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Financial Assistance, I-8530-05

Policy

Lodi Health is committed to provide financial relief to patients who need assistance in paying for their bill and have no other financial resource.

Purpose

The purpose of this policy is to define the eligibility criteria for financial assistance and/or, discounts and to provide administrative guidelines for the communication and implementation of this policy.

Definition

The distinction between financial assistance and bad debt is the inability of the individual to pay versus the unwillingness of the person to pay their account. This policy outlines the steps to take when screening a patient for eligibility, reviewing and application for financial assistance in accordance to SB:1276-Hospital Fair Billing Policies (Charity Care and Discount Payment Plans) and AB744 (Chapter 755, Statutes of 2006). Those with low income or with catastrophic medical bills may be medically indigent even though they are able to meet their basic living expenses.

A. The determination to provide financial assistance can be made prior to scheduling an inpatient or outpatient procedure, while receiving recurring outpatient services, during an inpatient stay, or up to 120 days following services or 90 days following the receipt of payment for benefits to the hospital from third party payer(s).

B. If complete information on the patient's insurance or financial situation is unavailable due to emergency treatment, or if the patient's financial condition changes, the designation for financial assistance may be made after rendering services and in some circumstances even after rendering of the bill. Any care giver who is aware of the potential need for financial assistance should request consideration as soon as possible on behalf of the patient.

C. No undue burden will be placed on the patient. Lodi Health will make available materials pertaining to alternative programs or services in the county and offer assistance in applying for these programs. Confidentiality of information and the dignity of the individual will be maintained for all who seek and/or are provided financial assistance. All patients who request an application for financial assistance should be provided an application, whether or not they meet the eligibility requirements.

Procedure

A. **Screening for the Patient's Eligibility:** It is important to outline the potential coverage options and discount /payment programs with the patient or the patient's legal representative. All potential payment sources must be identified and investigated before financial assistance is authorized. Other payment sources may include, but are not limited to, bank accounts, a personal loan, stocks and bonds, Medi-Cal coverage, The Victims of Crime Program, Covered California, homeowners or automobile insurance, or other insurance. Financial Assistance is the "payment" of last resort.

1. Is the patient uninsured or do they have high medical costs
2. Is there any other health benefit plan(s) that they are eligible for
3. How many days have past since the patient's discharge date or days since the last insurance payment.
4. What's the household size
5. Estimated Family Income- Is the income at or below $40,845.00

   Note: If the patient's family income is at or below 350% (percent) of the Federal Poverty Level, the patient should be encouraged to complete the application for financial assistance and all additional application requirements should be reviewed.

B. **The Application Process:** When establishing financial assistance, asset testing only considers monetary assets. Monetary assets exclude retirement or deferred compensation plans and include only 50% of monetary assets over $10,000. Fifty percent of monetary assets greater than $10,000 must be spent down before financial assistance will be considered. See ATTACHMENT A/B for specific percent awards for financial assistance.

1. If the patient is a potential financial assisted recipient, a Financial Disclosure form is to be completed and signed by the applicant, (see ATTACHMENT A).

   Note: Financial Disclosure forms are also available in the Patient Financial Services Office and Admission and Registration areas.

2. The Financial Counselor in Admissions and Patient Financial Services are available to assist the patient in completing the financial disclosure forms for income and asset evaluation. When other coverage, such as: Medi-Cal or Covered California is questionable, the Financial Counselor will assist the patient by way of referral and application.
3. Supporting documentation will vary by application, but should include pay stubs,

copies of last year's income taxes, the last three months of banking and savings statements to verify income. Copies of bills to verify expenses and/or residency, and a signed release to verify any and all information including a credit report and/or verification of assets will complete the application process.

4. A patient who is uninsured or meet the criteria for high medical costs; family income must be between 139 and 250% of the Federal Poverty Level as reported by the federal tax return or using 3 months recent paystubs to calculate annual income (non-taxable income from SSI shall be included); family assets must not exceed $110,000.00; special needs trust assets are included; the patient and or family member must not own an interest in more than one parcel of real property. Income from a qualified retirement plan shall not be included in the income calculation.
5. The family size to determine the FPL is defined as follows:
   - The patient's legal spouse or domestic partner.
   - The patient's legal guardian or parent.
   - Dependent children under 21 whether living at home or not.
   - Relatives who are care takers to the patient.
6. Financial Assistance will be provided to uninsured patients on a sliding scale basis, using the current published FPL as our guide. Discounts will be granted using the following criteria:
   - If Family income is equal to or less than 100% FPL = Free Care
   - If Family income is 101% to 250% FPL = 120% of Medicare fee schedule
   - If Family income is 251% to 350% FPL = 135% of Medicare fee schedule
   - If Family income is 351% to 500% FPL = 150% of Medicare fee schedule
   - If Family income is over 500% FPL = Payment case by case

C. **Discount For Services**

1. Discount Policy for Private Pay Patients who wish to pay their accounts in full within 30 days of first billing:
   - Inpatients: 40
   - Emergency: 40
   - Surgical Day Care: 40%
2. Discount Policy for Prompt Pay Outpatient Services is offered to patients who will pay for outpatient services at the time the patient is registered for such services, regardless of their insurance status or their financial status or ability to pay.
   - Outpatient Imaging Services: 50%
   - Outpatient Therapy Services: 55%
   - Outpatient Laboratory Services: 50
   - Medical Practice(s): 20% (excluding Galt location
3. **Administrative Process:**

   a. The determination will be made within 21 days from the date of submission of all required documentation
   b. At the time a decision is made, approving or denying financial assistance, the applicant will receive a letter stating the approval or denial of their application

c. Patients who disagree with the determination of their financial assistance application have the right to appeal the decision. Appeals must be submitted to the Chief Financial Officer of Lodi Health. The Chief Financial Officer will render a decision within 14 working days and notify the patient in writing of such decision
d. All applications will be kept on file in the Patient Financial Services Department in accordance with the Record Retention Policy
e. Incomplete applications will be held for 60 days from filing or 150 days from the first billing before the account is referred to a collection agency

D. **Catastrophic Discount:**

1. Healthcare services should not represent a catastrophic burden to patients and families with high medical costs and whose family income is at or below 500% of FPL, and is eligible to apply for the discount policy. High Medical Costs is defined as follows:
    a. A patient who is insured or whose insurance is not contracted with the hospital to receive a discounted rate from the hospital as a result of his or her third-party coverage.
    b. The patient's annual out-of-pocket medical costs incurred by the individual at the hospital exceed 10% of the patient's family income in the prior 12 months.
    c. The patient's documented medical expenses paid by the patient or patient's family exceed 10% of the patient's family income in the prior 12 months.
    d. These cases are to be evaluated and approved based on the level of write-off as indicated in the "Eligibility Criteria" outlined above and are reviewed on a case-by-case basis.

E. Financial assistance applies to co-payments, deductibles, co-insurance amounts and non-covered amounts.Coinsurance and deductible amounts for hospital services for Medicare patients may be considered for financial assistance provided the patient meets the established guidelines detailed above. In addition, the hospital will follow these principles:

- The hospital does not waive deductible and coinsurance as part of any advertisement or solicitation for the purpose of inducing more business.
- The hospital does not routinely waive coinsurance or deductible amounts. If a waiver is made, it is done without regard to the reason for admission, length of stay, or diagnostic related group.
- A waiver, if made, is not part of a price reduction agreement between the hospital and a third-party payer
- The hospital only waives coinsurance and deductible amounts after determining, in good faith, that the individual is in financial need or reasonable collections efforts have failed

F. When establishing repayment terms, employment status, along with potential future earnings, is considered as well

G. If financial assistance is applied and a third party payment is later received, the financial assistance adjustment will be reversed by the amount of the additional payment and may even require a refund to the patient if they paid in excess of the retro financial assistance calculation

H. The patient must reapply for financial assistance if subsequent services are rendered and there is still an inability to pay, if services were rendered more than six months prior

I. Exception to letter F above would be a recurring account in which multiple visit spans are included in one account. A financial assistance evaluation would include the entire visit span included in the account without need for reapplication for each visit

J. The collection agency may report accounts they determine to qualify for financial assistance. The same procedures and required documentation apply. If approved, the bad debt status is reversed and the financial assistance write-off applied.

K. The financial counselor will write-up the financial request and seek approval based on the following approval levels:
  - Supervisor/Manager $0 - 4,999
  - Director: $4,999 - $29,999
  - Chief Financial Officer: $29,999 - $99,999
  - Chief Executive Officer: $99,999 >

L. The following should not be classified as Financial Assistance Discounts:
  - Insurance company discounts/contractual allowances
  - Administrative adjustment
  - Employee/Physician discount

M. The support for financial assistance write-off is to agree with the general ledger account balance. All supporting documents are to be kept in auditable condition. Documents include the application, financial statement, copy of bill, copy of final patient account(s) status report, and the copy of the worksheet(s). (See Financial Assistance Discount ATTACHMENT B.

N. When adjusting off accounts for financial assistance, the proper adjustment code for all accounts (except Medicare accounts), will be ASPCH. If the accounts represent a Medicare deductible, adjustment code AMCSPCH should be used.

O. Patients eligible for financial assistance who have emergency services provided are also eligible for financial assistance for the Emergency Physician bill. Once financial assistance has been recognized and approved by the Hospital, the Emergency Room Physician will be notified of the need to provide financial assistance to the patient as well.