RESPONSIBLE DEPARTMENT: Revenue Cycle		SUBJECT: Financial Assistance
NUMBER OF PAGES: 8		REPLACES POLICY (NUMBER/DATE): All previous Charity policies at all FMOLHS hospitals FIN.04.29 FIN.04.29b
ORIGINAL EFFECTIVE DATE: 06/2013	REVISIONS EFFECTIVE: 09/01/2024	POLICY NUMBER: REV.10.001

SCOPE:

Applies to all emergency and other medically necessary care provided by FMOLHS entities, including all such care provided in the FMOLHS Hospital facilities and related entities (collectively, "FMOLHS"), including but not limited to:

- Our Lady of the Lake Hospital
- Our Lady of Lourdes Regional Medical Center
- St. Dominic-Jackson Memorial Hospital
- St. Francis Medical Center
- Our Lady of the Angels Hospital
- Assumption Community Hospital
- Retail and Specialty Pharmacies

PURPOSE:

The purpose of this Financial Assistance Policy (FAP) is to specify:

- Eligibility criteria for Financial Assistance in the form of free care and copay assistance.
- How to apply for Financial Assistance;
- How FMOLHS calculates amounts charged to patients.
- How the FAP is widely publicized within the community served by the Hospital and clinics and pharmacies.
- What actions FMOLHS may take in the event of non-payment; and
- Compliance with applicable state and federal laws and regulations.

POLICY:

FMOLHS is committed to providing financial assistance to those who have healthcare needs and are **uninsured or underinsured** for emergency and medically necessary care based on their individual financial situation. FMOLHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

DEFINITIONS:

340B program: program created under Section 340B of the Public Health Service Act allowing for certain safety net providers to purchase covered drugs at substantially discounted pricing.

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 FMOLHS 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. Generally, the patient is seen and/or admitted through the emergency room. See section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Financial Assistance: Financial Assistance is defined as medical services provided at no charge (or a reduced 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;
- 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 FMOLHS' full established rates for the provision of patient care services before deductions are applied.

Medicaid Indigency: Patients who do not qualify for traditional Medicaid but are presumed indigent by qualifying for limited-benefit State programs; and patients that have Medicaid coverage through a non-contracted state.

Medically Necessary Care: Medical treatment that is appropriate and necessary for treatment of the presented symptoms, as defined by Medicare and third-party payers

Presumptive Financial Assistance: Assistance granted on the basis of a scoring system, for uninsured and underinsured patients. A financial form on file is not required for approval of presumptive financial assistance.

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 low-income person who has private healthcare insurance. However, this does not apply when the third-party coverage does not provide coverage at an FMOLHS facility.

PROCEDURE *as implemented on October 1, 2023***:**

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** FMOLHS entities for the diagnosis and treatment of illness or injury. FMOLHS will determine whether a non-emergency service is

medically necessary care that is eligible for Financial Assistance. Services specifically **excluded** from eligibility for Financial Assistance 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 breast augmentation, abdominoplasty, Botox injections, blepharoplasty, chemical peels, skin tag removal, dermal fillers, sclerotherapy, and dermatological laser treatments.
    ii. Cosmetic dental procedures
    iii. Bariatric surgery
    iv. Circumcision (unless medically necessary)
    v. Genetic testing
    vi. Hormone replacement therapy
    vii. Stretta therapy
b. Personal items provided during an inpatient stay, e.g. guest trays, private rooms that are not medically necessary.
c. 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 non-FMOLHS treating physicians, physician assistants, or advanced practice clinicians in the Emergency Department may or may not be covered by this FAP. A list of providers rendering emergency and other medically necessary care in the Hospital facility is maintained in a document separate from the FAP and is available upon request. Patients may request paper copies, free of charge, by calling the Hospital's main phone number and asking for the Financial Counseling department at Our Lady of the Lake and the Admissions department at all other Hospitals. A listing of physical addresses, and phone numbers is located in ***Addendum A*** of this policy.

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 FMOLHS 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. FMOLHS will provide assistance to individuals in applying for government programs.

G. FMOLHS will not deny Financial Assistance under this FAP based on an applicant's failure to provide information or documentation that FMOLHS does not specify in this FAP or in the FAP application form. FMOLHS 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 FMOLHS personnel essential to the Financial Assistance process.

I. The actions FMOLHS may take in the event of non-payment are described generally in this FAP. **FMOLHS 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 for each FMOLHS Hospital/entity. Any needed change will be implemented within 120 days of the calculation. FMOLHS 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 Appendix A for the applicable FMOLHS entity.

K. **Notification** about FMOLHS 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 emergency rooms and admissions areas, and at other public places that FMOLHS may elect. FMOLHS 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 each FMOLHS Hospital. Paper copies of these documents will be provided to patients in the emergency room and other admission areas upon request and by mail.

L. FMOLHS management and facilities 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 each Hospital's website. See ***Addendum A*** for a listing of websites, physical addresses, and telephone numbers for each Hospital facility. Directions for returning the completed application are detailed in the financial assistance application. FHP patients may apply at the nearest FMOLHS hospital location.

B. The availability of financial assistance will be publicized to patients at intake or discharge. Financial Counselors will screen interested patients and assist in completing the application for financial assistance. Financial Counselors are available in the Hospital at the Admissions Department to assist in completing the application or answering any questions related to this FAP. The Admissions Department of each hospital can be found by following the clearly marked signage in the public pathways at the Hospital. Hospital addresses can be found in ***Addendum A.***

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 gross charges times the AGB percentage that applies to the entity where services will be rendered or will be rescheduled (in non-emergency cases only). If the uninsured person has started but not completed the financial assistance process, the uninsured person will be required to pay a non-refundable **Standard Deposit** (see ***Addendum B*** for Standard Deposits) or be rescheduled when a deposit can be paid, or information can be provided to complete the FAP application (in non-emergency cases). NOTE: For services rendered in provider-based physician clinics, a deposit equal to the AGB percentage times gross charges will be used instead of the standard deposit.

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** and may:

a. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

b. Include reasonable efforts by FMOLHS to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
c. Take into account the patient's available assets, and all other financial resources available to the patient.

B. **Verification of income is required** for any financial assistance request. The following documents must be provided:

a. A completed financial assistance application
b. Photo ID or legal ID
c. Most recent 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.
    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 FMOLHS 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.

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). FMOLHS 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 275%** of the FPL will qualify for a

a. full write-off of all hospital charges, excluding any Standard Deposits previously paid, assuming they meet the other eligibility criteria set out in the FAP.
b. Reduced prescription pricing if eligible for the 340B program.

B. Uninsured patients whose family income **exceeds 275%** of the FPL may qualify for

a. **catastrophic** medical assistance, depending on the patient's particular financial circumstances. If the patient's medical bills for the 12 months immediately preceding treatment are greater than or equal to twenty percent (20%) of their annual family income, the patient may be granted financial assistance in the form of a discount. This discount will be applied such that the patient amount owed would equal 10% of the annual family income amount.
b. Reduced prescription pricing if eligible for the 340B program.

C. Underinsured patient eligibility will be determined based on presumptive screening criteria (see below).

IV. PRESUMPTIVE FINANCIAL ASSISTANCE

A. Presumptive eligibility for financial assistance occurs when FMOLHS uses information other than that provided by the individual to determine eligibility for free care.
- Uninsured will be written off at 100%.
- Remaining balances will be adjusted off for underinsured patients.

B. Presumptive Financial Assistance may be granted via a Financial Assistance Scoring Model. The scoring system is similar to credit scoring and is produced by an FMOLHS-approved vendor. Only those accounts that fall below the scoring system minimum will be considered for presumptive financial assistance.

C. Uninsured patients with no health insurance or other third-party payment source that fall outside of the presumptive qualification for 100% adjustment will receive an uninsured discount.

V. MEDICAID INDIGENCY

Patients who do not qualify for traditional Medicaid but do qualify for limited-benefit state programs will be presumed indigent and their account balances adjusted accordingly. Examples include State-funded prescription programs; LACHIP; State food stamp programs; Medicaid Spend-Down; and other limited-benefit Medicaid programs. Patients that have Medicaid coverage through a non-contracted state also qualify for the Medicaid Indigency adjustment.

Note: *The information described herein does not create any legal rights and FMOLHS reserves the right to deviate from,revise or eliminate this policy, at any time, in its sole discretion.*

STATUTORY/REGULATORY AUTHORITY (including References):

N/A

ATTACHMENTS:

- Addendum A – Listing of FMOLHS Websites and Contact Numbers
- Addendum B – Standard Deposits

Policy Oversight by:

Vice President of Revenue Cycle

ADDENDUM A. Listing of FMOLHS Websites, Physical Addresses, and Contact Numbers

Hospital	Website	Admissions Department Location	Phone Number
Our Lady of the Lake Hospital	www.ololrmc.com/financialassistance	5000 Hennessy Blvd Baton Rouge, LA 70808	(225)765-7921 (800)327-3284
Our Lady of Lourdes Regional Medical Center	www.lourdesrmc.com/financialassistance	4801 Ambassador Caffery Lafayette, LA 70508	(337)470-2000
St. Dominic-Jackson Mem. Hosp.	www.stdom.com/financialassistance	969 Lakeland Drive Jackson, MS 39216	(601)200-2000
St. Francis Medical Center	www.stfran.com/financialassistance	309 Jackson Street Monroe, LA 71201	(318)966-4000
Our Lady of the Angels Hospital	www.oloah.org/financialassistance	433 Plaza Street Bogalusa, LA 70427	(985)730-6700
Assumption Community Hospital	www.ololrmc.com/financialassistance	135 Highway 402 Napoleonville, LA 70390	(985)369-3600

NOTE: Please do not use the above address for submitting financial assistance applications. The proper address can be found on the application form itself.

ADDENDUM B. Standard Deposits

Hospital	Surgical Procedure Standard Deposit	Radiology Standard Deposit	All Other Services Standard Deposit
Our Lady of the Lake Hospital	$200	$10	$10
Our Lady of Lourdes Regional Medical Center	$200	$25	$25
St. Dominic-Jackson Memorial Hospital	$200	$25	$25
St. Francis Medical Center	$200	$25	$25
Our Lady of the Angels Hospital	$200	$25	$25
Assumption Community Hospital	n/a	$10	$10