Banner Health

Title: Banner Lassen Medical Center Financial Assistance Policy for Hospital Patients	
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Approved by: Administrative Policy Committee, PolicyTech Administrators, CFO	
Discrete Operating Unit/Facility: Banner Lassen Medical Center	

I. Purpose/Population:

A. Purpose: This Banner Health ("BH") policy and the Financial Assistance Program ("FA Program") outlined herein are intended to establish a non-discriminatory and consistent methodology for the provision of free or discounted emergency and other medically necessary (non-elective) care at Banner Lassen Medical Center ("BLMC"). This policy also establishes the billing and collections policies for all professional services billed to BLMC patients.

B. Population: All Employees.

II. Definitions:

A. Amounts Generally Billed (AGB) - the amount the Hospital generally bills insured patients for a Covered Service, determined using the "look-back method" as set forth in 26 CFR 1.501(r) – 5(b)(3). The AGB percentage for the Hospital can be found online at: https://www.bannerhealth.com/-/media/files/project/bh/patients-visitors/billing/financial-assistance/agb-summary.ashx

B. Application Period – the period during which BH must accept and process an application for financial assistance under the FA Program. The Application Period begins on the date the Covered Service is provided and ends on the 240th day after BH provides the first billing statement.

C. BLMC Provider Billing – any billing generated for a professional service rendered by a BLMC Provider.

D. Balance After Insurance (BAI) - any amount due by the patient after insurance payments have been finalized (e.g., deductibles, co-payments, and co-insurance). BAI does not include a Medicaid patient's share of cost for Covered Services (as determined by the state to be an amount the patient must pay in order for the patient to be eligible for Medicaid), and BH is not authorized to provide financial assistance to fund or waive this amount.

E. BLMC Provider – a provider who is either: (1) employed by Banner Health (or a controlled affiliate of Banner Health) and provides professional services at BLMC; or (2) an independent provider who has assigned to BH the right to receive reimbursement for professional services provided at BLMC.

F. Charity Care - Covered Services provided to a patient for which the patient is not expected to pay any amount.

G. Covered Services – Medically Necessary services provided by the Hospital or a BLMC Provider.

H. Discounted Care - Covered Services provided to a patient for which the patient is expected to pay a discounted amount.

I. Emergent Services – the services necessary and appropriate to treat a medical condition of a patient that has resulted from the sudden onset of a health condition with acute symptoms which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions, or result in serious dysfunction of any bodily organ or part.

J. Essential Living Expenses – household expenses including the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school and childcare; child and spousal support; transportation and auto expenses, including insurance, gas and repairs; installment payments; laundry and cleaning; and other extraordinary expenses.

K. Federal Poverty Level (FPL) - the annual income level for varying household sizes as set by the federal government.

L. Financial Assistance Program (FA Program) – The Hospital's program governing the provision of Charity Care and Discounted Care.

M. Gross Charge – the rate for a Covered Service that is generally charged to all patients, regardless of whether a patient has Third Party Insurance coverage, and is filed annually with the California Office of Statewide Health Planning and Development.

N. Hospital – Banner Lassen Medical Center

O. Hospital Providers - Physicians and other medical staff that provide emergency or other medically necessary healthcare services within a Hospital, as listed in Appendix A by group or department.

P. Medicaid - all California state and county public insurance programs which include (but are not limited to) Medicaid, Medi-Cal, CICP, and FES.

Q. Medically Indigent Household - a household with medical expenses incurred during the previous 12 months, where the portion for which the household is responsible exceeds 50% of the household's total income for that year. For the purposes of determining whether a household is a Medically Indigent Household, all medical expenses are included, including non-BH medical expenses.

R. Medically Necessary – services provided by the Hospital or a BLMC Provider that meet all of the following criteria:

1. Are required to treat an illness, injury, condition, disease, or its symptoms;
2. Are consistent with the diagnosis and treatment of the patient's conditions;
3. Are provided in accordance with the standards of good medical practice;
4. Are not provided for the convenience of the patient or the patient's physician; and
5. Constitute the level of care most appropriate for the patient as determined by the patient's medical condition and not the patient's financial or family situation.

Services provided by the Hospital to treat an Emergent Condition are deemed Medically Necessary.

S. Patient Balance Management (PBM) - the operating unit of BH responsible for billing and collecting self-pay accounts for services, including co-payments and deductibles.

T. Patient with High Medical Costs – a patient whose family income does not exceed 400% of the FPL and either: (1) the annual out-of-pocket costs incurred by the patient at the Hospital exceed 10% of the family income in the prior 12 months; or (2) the annual out-of-pocket medical expenses of the patient's family in the prior 12 months, together with those incurred by the patient at the Hospital, exceed 10% of the family income in the prior 12 months.

U. Self-Pay Rate – the amount initially charged to an Uninsured Patient for a Covered Service.

i. Hospital Self-Pay Rate: 125% of the applicable AGB for a Covered Service.

ii. BLMC Provider Self-Pay Rate: 70% of the applicable Gross Charge for a Covered Service.

V. Third-Party Insurance - an entity (corporation, company health plan or trust, health care marketplace company, automobile medical pay benefit, workers' compensation, etc.) other than the patient (or guarantor) that will pay all or a portion of the patient's medical bills.

W. Underinsured Patient - a patient with Third-Party Insurance coverage, but with financial limitations or co-responsibility, including deductibles, co-payments, and co-insurance.

X. Uninsured Patient - a patient without Third-Party Insurance and who is not enrolled in a government insurance program. Uninsured Patients are initially charged the Self-Pay Rate for Covered Services.

III. Policy:

a. Non-Discrimination. BH provides quality healthcare to all patients regardless of race, color, religion, sex, national origin, disability, age, sexual orientation, gender identity, veteran status, and/or ability to pay.

b. Scope.

i. Medically Necessary Hospital Services. This Policy applies only to Covered Services at the Hospital, subject to the exclusions set forth below.

ii. Hospital Providers. Not all Hospital Providers are subject to this Policy. Appendix A specifies which Hospital Providers, by department or group, are covered under this Policy and which are not.

iii. Non-Hospital Facilities. This Policy does not apply to non-hospital BH facilities (e.g., Banner Imaging, Banner Urgent Care centers) or non-hospital providers (e.g., certain physicians, advanced practice providers). The Banner Health Physician Practices/Clinics/Home Health Financial Assistance Policy (No. 1455) governs such BH non-hospital facilities and non-hospital providers.

c. FA Program. This Policy establishes a BH FA Program which, based on the patient's household income and amount of medical expenses, determines a patient's qualification for Charity Care or Discounted Care. Financial assistance will be provided for patients who are: (1) Uninsured Patients or Underinsured Patients and who meet the household income guidelines as outlined in this Policy, and/or (2) are members of a Medically Indigent Household. BH will limit expected payment for Covered Services from patients at or below 400% of the FPL to what it would expect, in good faith, to receive for providing the same Covered Service from Medicare, Medi-Cal, the Healthy Families Program, or another government sponsored health program in which BH participates, whichever is greater.

i. Financial Assistance Based on Household Income. Uninsured Patients and Underinsured Patients will qualify for financial assistance based on household income if: (1) their household income is 400% of the FPL or less; and (2) they complete an application for financial assistance or are determined to be presumptively eligible (see Section III.D.iv of this Policy). The amount of financial assistance BH provides to approved Uninsured Patients and Underinsured Patients is determined in accordance with the following tables:

Hospital Charges		
Household Income	**Discount Applied – Uninsured**	**Discount Applied - Underinsured**
< 200% of FPL	100% discount off AGB	100% discount off BAI
200% - 300% FPL	75% discount off AGB	75% discount off BAI

> 300% - 400% FPL	50% discount off AGB	50% discount off BAI

BLMC Provider Billing Charges		
Household Income	**Discount Applied – Uninsured**	**Discount Applied - Underinsured**
< 200% of FPL	100% discount off BLMC Provider Self-Pay Rate	100% discount off BAI
200% - 300% FPL	75% discount off BLMC Provider Self-Pay Rate	75% discount off BAI
> 300% - 400% FPL	50% discount off BLMC Provider Self-Pay Rate	50% discount off BAI

ii. Financial Assistance Based on Medically Indigent Household Status. Uninsured Patients and Underinsured Patients may qualify for financial assistance based on Medically Indigent Household status if: (1) the patient is a member of a Medically Indigent Household, and (2) the patient submits a completed application for such financial assistance.

- Uninsured Patients and Underinsured Patients with Household Income 400% of FPL or Lower. Uninsured Patients and Underinsured Patients receiving financial assistance based on household income pursuant to Section III.C.i of this Policy may also qualify for financial assistance based on Medically Indigent Household status if, *after the application of the discount in accordance with Section III.C.i*, the household still meets the definition of Medically Indigent Household. If approved, BH will provide such patients with a 75% discount off the patient's remaining balance.

- Uninsured Patients with Household Income Higher than 400% of FPL. Uninsured Patients with a household income higher than 400% of the FPL will initially be charged the Self-Pay Rate for Covered Services. BH will provide Uninsured Patients who qualify as a member of a Medically Indigent Household with a 75% discount off the applicable Self-Pay Rate for Covered Services.

- Underinsured Patients with Household Income Higher than 400% of FPL. BH will provide Underinsured Patients who are approved for financial assistance based on being a member of a Medically Indigent Household with a 75% discount off the patient's BAI.

iii. Emergency Physician Discounts. California law requires physicians who provide Emergent Services to provide discounts to Uninsured Patients and Patients with High Medical Costs who are at or below 350% of the FPL. To meet this requirement and to maintain consistency throughout BH, BLMC Provider physicians who provide Emergent Services at the Hospital will provide discounts to Patients with High Medical Costs and Uninsured Patients who are at or below 400% of the FPL in accordance with Sections III.C.i and 3.C.ii of this Policy.

iv. Maximum Charge for Qualifying Patients. Uninsured Patients or Underinsured Patients who qualify for financial assistance under this policy may not be charged more than AGB for Covered Services. In the event that the application of the tables in Section III.C.i to Covered Services produce a result that exceeds AGB, the charge for such Covered Services will be reduced to AGB.

v. Insurance Coverage. BH will make all reasonable efforts to obtain information from each patient about whether Third Party Insurance or Medicaid may cover all or a portion of the charges for care received at BLMC. The Hospital will have applications for Medicaid programs available for patients who may be eligible for such programs.

vi. Applying for Financial Assistance. Unless determined to be presumptively eligible for financial assistance as provided in Section III.D.iv below, patients must apply for financial assistance. Patients can obtain a financial assistance application in person at the Hospital or by downloading it from the BH website. Patients can also request an application to be mailed to the patient by calling 1-888-264-2127. All applications for financial assistance must be either physically delivered to the Hospital, mailed to the address provided on the application form, or submitted per instructions contained on the BH website.

vii. Verification of Income/Ability to Pay

- Patient income will be verified using the following items, which must be provided by the patient:
    - Prior year income tax returns,
    - 3 most recent pay stubs; and/or
    - 3 most recent savings and checking accounts statements.

- If a patient has no documented income and/or is not required to file U.S. income taxes (e.g., a retired patient), BH may assess the patient's ability to pay by comparing the patient's debt to the patient's equity. Debt includes all monthly expenses such as housing, automobile, healthcare, etc. Equity includes liquid assets (cash, stocks, bonds, and other assets that can be liquidated within 7 days) to cover outstanding bills. BH will give patients with a debt-to-equity ratio greater than 50% the same discount as patients qualifying for financial assistance based on Medically Indigent Household status.

viii. Notification of Eligibility Determination. Upon determination of eligibility for the FA Program, whether the patient is deemed eligible for financial assistance or ineligible for financial assistance, BH will send written notification of its determination to the patient's last known address.

ix. Applying Financial Assistance Discounts.

- Patients qualifying for financial assistance will have the applicable discount applied to all Covered Services received by the patient: (i)

within the previous 12 months from the date of qualification; and (2) within 180 days after the date of qualification.
- Patients who apply and are approved for financial assistance but have already paid at least $5 more than the discounted price for the Covered Service will be refunded the amount of the excess payment.

x. Reasonable Payment Plans.
- If a patient has a remaining balance after all financial assistance discounts have been applied, BH will make reasonable payment plans available to the patient. Monthly payments under such reasonable payment plans will not be more than 10% of the patient's remaining monthly family income after monthly Essential Living Expenses are subtracted.
  As applicable, the Hospital will obtain written agreements from affiliates, subsidiaries, and/or external collection agencies that they will comply with the Hospital's definition and application of a reasonable payment plan.

d. Billing and Collections. BH may take any and all legal actions, including Extraordinary Collections Actions ("ECAs"), to obtain payment for services provided where payment has not been made as of 120 days past the date of the first billing statement for those services (the "Notification Period"). ECAs include, but are not limited to, filing a legal complaint, filing a lien, and reporting such debts to credit agencies. BH will not use wage garnishments or liens on primary residences as a means of collection on any FA-eligible patient account.

i. Deposits. The Hospital may require a deposit from an Uninsured Patient prior to providing any service, except that no deposit will be required prior to providing emergency services. All Uninsured Patients must be notified of the availability of financial assistance and be provided with an application form upon request.

ii. Single Patient Account. When a patient has more than one bill outstanding, BH may aggregate the outstanding bills to a single billing statement. However, no ECA will be initiated for any service until the end of the Notification Period for that particular service.

iii. Notification of Outstanding Bill. During the Notification Period, BH will mail billing statements to patients (and guarantors, if applicable) at the last known address. A billing statement will include:
- A summary of the services covered by the statement;
- The actual charges for each service (including amounts charged to a Third-Party Insurance provider);
- The amount required to be paid by the patient (or guarantor) for each service;
- A written notice informing the recipient of the availability of financial assistance under the FA Program, accompanied by a plain language summary of the FA Program and information regarding how to apply for financial assistance (the "Plain Language Summary Document");

- A request that the recipient inform BH if the patient has Third Party Insurance coverage, Medicare, Medicaid, or other coverage;
- A written notice informing the recipient of Medicare and Medicaid programs and information on how to apply for such programs; and
- The name and address of a local consumer assistance center at a legal services office.

BH may also attempt to contact patients and/or guarantors by phone or send emails and text messages notifying them of their outstanding balance and providing an opportunity to review the statements digitally.

iv. Presumptive Eligibility for Financial Assistance. Prior to initiating any ECA, BH will, either directly or via a third-party vendor, determine whether the patient/guarantor is presumptively eligible for financial assistance based on household income. Such determination will be made in accordance with the Presumptive Eligibility for Enhanced Financial Assistance for Uninsured Patients Procedure. If a patient/guarantor is determined to be presumptively eligible for financial assistance based on household income, the patient/guarantor is not required to fill out an application and the discounts in Section III.C.i will be automatically applied to the account in accordance with Section III.C.vii of this Policy. However, if the patient/guarantor has already paid for any of the Covered Services for which the discount would apply, the patient/guarantor must apply and be approved for the FA Program in order to have the discount applied to those Covered Services.

v. Final Collection Efforts Prior to ECA. Prior to initiating any ECA, BH will send a bill to the patient's (and/or guarantor's) last known address that informs the recipient of the specific ECAs BH intends to take if, by the last day of the Notification Period, the patient/guarantor does not: (1) apply for financial assistance under the FA Program; (2) pay the full amount due; or (3) establish a payment arrangement with BH. This billing statement will include the Plain Language Summary Document and will be sent at least 30 days prior to the end of the Notification Period. BH must also make a reasonable effort to orally notify the patient about the FA Program and how the patient may obtain assistance with the FA Program application process.

- If the patient/guarantor submits a complete application for financial assistance under the FA Program, BH will not initiate any ECA while the application is pending.
- If the patient/guarantor submits an incomplete application for financial assistance under the FA Program, BH will give the patient/guarantor a reasonable amount of time to provide the information needed to complete the application. If the patient/guarantor fails to provide the requested information by the deadline provided, BH may initiate an ECA.
- If the patient/guarantor provides a complete application for financial assistance under the FA Program after an ECA has been initiated, such ECA will be suspended until BH has made a final determination regarding the patient/guarantor's eligibility for the FA Program.

- If the patient/guarantor establishes a payment arrangement with BH, BH may initiate an ECA after three consecutive missed payments.

vi. Third Party Collection Efforts. If BH refers or sells a patient debt to another party during the Application Period, the written agreement must obligate such third party to comply with the relevant provisions in Section III.D of this Policy, as well as all applicable provisions of the Hospital Fair Pricing Policies Law. The agreement will also obligate such third party to require the same provisions if such third party refers or sells the debt to yet another party.

e. Write-Offs and Adjustments.

i. Eligibility. Regardless of whether a patient is eligible for financial assistance under the FA Program, BH will provide Uninsured Patients a 100% discount on a Covered Service and will waive the BAI for any Underinsured Patient if:
- The patient enrolls in Medicaid within 12 months *after* the Covered Service has been provided; or
- The patient enrolls in Medicaid at the time the Covered Service is provided but Medicaid funding is not available to pay for the Covered Service or Medicaid denies coverage for the Covered Service.

ii. Approval Authority for Write-Offs. All write-offs and adjustments must be approved in accordance with the following:
- Write-offs/adjustments up to $5,000: Must be approved by PBM Manager
- Write-offs/adjustments $5,000 and over: Must be approved by PBM Director. PBM Director may delegate this authority to the Hospital CFO.

f. Reservation of Right to Seek Reimbursement of Charges from Third Parties. If any third party is held to be legally liable for any portion of a patient's BH bill, BH will seek full reimbursement from such third party of all charges incurred by the patient at the applicable contractual or governmental rate or, if there is no applicable contractual or governmental rate, the applicable Self-Pay Rate, regardless of whether any financial assistance was provided to the patient under the FA Program.

g. Out of Network and Denied Services. Out of Network patients and patients whose claims have been denied by their private insurance company will be initially charged the applicable Self-Pay Rate for all Covered Services.

IV. Procedure/Interventions:

A. N/A

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

A. Patient Protection and Affordable Care Act, Section 9007
B. Internal Revenue Code, Section 501(r)
C. California Health and Safety Code Section 127400 et seq
D. California Welf. & Inst. Code Section 14124.74
D. 29 C.F.R. §1.501(r)-1 through §1.501(r)-7
E. Notice 2015-46, Internal Revenue Bulletin 2015-28 (July 13, 2015)
F. 79 Fed Reg 78954-79016

VIII. Other Related Policies/Procedures:

A. Banner Health Financial Assistance Policy for Hospital Patients (#770)
B. Banner Health Non-Hospital Facilities Financial Assistance Policy (#1455)

IX. Keywords and Keyword Phrases:

A. Financial Assistance Program
B. Patient Assistance Program
C. Uninsured Patients
D. Billing
E. Collections
F. Charity Care
G. Self-Pay Discount

Appendix:

A. Hospital Provider List

APPENDIX A

Hospital Provider List

The following list contains Hospital Providers, by Department or Group, that provide Medically Necessary healthcare services within BH Hospitals and which of those Hospital Providers are covered by this Policy.

Department or Group	Covered	Non-Covered
Banner Medical Group – Hospitalists	X	
Non-Banner Employed[1] – Hospitalists		X
Banner Medical Group – Intensivists	X	
Non-Banner Employed[1] – Intensivists		X
Banner Medical Group – Specialists[2]	X	
Non-Banner Employed[1] – Specialists[2]		X
Non-Banner Employed[1] – Anesthesiologists		X
Banner Medical Group – Telemedicine	X	
Non-Banner Employed[1] – Telemedicine		X
Banner Health Ground Ambulance Services	X	
Non-Banner Health Ground Ambulance Services		X

This Appendix will be reviewed quarterly and updated, if necessary. Revisions to the Hospital Provider List contained in this Appendix does not require approval of the BH Board of Directors.

[1] Non-Banner Providers that contract with Banner to provide Billing Services are treated as covered entities.

[2] Specialists includes but is not limited to: Emergency Room, Surgeons, Radiologists, Labor and Delivery, and Trauma providers.