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Financial Assistance- AD.0083

PURPOSE

The purpose of this policy is to establish guidelines pursuant to which Lakeland Regional Health Medical Center (LRHMC) and Lakeland Regional Health Systems (LRHS), collectively Lakeland Regional Health (LRH), will provide financial assistance for a patient whose financial status makes it impractical or impossible to pay the entire bill for emergent and urgent medical services provided by LRH. With the exception of the Uninsured Discount provision applicable to LRH, this policy applies only to services performed at a LRHMC Hospital/Hospital Based Clinics and the related professional fees for services performed at a LRHS facility by providers employed by LRH. This policy does not apply to other healthcare providers who independently bill for their services. This policy does not apply to non-medical services such as social, educational, or vocational services, or to elective services (ie: prescheduled surgical cases are excluded from Financial Assistance unless approved ahead of time by the LRH Medical Director; care given at Hospital Based Clinics is only included for Morrell Internal Medicine, Kathleen Family Medicine or Center for Fetal Care unless approved ahead of time by LRH Medical Director; and cosmetic or bariatric surgical procedures are excluded). The provision of free or discounted care to patients through this Financial Assistance Policy (FAP) is consistent with and essential to the execution of LRH's mission, vision, and values. Our policies guide our practices and ensure that we place people at the heart of all we do to deliver the best outcomes and safest care.

APPLICABILITY

This policy applies to Lakeland Regional Health's Workforce

POLICY

Applying for Financial Assistance

Applications for and information related to the Financial Assistance Program will be available in the admissions area and all patient registration areas. Information can also be obtained by calling

863-687-6218, emailing Financialassistance@myLRH.org or by going to the LRH website (myLRH.org).

LRH is committed to serving its community by helping to promote community-wide responses to patient needs in partnership with government and private organizations. In order to promote the health and well-being of the community served, patients will be eligible for free or discounted healthcare services based on this policy. The hospital will provide, without discrimination, care for emergency conditions (within the meaning of EMTALA) to individuals, regardless of whether they are eligible for financial assistance. Debt collection activities are prohibited from occurring in the Emergency Department or in other hospital venues if such activities interfere with the treatment of emergency medical conditions. The necessity for medical treatment of any patient is based on the clinical judgment of the provider without regard to the financial status of the patient.

Services that are pre-scheduled and/or deemed not emergent, medically necessary, experimental, related to a research study, self-pay bariatric/cosmetic surgical procedures covered under a flat rate agreement, pricing package or an elective cosmetic procedure are not covered under this policy. Patient balances for Bariatric procedures authorized by primary insurance may not be considered for financial assistance after insurance payments unless the remaining amount is more than the Bariatric/Cosmetic flat rate agreement of the self-pay patient and then it will be adjusted down to the flat rate agreement.

Eligibility Determinations

Eligibility can be determined once a completed and signed application form (can be an electronic signature) along with all required supporting documentation has been received. Medicare recipients must complete and sign the full application along with requested documentation. Presumptive eligibility tools may be used to verify income if the patient is unwilling or unable to sign an application and/or provide the required documentation.

To be eligible for financial assistance, the patient must cooperate with LRH to provide the information and documentation necessary to file claims for any available insurance coverage and to apply for and cooperate with documentation requirements for other programs that may be available to pay the patient's health care bills, including, but not limited to, Medicaid, Florida Kid Care, Victims of Crime, Polk Indigent Health plan or any County run indigent program. Should documentation not be supplied or should the application remain incomplete, financial assistance will NOT be granted, unless the patient meets the eligibility criteria of Presumed Indigent status discussed below. In these instances, the lack of compliance will be documented and the account will be subject to the normal account flow process of self-pay collection statements, referral to a collection agency, and credit bureau reporting.

Residency Requirement

For non-emergent or non-urgent services, only those patients residing in the LRHMC primary service area will be eligible for financial assistance pursuant to this policy. The following zip codes make up the LRHMC primary service area: 33801, 33803, 33805, 33809, 33810, 33811, 33812, 33813, 33815, 33823, 33849, 33860, 33868, 33802, 33804, 33806, 33807, 33835, 33840, 33846, 33863, 33563, 33564, 33565, 33566 and 33567.

Individuals outside of the eligible zip codes and eligible for other third-party coverage but choosing not to use their coverage or patients who seek care outside their provider network or from outside the

service area will be eligible for a uninsured discount based on the AGB percentage.

Patients may be required to provide valid proof of residency such as:

- Valid Florida driver's license
- Recent residential utility bill
- Lease agreement
- Vehicle registration card
- Voter registration card
- Statement from a family member who resides at the same address as the patient and presents verification of residency
- Letter from a homeless shelter, transition house, or other similar facility

Financial Assistance Guidelines

Accounts for which a completed Financial Assistance Application is received within 240 days of the first billing statement for services provided at an LRHMC facility or by the date stated in the notice describing the date after which credit bureau reporting may be initiated are eligible for a Financial Assistance Review.

The LRHMC Patient Financial Services Department maintains a chart based on the FPG (as amended from time-to-time) for use by personnel in calculating the financial obligation of any patient meeting the criteria for financial assistance described below.

To be eligible for a 100% Financial Assistance Adjustment (i.e., full write-off), the patient must be uninsured and the patient's Household Income must be less than or equal to 200% of the current FPG (adjusted for family size). If the patient's Household Income is greater than 200% and less than or equal to 400% of the current FPG (adjusted for family size), the patient will receive a Financial Assistance Adjustment that is based upon LRHMC's Amounts Generally Billed (AGB) percentage. By January 28th of each year, the AGB percentage will calculated by dividing the sum of allowed amounts for claims for services allowed by Medicare Fee-For-Service and all private health insurers during the prior twelve-month period ended September 30 by the gross charges for such claims. No individual eligible under this Financial Assistance Policy will be given a Financial Assistance Adjustment which is less than amount calculated using the AGB percentage. The AGB percentage in effect as of February 1, 2024 is 20%, thus the Financial Assistance Adjustment based on the AGB percentage is 80%. In all situations described in this paragraph, the Financial Assistance Adjustment will be applied to the outstanding balance of an account after payments by third parties, if any.

The Financial Assistance Adjustment based on the AGB percentage will also be applied to the outstanding balance, after payments by insurance, if any, of patients with Catastrophic Medical Expenses, as defined below. Uninsured patients of LRHMC who are not eligible for financial assistance based on the provisions of the policy will receive an Uninsured Discount based on the AGB percentage.

No patient shall be personally responsible to pay an amount for a service performed at a LRHMC facility which is in excess of an amount determined by multiplying the Financial Assistance Adjustment based on the AGB percentage by the billed charges for the service. If a patient is not eligible for a larger

adjustment based on the Financial Assistance programs of this policy, the patient will be given an adjustment equal to the uninsured discount based on the AGB percentage to reduce the amount owed by the patient after payment by insurance and the application of any contractual adjustment to an amount equal to the AGB percentage multiplied by the billed charges for the service.

If an individual is determined to be eligible for Financial Assistance for a service provided at a LRHMC facility, the applicable Financial Assistance Adjustment will be applied to any related services provided by LRH employed providers at the LRHMC facility.

Any excess payments made by a patient on an account which is eligible for a Financial Assistance Adjustment will be refunded.

If a patient is determined to be eligible for financial assistance, the patient shall be eligible for financial assistance for all emergent services rendered in the twelve-month period subsequent to the date of the determination and six months prior to the date of determination. Absent a reasonable belief that Household Income has changed materially, the limited application process will include completion of the required application and, if possible, verification of Household Income using presumptive eligibility tools.

After the Financial Assistance Adjustment has been made, the patient will be eligible for a payment plan with an annual payment not exceeding 10% of the patient's Household Income. Under extraordinary circumstances, the Chief Financial Officer may approve an exception allowing for longer payment terms.

If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date within 240 days of the original determination. Patients will be instructed to notify LRHMC of a change in financial status and will be advised that they may request a change in payment plan terms based on a change in financial status. Eligibility for financial assistance is reevaluated as outlined below:

- Household Income change
- Family size change

Efforts to Identify Individuals Who May Be Eligible for Financial Assistance

Reasonable efforts will be made to determine whether a patient is eligible for financial assistance. During the first 240 days after the first post-discharge or post-service (for Outpatients) billing statement, LRHMC or LRHMC's agent (i.e., a Collection Agency) will notify the patient about the Financial Assistance Policy. The patient will receive at least three billing statements that include language about applying for financial assistance and will receive one written notice that informs the patient that credit bureau reporting may be initiated if financial assistance is not applied for or the account is not paid. The written notice will include a Plain Language Summary of the Financial Assistance Policy. If it is deemed that a patient qualifies for financial assistance and any information has been mistakenly reported to a credit bureau prior to 240 days from the first post- discharge or post-service billing statement, any adverse information reported will be retracted.

All patients identified as potential financial assistance recipients will be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient is discharged, or in the case of outpatients or emergency patients, a LRHMC representative will mail the appropriate Financial

Assistance Application to the patient if the Financial Assistance Application is incomplete, the hospital will provide the individual with a written notice requesting the additional information and/or documentation needed to complete the application to be returned within thirty days of the written notice. The hospital or its agent (i.e., a Collection Agency) will also provide the patient with at least one written notice that informs the patient that credit bureau reporting may be initiated if the patient does not complete the application or pay the amount due. The written notice will specify the date, which shall be at least 30 days after the date of the notice, after which credit bureau reporting may be initiated. Credit bureau reporting is the only Extraordinary Collection Activity (ECA) that is permitted pursuant to this policy.

Documentation Requirements

All patients requesting Financial Assistance will be required to complete a Financial Assistance Application and provide the requested supporting documentation needed to verify eligibility. The application may be signed electronically. The statement shall include an acknowledgement that, in accordance with Section 817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or service is a felony of the third degree.

Presumptive financial assistance decisions for uninsured patients may be determined based on Income Determination form and/or third-party analytics, using a credit inquiry process only if the reported FPL of the patient meets the criteria for financial assistance and therefore a full application is not required and considered to meet presumptive eligibility. Medicare recipients are not eligible for this presumptive financial assistance.

One or more of the following forms of income verification may also be requested or used to validate information provided on the application:

- PARO/Search America/FAS or other presumptive eligibility tools
- W-2
- Current pay stubs
- Income tax returns
- Form approving or denying unemployment compensation or workers' compensation
- Written verification of wages from an employer
- Written verification from public welfare agencies or any governmental agency of the patient's income
- A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for the Medicaid fiscal year have been exhausted
- Self-employed patients or patients owning income-generating property may be required to provide detailed income and expense information pertaining to their business or investment properties.

Financial Counselors may approve Financial Assistance Adjustments for amounts up to $25,000. The Director of Patient Access will approve any Financial Assistance Adjustment from $25,000 - $50,000. The AVP/Revenue Cycle will approve any Financial Assistance Adjustment from $50,000 - $100,000. The CFO will approve any amounts greater than $100,000.

All records including applications, documentation, and authorization of financial assistance will be scanned into the patient account folder and maintained for a period of no less than seven (7) years.

Notification of Eligibility Determination

A written decision regarding eligibility will be provided to the patient unless the patient was approved under Presumptive Eligibility. This notification will state the amount of financial assistance (for approvals) or a notice of denial. LRHMC will provide a billing statement to the individual that indicates the amount owed, if any, shows or describes how the patient can get information regarding the AGB percentage for the care provided, and how the discount was determined.

The Supervisor of the Financial Assistance Team is responsible for assuring that eligibility determinations are made in a manner which is consistent with this policy. If a patient has questions about a determination, the patient will be given an opportunity to discuss the determination with the Supervisor and to have a review of the determination conducted by the Director of Patient Access, AVP/ Revenue Cycle and/or Chief Financial Officer.

Collection Activities

LRH will not engage in the following collection activities for any patients (even if they do not qualify for financial assistance):

- Place a lien on an individual's property
- Foreclose on an individual's real property
- Attach or seize an individual's bank account or any other personal property
- Commence a civil action against an individual
- Cause an individual's arrest
- Cause an individual to be subject to a writ of body attachment
- Garnish an individual's wages
- Demand payment for a prior bill as condition of receiving future services at LRHMC. This prohibition does not apply to office-based services provided by LRH.

LRHMC or its representatives (i.e., a collection agency) may report a patient to a credit bureau if the patient has received a written notice (and an attempt has been made to provide oral notification) specifying the date, which shall be not less than 30 days after the date of the notice, after which credit bureau reporting may occur. Credit Bureau reporting may not occur earlier than 240 days after the date the patient received the first billing statement for the care provided. These limitations do not apply to LRHS.

Measures to Widely Publicize

Information about the Financial Assistance Program shall be disseminated by various means, including written and verbal communications with patients regarding their bill. Signage shall be visible at all points of registration and throughout public locations in the hospital in order to notify patients of the financial assistance program. At a minimum, signage shall be posted in all patient intake areas, including, but not limited to, the Emergency Department and the Admission/Patient Registration area. Conspicuous written

notice of the availability of financial assistance will appear on patient billing statements. Copies of the Financial Assistance Policy, applications, and a Plain Language Summary of the Financial Assistance Policy will be made available upon request and without charge. Notification of the Financial Assistance Policy and a Plain Language Summary of this policy shall also be available on the LRH website. All public information and/or forms regarding the Financial Assistance Policy shall be available in English and Spanish. Information sheets summarizing the Financial Assistance Policy will be made available to local public agencies such as The Polk HealthCare Plan, Lakeland Volunteers in Medicine, the Health Department, and other entities as deemed appropriate.

Monitoring and Reporting

The cost of care provided pursuant to this Financial Assistance Policy is reported annually in LRHMC's Community Benefit Report. LRHMC reports the cost of care provided (not charges) using the most recently available cost to charge ratio or other basis which conforms to guidance of the Healthcare Financial Management Association Principles and Practices Board, Generally Accepted Accounting Principles, or Internal Revenue Service Guidelines. Any financial assistance offered under this policy is subject to review to ensure compliance with this policy.

Additional Financial Assistance Guidelines and Eligibility Criteria (Presumed Indigent)

In the following situations, a patient may be deemed to be eligible for a 100% reduction from charges: (In the below situations, a written notice is not required to be sent to the patient informing them of the 100% Financial Assistance Adjustment)

If a patient is currently eligible for Medicaid, Medicaid HMOs, The Polk HealthCare Plan, any county run indigent program or similar means tested government assistance programs which base eligibility on Household Income of less or equal to 200% of FPG, but was not eligible for coverage due to benefits exhausted or benefit not covered through the programs. Upon verification of eligibility for these programs, LRHMC will deem the patient to be eligible for a 100% Financial Assistance Adjustment as Presumed Indigent.

If a patient is receiving free care from a community clinic (ex. Lakeland Volunteers In Medicine, Health Department or Central Florida Health Care) which bases eligibility for services upon income, and the community clinic refers the patient to LRHMC for services, the patient will be considered eligible for a 100% Financial Assistance Adjustment as Presumed Indigent.

If a patient, that is not receiving Medicare, is found to be uninsured, and a Financial Assistance Application is not completed, the third-party tool analytics using a credit inquiry process to confirm the FPL of the patient and if within the FPL % above, then the patient will be considered eligible for the appropriate Financial Assistance Adjustment as Presumed Indigent.

If a patient is confirmed homeless by using a shelter address or confirmed no address via a third-party address verification tool, along with the third-party tool analytics using a credit inquiry process only if the reported FPL of the patient for then the patient will be considered eligible for a 100% Financial Assistance Adjustment as Presumed Indigent.

Victim of a violent crime of sexual assault and treatment related to same will be presumed indigent for

any patient responsibility after any third-party payments have been made.

If a patient is deceased, LRHMC will review state and local probate documents for proof of an estate. If no estate is found to be sufficient to cover the account balance after applying the AGB percentage, then the patient will be presumed indigent.

If a patient has a current bankruptcy judgment, LRHMC will verify such judgment and the patient will be presumed indigent.

If an uninsured patient that has an encounter balance that was not previously determined to be eligible, either through lack of information or incorrect information obtained, but LRH exhausted all collection efforts with no payment and account meets the criteria for a bad debt write-off, then LRH may review encounter eligibility by using any of the presumed indigent criteria noted above to confirm financial assistance eligibility in lieu of writing off to bad debt.

PROCEDURE

None

DEFINITIONS

Federal Poverty Guidelines (FPG): Poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Household: The patient, the patient's spouse, all of the patient's dependents, and anyone who may claim the patient as a dependent. If the patient is under the age of eighteen, the household includes the patient, the patient's natural or adoptive parent(s), anyone claiming the patient as a dependent, and the parent'(s) other dependents.

Household Income: A Household's total income from all sources for the calendar year prior to the submission of the Financial Assistance Application, including, without limitation, gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, regular support from family members not living in the Household, government pensions, private pensions, insurance and annuity payments, net income from rents, family-owned business interests, royalties, estates, trust funds, child support, and alimony. If the calendar year prior to the submission of the Financial Assistance Application is not representative of Household Income due to a material change is circumstances, the most recent twelve month period prior to the submission of the Financial Assistance Application will be used. Absent a reasonable belief that tax return information is not an accurate representation of Household Income, the tax return for the year prior to the submission the Financial Assistance Application will be used to determine Household Income if it is available.

Catastrophic Medical Expenses: A balance due to LRHMC for all outstanding accounts, after payment by all third parties are eligible for a Financial Assistance Discount up to 80% of the balance remaining after all third party payments (or the yearly AGB percentage as calculated each year) if their FPL is 200% or under. This is the only Financial Assistance offered to those patients who are insured and they are subject to the full Financial Assistance Application and documentation required process.

Uninsured Patient: An individual who is uninsured, having no coverage by (i) a commercial third-party insurer, (ii) an ERISA plan, (iii) federal or state healthcare program (including without limitation Medicare, Medicaid, and Champus), (iv) workers' compensation, (v) medical savings accounts, (vi) third-party liability coverage, or (vii) other coverage for all or any part of his or her bill.

Workforce: All LRH employees, volunteers, trainees/students, contractors, and medical staff.

Presumed Indigent: A patient at the time of service that is currently eligible for Medicaid, Medicaid HMO, Polk Healthcare Plan, any county run indigent program or similar means tested government assistance programs which base eligibility on household income of less or equal to 200% of FPG or verified by the third-party tool analytics using a credit inquiry process.

REFERENCES

None

Approval Signatures

Step Description	Approver	Date
	Danielle Drummond: 0001 President & Chief Executive Officer - LRHS	05/2024
	Jonn Hoppe: 1011 Executive VP, Chief Legal Officer-General Cou	05/2024
	Lance Green: 0005 Executive Vice President/Chief Financial Offi	05/2024
	Gina Riley: 4250 Director - Patient Access	05/2024