

Surgical Specialty Center of BR

Policy/Procedure

Manual: Business Office	Policy No: DM.BO.CHTYWRT.720
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SCOPE: Applies to those uninsured or underinsured emergency and other medically necessary care provided by the 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:

SSC 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. SSC 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 the Hospital** 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 ear piercing, breast augmentation, abdominoplasty, Botox injections, blepharoplasty, chemical peels, skin tag removal, dermal fillers, sclerotherapy, and dermatological laser treatments.

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- ii. Cosmetic dental procedures
 - iii. Bariatric surgery
 - iv. Circumcision
 - 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 Hospital, are not covered by this FAP. A list of providers rendering professional services in the Hospital facility is maintained in a document separate from the FAP and is available on the Hospital website. Patients may request paper copies, free of charge, by calling the Hospital admissions department
- 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 SSC 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.
- 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

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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 by SSC see Addendum C. 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 Addendum A.
- K. **Notification** about SSC 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 admissions areas, and at other public places that SSC may elect. SSC 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 the Hospital. Paper copies of these documents will be provided to patients upon request and by mail.

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- L. SSC management 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 the Hospital’s website. See **Addendum A** for information. 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.
- 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 a portion of their patient responsibility, or be rescheduled (in non-emergency cases only).
- 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**.
- B. **Verification of income is required** for any financial assistance request. The following documents must be provided:
 - a. A completed financial assistance application

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- b. Photo ID or legal ID
- c. Current and prior year 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 for the last six months.
 - 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 SSC 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.

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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). SSC 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 138%** of the FPL will qualify for a full write-off of all hospital charges, assuming they meet the other eligibility criteria set out in the FAP.
- B. **Underinsured** patients (see Definitions section) will be treated as **uninsured** patients for purposes of financial assistance.

IV. 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 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

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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 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 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. SSC 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 Finance department manager at the Hospital has final authority and is responsible for determining that reasonable efforts have been made so that ECAs are then allowable.

V. DEFINITIONS:

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

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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 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. The hospital does not have an emergency room, but will triage patients who have presented to the hospital. The hospital complies with the required EMTALA rules and regulations.

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;

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- 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

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

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adjustment, for the services not covered. This does not apply when the third-party coverage does not provide coverage at SSC for services that would otherwise be authorized in the payer's network of providers.

ATTACHMENTS: Addendum A – Listing of Hospital Website and Contact Numbers
Addendum B – FPL Guidelines
Addendum C – Amounts Generally Billed (AGB)

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ADDENDUM A. Listing of Hospital Website, Physical Address, and Contact Number

Hospital	Website	Admissions Department Location	Phone Number
Surgical Specialty Center	www.sscbr.com	8080 Bluebonnet Blvd. Baton Rouge, LA 70810	(225)408-5585

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ADDENDUM B. Federal Poverty Level Guidelines

The U.S. Department of Health and Human Services Federal Poverty Level table as published annually in the Federal Register. Latest information is available on this Website

<https://aspe.hhs.gov/poverty-guidelines>

ADDENDUM C. Amounts Generally Billed (AGB)

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The current AGB calculation percentage is thirty-three percent (34%).

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