Purpose

This policy is designed to help LCMH staff identify patients that present for treatment and may be uninsured or underinsured and may become eligible for financial assistance. There are patients who at times present for medical services that do not have a payer source or the ability to pay for their services in full. This policy provides financial relief to patients who qualify based on comparison of their financial resources and/or income to Federal Poverty Guidelines. This policy does apply to all departments of the hospital but does not apply to all independent practitioners.

Definitions

A. Federal Poverty Guidelines (FPG) – The federal government establishes and publishes annual poverty guidelines in the Federal Registry. The guidelines compare the family's yearly/monthly income with the size of the family/dependants.
B. Family/Dependants – The family unit is a group of individuals related by blood, marriage, adoption or resident, whose income can be applied to the patient's medical expenses. Children over eighteen years of age that are not a student, emancipated minors and children living under the care of individuals, not legally responsible for their support will not be considered part of the family/dependants, unless those individuals are claimed as dependants on the responsible parties income tax.
C. Amounts Generally Billed (AGB) – This is a calculation performed by the hospital annually. This calculation identifies a percentage that an eligible patient may be billed for services. (see attachment E)
D. Louisiana Resident – Persons are considered a resident of the state of Louisiana when they actually live in the state and can provide evidence of intent to remain; there is no requirement of United States (US) citizenship, but if not a US citizen they must be a qualified alien.
E. Qualified Alien – Person authorized by the U.S. Citizenship and Immigration Services (USCIS) for legal entry and continued stay in this country.
F. Non-emergent Patient – Patient whose medical conditions does not require emergency treatment based on the hospital medical screening standards for emergency care.

Eligibility Criteria

A. Financial assistance is secondary to all other financial resources available to the patient which includes group or individual medical plans, workers compensation, Medicare, Medicaid or medical assistance programs, automobile insurance including liability insurance, medical payments and un/underinsured motorist, other state, federal or military programs, third party liability or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.
B. Patients who refuse or otherwise fail to provide information regarding other coverage will not be eligible for financial assistance.
C. Patients will not be discriminated against in regards to race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability.
D. Financial assistance will be available for all inpatient and outpatient services.
E. Patients who meet the criteria enabling them to qualify for financial assistance will be considered under this policy based on the following criteria:
    - The full amount of uncovered hospital charges will be eligible for a 100% adjustment for a patient whose gross family income is at or below 200% of the current FPG.
F. If the patient's family income exceeds 200% of the current FPG the patient may qualify for a reduced share of charges based on a percentage calculation below.

Income Level (based on FPG)	Patient Portion	Discount off Total Charges
200% or below	0%	100%
201% to 500%	AGB %	Difference AGB & Total Charges

G. Patients who have primary insurance coverage will be eligible to apply for financial assistance, see Attachment A.

H. Patients who have primary coverage with Medicare will also be eligible to apply for financial assistance but will require additional documentation, see Attachment B.
I. The responsible party's financial obligation which remains after the application of all applicable discounts shall be payable as negotiated between Lake Charles Memorial Hospital and the responsible party.
J. Patients who present for high cost services such as inpatient, surgical, etc and do not have a payer source available will be screened by LCMH financial counselors to determine which programs the patient may qualify for.
K. Upon completion of the financial screening the financial counselor will aid the patient with applying for all applicable programs (which includes all Medicaid programs, VA, SSA, crime victims, etc.)
L. In Emergent situations services are rendered regardless of a payer source or the patient's ability to pay. These patients will be notified by written correspondence of their option to apply for programs which they may be eligible for.
M. Patients who are approved for either the full coverage or partial coverage programs will receive an approval for a period of time defined below as well as outstanding balances for the applicant that meet the program guidelines will be included in the approval. Patients will be required to reapply once their approval time frame is exhausted.
    a. Patients with fixed incomes such as Social Security, Retirement, other government support programs or those who are self employed and have proven income based on previous years tax information will receive approval for a one year time frame from the application date one year forward
        - Self-Employment income will be verified by the current year Federal Income Tax Form, using the gross income, on line 22 of the 1040 schedule. The Department of Labor information can be used as secondary income verification. If taxes were not filed, receipts, check stubs, contracts or sub-contract agreements for the prior 30 days can be substituted.
    b. Patients who are employed, unemployed or who have provided another means of support will receive an approval for a six month time frame from the application date six month forward.
    c. A review of all of the applicants outstanding balances will also take place and accounts with dates of service within 240 days from the application date will be adjusted based on the level the patient is qualified for.

N. A patient whose out of pocket medical expenses for the twelve months prior to services exceed or is equal to 20% of the gross annual income will be eligible to participate in Medical Indigence coverage program which will cover services at 100% for a period of twelve months from the time the 20% of medical expense is reached. (Please see attachment C for additional information)
    - Patients will be requested to provide documentation of outstanding medical bills for the twelve months prior to the service date.

Application Process

A. Patients are notified of the hospitals financial assistance programs through-out the billing cycle. The initial notification is placed on the first statement sent to the patient as well as the plain language summary which gives a brief description of the policy is included on every statement that is sent to a patient.
B. Patients are sent statements which progress in intensity each month for a period of 120 days before the account may be referred to an outside agency for further collection efforts.
C. In the event that a patient contacts the business office and inquires about financial assistance they are sent an application which includes the plain language summary along with a listing of required documentation.
D. A patient may also apply in person by visiting the Moss Campus screening department, the Main Campus Business Office or the Financial Counseling department.
E. Once an application is received all collection activities are placed on hold pending the outcome of the application determination. In the event that an application is received and the account has already been referred to an outside agency for further collection activities the agency is notified and the account is placed on hold pending the determination of the application.
F. The application is then evaluated to determine if all necessary documents for making a determination are included. If all documents are present then the information from the patient's application is processed and a determination is made.
G. A determination coversheet is provided to every patient. This cover sheet provides the determination reached for their application. An attached letter that is specific to the determination reached is also attached to further explain the determination to the patient.

H. When an application is approved and patient is determined to qualify for either the full or the partial programs then accounts are documented and the appropriate financial assistance payor source is added to the account/s. Any outside agency is notified to cease collection activities and the account/s is processed for the appropriate discount.
I. In the event that a patient does not qualify and the application is denied a determination cover sheet reflecting the denial along with a letter further explaining the denial and the available self pay discount programs is attached. The account is then taken off of hold and collection activities will resume.
J. In the event that a patient has not provided all of the documents necessary for completing their consideration the determination cover sheet is provided to the patient listing the documents necessary to complete their application consideration.
O. A patient is instructed to return any outstanding items within 10 days from the date of the request. However, an application will remain valid for up to 30 days in the event that a patient does return documents after the recommended 10 day period.
K. Patients may apply for financial assistance for accounts with an outstanding patient responsibility balance for up to 240 days from the date the patient is first billed for services.
L. If an application is approved for coverage through the program payments that are received from a patient after the application date may be refunded to the patient if the patient does not have other accounts that are outstanding from the patient that did not fall within the application time frame.

Final Determination

A. All patients are requested to provide documentation in order to apply for programs that they may be eligible for. The following documents will be considered sufficient evidence upon which to base the final determination of eligibility:
    - Documentation of 1 full months income (for all household income) (this must be current information and provided for the previous 30-45 day period)
    - Social Security cards for all household members.
    - Proof of Louisiana Residency (Louisiana Drivers License w/current mailing address of a household member, utility bill in a household members name with the current mailing address or a government letter addressed to a household member with the current mailing address).
    - In the event the patient does not qualify for full coverage and is being considered for the Medical indigence program copies of all outstanding medical bills.
    - Copy of photo ID for the responsible person if it was not provided as a Proof of Residency.
    - Copy of most current Federal Income Tax Return filed (for self employed patients or patients without current income) if the household does not have an income a statement of support form will be required along with a copy of the supporting persons picture ID.
    - Additional documentation may be requested based on the individual circumstances related to the case.
B. The patient and LCMH are responsible for pursuing other sources of funding, including Medicaid, Medicare, etc. The responsible party may be required to provide written verification of ineligibility for all other sources of funding.
C. If the responsible party is not cooperative with financial counselors regarding Medicaid applications, applications for Crime Victims Assistance, etc they will not be eligible for financial assistance.
D. If the account is due to an automobile accident the account will not be eligible for financial assistance until proof of benefits exhaustion or a denial letter from the auto insurance or the patient's attorney is received.

Insurance Primary Payor Source
Attachment A

Purpose

Lake Charles Memorial Hospital has contracted with multiple commercial insurance companies and has agreed to bill patients for amounts due regarding co-insurance, deductibles, and co-pays as determined by their coverage. LCMH will review on a case specific basis and will proceed accordingly as we are contractually obligated. Should there be no specifications regarding the patient portion LCMH will follow the guidelines below.

Criteria

A. Patients who have primary commercial insurance coverage will be considered eligible to apply for participation in the financial assistance program should they meet the requirements of the policy.

B. Patients who meet the eligibility for participation in the full financial assistance program will not be charged any amounts due after insurance processing as they are considered medically indigent.

C. Patients who meet the eligibility for participation in the partial financial assistance program will not be held responsible for more than the amounts generally billed percentage which is calculated yearly. If the AGB% of the total charges is less than their out of pocket amount then patients would not be charged more than the AGB%. If the patient's responsibility per their insurance is less than the AGB amount then the patient would be charged the lesser amount and would be held responsible for the insurance patient responsibility. (see attachment E for information regarding the AGB)

D. If the patients insurance denies a claim in full as it is not covered by the policy then the patient will be considered under the self pay portion of the financial assistance policy.

Medicare Additional Criteria
Attachment B

Purpose

Lake Charles Memorial Hospital is a Medicare provider and as such has agreed to follow Medicare Provider guidelines in regards to establishing medical indigence. Medicare patients will follow the guidelines in this attachment in order to be considered for the financial assistance program.

Criteria

In addition to the documentation requested in the financial assistance policy Medicare also requires a total resource evaluation including evaluation of patient's available assets that are easily convertible into cash and are unnecessary for patients daily living.

a. Medicare patients must provide copies of most recent complete bank statements including both checking and savings accounts. An evaluation will be made of the available balance removing the amount previously claimed as monthly income. (example: Patient has a checking account balance of $4,000 but their monthly income recently deposited for $2,000 so the checking account balance includes this income – the monthly income will be deducted from the balance as it is already claimed as income in previous steps of the financial assistance evaluation process)
b. Social security payment direct express card is not required as it only reflects income that is previously considered in the financial assistance evaluation.
c. Medicare patients must also provide proof of Certificate of Deposits (CD), Cash in a Safety Deposit Box, Stocks and or bonds
d. IRA's, 401K's and life insurance policies are not considered easily convertible into cash and therefore are not required

Lake Charles Memorial Health System will also take into consideration any extenuating circumstances that would affect the determination of the Medicare patient's indigence.

An analysis performed on the assets presented and electronically documented are in total not to exceed the limit of $4,000 per person or $6,000 per couple.

Medically Indigent Criteria
Attachment C – Added 1/15/2015

Purpose

This policy is designed to help LCMH staff identify patients that may be eligible for financial assistance due to medical indigence. There are patients who at times present for medical services that do not meet the income requirements for the full participation in the financial assistance program however they have experienced a hardship due to medical expenses.

Criteria

A patient whose family out of pocket medical expenses for the twelve months prior to services exceeds or is equal to 20% of the gross annual income will be eligible for full participation in the medically indigent financial assistance program for a period of one year from the approval date.

- Patients will be requested to provide documentation of outstanding medical bills for the twelve months prior to the service date.
- The patients out of pocket responsibility will be determined by calculating Total Family Yearly Income x 20% = This amount will be the amount that the patient is responsible for out of their pocket prior to Medically Indigent approval
- Once Medical Indigence is established the approval date will start from the date the patient reaches their out of pocket responsibility for one year forward.
- In the event that a patient has another payor source including participation in the partial financial assistance program only the amount the patient is held responsible for is to be considered as the patients out of pocket expense.

The Medical Indigence Worksheet must be completed and once calculations are complete must be approved by a supervisor, manager or director prior to final determination.

Unemployed Patient Living off Resources
Attachment D – Added 2/9/2015

Purpose

This purpose of this attachment is to provide additional direction in the event a patient is not employed and is living off of previously saved resource or account such as a checking, savings account, retirement or any other resource that is convertible to cash .

Criteria

In addition to documentation requested in the financial assistance policy patients who are unemployed and have not other source of income but are living off of a previously saved resource must also provide the following:

a. Documentation of assets that are easily convertible to cash and unnecessary for the patient's daily living.
    i. This does not include retirement assets or primary residential equity.
b. Most current bank statement showing their checking and savings account.
    ii. The bank statement will be reviewed to see what funds are available to them

Lake Charles Memorial Health System will also take into consideration any extenuating circumstances that would affect the determination of the Medicare patient's indigence.
An analysis performed on the assets presented and electronically documented are in total not to exceed the limit of $4,000 per person or $6,000 per couple.

Example 1: Patient is living off of an IRA totaling $150,000 and is receiving a monthly amount $2000.00 that the patient is living off of from this IRA.

- The total amount of the IRA would not be considered as it is retirement account
- The monthly amount being received would be considered as monthly income and considered according to the guidelines

Example 2: Patient has recently lost his job at the time of separation from the job the patient cashed out his retirement account and received a check for $10,000 which he has deposited into the bank and is now living off of.

- This amount would be considered as it has been converted into cash that he has received
- The patient is married and therefore is over resources at this time as the amount that he has on hand exceeds the $6,000 per couple maximum
- The patients monthly income would be zero however the patient is over resources for the financial assistance program

Amounts Generally Billed
Attachment E – Added 3/4/2015

Purpose

This purpose of this attachment is to provide detailed information regarding the calculation of the amounts generally billed (AGB).

Definitions

Amounts Generally Billed (AGB) – This is a calculation performed by the hospital annually. This calculation identifies a percentage that an eligible patient may be billed for services.

Criteria

In accordance with section §1.501(r)-5(b) in the of the 501R regulations Lake Charles Memorial Hospital has chosen to use the look back method in order to determine the hospitals AGB. This calculation is performed annually and any changes that are made to the AGB percentage will go into effect within 120 days from the calculation being performed. Patients who currently are participating in a program that may be affected by a change in the AGB percentage are notified at the time of the financial assistance approval in writing that this calculation is re-evaluated yearly and is subject to change. Those patients are also notified in writing prior to the change taking place.

The hospital performs this calculation by evaluating all accounts with Insurance, Medicare and Medicaid for a year prior to the calculation taking place. A comparison is done from the total charges of the overall accounts to the amounts that were adjusted due to the hospitals contractual agreements with said payor sources this calculation determines the average contractual percentage for patients with a payor source. This percentage is established as adjusted amount and the remaining difference is the amount established as the Amounts Generally Billed (AGB) percentage and is therefore billable to the patient.

Patients who are approved for financial assistance through Lake Charles Memorial Hospital will not be billed for more than the amounts generally billed (AGB). Patients who participate in the partial approval program will be held responsible for a discounted amount based on the amounts generally billed (AGB) percentage that is established in the annual evaluation.

Other Charity Approvals
Attachment F – Added 2/12/2016

Purpose

Lake Charles Memorial Hospital recognizes that there are instances where a patient or patient's guarantor is unable to meet the financial obligations due to they do not meet all criteria for the financial assistance program or have failed to cooperate with filing an application for financial assistance.

Definitions

Charity - Patients who do not meet criteria of the financial assistance program however have proven that they are financial unable to afford to pay their medical expenses incurred at Lake Charles Memorial Hospital. These patients are most often patients who reside in a different state but have cooperated by supplying all information and meet all other criteria of the financial assistance program.

Presumptive Charity – Patients who have not cooperated with applying for the financial assistance program but by utilizing available reference resources Lake Charles Memorial Hospital does not believe that the patient has a means to resolve their debt. Lake Charles Memorial Hospital will presume their eligibility for Presumptive Charity.

Criteria

Only accounts and the current outstanding balance will be considered for Charity and Presumptive Charity. The patient will not receive an ongoing approval for a timeframe moving forward as they will need to seek services in their local state for assistance or apply for the full financial assistance program and cooperate by returning all necessary documentation.

Charity

Patients who apply for and cooperate with providing documentation for the financial assistance program however they are not a Louisiana resident, therefore, do not meet the criteria for the Full coverage or Partial coverage financial assistance programs may be considered for their outstanding balances to be adjusted as a Charity account. Patients that have Medicaid with other states but LCMH does not have a provider number can also be considered as Charity. The applicant must meet the financial criteria based on the Financial Assistance Policy. The patients specifically approved account or accounts will be adjusted to the Charity adjustment code and the patient will no longer be billed for the approved services.

Presumptive Charity

LCMH recognizes that not all patients or patient's guarantors are able to complete the financial assistance application or provide requisite documentation. LCMH further recognizes that some patients or their guarantors are non-responsive to the application process, therefore, the hospital will utilize other electronic sources to make an informed decision on the financial need of the patient to qualify them for the Financial Assistance Program (UCC). Patients who have not cooperated with the Financial Assistance Program (UCC) either by not returning all of the requested documentation for the program or have not applied for the program or have ignored bills and other communication from the hospital may be considered for presumptive charity. Also those not capable of completing the traditional process may be considered for presumptive charity. These evaluations are a soft check and do not affect the patients credit in a negative way. Once it is identified that a patient is not likely to resolve their balances financially then these accounts are presumed to be Charity (Presumptive Charity). Presumptive Charity will be a last resort to qualify patients for the UCC program and will only be utilized after hospital as exhausted all collection efforts. Once all collection efforts are exhausted and it is identified that a patient does qualify for Presumptive Charity the account would be included in the hospital reporting for reimbursement under the hospital Cooperative Endeavor Agreement (CEA).

The account is taken out of the active AR and placed in the bad debt AR. The account is not assigned to any agency for further collections and is instead identified by an agent code that shows Presumptive Charity Bad Debt for the purpose to identify them to seek reimbursement under the CEA. This classification reflects that the hospital has identified the patients low likelihood of payment and is not pursuing further for collections. In the event the patient makes a payment or contacts the office to set up payment arrangements the Presumptive Charity Bad Debt assignment can be reversed and normal collection activities can resume. In the instance that a patient files for financial assistance after an account has been classified as Presumptive Charity Bad Debt the financial assistance application will be considered under the usual guidelines and any approval will be applied as defined in the policy.

Ryan White CARE Act Eligibility
Attachment G – Added 3/1/2016

Purpose

To comply with the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, Title XXVI, HIV Health Care Services Program in regards to annual cap on charges for applicable HIV patients. Section 2617 (c) of the Act mandates a limitation of the patient's financial responsibility under the program.

Definitions:

- Ryan White CARE Act requires all grantees or recipients receiving funding under the Ryan White CARE Act, to post a schedule of charges.
- Schedule of Charges – Table identifying the patient's financial responsibility for services provided in an applicable Lake Charles Memorial Health System (LCMH) clinic that is treating HIV patients for primary care.
- Eligible medical expenses – Any patient out-of-pocket medical expense, including inpatient and outpatient medical bills, enrollment fees, health insurance premiums, deductibles, cost sharing, co-payments, and coinsurance.
- Annual Cap – Limitation placed on the maximum financial responsibility that an HIV patient would be responsible for based on their individual income during a calendar year (January1-December31).

Policy:

Lake Charles Memorial Health System (LCMH) Patient Access Staff will provide a schedule of patient financial responsibility for HIV patients receiving outpatient treatment in a clinic setting at LCMH. The annual cap on the Schedule of Patient Financial Responsibility does not apply to services received at other private medical providers.

It is the responsibility of the patient to provide supporting documentation of all individual medical expenses to the Financial Counselor, in order to meet the annual cap. The annual cap is based on individual income for the calendar year. Persons meeting the annual cap will not be financially responsible for future outpatient services provided in any applicable LCMH outpatient clinic treating HIV patients for primary care throughout the end of the calendar year. The patient will be responsible for any inpatient admission charges.

Upon providing supporting documentation of individual medical expenses and being determined that the annual cap has been met, eligible discounts may be retroactive to the date the patient met the medical expense cap criteria for that calendar year and will be applied throughout the remainder of the calendar year. In the event that a patient has another payor source including participation in the partial financial assistance program only the amount the patient is held responsible for is to be considered as the patients out of pocket expense.

Procedures:

- A notice announcing the schedule of patient financial responsibility will be made available to all patients receiving services in the HIV outpatient clinic via either signage and/or a brochure.
- The documentation of individual monthly gross income will be performed by the Patient Access staff using the method utilized in each financial screening case. The FPG % will be noted in the system where required.
- Patients who may be potentially eligible for the annual cap are responsible for providing documentation of their individual income to the LCMH Patient Access Staff for accurate determination of the level of patient financial responsibility.

Income Criteria	Annual Cap of Patient Financial Responsibility
At or Below 200% of FPL	Free Care (no fees from patient required)
201%-300% of FPL	Patient responsible for 7% of annual gross income
301% or greater of FPL	Patient responsible for 10% of annual gross income

Patients Approved for Government Programs Expedited Approval (Draft submitted 6/13/16)
Attachment H – Added 6/1/2016

Purpose

This purpose of this attachment is to provide additional direction in the event a patient currently qualifies for Food Stamps or a Louisiana Medicaid program Lake Charles Memorial hospital may utilize proof of that coverage to prove the applicant qualifies for coverage through the financial assistance program. This is appropriate because the applicant has proven all of the eligibility criteria necessary for approval for the Lake Charles Memorial Hospital program to the State of Louisiana and their approval will support this information.

In order for a patient to qualify for food stamps or a Medicaid program the patient has proven US Citizenship, Louisiana Residence & that their income falls under 200% of the federal poverty guidelines.

Criteria

Lake Charles Memorial Hospital must receive proof of the applicant's coverage through Food Stamps or a Louisiana Medicaid Program by one of the following support documents.

- A Food Stamp or Medicaid decision Letter from the Louisiana State agency with the applicable effective date and coverage time frame (which must reflect current dates)
- A Print out from the Food Stamp or Medicaid office showing their eligibility with the applicable effective date and coverage time frame (which must reflect current dates)
- Proof of coverage verified verbally and recorded by a Lake Charles Memorial Hospital representative with an employee of the applicable Louisiana state agency. This must be documented included the phone number called, who was spoken to and the specific information verified on behalf of the patient. This documentation will be listed on the account in notes and included in the documentation to support the financial assistance application.

Examples

It is important that each team member understand when it is appropriate to utilize the Food Stamp or Medicaid approval. Please see below examples of applicable situations.

Example 1:
Patient applies for UCC for the month of June but doesn't have all supporting documents for a Financial Assistance approval. Based on the patients federal poverty guideline level Lake Charles Memorial Hospital processes a Medicaid application. The patient becomes eligible for Medicaid through the expansion program beginning July 1st. However, the patient has dates of service prior to the date their eligibility became effective through Medicaid.

Once Lake Charles Memorial is informed of the Medicaid approval by one of the above methods then it is appropriate to go back to prior dates of service based on the policies allowance to approve for Financial Assistance for prior dates of service. This is because the patient has proven all of the information needed for a Financial assistance approval directly to the State of Louisiana.

Example 2:
Patient is inpatient the patient reports that he is on food stamps. The financial counselor contacts a Louisiana State Representative to confirm this patient's coverage through food stamps and documents according to the policy. The financial counselor will proceed according to their criteria to determine if a Medicaid application is necessary however, the patient temporary financial assistance approval can be approved pending the Medicaid decision as the patient has already proven all of the information needed for a Financial assistance approval directly to the State of Louisiana.