

**Parish Hospital Service District for the Parish of Orleans, District A, a Political Subdivision of the State of Louisiana (the “District”) d/b/a New Orleans East Hospital (the “Hospital”)**

**Policy: Financial Assistance, Billing and Collection Policy**

**Policy No:**

**Revised:**

**Supersedes Policy:**

**Authorized By:** Parish Hospital Service District for the Parish of Orleans, District A, a Political Subdivision of the State of Louisiana (the “District”) Board of Commissioners

**PURPOSE:**

The purpose of this policy is to outline the circumstances under which financial assistance may be provided to qualifying low income patients for medically necessary healthcare services provided at the District, as well as the billing and collection policy for the facility.

New Orleans East Hospital is a Louisiana hospital service district, created by Act No. 830 of the 2006 Regular Session of the Louisiana Legislature, which has been codified as La. Rev. Stat. Ann. §46:1094 through §1097, to serve the New Orleans East community which has been deprived of local acute care hospital and emergency department services since the community experienced the devastating effects of Hurricane Katrina in August 2005. The District entered into a Special Services Cooperative Endeavor Agreement with LCMC Health so that LCMC Health may manage the day-to-day operations of Hospital.

**POLICY:**

The District’s commitment to its mission and core values through compassionate service. It is both the philosophy and practice of the District that medically necessary healthcare services are available to patients, and those in emergent medical need, without delay and regardless of their ability to pay.

Patients qualifying for the District financial assistance will receive care provided at a discounted fee. The District will not discriminate on the basis of age, sex, race, creed, color, disability, sexual orientation, national origin, or immigration status when making financial assistance determinations.

This policy was developed to comply with the Louisiana Health Care Consumer Billing and Disclosure Protection Act (R.S. 22:1871) and Emergency Care (R.S. 40:2113.4, R.S. 40:2113.6), the Centers for Medicare and Medicaid Services (CMS) Medicare Bad Debt requirements (42 CFR § 413.89), and The Medicare Provider Reimbursement Manual (Part 1, Chapter 3). This policy also addresses Internal Revenue Code Section 501(r) regulations as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as promulgated on December 31, 2014.

**DEFINITIONS:**

The following definitions are applicable to all sections of this policy.

**Amount Generally Billed:** The amount generally billed is the expected payment from patients, or a patient's guarantor, eligible for financial assistance. For uninsured patients this amount will not exceed the rate of average payment received retrospectively from Medicare and private health insurers, including all patient responsibility. For patients with third-party coverage, the payer will determine allowable amount and patient's financial responsibility.

**Applicant:** Is the person who applies for a financial assistance discount. Generally, this is the patient unless the patient is a minor child or has a legal guardian, in which case the applicant is the parent or legal guardian of the patient. If the patient is a child whose custodial parent is a Louisiana resident, or who otherwise resides in Louisiana, then the child can be considered a Louisiana resident.

**Assets:** Certain assets will be considered in making a determination of eligibility for financial assistance such as:

- Monies in a checking account,
- Monies in a savings account,
- Monies in a Certificate of Deposit (CD),
- Cash in a safety deposit box, personal safe, and/or cash on hand,
- Stocks and/or Bonds and/or other.

**Collection Actions:** As approved by the District' governing body, the use of third-party collection agencies as well as other legal activities identified as reasonable collection efforts in this Policy may be used by the District when pursuing payment for medical services provided to patients.

**Days:** All references to days shall mean calendar days unless otherwise specified herein.

**Dependents:** A spouse, minor child, or parent whose Family member is responsible for his/her support (see definition of Family).

**Discounted Care:** Financial assistance that provides a percentage discount, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes between 250-400% of the Federal Poverty Level.

**Effective Date** The admitting date of the encounter, determined after a patient has qualified for financial assistance or discounted care.

**Eligibility Qualification Period:** Patients determined eligible shall be granted financial assistance for a period of six (6) months from the date the application was approved. Financial assistance shall also be applied to eligible accounts incurred for services received up to 240 days prior to the date the application for financial assistance was approved.

Eligible Services: The following services are eligible under this financial assistance policy:

- Trauma and emergency medical services provided in an emergency room setting;
- Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
- Treatment or services provided in response to life-threatening circumstances in a non-emergency room setting;
- Medical services and supplies that are reasonable and necessary for the diagnosis and treatment of illness or injury.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd), the term “emergency medical condition” means:

- (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
    - Serious impairment to bodily functions, or
    - Serious dysfunction of any bodily organ or part; or
  - With respect to a pregnant woman who is having contractions—
    - That there is inadequate time to complete a safe transfer to another hospital before delivery, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

EMTALA: Is the Emergency Medical Treatment and Active Labor Act (42 U.S.C. §1395dd) – the care or treatment for emergency medical conditions.

Extraordinary Collection Actions: As promulgated through the Internal Revenue Code Section 501(r), are actions that require a legal or judicial process, including without limitation, liens on residences, writs of body attachments, foreclosures on property, seizing a bank account, civil actions against an individual, wage garnishment, sales of debt and arrest.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Assets: An applicant’s family assets are the combined assets (as follows) of all adult members of the family living in the household. Assets include:

- Bank Accounts
- Certificates of Deposit (CD’s)
- Investment Accounts,
- Real Estate (excluding primary residence)

- And miscellaneous other assets.

Retirement fund assets are not considered to be part of family assets.

**Family Income:** An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parents and/or step-parents, or caretaker relatives.

Family Income/ Income is determined by calculated the following sources of income for all qualifying family members:

- Wages, salaries, tips
- Social Security Income
- Business Income
- Pension or Retirement Income
- Dividends and Interest
- Rents
- Royalties
- Disability Payments
- Unemployment Compensation
- Child Support and/or Alimony
- Income from estates and trusts
- Legal Judgments
- Equity in real property

The following shall be excluded from family income:

- Equity in a Primary Residence
- Retirement Plan Accounts
- Irrevocable Trusts for Burial Purposes
- Federal or State Administered College Savings Plans.

For patients under 18 years of age, family income includes that of the parents and/or step-parents, unmarried or domestic partners, who may or may not live with the minor.

**Federal Poverty Guidelines:** (FPL) are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

**Federal Poverty Level:** The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human

Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

**Financial Assistance:** Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for medically necessary care provided by the District.

**Free Care:** A 100% waiver of patient financial obligation resulting from eligible medical services provided by the District for eligible uninsured and underinsured patients, or their guarantors, with annualized family incomes at or below 250% of the Federal Poverty Level.

**Guarantor:** An individual other than the patient who is responsible for payment of the patient's bill.

**Gross charges:** Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

**Gross Income:** is the sum of all non-excluded income from salaries, Social Security benefits, pensions, rents, self-employment or any other source which is applicable to the family unit. This income shall be rounded to the nearest dollar when applied to the scale for medically indigent eligibility determination.

**Louisiana Resident:** shall mean a person who is considered a resident of the state of Louisiana when they actually live in the state and can provide evidence of intent to remain. The applicant must be a United States citizen or a qualified alien.

**Medical Hardship:** Financial assistance provided to eligible patients with annualized family incomes in excess of 400% of the Federal Poverty Level and financial obligations resulting from medical services provided by the District, and other healthcare providers, in excess of 25% of the family income.

**Medical Support Obligation:** Is the obligation of either or both parents to provide health insurance coverage for a dependent child and/or to pay a monetary sum toward the cost of health insurance provided by a public entity, parent, or other person.

**Medically Necessary:** As defined by the State Medicaid programs, as services or supplies which are medically appropriate and necessary to meet basic health needs consistent with the diagnosis of the patient's condition. Treatment should be in accordance with standards of good medical practice with demonstrated value and consistent in type, frequency and duration with scientifically based guidelines of national medical research or healthcare coverage organizations or governmental agencies. Treatment to be required to meet the medical need of the patient for reasons other than convenience of the patient or the patient's practitioner or caregiver. Treatment is to be rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service within a proper balance of safety, effectiveness and efficiency.

**Payment Plan:** An extended payment plan that is agreed to by both the District and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

**Qualification Period:** Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to unpaid bills incurred for eligible services that are active within the District accounts receivable.

**Qualified Legal Alien:** Is a person authorized by the United States Citizenship and Immigration Services for legal entry and continued stay in the country according to the Immigration and Nationality Act. Proof of Qualified Alien includes work/educational Visa, Green Card (I-688), Residence Card (I-551) or Passport.

**Uninsured Discount:** Patients ineligible for financial assistance and having no third-party coverage for emergency or medically necessary services provided by the District will be granted a discount equal to that of the average amount generally billed.

**Underinsured Patient:** An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by the District.

**Uninsured Patient:** A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and Tricare,) Worker's Compensation, or other third-party assistance to assist with meeting a patient's payment obligations.

**ELIGIBLE SERVICES:**

Services eligible under this financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following.

- Emergency medical services provided in an emergency setting. Care provided in an emergency setting will continue until the patient's condition has been stabilized prior to any determination of payment arrangements.
- Services for a condition that, if not treated promptly, would lead to an adverse change in the health status of a patient.
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
- Other medically necessary services, for example, inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms. Also, services typically defined by Medicare or other health insurance coverage as "covered items or services."
- Services of healthcare providers employed by and delivered in the District.

Services not eligible for financial support include the following:

- Skilled Nursing Facility and Residential Services;
- Retail pharmacy;
- Optical shop services;
- Private duty nursing;
- Corporate health services;
- Driving assessments;
- Hearing aids are not considered to be medically necessary;
- Cosmetic treatment and/or procedures unrelated to severe congenital malformations or physical disfigurements caused by injury or illness determined not medically necessary by a licensed physician;
- Bariatric or gender reassignment surgery determined not medically necessary by an independently licensed physician,
- Acupuncture;
- Dental services that are not considered to be medically necessary by the Center for Medicare and Medicaid Services (CMS) and/or State programs;
- Services that are not considered medically necessary as defined above;

There are physicians who provide services at the District who are not employed by the District. Services provided by these physicians are not subject to this policy and these physicians may not offer financial assistance.

**ELIGIBILITY CRITERIA:**

Financial assistance will be extended to uninsured and underinsured patients, or a patient's guarantor, in accordance with the District policy. Eligibility will be considered for those individuals who are unable to pay for their care; it will be based on a combination of family income, assets, and medical obligations.

Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws. Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by the District as possible sources of payment for care, may be denied financial assistance.

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance. They are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

Financial assistance is typically not available for patient co-payment or balances after insurance when a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Financial assistance will be offered to underinsured patients providing such assistance is in accordance with insurer’s contractual obligations.

**FINANCIAL ASSISTANCE:**

The type of assistance to be provided will be based on a combination of family income, family assets, and medical obligations. The federal poverty level will be used to determine an applicant’s eligibility for financial assistance. Eligible applicants will receive the following assistance.

**Uninsured Discount:** Patients with no third-party coverage will be granted a discount on the District bills equal to that of the amount generally billed.

**Full Free Care:** The full amount of the District charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 250% of the current federal poverty level and assets are not available to pay the amount due.

**Discounted Care:** The District sliding fee scale will be used to determine the amount eligible for financial assistance for any uninsured or underinsured patient, or patient guarantor, with gross family incomes greater than 250% but at or below 400% of the current federal poverty level after all third-party payment possibilities available to the applicant have been exhausted or denied and personal financial resources have been reviewed and assets are not available to pay for billed charges.

Discounts will be provided based on the family income of the patient, or the guarantor, according to the following schedule:

<b>Annual Family Income based on current U.S. FPL Limit/Guidelines</b>	<b>Discount off Generally Billed Amounts (Charges)</b>	<b>Patient or Guarantor Owes</b>
Less Than 250% FPL	100%	0%
251%-400% FPL	75%	25%

Example 1: A patient has a gross family income of \$28,000 and the FPL for that family size is \$24,600. Divide the family income of \$28,000 by the FPL of \$24,600 which yields 114%. The patient would qualify for 100% financial assistance because their FPL is below 250% of the FPL guideline.

Example 2: A patient has a gross family income of \$58,000 and the FPL for that family size is \$20,420. Divide the family income of \$58,000 by the FPL of \$20,420 which yields 284%. The patient would qualify for 80% financial assistance.



**Medical Hardship:** The District charges may be eligible for financial assistance for patients or guarantors with family income greater than 400% of the federal poverty level when circumstances indicate severe financial hardship. A patient whose financial resources exceed the eligibility thresholds under this policy may qualify for financial assistance under exceptional circumstances. If the patient's Annual Family Income exceeds 400% of the FPL, and the patient supplies information to support Medical Hardship, he/she will be considered for assistance if his/her total financial responsibility is greater than 25% of their Annual Family Income or 50% of total assets.

**Payment Plans:** Payment in full is expected, for balances due, within 30-days of the initial invoice. If unfeasible for a patient or guarantor to pay in full within this timeframe, a payment plan may be extended for up to three months. Arrangements for payment plans must be made with the District Customer Service or Patient Financial Counselor. If approved, the plan will be interest-free. Payment plans are developed only after Financial Assistance eligibility is determined.

Patients are responsible for communicating with customer service anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

#### **EMERGENCY MEDICAL SERVICES:**

Consistent with EMTALA, the District's policy requires an appropriate medical screening be provided to any individual requesting treatment for a potential emergency medical condition – regardless of ability to pay. If, following an appropriate medical screening, facility personnel determine that the individual has an emergency medical condition, the facility will provide services, within its capability, necessary to stabilize the individual's emergency medical condition, or will facilitate an appropriate transfer as defined by EMTALA. The District prohibits any actions, such as demanding payment before receiving treatment for emergency medical conditions or conducting debt collection activities that may interfere with or delay the provision, without discrimination, of emergency medical care. The District's EMTALA Policy is available on the District's website and attached as Appendix A to this Policy.

#### **AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE:**

The District has elected to use the look-back method in determining the amount generally billed (AGB). Under this method the Health System calculates the percentage discount annually on allowed claims for emergency and other medically necessary care provided to patients covered by Medicare and private health insurers including all patient responsibility over a twelve-month period. Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under The District financial assistance policy.

Questions concerning amount generally billed should be directed to the District Customer Service department at 504-592-6600, Monday – Friday between the hours of 8:30 am and 4:30 pm.

For more information on the amount generally billed (AGB) percentages, please contact:

New Orleans East Hospital,  
 Attn: Financial Assistance,  
 5620 Read Blvd  
 New Orleans, LA 70127  
 (504) 592-6574

Example:

Gross Charges incurred from visit to Emergency Department:	\$200.00
Amount generally billed (AGB) discount	(\$100.00)
Net amount due from patient, for patient obligation	\$100.00
75% financial assistance discount (income @ 300% of FPL)	<u>(\$75.00)</u>
Due from patient	\$ 25.00

**APPLYING FOR FINANCIAL ASSISTANCE:**

Eligibility determinations for financial assistance will be based on the District policy and an assessment of the applicant’s financial circumstances and need. Patients will be informed of the financial assistance policy and the process for submitting an application. Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement. Patients, or patient’s guarantor, have a responsibility to cooperate in applying for financial assistance by providing information on family size and documentation of income and assets.

The District will make reasonable effort to explain the benefits of Medicaid and other available public and private coverage programs to patients, or a patient’s guarantors. The District will take steps to help patients, or a patient’s guarantor, apply for programs that may assist them in obtaining and paying for healthcare services. Patients identified as potentially eligible will be expected to apply for such programs; those patients choosing not to cooperate in applying for programs may be denied financial assistance.

In the case of incomplete applications, the applicant will be notified in writing of all required information or documentation to complete the application. The applicant will be informed that this information must be received within 30-days of the date the notification was postmarked. If the applicant does not respond with the information needed to complete the application within the 30-day timeframe, the request for assistance will be denied.

Information on the District financial assistance policy will be communicated to patients in easy-to-understand, culturally appropriate language, and in the primary language spoken by the lessor of 1,000 or 5% of the residents in communities comprising the District service area.

***Documentation:***

Eligibility for financial assistance shall be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, the District may seek additional information.

***Income & Asset Documentation:***

Applicants will also be asked to provide information on income and monetary assets as listing in the income and asset definitions.

A financial assistance application form must be completed, and documentation provided in order to make an eligibility determination. If an application is incomplete, or there has been a request for additional information, the application will remain active for 30-days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30-day timeframe, the application will be denied.

Financial assistance applications are to be submitted to the following office:

New Orleans East Hospital,  
Attn: Financial Assistance,  
5620 Read Blvd  
New Orleans, LA 70127  
(504) 592-6574

***Determining Financial Assistance:***

The following factors will be considered when determining the amount of financial assistance for which a patient is eligible based on resources:

- Patient must request assistance by submitting an application for financial assistance or are deemed eligible as outlined in the presumptive eligibility section in this document;
- If a Louisiana resident is already deemed medically indigent and receives benefits from any Medicaid or state assistance program such as SNAP, WIC, TANF, or GNOCHC, they will automatically qualify for financial assistance;
- Individual or family income, employment status, family size, financial obligations including living expenses and other items of a reasonable and necessary nature;

- All other resources must be applied first, including, but not limited to, third-party payers, Victims of Crime (a state-level program for crime victims to recover some hospital costs), and Medicaid;
- If a patient does not have Medicaid, but would qualify, he or she must cooperate with the Medicaid application process prior to applying for financial assistance;
- Financial assistance may also be provided to non-Louisiana residents who experience an emergency medical condition in Louisiana and require immediate medical treatment.

***Application Process:***

Patients may request financial assistance by contacting a Financial Counselor at 504-592-6575. In addition to the financial assistance application, patients must provide information regarding any resources available to them. The list of required items is found on the Approved Document List that is available on the <http://www.noehospital.org/main/home> and attached as Appendix B to this Policy.

The following factors are to be considered in determining eligibility of the guarantor for financial assistance:

- Proof of Louisiana residency.
- Copy of denial letter from Medicaid (including Medicaid waiver programs). If the patient immigrated to the country within the past five (5) years and is ineligible for Medicaid, documentation or explanation of the situation is required.
- Complete copy of most current tax return including all schedules, if filed; or non-filing statement if tax return not filed in most recent tax year.
- A copy of three (3) most recent pay stubs from each income earner within the family. (If more than one employer within a calendar year, proof of gross income earned at each employer, with corresponding dates of employment will be required).
- If social security income: a copy of check or a copy of bank statement showing the most recent social security deposit.
- If unemployed: verification of any compensation received. Example: unemployment compensation, workers compensation.
- If no income: a notarized letter of support written by the person or persons who are providing financial support. Three (3) most recent statements for each checking account, savings account, mutual fund/money market accounts, IRA accounts, Certificate of Deposit accounts (CD), and any other security accounts or investment accounts.
- Three (3) most recent (or quarterly) statements for assets.
- Copy(s) of mortgage statements and tax values of all real property with the exception of the primary residence.
- If all required documentation is not received (i.e., the application is incomplete), the applicant will be provided with information relevant to completing the application along with a summary of this financial assistance policy.
- Eligibility for persons who are self-employed will be based on the guarantor's income as reflected in the most current year's federal income tax return. The

responsible person shall be advised of his/her responsibilities to report any changes in the family unit income, employment, composition, etc.

The District may grant financial assistance based on evidence other than that described in a FAP or FAP application form or based on an attestation by the applicant, even if the FAP or FAP application form does not describe such evidence or attestations.

**QUALIFICATION PERIOD:**

Completed requests for financial assistance shall be promptly processed and applicants will be notified within 30-days of receipt of a completed application. If eligibility is approved, the District will grant financial assistance for a period of six months (prospective) basis from the date of approval. New Orleans Easy Hospital will grant financial assistance for a period of six months applied to unpaid bills incurred for eligible services at all LCMC facilities that are within 240 days of the first post-discharge statement. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

If denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

**PRESUMPTIVE ELIGIBILITY:**

The District understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by the District to determine whether a patient's account is uncollectible, and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

- Homelessness or receipt of care from a homeless clinic;
- Participating in Women, Infants and Children programs (WIC);
- Receiving SNAP (Supplemental Nutritional Assistance Program) benefits;
- Patient deceased with no known estate:

This information will enable the District to make an informed decision on the financial need of patients utilizing the best estimates available in the absence of information provided directly by the patient.

**Other Presumptive Financial Assistance Eligibility:**

For patients, or their Guarantors, who are non-responsive to the District's application process, other sources of information may be used to make an individual assessment of financial need. This information will enable the District to make an informed decision on the financial need of non-responsive patients, utilizing the best estimates available in the absence of information provided directly by the patient

For the purpose of helping financially needy patients, the District may use a third-party to review a patient's, or the patient's Guarantor's, information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capability score. The model's rule set is designed to assess each patient based upon the same standards and is calibrated against historical Financial Assistance approvals by the District. This enables the District to assess whether a patient is characteristic of other patients who have historically qualified for Financial Assistance under the traditional application process.

When the model is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows the District to screen all patients for Financial Assistance prior to pursuing any extraordinary collection actions. The data returned from this review will constitute adequate documentation of financial need under this Policy.

In the event a patient does not qualify for presumptive eligibility based on this model, the patient may still provide requisite information and be considered under the traditional FAA process.

Patient accounts granted presumptive eligibility based on this predictive model will be reclassified as financial assistance and any remaining balance due will be forgiven. For these accounts, refunds will only be granted if the patient subsequently completes and is approved through the application process.

Patient accounts granted presumptive eligibility status will be provided free care for eligible services for retrospective dates of service only. This decision will not constitute a state of free care as available through the traditional application process. These accounts will be treated as eligible for Financial Assistance under this Policy. They will not be sent to collection, will not be subject to further collection action, and will not be included in the District bad debt expense. Patients will not be notified to inform them of this decision.

Presumptive screening provides a community benefit by enabling a Hospital Organization to systematically identify financially needy patients, reduce administrative burdens and provide Financial Assistance to patients and their Guarantors, some of whom may have not been responsive to the financial assistance application process.

**REFUNDS:**

If a patient is approved for financial assistance through the application process and has made a payment to the accounts which qualify for financial assistance within the last year from the date the application is received; the patient will be refunded to the extent consistent with the level of financial assistance awarded, with the exception of co-payments, for payments over \$5.00.

**APPEALS AND DISPUTE RESOLUTION:**

Applicants denied financial assistance may appeal the determination in writing by providing information on the reason for the appeal and any relevant information. An appeal letter must be received within 30-days of the date of the determination letter.

Disputes and appeals may be filed by contacting:

New Orleans East Hospital  
Attn: Financial Assistance,  
5620 Read Blvd  
New Orleans, LA 70127

The appeal will be reviewed, and a written decision provided to the patient within 30-days of receiving a completed, written appeal.

**NOTIFICATION OF FINANCIAL ASSISTANCE:**

Information on financial assistance will be available to patients and the community served by the District. The District financial assistance policy, application and a plain language summary of the policy will be available on the system's website.

Financial assistance information will also be provided in the patient admission information package. Information on the District financial assistance policy and instructions on how to contact the District for assistance and further information will be posted in hospital and physician clinic admitting and registration locations, as well as the hospital(s) emergency departments. Financial assistance information will also be included in patient statements.

A request for financial assistance may be made by the patient, a patient's guarantor, a family member, close friend, or associate of the patient, subject to applicable privacy laws. The District will respond to oral or written requests for more information on the financial assistance policy made by a patient or any interested party. Any District staff member may make a referral of a patient to a financial counselor to examine eligibility for financial assistance.

The District will distribute informational materials on the financial assistance policy to agencies and non-profit organizations serving the low-income population in the particular hospital or clinic service area.

**BILLING AND COLLECTIONS PROCESS:**

The District’s billing and collection policies shall comply with federal and state regulations and laws governing healthcare billing and collections. The amounts to be collected from uninsured patients for emergency or other medically necessary care shall not exceed Amounts Generally Billed (AGB) as determined by the rates paid by an average of commercial insurers and Medicare for services.

The District may pursue collection actions against patients found ineligible for financial assistance, or patients who are no longer cooperating in good faith to pay the remaining balance.

No collection agency, law firm, or individual may initiate legal action against a patient for nonpayment of a District bill without the written approval of an authorized District employee.

The District Health will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy.

**RECORD KEEPING:**

The District will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

**POLICY APPROVAL:**

This policy was last reviewed and approved by the District Finance Committee of the Board of Trustees on December 3, 2015. The District Financial assistance policy is subject to periodic review. Significant changes to the policy must be approved by the District Board of Trustees (or designated committee).

The District reserves the right to modify or change this Policy at any time with the approval of The District’s governing body.

	Approved by:	Date Approved
Policy Approved	Parish Hospital Service District for the Parish of Orleans, District A, a Political Subdivision of the State of Louisiana (the “District”) Board of Commissioners	July 2018

Appendix A- The District’s EMTALA Policy

Appendix B - Approved Document List