POLICY #___425.1__

Subject: **Saint Mary's CARE Policy**

Effective Date: July 1, 2013

Revised:

Replaces: Saint Mary's Financial Assistance Policy (FAP)

PURPOSE: The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their ability to pay. The underlying theory is that a person, for a reasonable period of time can only be expected to pay a maximum percentage of their disposable income towards charges incurred. Any "self-pay" balance in excess of this amount would place an undue financial hardship on the patient or their family and "may" be adjusted off as Financial Assistance.

POLICY: Recognizing its charitable mission, it is the policy of the hospital to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. Discounted care will be provided to uninsured or underinsured patients who meet the established eligibility criteria and complete the required application (all components in a timely manner) and review process.
All medically necessary services of this facility will be available as uncompensated services.

1. All self-pay accounts will be eligible for 40% self-pay discount, off of the published charges, regardless of their income or assets. Accounts must be in the Self-Pay Financial Class for the discount to be taken.
2. Elective cosmetic procedures are not eligible for charity care.
3. Insured patients with balances, due to deductibles, co-payments, or co-insurance, non-covered charges are not eligible for charity care. Unless they exceed the 25 % of gross monthly income, established for catastrophic bill(s).
4. A patient may only request Charity Care while the account is still active receivable.
5. Incomplete applications and falsified applications will not be considered eligible for Charity Care.
6. Patients gross income and family size will be considered in determining eligibility for Charity Care.
7. Patients found eligible for Charity Care will be eligible for care for any balance due at the time of application approval and any medically necessary services within the six months prior to application approval date and six month post date of application approval.
8. Charity Care will be given at 400% of the Federal Poverty Income Levels. A sliding fee scale will be applied at 350% of the Federal Poverty Income levels.
9. Signage (in 48 or 72 font) and one page summary describing STMH charity care policy will be in English, Spanish, Portuguese, and Albanian, and placed in Registration, Emergency Department, all Social Services departments, Patient Financial Services (PFS), Cashiers office, Financial

Advocate work area, and the Lobby.

DEFINITIONS:

- Self-pay patient is one who is financially responsible, either personally or as a guarantor, for the payment of the charges associated with the health care services provided by Saint Mary's Hospital.
- Uninsured Patient
    a. Whose income is at or below 400% of the Federal Poverty Income levels;
    b. Who has applied and been compliant in the eligibly process and has been denied eligibility for any medical or health care coverage;
    c. Who is not eligible for coverage under Medicare, Tricare, or any other Federal programs, or privately sponsored health or accident insurance, including, but not limited to, workers' compensation, settlements or judgments arising from suits, claims or proceedings involving motor vehicle accidents or alleged negligence; and
    d. Who is liable for one or more hospital charge.
- Charity is the demonstrated inability of a patient to pay.
- Bad debts are the unwillingness of the patient to pay.
- Charity care does not include bad debt, contractual adjustments, or unreimbursed costs from other community services. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity and bad debt. If the patient is able but unwilling to pay, the hospital will classify the account as bad debt.
- Earned income is the sum of all household wages or salaries received on weekly, monthly, or yearly bases.
- Catastrophic illness is any medical condition, either acute or chronic, which incurred expenses that are not fully covered by private insurance, state, federal programs, or other sources. This will also include expenses that exceeded the patient's maximum benefits. Patient will be eligible for discount consideration, as catastrophic, if their outstanding balance exceeds 25% of their gross monthly income.

PROCEDURE:

1. Charity and discounted care include services provided to the following:
    • Uninsured or underinsured low-income patients who do not have the ability to pay all or part of their bill as determined by the financial guidelines in this policy;
    • Insured patients whose coverage is inadequate to cover a catastrophic situation;
    • Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large (as defined earlier in the definitions section) medical bills; and
    • Patients deemed medically indigent by virtue of their documented eligibility for Medicare and Medicaid benefits.

2. The following factors are to be considered when determining the amount of charity service for which a patient is eligible at the time of service (See Appendix A for Financial Assistance Application):
    • The patient's individual or family income, as appropriate, using the income guidelines as published by the Federal Government on April 1 each year (Federal Income Guidelines: See Appendix B for the current year Federal Income Guidelines and Appendix C for the sliding fee scale);
    • Family size; and
    • All other resources must be applied first, including third-party payers, Victims of Crime (i.e., 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 application process. If the application is denied or is identified as ineligible based on the Medicaid income criteria, consider for charity and discounted care.

3. Determine the appropriate amount of charity service in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. Note: A third party might pay part of an account, the patient may pay part, and another part might meet charity services. If the patient does not pay the amount deemed to be his or her responsibility, the uncollectible remainder would become bad debt.

4. Require evidence of eligibility. Documentation should be submitted within 14 days from the date of service (to include before and after the date of service). Additional time for completion of the application process may be extended as appropriate. The patient must provide supporting documentation of income, which can include the following:
   - Paycheck, general relief (i.e., a county-level public assistance program), Social Security, pension, unemployment or disability check stubs, tax return, or other proof of income.
   - The patient must sign the charity form.

5. Charity-care provisions will be reevaluated for a patient's eligibility when the following occur, it is the patients responsibility to bring this data forth to STMH for consideration:
   - Subsequent rendering of services;
   - Income change;
   - Family size change;
   - When any part of the patient's account is written off as a bad debt or is in collections; and
   - When six months have passed since the last application or when circumstances change, whichever comes first.

6. Determine eligibility for charity service at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.

7. Financial Advocates will initiate and approve/deny the application prior to submitting to the appropriate manager, based on account balance (See Number 9).

8. Patients will be notified in writing within 3 business days (Monday - Friday), from the date the ***"COMPLETED***" application is received, regarding qualification for charity care, the remaining balance due, and any expected re-payment terms.

9. Financial Advocates will determine the write-off amount based on the aforementioned guidelines and the correct contractual allowance code (**See Appendix D**). If the patient does not meet the financial criteria but has extenuating circumstances such as catastrophic illness, the account will be referred to the supervisor who will make a recommendation to the Manager/Director. Charity and discounted care approval authority is as follows:
   - Write-offs from $.01 to $1,000 require approval by the appropriate Financial Advocate handling the account;
   - Write-offs from $1001 to $9,999 require approval by the Supervisor of Patient Access;

- Write-offs from $10000 to $19,999 require approval by the Manager of Patient Access;
- Write-offs $20,000 to $49,999 require approval by the Director of Patient Access;
- Write-offs greater than $50,000 require approval by the Chief Financial Officer or Corporate Director Revenue Cycle.

10. Patient Advocate staff will ensure that patients and physicians are notified, in writing, regarding approval, denial, or pending status of uncompensated care. The notification will include the appeal process for any denied application.

11. The appeal process for denied charity and discounted care applications includes the following activities:
    - Prompt notification of the denial and the specific reasons will be provided to each charity and discounted care applicant. The notification will also provide examples of additional information, which may be used to appeal the denial. Upon notification of the denial, the charity applicant will have 30 days to appeal the decision from the date of the denial letter.
    - Additional information will be accepted by the provider and re-evaluated by the Supervisor/Manager.
    - If the initial denial is upheld, prompt notification will be provided to the applicant.
        - The Director of Patient Access or Corporate Director Revenue Cycle will review all appeals over $50,000. A written determination will be issued within 15 days of the re the appeal.

12. The hospital will retain all charity and discounted care applications and supporting documentation within scanning for seven years.

13. The hospital will update the income eligibility criteria annually, April, using the Federal Poverty Guidelines (FPG) published by the Centers for Medicare & Medicaid Services (CMS). If CMS issues more than one update, the updated criteria shall become effective as of the issue date. (See Appendix B).

14. The base level for the charity and discount care income eligibility will be set at 45%.

15. A charity and discounted care budget will be established once a year during the annual budget process and submitted to the Board of Directors of Saint Mary's Hospital for approval. However, need for financial assistance will take priority over a fixed budget amount; the Board will be promptly advised if charity and discounted care needs exceed the current budgetary provisions. A formal appeal process shall be implemented to permit rapid review of all appealed charity denials. The Director of Patient Access or Corporate Director – Revenue cycle shall review all final appeals of charity determinations.

Reference Material:

- The AHA Board of Trustees Statement of Principles and Guidelines on Hospital Billing and Collection Practices (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf);
- Internal Revenue Code Section 501® requirements for tax-exempt hospitals (http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120716-legal-adv.pdf).

Creation Date: September 1, 2004

Revision Date: March 15, 2013
Key Content Expert:
JCAHO Reference:

EXHIBIT A: FINANCIAL ASSISTANCE APPLICATION

Saint Mary's HOSPITAL

Patient Name : _____ Date: _____

Current Address: Street_____

City, State, Zip _____

Phone # _____

Account(s)#: _____

Employer's Name & Address: _____

Spouse's Employer and Address: _____

Medical Insurance:_____ Policy/Claim#: _____

Insurance Company Name: _____

Address: _____

Number of Dependents (list ages, including self): _____

_____

Monthly Income (List source/amount): Patient's income_____

Spouse's income _____

Other income_____

I hereby attest that the above information is true and accurate. I understand that in order for me to be eligible, the information contained herein must be verified. I agree to provide Saint. Mary's Hospital with the necessary verifications, and, if requested by the Hospital, I agree to cooperate and follow through with application for State and/or Federal assistance as well as any other third party payors.

Patient/Guarantor: _____ Date: _____

Financial Counselor: _____ Approved by: _____ Date:_____

- All income must be verified. Please provide last 4 pay stubs.
- If you are self-employed, please provide a complete copy of last year's filed Income Tax Return (including ALL schedules (i.e. for example, Schedule C).

*Please note we will notify physicians who are part of the Franklin Medical Group of your eligibility.

Appendix B

2014 FEDERAL POVERTY GUDELINES AND SLIDING FEE SCALE

Household Size	100%	133%	150%	200%	300%	400%
1	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
2	15,510	20,628	23,265	31,020	46,530	62,040
3	19,530	25,975	29,295	39,060	58,590	78,120
4	23,550	31,322	35,325	47,100	70,650	94,200
5	27,570	36,668	41,355	55,140	82,710	110,280
6	31,590	42,015	47,385	63,180	94,770	126,360
7	35,610	47,361	53,415	71,220	106,830	142,440
8	39,630	52,708	59,445	79,260	118,890	158,520
For each additional person, add	$4,020	$5,347	$6,030	$8,040	$12,060	$16,080

EXHIBIT C
SLIDING SCALE DISCOUNT

Between 250% and 400% of Poverty Guidelines

	250% 100%	265% 90%	280% 80%	295% 70%	310% 60%	325% 50%	340% 40%	350% 30%	400% 20%	2014 FPL
1	$ 28,725	$ 30,449	$ 32,172	$ 33,896	$ 35,619	$ 37,343	$ 39,066	$ 40,215	$ 45,960	**$ 11,490**
2	$ 38,775	$ 41,102	$ 43,428	$ 45,755	$ 48,081	$ 50,408	$ 52,734	$ 54,285	$ 62,040	**$ 15,510**
3	$ 48,825	$ 51,755	$ 54,684	$ 57,614	$ 60,543	$ 63,473	$ 66,402	$ 68,355	$ 78,120	**$ 19,530**
4	$ 58,875	$ 62,408	$ 65,940	$ 69,473	$ 73,005	$ 76,538	$ 80,070	$ 82,425	$ 94,200	**$ 23,550**
5	$ 68,925	$ 73,061	$ 77,196	$ 81,332	$ 85,467	$ 89,603	$ 93,738	$ 96,495	$ 110,280	**$ 27,570**
6	$ 78,975	$ 83,714	$ 88,452	$ 93,191	$ 97,929	$ 102,668	$ 107,406	$ 110,565	$ 126,360	**$ 31,590**
7	$ 89,025	$ 94,367	$ 99,708	$ 105,050	$ 110,391	$ 115,733	$ 121,074	$ 124,635	$ 142,440	**$ 35,610**
8	$ 99,075	$ 105,020	$ 110,964	$ 116,909	$ 122,853	$ 128,798	$ 134,742	$ 138,705	$ 158,520	**$ 39,630**

APPENDIX D: PARAGON ADJUSTMENT CODES

TYPE	CODE	DESCRIPTION	Charity or Free Care
A	48820	REDUCTION TO COST IP SELF PAY	Charity
A	48830	REDUCTION TO COST OP SELF PAY	Charity
A	48840	FREE SERVICE IP SELF PAY	Charity
A	48853	FREE SERVICE OP SELF PAY	Charity

Saint Mary's Hospital

POLICY #___409____

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Subject: **Self Pay Collection Policy**

Effective Date: 5/1/05

Revised 02/01/13

Replaces: NEW

POLICY

It is the policy of St. Mary's Hospital (SMH) that personnel will review outstanding accounts on a daily basis for timeliness of payment, and that personnel will conduct their collection activity and contact with individual patients with professionalism, courtesy and fairness.

PURPOSE

1. To ensure that policies and procedures exist for the timely and fair collection of all patient balances.

PROCEDURE

1. Admission:

All self-pay patients are interviewed by a financial counselor at the point of service. The Financial Counselor will determine if:

- The patient has any insurances that may have been overlooked;
- There is any third-party liability;
- The patient may be eligible for financial assistance, including but not limited to: Medicaid; HUSKY; a Free-Bed fund; and Charity Care;
- Accounts that are determined to be presumptively eligible for any state assistance will be moved from Self-Pay (SFPY) financial class to Welfare Pending (WLFP) financial class.
- Whenever is it determined that the patient qualifies for Charity Care, Financial Counselor will adjust the balance by the appropriate amount, and any resulting balance will become the patient's responsibility.
- If patient is deemed liable for any balance, a deposit will be requested.
- If charity care determination cannot be made, at the point of service, a deposit equal to 50% of the estimated charges will be required prior to any elective procedure.

In the event that a Financial Counselor is not available at the time of admission, they will attempt to contact patients after reviewing their admission record. Financial Counselors will attempt to visit with the patient if they are still in-house; otherwise they will call the patient's home after the patient is discharged.

2. Collection Follow-Up

A. Statements are sent to patients and/or guarantors who have outstanding balances. The timing and frequency of these statements, for both patients with a monthly payment

arrangement and those without, are based upon the statement table/schedule set up in Paragon.

- All accounts that are registered as SFPY will be transferred to Financial Health Strategies (FHS) for follow –up. SMH has contracted with FHS to operate as our Business Office for self-pay accounts. Accounts will be transferred on a daily basis. (see PARPROC for transferring procedures)
- If we get a letter from a patient quoting the Fair Debt Collection Practices Act, 15 USC 1692c, 805(c):

  (c) Ceasing Communications, "If a consumer notifies a debt collector in writing that the consumer refuses to pay a debt or that the consumer wishes the debt collector to cease further communication with the consumer, the debt collector shall not communicate further with the consumer with respect to such debt..."

  We will notify FHS to:

  1. Stop all activity on the account.
  2. Return the account to SMH and SHM staff will refer the account to our collection agency, with a copy of the letter.

  The collection agency is expected to:

  1. Send the validation notice, to the consumer, stating that a new collector is involved.
  2. Then cease all activity and refer the account to their attorney for suit.

B. Accounts will be manually transferred to a bad debt status if one or all of the following has occurred:

- Account has been returned from FHS as part of their “Return File” marked uncollectible. FHS is required to return all accounts that have reached the timeframe of 90 days, with no payments made in the last 45 days.
- Mail is returned stamped “Moved No forwarding Address” and the account is noted as such in the system;
- There is a system note listed in the follow-up history that the third message level on the monthly statement has been mailed;
- No adequate payment has been made in the last thirty (30) days and the patient is not on a payment plan. Adequate is defined as an amount representing 10% or less of the previous balance due.

C. All attorneys representing patients in liability cases are contacted. If we are assured that the case will be settled within 120 days, the account will not be transferred to bad debt. If the settlement date requirement cannot be satisfied, the account is placed with the TCORS (Tobin, Carberry, O’Malley, Riley& Selinger) law firm so that the hospital’s interest can be protected (see TCORS procedures).

3. Bad Debts:

- Accounts are manually transferred from an active (AR) status to a bad debt status by collection personnel;

- Bad debt files are turned over weekly to a collection agency or collection attorney via electronic transfer on a weekly basis;
- Bad debts may be determined at any time during the life of the account;
- Collection personnel may make a determination to turn over an account to a collection agency at any time during the collection process;
- All accounts with a balance due AFTER a Medicare payment has been received MUST have received a minimum of four (4) patient statements over a period of greater than 120 days, and have NOT had a payment posted to the account within the last 120 days before it can be transferred to bad debt.
- Bad debt accounts for Medicare patients must be sent under a separate file to the collection agencies.

4. Settlements:

- FHS Collectors have been given the authority make settlements on accounts that are considered "reasonable". SMH management reserves the right to withdraw this authority at any time.
- SNH Customer Service personnel may offer attorneys representing patients a 5% discount for payment within thirty (30) days, provided the attorney agrees in writing to accept these terms and to discount their fees by the same amount. Any amount exceeding 5% must be approved by management.

- Occasionally, management will authorize collection personnel to offer higher discounts to patients that have previously agreed to payment plans that have had an outstanding balance for more than three (3) years in an effort to settle the account.

5. Collection Agencies:

- Accounts that are sent to bad debt will be assigned to one (1) of the two (2) agencies currently contracted with St. Mary's.
- Account are assigned based on the following Alpha categories:
  I. A - L - PMS
  II. M – Z - Outsource Group
- Accounts can be withdrawn from the agencies at any time (see procedure for "removal of account from bad debt").
- If an account has been turned over to the collection agency for a period greater than fourteen (14) days, any request for payment arrangement or settlement must be forward to the agency.
- Collection agencies are required to returned "uncollectible accounts" that are aged greater than 150 days from the date they were transferred.
- All accounts that are returned from the agencies as uncollectible are to be written off to the following codes**: 48903 – Agency Uncollectible**
  48913 – Agency Uncollectible Medicare

6. St. Mary's Policy for Attachment of Wages & Properties

St. Mary's does not have a written agreement with any of the Collection Agencies, regarding the procedures they must follow for attachment of wages and properties. According to Outsource Group, they follow a generally accepted policy for all clients. This is a summary of their established policy:

- Account received.
- Initial dunning notice issued within 24 hours of placement.
- Phone attempt made to contact patient.
- If contact is made, the following may occur:
    1. If patient is unable to pay (unemployed, no assets, etc) the account is returned or if permission is granted by SMH, it is maintained for later follow up.
    2. If patient is bankrupt, account is closed and returned.
    3. If patient disputes charges, collection activity is suspended and proof requested from the hospital.
    4. If patient request financial assistance, collection activity is suspended and the patient is either mailed a SMH financial assistance application or given phone number to contact SMH for an application. If application is mailed to patient, SMH customer service staff is notified by phone and they are requested to document the account.
    5. If settlement is offered, authorization is sought from SMH.

- If all efforts to contact patient fail, or if patient refuses to pay, and it is verified that patient has income or assets that could be used to satisfy charges, the following steps are taken:
    1. Documentation is made of all collection efforts, including: efforts to contact patient, letters sent, income & asset verified, etc.
    2. Authorization is sought from SMH to proceed with litigation.
    3. After authorization is received, the account, along with the documentation, is forwarded to Attorney's Nathanson & Cipriano; P.O. Box 5516; Hamden, Ct 06518.

Summary of Litigation Procedure Followed by Nathanson & Cipriano's Office:

- Account received and documented. File created.
- First demand letter sent to patient.
- File reviewed and approved by Attorney.
- Signed letter sent to patient and Affidavit of Debt sent to collection agency.
- File is designated for either small claims or civil writ.
- Writ is reviewed and signed by Attorney.
- Writ sent to court; summon and complaint sent to State Marshal for service.
- If patient files an answer, case is scheduled for hearing. SMH is notified of hearing and a representative sent to the hearing.
- If no answer is filed a default judgment is entered.
- Once judgment is received, a payment plan is established in accordance with the court order.
- If patient defaults on payment plan and there is verification of employment, application is made for wage execution.
- If there is verified real estate, a judgment lien is filed. NO FORECLOSURE IS DONE ON ANY JUDGMENT LIEN.