Banner Health

Policy and Procedure
Policy #: A21
Status: Active
Version #: 2
Effective Date: 5/14/2001
Revised Date: 4/21/2004
Scope: Banner Health
Population: All Employees

Title: *Financial Assistance Program for Insured Patients*

I. Purpose:

Banner Health (Banner) is dedicated to providing quality healthcare to all patients regardless of age, sex, race, religion, disability, veteran status, national origin and/or ability to pay. Banner makes every effort to complete a financial evaluation at the earliest possible point in the registration/accounting process for all patients indicating an inability to meet their financial obligation and will provide a Financial Assistance Program application once all other options for reimbursement have been exhausted. Banner's Financial Assistance Program for Insured Patients addresses the interest of providing access to care for those without the ability to pay their portion of the costs of their care.

This policy applies solely to patients who have third party coverage for the Covered Services Banner provides to them, either through governmental sources or commercial insurance. It is intended to apply only to the portion of charges for Covered Services for which the patient has personal responsibility, e.g. co-insurance, deductibles, co pays, and does not apply to non-Covered Services. This policy does not apply to charges for services from other providers whose services are coincident to those provided by Banner, e.g., surgeons, anesthesiologists.

II. Policy:

A. Definitions.

Medicaid: The use of the term "Medicaid" throughout this document will refer to all State and Federal Programs which include (but is not limited to) Medicaid, Medi-Cal, AHCCCS, CICP, FES, etc.

Covered Services: Those inpatient and outpatient services provided by a Banner hospital and which are Medically Necessary in accordance with the standards of Banner's Medicare fiscal intermediary.

Medically Necessary: Services required to identify or treat an illness or injury that is either diagnosed or reasonably suspected to be medically necessary. The most appropriate level of care, depending on a patient's medical condition, may be a home, a physician's office, an outpatient facility, or a long-term care, rehabilitation or hospital bed. A service must:

- be required to treat an illness or injury or
- be consistent with the diagnosis and treatment of the Patient's conditions; and
- be in accordance with the standards of good medical practice; and
- be not be for the convenience of the Patient or the Patient's physician; and
- be performed at the most appropriate and readily available level of care or manner required by the Patient's medical condition; or
- be that 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.

B. Insured patients who are unable to pay for their portion of hospital services are potential Financial Assistance Program patients. The criteria under which a patient will be considered for eligibility will be based upon the following:

1. Income (using poverty levels established annually by the Department of Health and Human Services);

2. Household size;
3. Assets and liabilities;
4. Estimated medical bill;
5. Other extenuating circumstances.

C. Patients eligible for Financial Assistance Program consideration will receive Medically Necessary services on an uncompensated or reduced basis using the matrix below. Eligibility will be based on the financial evaluation and determination of their ability to meet the financial obligation for the claim in question.

D. Upon approval for eligibility, write-offs will be processed promptly in accordance with procedures, state statutes and regulations.

E. Patients who are able, but unwilling, to pay for hospital services are considered uncollectible bad debts and will be referred to outside agencies for collection.

F. Services will be eligible for write-off if:
1. A patient qualifies for Medicaid after service has been provided by Banner. This includes any bills for services that predate Medicaid coverage.
2. A patient qualifies for Medicaid but funding is not available to pay for services or Medicaid denies coverage for particular Covered Services.

G. Financial Assistance Program write-offs will be granted subject to the following approval limits:
1. Up to $5,000 - Patient Accounts Manager
2. Over $5,000 – Patient Accounts Director

H. The Patient Accounts Director will be responsible to monitor the appropriateness of the Financial Assistance Program, the charges, patient days, and allowances.

I. A patient who fails to fully cooperate with the Medicaid eligibility process will not be eligible for Banner Financial Assistance Program. **(ADMITTING)**

III. Procedure/Intervention(s):

A. Document eligibility for Financial Assistance Program.
1. Notify Medicaid on inpatients with no insurance or insufficient coverage, who cannot pay in full at time of service.

2. Request a copy of the patient's past year's Federal income tax return, current bank statements, pay stubs and a completed Banner Financial Assistance application.

3. Use the Federal Poverty Guidelines as a source to determine eligibility for Financial Assistance Program multiplied by the factors in the attached grid ***(see section V: Additional Information)***. Net worth (assets

less liabilities) will be factored into the income guidelines in cases where guarantor has significant assets, but may not have a steady income.

4. Provide patient and /or the family with guidance through this process. **(FINANCIAL COUNSELING DEPARTMENT)**

5. Write-off the patient account using the appropriate general ledger account number when it is determined that the write-off is appropriate. A monthly allowance for Financial Assistance Program is also calculated to properly reserve accounts receivable. **(FINANCE)**

6. The appropriate Financial Assistance Program funding will be reversed if patient becomes eligible for any third-party funding source.

IV. Documentation (Documents & Forms):

N/A

V. Additional Information:

Financial Assistance Program matrix below outlines the discount from billed charges, with pro forma illustrations for a family size of 4 on following pages:

	Account Balance						
Income Level	**<$1,000**	**$1,001 - $2,500**	**$2,501 - $5,000**	**$5,001- $10,000**	**$10,001 - $25,000**	**$25,001 - $50,000**	**>$50,000**
0 – 100% of FPL	100%	100%	100%	100%	100%	100%	100%
101 - 150% of FPL	80%	85%	100%	100%	100%	100%	100%
151 - 200% of FPL	70%	75%	80%	100%	100%	100%	100%
Over 201% of FPL	0%	0%	0%	0%	0%	0%	0%

Pro forma illustration:

	Account Balance						
Income Level Max, 4 Family Members	**<$1,000**	**$1,001 - $2,500**	**$2,501 - $5,000**	**$5,001- $10,000**	**$10,001 - $25,000**	**$25,001 - $50,000**	**>$50,000**
< 18,400	100%	100%	100%	100%	100%	100%	100%
< 27,600	80%	85%	100%	100%	100%	100%	100%
< 36,800	70%	75%	80%	100%	100%	100%	100%
> 36,800	0%	0%	0%	0%	0%	0%	0%

VI. References:

N/A

VII. Other Related Policy/Procedures:

A. Financial Assistance Policy for Uninsured Patients

VIII. Cross Index As:

Financial Assistance Program