Banner Health

Title: **Financial Assistance for Hospital Patients**	
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Approved by: Administrative Policy Committee, Banner Health Board of Directors, Chief Financial Officer, PolicyTech Administrators	

Discrete Operating Unit/Facility:

Hospitals

Banner Baywood Medical Center
Banner Behavioral Health
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Ocotillo Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner—University Medical Center Phoenix
Banner—University Medical Center South
Banner—University Medical Center Tucson
Cardon Children's Medical Center
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional MedCenter
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Banner Corporate

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
Occupational Health/Employee Services
Rural Health Clinics

Banner Home Care and Hospice (BHCH)

Banner Pharmacy Services

Insurance

Banner Health Network
Banner Plan Administration
University Physicians Health Plans

Post-Acute Services (PAC)

Research

I. Purpose/Population:

A. **Purpose**: This policy and the Financial Assistance Program outlined herein are intended to ensure a non-discriminating and consistent methodology for the provision of free or discounted emergency and other medically necessary care at Banner Health (BH) hospitals. This policy only applies to BH hospitals and not to other BH facilities or non-hospital providers (e.g., physicians, ASCs, imaging, urgent care). It should be used as a companion to Banner's policy entitled Banner Health Physician Practice/Clinics Financial Assistance Program. In addition, BH offers Uninsured Patient Discounts under a separate policy for Uninsured Patients that do not qualify for the Financial Assistance Program outlined in this policy.

Upon adoption by the BH Board of Directors, acting in its capacity as the governing body for each such hospital, this policy and the Financial Assistance Program set forth herein will constitute the official financial assistance policy (within the meaning of Section 501(r) of the Internal Revenue Code) for each such hospital.

B. **Population**: All Employees.

II. Definitions:

A. Amounts Generally Billed (AGB) means the Gross Charges for Medically Necessary services provided to a patient, multiplied by the Hospital-Specific AGB Percentage. The AGB is specific to each Hospital and is calculated based upon the "historical look-back method, as prescribed in Treasury Regulations 1-501(r)-5(b)(3)(ii)(B).

B. Balance After Insurance (BAI) means amounts due by the patient after insurance adjudication is complete (e.g. deductibles, co-payments, and co-insurance). BAI does not include the patient's share of cost for Medicaid/AHCCCS as determined by the state to be an amount the patient must pay in order for the patient to be eligible for Medicaid/AHCCCS, and BH is not authorized to provide financial assistance to fund or waive this amount.

C. Billing and Collections Policy means the BH Policy entitled: "Patient Financial Services: Billing and Collection Policy for Self-Pay Accounts," as the same may be amended from time to time.

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

E. Continuum of Care means continuing care that is Medically Necessary to keep the patient out of an Emergent Condition.

F. Covered Services means those inpatient and outpatient services provided by a BH hospital which are Emergent or otherwise Medically Necessary care in accordance with the standards of BH's Medicare fiscal intermediary.

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

H. Eligible Individual means an individual eligible for Financial Assistance under this policy and the Financial Assistance Program hereunder without regard to whether the individual has applied for financial assistance.

I. 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.

J. Emergent Services means the services necessary and appropriate to treat an Emergent Condition.

K. Federal Poverty Level (FPL) means the annual income level for varying household sizes set by the federal government to establish households living above or below the defined poverty level.

L. Gross Charges means the rates for Covered Services that are filed annually with the Arizona Department of Health Services or other applicable state agency for the relevant Hospital. If rates are not required to be filed annually with any state agency by the relevant Hospital then the Gross Charges will be the rates for Covered Services as set forth in the chargemaster for that Hospital at the time the Covered Services are rendered.

M. Hospital means each hospital owned or leased by BH, and each hospital operated by BH at which the BH Board of Directors has governing body authority over the operations of such hospital.

N. Hospital-Specific AGB Percentage means, for each Hospital, a percentage derived by dividing (1) the sum of all claims for services provided at such Hospital during the Relevant Period allowed by Medicare fee-for-service and all private health insurers as primary payors, together with any associated portions of these claims required to be paid by Medicare beneficiaries or insured individuals in the form of co-pays, co-insurance or deductibles (without regard to whether such amounts were actually paid), by (2) the Gross Charges for such Medically Necessary Services. The Hospital-Specific AGB Percentage shall be calculated for the initial Relevant Period no later than November 14th of each year, for the most recently completed Relevant Period. Each Hospital-Specific AGB Percentage will be effective until the next annual calculation the Hospital-Specific AGB Percentage. The calculation of the Hospital-Specific AGB Percentage for each Hospital shall comply with the "look-back method" described in Treasury Regulation 1-501(r)-5(b)(3)(ii)(B). (see also Section II.A above).

O. Medicaid means all State and Federal Programs which include (but are not limited to) Medicaid, Medi-Cal, AHCCCS, CICP, and FES.

P. Medically Indigent Household means a household with medical expenses incurred during the previous 12 months for which the household is responsible which 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.

Q. Medically Necessary means those services required to identify or treat an illness or injury that is either diagnosed or reasonably suspected; considering the most appropriate level of care. To be Medically Necessary, a service must:

1. Be required to treat an illness or injury;
2. Be consistent with the diagnosis and treatment of the patient's conditions;

3. Be in accordance with the standards of good medical practice;
4. Not be for the convenience of the patient or the patient's physician; and
5. 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.

Emergent Services are deemed to be Medically Necessary.

R. PFS means Patient Financial Services, the operating unit of BH responsible for billing and collecting Self-Pay accounts for Hospital services, including co-payments and deductibles.

S. Relevant Period means the 12-month period ending on November 30, 2013, for financial assistance provided from January 1, 2014 until the Hospital Specific AGB Percentage is calculated based on claims paid during the 12-month period ending on September 30, 2014. Thereafter, the Relevant Period means each 12-month period ending on September 30.

T. Self-Pay Rate means, for each Hospital, 125% of the AGB for that Hospital.

U. Third-Party Insurance means an entity (corporation, company health plan or trust, 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.

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

W. Uninsured Patient means a patient without Third-Party insurance and ineligible for government programs, in either case that may be billed for Covered Services provided to the patient.

III. Policy:

A. General. BH provides quality healthcare to all patients regardless of age, sex, sexual orientation, gender preference, race, religion, disability, veteran status, national origin and/or ability to pay. This policy establishes BH Financial Assistance programs which, based on household income and the level of medical expenses, determine a patient's qualification for Charity Care or Discounted Covered Services. Eligibility for financial assistance will be provided for those individuals who are Uninsured or Underinsured and who meet the household income guidelines as outlined in this policy, or are members of a Medically Indigent Household.

B. Financial Assistance for Uninsured Patients. Uninsured Patients will qualify for BH financial assistance if: (a) their household income is less than 400% of FPL, (b) they cannot qualify for Medicaid/AHCCCS or other government program, or are unable to reasonably complete the application process for such governmental programs, and (c) they complete an application for financial assistance (unless determined to be presumptively eligible, as provided below), in accordance with the following table:

Financial Assistance-Uninsured Patients Charity and Discounted Care	
Household Income	Amounts Charged
200% of < FPL	Full Charity 100% Discount, write-off entire patient account
>200%-300% FPL	75% discount off AGB (i.e., patient owes 25% of AGB)
>300%-400% FPL	50% discount off AGB (i.e., patient owes 50%
>400% FPL	Does not qualify for BH Financial Assistance Policy; refer to Self-Pay Rate for Uninsured Patients below

C. Financial Assistance for Underinsured Patients. Underinsured Patients will qualify for financial assistance if: (a) they complete an application for financial assistance, in accordance with the following table:

Financial Assistance—Underinsured Patients with a Balance After Insurance	
Household Income	Balance after Insurance
<200% of FPL	100% discount of BAI
>200%-300% FPL	75% discount of BAI
>300%-400% FPL	50% discount of BAI
>400% FPL	Does not qualify for BH financial assistance unless a member of a Medically Indigent Household

D. Financial Assistance for Members of Medically Indigent Households. Patients who are members of Medically Indigent Households will qualify for BH financial assistance, subject to application for financial assistance, as follows:

1. If an Uninsured Patient, the patient is responsible for 25% of the patient liability (including any adjustment of the patient liability amount pursuant to application of the BH Financial Assistance Policy for Uninsured Patients, i.e., if the Uninsured Patient is a member of a Medically Indigent Household which has a household income of 400% of FPL, the patient would owe 25% of the BAI (without regard to the amount of the BAI).
2. If an Underinsured Patient, the patient is responsible for 25% of the BAI (without regard to the amount of the BAI).

E. Self-Pay Rate for Uninsured Patients. Uninsured Patients who do not qualify for financial assistance, whether due to failure to apply (unless determined to be presumptively eligible, as provided below), having a household income in excess 400% of FPL, not being a member of a Medically Indigent Household or any other reason, will be charged the Self-Pay Rate (i.e., 125% of AGB) for services received.

F. Write-Offs and Adjustments.

1. Covered Services will be eligible for write-off, in whole or in part if;

   a. A patient qualifies for Medicaid/AHCCCS after service has been provided by BH (100% write-off). This includes any bills for services that predate coverage;

b. A patient qualifies for Medicaid/AHCCCA, but funding is not available to pay for services or Medicaid/AHCCCS denies coverage for Covered Services (100% write-off).
c. A patient is approved for financial assistance based on the guidelines and requirements outlined above in this policy, upon approval, write-offs and adjustments will be processed promptly in accordance with this policy, applicable procedures, state statutes and regulations.

2. Signature Authority for Write-Offs. Financial Assistance Program write-offs will be granted subject to the following approval limits:

   a. Up to $5,000 – PFS Manager;
   b. Over $5,000 – PFS Director, unless delegated to hospital CFO by the Director.

3. Notification of FAP-Eligibility. Upon determination of eligibility, an individual who is determined to be eligible for the Enhanced Financial Assistance Program shall be notified in writing of such determination.

G. Providers Not Covered. This policy does not apply to charges for services from physicians and allied health professionals who are either employed or not employed by BH or its affiliates, including in all departments of the Hospital (e.g., emergency department physicians, radiologists, pathologists, surgeons, anesthesiologists, and hospitalists). These physicians and other providers are not part of the Hospital and are not substantially related to the Hospital within the meaning of Section 501(r) of the Internal Revenue Code. Each Hospital will maintain a list of all departments of the Hospital indicating that charges for services from both Banner employed and non-Banner employed providers are not covered by this policy. As noted previously above, there is a separate BH policy which deals with Providers; Banner Health Physician Practice/Clinics Financial Assistance Program.

H. Reservation of Right to Seek Reimbursement of Charges from Third Parties. If any first- or third-party payor is liable for any portion of a patient's bill, BH will seek full reimbursement of all charges incurred by the patient at the applicable contractual or governmental rate applicable to such payor or, if there is no applicable contractual or governmental rate, the Self-Pay Rate, from such first- or third-party payors, including situations governed by the provisions of A.R.S. Section 33-931, et. Seq. (or the analogous provisions of the laws of other states as applicable) despite any financial assistance granted pursuant to this policy.

I. Eligibility Period. If a patient qualifies for financial assistance under this policy (other than because of the patient's membership in a Medically Indigent Household), all outstanding balances for Covered Services 12 months prior to and 180 days post qualification will be eligible for the appropriate discount or write-off. Any account within the current fiscal year or the previous 12 months and that has been placed in bad debt will be returned from the vendor and written off based on BH Financial Assistance guidelines.

J. Refunds. If an individual who has paid for services is subsequently determined to be FAP-Eligible, the Hospital will refund any amount paid for care by the FAP-Eligible Individual that exceeds the amount a FAP-Eligible Individual would have paid; however, the Hospital is not required to refund excess payments of less than $5.

K. Methods for Applying for Financial Assistance. Unless determined to be presumptively eligible, patients must apply for financial assistance. Patients may apply for financial assistance by any of the following methods:

1. Advising PFS personnel at or prior to the time of registration that they are unable to pay some or all the actual or anticipated hospital charges.
2. PFS personnel will offer all Uninsured Patients a financial assistance application form.
3. PFS and BH selected Medical Eligibility vendors will assist the patient in applying for Medicaid and for financial assistance under this policy.
4. Downloading the financial assistance application form from the BH or BH Hospital website and mailing to the PFS department at the address on the application form.
5. Requesting an application from PFS by phone: 480-684-7409 or, if outside Arizona, 855-244-7460 or, by mail: 525 W. Brown Road, Mesa, AZ 85201 and returning a completed application to the above address.
6. Any of the methods specified in the Billing and Collection Policy.

L. Presumptive Eligibility. BH may determine that an individual is eligible for financial assistance based on information other than that provided by the patient or a prior determination of eligibility for financial assistance. Such information will be obtained by accessing, either directly or using a third-party vendor, information from credit agencies (e.g., Equifax), using the individual's social security number, to determine the individual's annual income and family size, and then comparing such information to the eligibility criteria under this Policy. Such determination will be made in accordance with the "Presumptive Eligibility for Financial Assistance for Patients – Procedure" policy, as the same is modified from time to time. Upon such a presumptive determination, the application requirement is deemed waived, and the patient shall be treated for all purposes as being eligible for financial assistance from the effective date of the determination. Some qualifying indicators for presumptive eligibility may be:

1. Patient is documented as being homeless;
2. Patient has expired with no known estate;
3. Patient is currently incarcerated;
4. Patient currently qualifies for public health programs including, but not limited to; Social Security, unemployment benefits, Food Stamps, WIC or other indigent related 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. C.R.S. 25-3-112 (Colorado SB 12-134)
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. Patient Financial Services: Billing and Collections Policy for Self-Pay Accounts (#772)

IX. Keywords and Keyword Phrases:

A. Financial Assistance Program
B. Patient Assistance Program
C. Uninsured Patients
D. Legal
E. Board
F. Finance
G. Charity Care

X. Appendix:

A. Summary of Financial Assistance Programs at all Hospitals and Operated by Banner Health (BH)

Appendix A

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Banner Health offers Financial Assistance Programs to Uninsured, Underinsured and Medically Indigent patients. This policy only applies to Banner hospitals and not to other BH facilities such as ASCs, imaging or urgent care. An Uninsured Patient means a patient without benefit of health insurance or government programs that may be billed for Covered Services provided to them based on Federal Poverty Level (FPL) guidelines, not otherwise excluded from this policy. An Underinsured Patient means a patient with qualified insurance coverage with significant limitations or co-responsibility. A Medically Indigent Patient means a patient with family medical expenses for a given calendar year which exceeds 50% of the household's total income.

If you are an Uninsured patient, you may qualify for a discounted rate if you do not meet the qualifications for the Financial Assistance Program based on Federal Poverty Level guidelines. Qualification for the discounted care means, you will be charged 1.25 x AGB (Amounts Generally Billed,) which is based upon the average of the amounts that would have been paid to the Hospital by private health insurers and Medicare (and co-pays and deductibles) for the medically necessary services you receive, if you had been insured.

If you are an Uninsured patient, you will qualify for BH Financial Assistance (1) if you have an annual household income and household size that is equal to or less than 400% of the Federal Poverty Level and lack other assets to pay the Hospital's full charges and, (2) if requested to do so by the Hospital, you apply for Medicaid/AHCCCS, fully cooperate in the application and determination process, or are unable to reasonably complete the application process, and are denied Medicaid/AHCCCS coverage.

If you are an Underinsured patient, you may qualify for BH Financial Assistance for Underinsured/Balance After Insurance discount. You will need to apply for consideration and meet both Hospital bill balance requirements stated in the Financial Assistance Policy and Federal Poverty Level guidelines.

If you qualify for BH Financial Assistance, you will in no case be charged more than Amounts Generally Billed for emergency services or other medically necessary services. In addition, you will never be required to make advance payment or other payment arrangements to receive emergency services. However, to receive non-emergency services, you will be required in most situations to make a substantial advance deposit or other payment arrangements based upon an estimate of the Amounts Generally Billed.

A free copy of the hospital's financial assistance policy, the billing and collections policy, and the application forms are available on the Banner website at Bannerhealth.com. Copies are also available by mail by contacting Banner Patient Financial Services at (480) 684-7409 or, if outside Arizona (855) 244-7460.The Banner Patient Financial Services staff is available to answer questions and provide information about the Financial Assistance Programs, the application process and nonprofit organizations and government agencies that can assist with these applications. Spanish and other translations of this Summary, the Hospital's financial assistance and billing policies, and the applications forms are available on the Banner and Hospital websites and in the hospital's Admitting area. They may also be requested by contacting the Banner Patient Financial Services staff at (480) 684-7409 or, if outside Arizona (855) 244-7460.