit a copy of the prior year's federal income tax return, current bank statements, and pay stubs (if employed). In all other states, uninsured patients must apply for, and be denied Medicaid unless Banner determines, based on screening criteria, that the uninsured patient will not qualify for Medicaid in that state. An uninsured patient who is required to apply for Medicaid but does not cooperate fully with the Medicaid eligibility process will not be eligible for participation in the Enhanced Financial Assistance Program.

G. Write-Offs. Services will be eligible for write-off, in whole or in part, if:

1. A patient qualifies for Medicaid after service has been provided by BH (100% write-off). This includes any bills for services that predate coverage.
2. A patient qualifies for Medicaid but funding is not available to pay for services or Medicaid denies coverage for particular Covered Services (100% write-off)
3. A patient is approved for participation in the Basic or Enhanced Financial Assistance Program (complete or partial write-off, depending upon the amount of discount available under the applicable program).

Upon approval, write-offs will be processed promptly in accordance with procedures, state statutes and regulations.

H. Signature Authority for Write-Offs. Financial Assistance Program write-offs will be granted subject to the following approval limits:

1. Up to $5,000 - Patient Accounts Manager
2. Over $5,000 – Patient Accounts Director , unless delegated to hospital CFO by the Director

I. Patients who are able, but unwilling, to pay for hospital services are considered uncollectible bad debts and will be referred to outside agencies for collection. Patients who qualify for either the Basic Financial Assistance Program or the Enhanced Financial Assistance Program and who fail to pay the balance when due, after

application of the appropriate discount, are considered uncollectible bad debts for the amount of such balance and will be referred to outside agencies for collection.

J. The Patient Accounts Director will be responsible to monitor the appropriateness of the Financial Assistance Program, the charges, patient days, and allowances.

III. Procedure/Intervention(s):

A. Document eligibility for Enhanced Financial Assistance Program.

1. Notify Medicaid on inpatients with no insurance or insufficient coverage, who cannot pay in full at time of service..
2. Explain Enhanced Financial Assistance Program. Request a copy of the patient's past year's Federal income tax return, current bank statements, pay stubs and a completed BH Financial Assistance Application.
3. Use the Federal Poverty Guidelines as a source to determine eligibility for Enhanced Financial Assistance Program multiplied by the factors in the attached grid (***see section V: Additional Information***). Net worth (assets less liabilities) may be factored into the income guidelines in cases where uninsured patient or guarantor has significant assets, but may not have a steady income.
4. Provide patient and/or family with guidance through this process. **(FINANCIAL COUNSELING DEPARTMENT)**
5. Write-off the patient account using the appropriate general ledger account number when it is determined that the write-off is appropriate. A monthly allowance for Financial Assistance Program is also calculated to properly reserve accounts receivable. **(FINANCE)**
6. The appropriate Financial Assistance Program funding will be reversed if patient becomes eligible for any third-party funding source.

B. Document eligibility for Basic Financial Assistance Program.

1. Explain Basic Financial Assistance Program.
2. Request an affidavit as to annual household income for prior year.
3. Determine if annual household income is less than $125,000, determine eligibility for Basic Financial Assistance Program. Net worth (assets less liabilities) will be factored into the income guidelines in cases where uninsured patient or guarantor has significant assets, but may not have a steady income.
4. Provide patient and/or family with guidance through this process. **(FINANCIAL COUNSELING DEPARTMENT)**
5. Write-off the patient account using the appropriate general ledger account number when it is determined that the write-off is appropriate. A monthly allowance for Financial Assistance Program is also calculated to properly reserve accounts receivable. **(FINANCE)**

6. The appropriate Financial Assistance Program funding will be reversed if patient becomes eligible for any third-party funding source.

IV. Documentation (Documents & Forms):

N/A

V. Additional Information:

Discounts under the Enhanced Financial Assistance Program are outlined in the following matrices, with the discounts represented as the percentage of the expected Medicare DRG reimbursement (for inpatients) or the Usual and Customary Charges (for outpatients) that a patient would be expected to pay. The percentages shown do not represent the discount from charges. Pro forma income thresholds are shown to illustrate the application of these percentages to a guarantor with a family size of 4:

A. **ARIZONA**

Arizona							
NOTE: Percentages shown below represent the percentage that is applied to the expected Medicare DRG payment (for inpatients) or to the Usual and Customary Charges (for outpatients) to arrive at the amount due from the patient. It does not represent the discount %.							
Income Level	**Pro forma Family of 4**	**Inpatient Percentage**	**Outpatient Percentage**				
0 - 150% of FPL	$29,025	0%	0%				
151 – 200% of FPL	$38,700	25%	6%				
201 – 250% of FPL	$48,375	42%	9%				
251 – 300% of FPL	$58,050	58%	12%				
301 – 350% of FPL	$67,725	75%	15%				
351 – 400% of FPL	$77,400	92%	18%				
401 – 450% of FPL	$87,075	108%	21%				
451 – 500% of FPL	$96,750	125%	24%				

C. **COLORADO, CALIFORNIA, NEVADA, WYOMING, NEBRASKA, ALASKA (unless superseded by a policy adopted by Greater Fairbanks Community Hospital Foundation and approved by Banner)**

Colorado, California, Nevada, Wyoming, Nebraska, Alaska							
NOTE: Percentages shown below represent the percentage that is applied to the expected Medicare DRG payment (for inpatients) or to the Usual and Customary Charges (for outpatients) to arrive at the amount due from the patient. It does not represent the discount %.							
Income Level	Pro forma Family of 4	Inpatient Percentage	Outpatient Percentage				
0 - 150% of FPL	$29,025	0%	0%				
151 - 200% of FPL	$38,700	25%	15%				
201 - 250% of FPL	$48,375	48%	30%				
251 - 300% of FPL	$58,050	70%	35%				
301 - 350% of FPL	$67,725	93%	40%				
351 - 400% of FPL	$77,400	115%	45%				
401 - 450% of FPL	$87,075	138%	50%				
451 - 500% of FPL	$96,750	160%	55%				

References:

N/A

VI. Other Related Policy/Procedures:

This policy replaces the ***Charity Care*** policy.

VII. Cross Index As:

A. Financial Assistance Program
B. Uninsured Patients
C. Legal
D. Board
E. Finance