Title: **Banner Health Non-Hospital Facilities Financial Assistance Policy**	
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Approved by: Administrative Policy Committee, Chief Financial Officer, PolicyTech Administrators	
Discrete Operating Unit/Facility:	**Ambulatory Services** Banner Behavioral Health Outpatient Services Banner MD Anderson Cancer Center Banner Medical Group Banner Surgery Centers Banner Urgent Care Services Banner University Medical Group Banner Alzheimer's Institute Occupational Health/Employee Services Rural Health Clinics Banner Health Clinics Banner Imaging Services Banner Home Care and Hospice (BHCH) Banner Pharmacy Services Post-Acute Services (PAC) Research

I. Purpose/Population:

A. Purpose: This policy is intended to establish a non-discriminatory and consistent methodology for the provision of free or discounted emergency and other medically necessary (non-elective) care by Banner Health ("BH") providers in non-hospital facilities; This policy also establishes the billing and collections policies for such services billed to patients.

B. Population: All Employees.

II. Definitions:

A. 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.

B. BH Provider Billing – any bill generated for a professional service rendered by a BH Provider.

C. BH Provider – a provider who is either: (1) employed by BH, Banner Medical Group, Banner Medical Group Colorado, Banner—University Medical Group, or any other controlled affiliate of BH; or (2) an independent provider who has assigned to BH the right to receive reimbursement for professional services provided.

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

E. Covered Services – includes inpatient, outpatient, and emergent Medically Necessary services for which a BH Provider Billing is generated.

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

G. Emergent Condition - means 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 of the patient or result in serious dysfunction of any bodily organ or part.

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

I. 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.

J. Medicaid - all state public insurance programs which include (but are not limited to) Medicaid, AHCCCS, CICP, and FES.

K. 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.

L. Medically Necessary – services provided by a BH 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 a Hospital to treat an Emergent Condition are deemed Medically Necessary.

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

N. Qualified Clinic – any health center, clinic, or other non-hospital practice setting in which a BH Provider physician practices regularly and is receiving, either directly or indirectly, student loan repayment assistance through any governmental program which requires that any physician receiving such student loan repayment assistance must practice in a setting that offers a sliding fee scale for patients based upon the patient's individual or individual income.

O. Self-Pay Rate - the amount for Covered Services charged to Uninsured Patients, which is equal to a 30% discount off the Gross Charge for that Covered Service.

P. 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.

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

R. 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. This Policy applies to Covered Services provided a BH Provider at BH non-hospital facilities. This policy does not apply to cosmetic and non-Medically Necessary care and procedures, except as may be determined on a case-by-case basis.

c. Program. This Policy establishes the BH Financial Assistance Program for non-hospital facilities 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 for Covered Services 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. Qualified Clinic patients will be charged for Covered Services on a sliding scale, as set forth Sections III.C.i and III.C.ii below.

    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:

Qualified Clinics and BH Providers (excluding Colorado)		
Household Income	**Discount Applied – Uninsured**	**Discount Applied - Underinsured**
< 200% of FPL	100% discount off Self-Pay Rate	100% discount off BAI
200% - 300% FPL	75% discount off Self-Pay Rate	75% discount off BAI
> 300% - 400% FPL	50% discount off Self-Pay Rate	50% discount off BAI

Colorado patients receiving care at Qualified Clinics in Colorado may qualify for higher discounts under Colorado HB 21-1198 (Health Care Billing Requirements for Indigent Patients).

Colorado Qualified Clinics and BH Providers		
Household Income	**Discount Applied – Uninsured**	**Discount Applied - Underinsured**
< 200% of FPL	100% discount off Self-Pay Rate	100% discount off BAI
200% - 250% FPL	Colorado Discounted Care Pricing (CDCP) if approved. If not approved for CDCP, 75% discount off Self-Pay Rate	Colorado Discounted Care Pricing (CDCP) if approved. If not approved for CDCP, 75% discount off BAI
> 250% - 300% FPL	75% discount off Self-Pay Rate	75% discount off BAI
> 300% - 400% FPL	50% discount off 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 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. 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 a hospital, clinic, or other BH facility 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 a BH Facility, mailed to the address provided on the application form, or submitted per instructions contained on the BH website.

iv. 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.

v. Notification of Eligibility Determination. Upon determination of eligibility for the financial assistance, 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.

vi. 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.

vii. Qualified Clinics

- Patients of Qualified Clinics will be eligible for Charity Care or Discounted Care as outlined Sections III.C.i and III.C.ii.
- The manager of a BH physician receiving student loan repayment assistance under government program should notify the PBM Director that such physician's facility should be treated as a Qualified Clinic under this Policy.
- Each Qualified Clinic will have appropriate signage notifying patients of availability of financial assistance.
- Qualified Clinic staff will notify patients who qualify under this Policy of the appliable Charity Care or Discounted Care amount.
- Qualified Clinic staff will perform prequalification screening process with patient prior to services being rendered.
- To maintain eligibility at a Qualified Clinic, a patient must reapply for financial assistance every 6 months, or if their financial situation changes.

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.

i. Deposits. BH 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; and
- A written notice informing the recipient of the availability of financial assistance, accompanied by a plain language summary of the this Policy and information regarding how to apply for financial assistance (the "Plain Language Summary Document").

BH may also send patients (and guarantors) 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.vi 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 financial assistance 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; (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 financial assistance and how the patient may obtain assistance with the financial assistance application process.

- If the patient/guarantor submits a complete application for financial assistance, BH will not initiate any ECA while the application is pending.
- If the patient/guarantor submits an incomplete application for financial assistance, 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 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 financial assistance.
- If the patient/guarantor establishes a payment arrangement with BH, BH may initiate an ECA after three consecutive missed payments.

e. Write-Offs and Adjustments.

i. Eligibility. Regardless of whether a patient is eligible for financial assistance, 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 or Home Health Patients Account Manger
- Write-offs/adjustments $5,000 and over: Must be approved by PBM Director or Home Health Director.

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 Self-Pay Rate, regardless of whether any financial assistance was provided to the patient.

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 Self-Pay Rate for all services received.

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. Colorado Indigent Care Program, C.R.S. 25.5-3 (HB 21-1198)
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 Lassen Medical Center Financial Assistance Policy for Hospital Patients (#3658)

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

X. Appendix:

A. N/A