



<b>RESPONSIBLE DEPARTMENT:</b> Revenue Cycle	<b>SUBJECT:</b> Financial Assistance
<b>NUMBER OF PAGES:</b> 13	<b>REPLACES POLICY (NUMBER/DATE):</b> All previous Charity policies at all FMOLHS hospitals
<b>Original Date:</b> June 28, 2013 <b>Revised Date :</b> June 25, 2018 <b>Effective Date:</b> July 1, 2018	<b>POLICY NUMBER:</b> FIN.04.29

**SCOPE:**

Applies to all emergency and other medically necessary care provided by FMOLHS Hospital facilities, including all such care provided in the FMOLHS Hospital facilities by substantially related entities. FMOLHS Hospital facilities include:

- Our Lady of the Lake Regional Medical Center
- St. Francis Medical Center
- Our Lady of Lourdes Regional Medical Center
- St. Elizabeth Hospital
- Our Lady of the Angels Hospital
- Assumption Community Hospital

**PURPOSE:**

The purpose of this Financial Assistance Policy (FAP) is to specify:

- Eligibility criteria for Financial Assistance in the form of free care;
- How to apply for Financial Assistance;
- How the Hospital calculates amounts charged to patients;
- How the FAP is widely publicized within the community served by the Hospital;
- What actions the Hospital may take in the event of non-payment; and
- Compliance with applicable state and federal laws and regulations.

**POLICY:**

FMOLHS is committed to providing financial assistance to those who have healthcare needs and are uninsured or underinsured, for medically necessary care based on their individual financial situation. FMOLHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

- A. To **determine** whether an individual is **eligible** for Financial Assistance, the **individual must apply** for Financial Assistance. This FAP describes how to apply, as well as specifies the eligibility criteria that an individual must satisfy to receive Financial Assistance. The information and **documentation required** to be submitted as part of the FAP application is also set out in this FAP.

B. This FAP **applies to all emergency and other medically necessary care provided by FMOLHS Hospitals** for the diagnosis and treatment of illness or injury. The Hospital will determine whether a service is eligible for Financial Assistance. Services specifically **excluded** include, but are not limited to, the following:

- a. Care that is not medically necessary, including but not limited to
  - i. Cosmetic procedures, such as breast augmentation, abdominoplasty, Botox injections, blepharoplasty, chemical peels, skin tag removal, dermal fillers, sclerotherapy, and dermatological laser treatments.
  - ii. Cosmetic dental procedures
  - iii. Bariatric surgery
  - iv. Circumcision
  - v. Genetic testing
  - vi. Hormone replacement therapy
  - vii. Stretta therapy
- b. Personal items provided during an inpatient stay, e.g. guest trays, private rooms that are not medically necessary.
- c. Charges resulting from procedures that are not covered by third-party insurance, despite being medically necessary, due to the patient's failure to follow insurance payer guidelines where a patient knowingly received services in a non-contracted hospital.
- d. Motor vehicle accidents where third-party liability is being pursued for payment of hospital expenses (e.g., those involving patients with no health care insurance).

C. **Professional services** provided by treating physicians, physician assistants, or advanced practice clinicians in the Emergency Department and all other Hospital departments, may or may not be covered by this FAP. A list of providers rendering emergency and other medically necessary care in the Hospital facility is maintained in a document separate from the FAP and is available on each FMOLHS Hospital's website. The website listings specify which providers are covered by this FAP and which are not. Patients may request paper copies, free of charge, by calling the Hospital's main phone number and asking for the Financial Counseling department at Our Lady of the Lake and the Admissions department at all other Hospitals. A listing of websites, physical addresses, and phone numbers is located in **Addendum A** of this policy.

D. If a patient has **potential payment resources** such as, but not limited to, health insurance or third-party settlement proceeds, the individual may not be eligible for Financial Assistance.

- E. Financial Assistance is not considered to be a substitute for personal responsibility. **Patients are expected to cooperate** with FMOLHS procedures for obtaining financial assistance or other forms of payment, **and to contribute** to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so.
- F. If an FAP applicant is or may be eligible for funds from local, state, or federal programs that cover some or all of the costs of health care services, the FAP applicant is expected to apply for such programs before a determination of eligibility is made under this FAP. Financial assistance is generally **payer of last resort** to all other financial resources available to the patient including: insurance; government programs, such as but not limited to VA benefits, Medicare, and Medicaid; third-party liability; and personal assets, including existing liquid assets. The Hospital will provide assistance to individuals in applying for government programs
- G. The Hospital will not deny Financial Assistance under this FAP based on an applicant's failure to provide information or documentation that the Hospital does not specify in this FAP or in the FAP application form. The Hospital will notify the individual in writing of the decision on their eligibility under this FAP and the basis for the decision.
- H. Financial Assistance documentation obtained from patients will be secured; access to this documentation will be limited to those essential to the Financial Assistance process.
- I. The actions the Hospital may take in the event of non-payment are described generally in this FAP. **The Hospital will make reasonable efforts to determine whether an individual is eligible for assistance under this FAP before engaging in any extraordinary collection action (ECA).** Following a determination of FAP eligibility, a FAP-eligible individual will not be charged more for emergency or other medically necessary care than the Amounts Generally Billed (AGB) to individuals who have insurance covering such care.
- J. The **Amounts Generally Billed (AGB)** calculation will be performed annually for each FMOLHS Hospital. Any needed change will be implemented within 120 days of the calculation. The Hospital will limit the amounts that it charges for emergency or other medically necessary care provided to individuals eligible for Financial Assistance to the average amounts generally billed for commercially insured and Medicare patients. AGB is determined by multiplying the gross charges for eligible care by an AGB percentage. The AGB percentage is based on all claims allowed by Medicare and private health insurers over a specified 12-month period, divided by the associated gross charges for those claims. Written copies of the AGB percentage currently being used may be obtained, free of charge, by calling the phone number in Appendix A for the applicable Hospital facility.

- K. **Notification** about FMOLHS financial assistance programs will be disseminated through various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms and admissions areas, and at other public places that FMOLHS may elect. FMOLHS also shall publish and widely publicize on facility websites the following: this financial assistance policy, a plain language summary of the policy, and the financial assistance application. These documents shall be provided in the primary languages spoken by limited-English proficiency populations served by each FMOLHS Hospital. Paper copies of these documents will be provided to patients in the emergency room and other admission areas upon request and by mail.
- L. FMOLHS management and facilities shall **comply with** all other federal, state, and local **laws, rules, and regulations** that may apply to activities conducted pursuant to this Policy.

## **I. APPLICATION PROCESS**

- A. Completing, signing, and submitting an application for Financial Assistance, as well as submitting the required documentation set out in this policy, is required in order to determine if an individual qualifies for Financial Assistance. Applications are available at all Admission Departments and on each Hospital's website. See *Addendum A* for a listing of websites, physical addresses, and telephone numbers for each Hospital facility. Directions for returning the completed application are detailed in the financial assistance application.
- B. The availability of financial assistance will be publicized to patients at intake or discharge. Financial Counselors will screen interested patients and assist in completing the application for financial assistance. Financial Counselors are available in the Hospital, at the Admissions Department, to assist in completing the application or answering any questions in regard to this FAP. The Admissions Department of each hospital can be found by following the clearly marked signage in the public pathways at the Hospital. Hospital addresses can be found in *Addendum A*.
- C. The patient or the patient's guarantor are required to supply personal, financial, and other documentation relevant to making a determination of financial need **within thirty (30) days** of the request for assistance. The applicant must provide the requested information for the patient, spouse, family members who reside together, and dependents claimed on the same tax return. **Applications not meeting these conditions may be returned to the applicant or considered denied.**

- D. An uninsured person who fails to supply the information necessary for an accurate determination shall be presumed to be able to pay the full charge for services rendered and will be required to pay a deposit equal to gross charges times the AGB percentage that applies to the Hospital where services will be rendered, or be rescheduled (in non-emergency cases only). If the uninsured person has started but not completed the financial assistance process, the uninsured person will be required to pay a non-refundable **Standard Deposit** (see *Addendum C* for Standard Deposits for each Hospital) or be rescheduled when a deposit can be paid or information can be provided to complete the FAP application (in non-emergency cases). NOTE: For services rendered in provider-based physician clinics, a deposit equal to the AGB percentage times gross charges will be used instead of the standard deposit.
  
- E. Although applications may be denied if not completed within 30 days, the application will be re-opened and reconsidered if the patient contacts us and requests reconsideration within 240 days after post-discharge billing.

## **II. FINANCIAL ASSISTANCE DETERMINATION**

- A. Financial assistance will be determined in accordance with procedures that involve an **individual assessment of financial need** and may:
  - a. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);
  - b. Include reasonable efforts by FMOLHS to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
  - c. Take into account the patient's available assets, and all other financial resources available to the patient.
  
- B. **Verification of income is required** for any financial assistance request. The following documents must be provided:
  - a. A completed financial assistance application
  - b. Photo ID or legal ID
  - c. Most recent tax returns for the patient/guarantor, family members living in the house, and dependents claimed on the patient's/guarantor's tax return. If patient/guarantor is not required to file federal taxes (because of low income or no income), a statement from the IRS is required.
  - d. Proof of income for the patient/guarantor, family members living in the house, and dependents claimed on the patient's/guarantor's tax return.
    - i. If employed: Last 3 paystubs, last 3 months' bank statements, last available W-2's.

- ii. If self-employed: Monthly income statement for self-employment or a copy of general business ledger/business checking account summary.
  - iii. If not employed: a copy of benefit information from Social Security disability, other Social Security income/benefits, 1099R, pension, public assistance, worker's compensation, trust fund, unemployment, military support, child support, and alimony; public assistance checks; retirement checks; and/or notarized statement of support.
- C. Requests for financial assistance shall be processed promptly and FMOLHS shall **notify the patient or applicant in writing within 30 days of receipt of a completed application.**
- D. Financial assistance write-offs will be applied to the **date of service for which the financial assistance application was initiated** and for future dates of service within the following six months. NOTE: Insurance verification will be performed for each episode of care to determine if the patient remains uninsured.
- E. Patients must **re-apply** for financial assistance after the six-month period for which the original application was approved.

### **III. ELIGIBILITY AND AMOUNT OF WRITE-OFF:**

Eligibility for write-off is determined based on the number of persons in the household and annual family income as a percentage of the federal poverty level (FPL). FMOLHS will use the Federal Poverty Guidelines that are updated and published annually by the U.S. Department of Health and Human Services in the *Federal Register*. The latest information is available on this website: <https://aspe.hhs.gov/poverty-guidelines>.

- A. Uninsured patients whose family income is at or **below 250%** of the FPL will qualify for a full write-off of all hospital charges, excluding any Standard Deposits previously paid, assuming they meet the other eligibility criteria set out in the FAP.
- B. Uninsured patients whose family income **exceeds 250%** of the FPL may qualify for **catastrophic** medical assistance, depending on the patient's particular financial circumstances. If the patient's medical bills for the 12 months immediately preceding treatment are greater than or equal to twenty percent (20%) of their annual family income, the patient may be granted financial assistance in the form of free care.
- C. **Underinsured** patients (see Definitions section) will be treated as **uninsured** patients for purposes of financial assistance.

#### **IV. PRESUMPTIVE FINANCIAL ASSISTANCE**

- A. Presumptive eligibility for financial assistance occurs when the Hospital uses information other than that provided by the individual to determine eligibility for free care. Accounts meeting presumptive criteria will be written off at 100%.
- B. A patient may be eligible for financial assistance even if they have no financial assistance form on file, where the patient or other sources can provide sufficient evidence of presumptive eligibility. In these instances, collection activity (pursuant to the actions described in section V below) will continue while the due diligence is being completed or until the patient's account is reviewed. A list of information obtained from other sources is included in *Addendum B*.
- C. A scoring system may also be used in order to determine if a patient is eligible for presumptive financial assistance. The scoring system is similar to credit scoring and is produced by an FMOLHS approved vendor. Only those accounts that fall below the scoring system minimum will be considered for presumptive financial assistance. If a patient has been denied financial assistance due to non-compliance or income that has been discovered, he/she will not be eligible for a presumptive financial assistance write-off.

#### **V. COLLECTION ACTIONS**

- A. In the event of non-payment on the part of the patient/guarantor, the Hospital will engage in the following **collections actions**: sending billing statements, calling patients for open balances, transferring accounts to billing or collection agencies for follow up, and filing claims in bankruptcy proceedings. The Hospital may also engage in **extraordinary collection actions (ECAs)**, which include wage garnishments, liens, reporting to outside credit agencies, foreclosure, bank account seizure, personal property seizure, and law suits.
- B. The Hospital will make **reasonable efforts** to determine whether an individual is eligible to receive free care before initiating the ECAs. Reasonable efforts include:
  - a. Notifying the individual about the FAP (including reasonable efforts to notify the individual orally about the policy and how to obtain assistance);
  - b. Refraining from any extraordinary collection actions for a period of at least 120 days from the date the Hospital Facility provides the first post-discharge billing statement for the care; and
  - c. Giving the individual a written notice which indicates that financial assistance is available for eligible individuals and notifies the individual (at least 30 days in advance) of the type of ECAs the Hospital intends to initiate and the deadline

after which such ECA may be initiated. This written notice will also include a plain-language summary of the FAP.

- C. Applications for financial assistance will be processed **up to 240 days after the date of the first post-discharge billing statement** for the care. The Hospital Facility has no obligation to process applications received after such date. Upon receipt of a timely application, any ECAs already initiated will be temporarily suspended while the application is being processed.
- D. If an individual submits an incomplete application during the 240-day period beginning after the first post-discharge billing statement for the care, efforts in addition to those discussed above should be undertaken before ECAs are initiated or resumed. The Hospital will notify the individual about how to complete the application, including a written notice that describes the additional information required and/or documentation that must be submitted. The written notice will also contain contact information for how to get more information on the FAP process and how to obtain assistance with the application process. The Hospital Facility will give the individual a reasonable opportunity to provide the missing information before initiating or resuming ECAs.
- E. Once a completed application is submitted, the Hospital will process it in a timely manner and notify the individual in writing as to whether they qualify and the basis for such determination. The Hospital will make reasonable efforts to reverse any ECAs taken against the individual related to amounts no longer owed.
- F. FMOLHS will not impose ECAs for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance under this financial assistance policy. The Admissions department manager at each Hospital has final authority and is responsible for determining that reasonable efforts have been made so that ECAs are then allowable.

## **VI. DEFINITIONS:**

For the purpose of this policy, the terms below are defined as follows:

**Contractual Allowance:** The difference between the level of payment established under a contractual agreement with a third party payer and the patient's gross charges.

**Extraordinary Collection Actions (ECAs):** ECAs apply when the Hospital facility impacts credit reporting or initiates legal processes such as liens, foreclosures, seizures of bank accounts or personal property, garnishment of pay, and/or arrest. ECAs do not include: calling patients for open balances; sending statements; or filing a claim in a bankruptcy proceeding.

**Emergency Care:** The patient requires immediate medical intervention due to a severe, life-threatening, or potentially disabling condition. Generally the patient is seen and/or admitted through the emergency room. See section 1867 of the Social Security Act (42 U.S.C. 1395dd).

**Financial Assistance:** Financial Assistance is defined as medical services provided at no charge to patients who are uninsured or underinsured and unable to pay based on income level (as based on the U.S. Department of Health and Human Services Federal Poverty Guidelines), financial analysis, demographic indicators and/or further healthcare needs based on diagnosis. Financial Assistance does not include: contractual allowances from government programs and contractual allowances from insurance.

**Family:** Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption.

**Family Income:** Using the Census Bureau guidelines, the following is used when computing family income:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Determined on a before-tax basis;
- Includes the income of all family members who reside together and dependents claimed on the income tax return. (Non-relatives, such as housemates, do not count.)
- For dependents who live outside the home, family income shall include the dependent's income, along with the income of those who claim the dependent on their tax return.
- Family Income also includes resources or property that are easily convertible to cash; including but not limited to checking accounts, savings accounts, stocks, bonds, certificates of deposits, and cash. IRA's and 401K's are excluded until money is removed.

**Federal Poverty Guidelines:** A simplification of the Census Bureau's poverty thresholds used for administrative purposes such as determining financial eligibility. Each year the Department of Health and Human Services (HHS) publishes the guidelines in the Federal Register.

**Gross Charges:** The total charges at the Hospital's full established rates for the provision of patient care services before deductions are applied.

**Medically Necessary Care:** Medical treatment that is appropriate and necessary for treatment of the presented symptoms, as defined by Medicare and third party payers

**Presumptive Financial Assistance:** Assistance granted on the basis of a scoring system or other data sources that provide sufficient evidence of eligibility. A financial form on file is not required for approval of presumptive financial assistance.

**Uninsured Patient:** A person receiving healthcare services that does not have healthcare insurance and will not qualify for any state/ federal programs.

**Underinsured Patient:** A person receiving healthcare services who has private healthcare insurance, but whose coverage does not cover specified care. Patients with commercial insurance are not generally eligible for financial assistance write-offs due to health-plan and legal requirements related to billing patients for their full cost-share portion of the provided services. However, if third-party coverage does not provide benefits for the hospital services due to health plan exclusions, pre-existing conditions, waiting period prior to eligibility, or exhaustion of benefits, the patient may be considered uninsured and eligible for a financial assistance adjustment, for the services not covered. This does not apply when the third-party coverage does not provide coverage at an FMOLHS facility for services that would otherwise be authorized in the payer's network of providers.

**ATTACHMENTS:** **Addendum A – Listing of Hospital Websites and Contact Numbers**  
**Addendum B – Presumptive Financial Assistance**  
**Addendum C – Standard Deposits**

<b>ADDENDUM A. Listing of Hospital Websites, Physical Addresses, and Contact Numbers</b>
--

Hospital	Website	Admissions Department Location	Phone Number
Our Lady of the Lake	<a href="http://www.ololrmc.com/financialassistance">www.ololrmc.com/financialassistance</a>	5000 Hennessy Blvd Baton Rouge, LA 70808	(225)765-7921 (800)327-3284
St. Elizabeth Hospital	<a href="http://www.steh.com/financialassistance">www.steh.com/financialassistance</a>	1125 W Hwy 30 Gonzales, LA 70737	(225)647-5000
St. Francis Medical Center	<a href="http://www.stfran.com/financialassistance">www.stfran.com/financialassistance</a>	309 Jackson Street Monroe, LA 71201	(318)966-4000
Our Lady of Lourdes	<a href="http://www.lourdesrmc.com/financialassistance">www.lourdesrmc.com/financialassistance</a>	4801 Ambassador Caffery Lafayette, LA 70508	(337)470-2000
Our Lady of the Angels Hospital	<a href="http://www.oloah.org/financialassistance">www.oloah.org/financialassistance</a>	433 Plaza Street Bogalusa, LA 70427	(985)730-6700
Assumption Community Hospital	<a href="http://www.ololrmc.com/financialassistance">www.ololrmc.com/financialassistance</a>	135 Highway 402 Napoleonville, LA 70390	(985)369-3600

NOTE: Please do not use the above address for submitting financial assistance applications. The proper address can be found on the application form itself.

## **ADDENDUM B. Presumptive Financial Assistance**

Information obtained from sources other than the patient may be used to determine presumptive eligibility. Such information includes evidence that the patient is participating in one or more of the following:

1. State-funded prescription programs;
2. LACHIP, subsidized housing, free or reduced school lunches, etc. for the patient/guarantor's children;
3. Louisiana food stamp program;
4. State Medicaid program. For patients that have Medicaid coverage, the financial assistance determination will rely on information from the Medicaid program, including evidence that:
  - Patient is currently on Medicaid, but has a prior balance within 12 months of the approval date
  - Patient currently has Medicaid with limited benefits (only covers family planning)
  - Patient is in a hospice and has Medicaid only
  - Patient has Medicaid through a non-contracted state
  - Patient qualifies for Medicaid with a "spend-down requirement"
  - Patient is eligible for other state or local assistance programs that are unfunded (i.e., Medicaid spend-down);
  - Patient is deceased with no known responsible party or estate. The due diligence efforts to verify the estate assets are to be documented via the hospital approved website.

Additionally, a patient may be presumed to be eligible for financial assistance if there is an independent, qualified attestation that the patient is homeless.

**ADDENDUM C. Standard Deposits**

Hospital	Surgical Procedure Standard Deposit	Radiology Standard Deposit	All Other Services Standard Deposit
Our Lady of the Lake	\$200	\$10	\$10
St. Elizabeth	\$200	\$10	\$10
St. Francis Medical Center	\$200	\$25	\$25
Our Lady of Lourdes	\$200	\$25	\$25
Our Lady of the Angels Hospital	\$200	\$25	\$25
Assumption Community Hospital	n/a	\$10	\$10