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Owner:	*Mary Edwards: Revenue Cycle Manager*
Department:	*Administration*
Categories:	*Patient Financial Services*
Applicability:	*Lake Regional Health System*

Financial Assistance and Sliding Fee Schedule

PURPOSE

To identify circumstances where Lake Regional Health System (LRHS), Lake Regional Medical Group (LRMG) and/or Lake Regional Physicians Group (LRPG) 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 LRHS, LRMG and/or LRPG. 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, listed on your statement and/or the LRHS website. The provisions of free and discounted care through the LRHS, LRMG and/or LRPG's financial assistance (FA)/Sliding Fee Schuedule (SFS) programs are consistent, appropriate, and essential to the execution of our Mission Statement, and are consistent with our tax-exempt and charitable status and requirements set forth by the National Health Service Corp (NHSC). A list of the certified NHSC clinics are available on the LRHS website.

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, LRMG and/or LRPG 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 (FA) and/or SFS, 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 FA/SF. The patient's physician will have the final decision on the emergent need and medical necessity of the service in question and its coverage under the LRHS/LRMG and/or LRPG's FA/SFS policy. If the physician deems the service to be non-emergent and/or not medically necessary, LRHS, LRMG and/or LRPG retains the right to reschedule the service until the patient has been financially cleared.

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 FA, 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 and family size.

In the evaluation of an application for SFS, a patients income will be verified by obtaining the last year's federal taxes as well as two recent pay stubs. A determination will be made on the application based on the current year's Federal Poverty Guidelines to include family/household

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income and family size.

- 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.

POLICY

To identify patients that qualify for FA for services provided at LRHS, LRMG and/or LRPG. LRHS, LRMG and /or LRPG 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,LRMG and LRPG 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, on May 1st, 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 FA 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 four months before or
- After six (6) months has passed since last applied.

To be considered for FA, a patient must provide information and/or the documentation necessary to apply and have an account balance equal to or greater than $250. The patient must provide other existing financial resources that may be available to pay for their health care, such as Medicaid or any other payer. If the patient has not applied for Medicaid, LRHS, LRMG and/or LRPG reserve the right to require the patient to seek out eligibility for Medicaid, prior to accepting an application for FA. Self-pay patients as well as self-pay after insurance are eligible to apply for FA.

Patients at or under 200 percent FPG, will receive 100 percent adjustment. Self-pay patients over the 200 percent FPG, will receive a 62 percent self-pay discount based on LRHS' Amount Generally Billed (AGB). Patients with self-pay after insurance, that are greater than 200 percent FPG, will not receive the 62 percent self-pay discount and the balance will be billed to the patient.

Self-pay patients are eligible to a apply for Sliding Fee Scale (SFS) for services provided at LRPG. Determination for SFS is based on the federal poverty guidelines (FPG) and requirements set forth by the National Health Service Corp (NHSC). Self-pay after insurance

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patients may not apply for SFS, however they are eligible to apply for FA and will follow the same guidelines listed above. Patients at or under 200 percent FPG, will receive 100 percent SFS adjustment. Self-pay patients over the 200 percent FPG, will receive a 62 percent self-pay discount based on LRHS' Amount Generally Billed (AGB).

Patients are responsible for completing an application 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.

Patients that are enrolled in a church funded insurance, must provide documentation on the amount of payment that the organization will reimburse before consideration of FA will be completed. If there is other funding sources, they must be utilized prior to applying for a FA adjustment.

SPECIAL INSTRUCTIONS

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I. Definitions

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

B. **Amounts Generally Billed**: Calculation used by comparing collections to gross charges for all commercial, managed care and medicaid patients for a recent 12-month period ending 120-days to the start of the System's fiscal year.

C. **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.

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/Sliding Fee Schedule:** Health care services that were never expected to result in cash inflows. Financial Assistance/Sliding Fee Schedule 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, Manager of Revenue Cycle, Director of Resource Management, Patient Financial Services Collection Supervisor, Patient Access Manger 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) for SFS, only paycheck stubs and tax returns will be used as proof of income and not bank statements.

L. **Qualified Patient** : Financially Needy: A person who is uninsured or under insured.

M. **Self-Pay Patient**: Someone that pays out-of-pocket for health-related services in absence of insurance

II. Financial Assistance Guidelines and Eligibility Criteria

A. To be eligible for a 100 percent reduction from charges (i.e., full write- off) for FA, the patient's household income/family size must be at or below 200 percent of the current FPG. Self-pay patients with income above 200 percent of the FPG, will receive a 62 percent self-pay discount based on LRHS's AGB. Patient's with self-pay balances after insurance over the 200% FPG, will not qualify for FA and no other discount will apply. The FA policy will be updated May 1st every calendar year with the latest FPG.

B. Financial assistance applications will be considered as long as an account is open and no

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older than 365 days from the date of service (even if in bad debt collection process) or when a change in financial status is determined as long as the balance is $250 or greater. A financial assistance application will not need to be repeated for dates of service incurred up to six (6) months after and six (6) months prior the date of application approval as long as the account is not older than 365 days from the date of service. All accounts have to be medically necessary and not considered elective in order to be eligible for FA.

C. After the FA 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, LRMG and LRPG's Self-Pay Payment Plan 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. If the patient/co-worker has a balance due after financial assistance has been applied and the balance does not get paid, LRHS, LRMG and LRPG, reserves the right to reverse the FA adjustment and bill the balance due. That balance then follows the LRHS, LRMG and LRPG's Collections and Bad Debt policy.

F. Once FA is approved, a letter will go out to the patient confirming the terms of the FA acceptance. Any account during this six (6) month period that was classified as bad debt will be written off as FA as long as it was considered medically necessary.

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III. Sliding Fee Schedule Guidelines and Eligibility Criteria

A. To be eligible for a 100 percent reduction from charges (.i.e, full write-off) for SF, the patient's household income/family size must be at or below 200 percent of the current FPG. Income above 200 percent of FPG, will receive a 62 percent self-pay discount based on the LRHS's AGB. Patient's will self-pay after insurance, do not qualify for SFS. The SFS policy will be updated May 1st every calendar year with the latest FPG.

B. SFS applications will be considered as long as an account is open. A SFS application will not need to be repeated for dates of service incurred up to six (6) months from the date of the application. All accounts must be considered medically necessary and not considered elective in order to be eligible for SFS.

C. After the SFS 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 /LRMM Self-Pay Payment Plan 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. If the patient has a balance due after SFS has been applied and the balance does not get paid, LRHS/ and LRPG reserves the right to reverse the SFS adjustment and bill the balance due. That balance then follows the LRHS and LRPG's Collections and Bad Debt policy.

F. Once SFS is approved, a letter will go out to the patient confirming the terms of the SFS

acceptance.

IV. Presumptive Financial Assistance Eligibility

A. There are instances when a patient may appear eligible for FA and/or SFS discounts, but the FA/SFS 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 percent 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.

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PROCEDURE FOR FINANCIAL ASSISTANCE

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 Patient Access Manager and/or Credit/Collection Supervisor should approve financial assistance for amounts up to $5,000. Amounts greater than $5,000, but lower than $25,000 should be approved by the Manager of Revenue Cycle, amounts greater than $25,000 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, however due to the volume or applications and/or extenuating circumstances, if may exceed longer than 30 days. 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.

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C. Collection activity will be suspended during the consideration of a completed application and 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.

PROCEDURE FOR SLIDING FEE SCHEDULE

Identification of Potentially Eligible Patients

A. Preferably before the first appointment, a completed application, including required documentation of the home address, household income and insurance coverage, if any, must be on file and approved by the Clinic Manager and/or a member of the Business Office, before a discount is granted. If the applicant appears to be eligible for Medicaid, a writtent denial from Medicaid may also be required. Patient's may be required to seek out eligiility for Medicaid, prior to accepting an application for SFS.

B. 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

Determination of Eligibility

A. All patients identified as potential SFS recipients should be offered the opportunity to apply for assistance.

B. Requests for SFS may be received from:

   1. The patient or guarantor,
   2. Church sponsored programs,
   3. Physicians or other caregivers,
   4. Admiistration 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 verifiy eligibility.

   1. In the evaluation of an application for SFS, a patient's income will be verified by obtaining last year's federal taxes as well as two recent pay stubs.
   2. The Clinic Manager and/or a member of the Business Office, should approve SFS amounts. The SFS adjustment will be made by a member within the Business Office, after the application has been approved.

D. After appropriate approval and adjustments are completed, a record, paper and/or electronic, should be maintained reflecting authorization of SFS. These documents should be kept for a period of six (6) years.

Notification of Eligibility Determination

A. If the SFS application is not approved at the time the patient is present, the length of time to review and approve the application and provide a decision to the patient, should be provided. A prompt turnaround and a written decisioon, which provides reason(s) for denial (if appropriate) will

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be provided, generally within 7 (seven) days of the determination, however due to the volume of applications and/or extenuating circumstances, if may exceed longer than 7 (seven) days. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

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

C. Collection activity will be suspended during the consideration of a completed application and a note will be entered into the patient's account.

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Attachments

2021 LRHS Fin Asst Guidelines.xlsx
2020 LRHS Fin Asst Guidelines.xlsx

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Approval Signatures

Step Description	Approver	Date
Board of Directors	Dane Henry: Chief Executive Officer	8/2/2021
Board of Directors	Dane Henry: Chief Executive Officer	6/15/2021
	Patrick Neece: Chief Information Officer	6/10/2021
	Henry Zeisel: Executive Vice President Finance/ CFO [JH]	4/21/2021
	Harbaksh Sangha: Chief Medical Officer & VP of Medical Affairs	4/14/2021
	Tom Williams: Vice President of Human Resources	4/13/2021
	Melissa Hunter: Executive Vice President and Chief Nursing Officer	4/6/2021
	Kevin McRoberts: Executive Vice President/COO	4/1/2021
	Michael Burcham: Vice President of Physician Practices	3/31/2021
	Jennifer Bethurem: Vice President of Public Relations and Marketing	3/30/2021
	Dana Christiansen: Revenue Cycle Director	3/29/2021
	Mary Edwards: Revenue Cycle Manager	3/29/2021

Applicability

Lake Regional Hospital, Lake Regional Medical Group

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