St. Vincent's Medical Center
FYE 9/30/2015
Annual Filing Requirements

Report 15
Docket # 15-035AR

Listing of Uncompensated Care Policies and Procedures Enclosed

Item 1 - St. Vincent's Medical Center Patient Financial Services Policy for Collection and Bad Debt Referral
Item 2 - St. Vincent's Medical Center Administrative Policy for Financial Assistance (Charity Care)
Item 3 - St. Vincent's Medical Center Administrative Policy for Patients with No Medical Insurance
Item 4 - Ascension Health Policy 16 Billing and Collection for the Uninsured (Referenced in Items 2 and 3)
Item 5 - Ascension Health Policy 9 Care of Persons Living in Poverty and Other Vulnerable Persons (Referenced in
Item 6 - Financial Assistance Eligibility Matrix

ST. VINCENT'S MEDICAL CENTER
PATIENT FINANCIAL SERVICES

Subject: Collection & Bad Debt Referral

Effective Date: 12/1/13 Category: Financial

Policy: All patients receiving services are given the opportunity to take advantage of policies developed to assist them financially. These policies include Charity Care, Free Bed Funds, financial counseling as well as State & Federal programs In addition, patients are given the opportunity to make payment within a reasonable amount of time. The Medical Center reserves the right to refer patients who choose not to pay an amount determined to be their responsibility to a licensed collection agency.

Purpose: To collect outstanding balances from patients as a result of deductibles, co-payments or services rendered within a reasonable time-frame. If amount due is determined to be uncollectable, the balances are adjusted and referred to a licensed collection agency.

1. A determination is made that a balance is the responsibility of the patient based as a result of carrier payments or a review of the account by a representative of Patient Financial Services. At that point GE CENTRICITY accounts are changed, manually or by system functions, to Phase 7; CERNER accounts are changed, manually or by system functions, to SELFPAY or SELFPAY AFTER INSURANCE depending on the circumstances.

2. The changing of the account to Phase 7 (GE CENTRICITY) or SELFPAY/SELFPAY AFTER INSURANCE (CERNER) triggers the dunning cycle for follow-up and processing. The account retains an active Accounts Receivable status.

3. All self pay balances (either true self pay or balance after insurance), regardless of payor type, shall receive the minimum of an initial statement to be sent upon receipt of the account, 2 guarantor statements (SP2 & SP3 – CERNER) as well as a final notice sent 15 days prior to referral to bad debt. Referral to bad debt, total number of calls and total number of letters sent will be at the discretion of SVMC who agrees to initiate every reasonable effort to collect the amount placed with them. SVMC is required to initiate collection activity for a period of no less than 120 days before referral for bad debt with the exception of skips, bankruptcies, and deceased patients.

4. Accounts will be followed up for a minimum of 120 days with the following exceptions:

    - Upon notification DECEASED PATIENTS with a balance under $2500.00 in these categories will be placed on a Bad Debt Report and placed with our

licensed collection agency as referenced in Step #5. Encounters will proceed through the dunning cycle until at which time it's noted A): there is no estate and/or B): there is no spouse. At that point the encounter would be eligible for placement with a collection agency.

- SKIPS with a balance under $2500.00 will be placed on a Bad Debt Report and placed with our licensed collection agency as referenced in Step #5. GE accounts over $2500 will remain with the billing vendor and a skip tracing process/mechanism is utilized to determine the correct address and/or phone number. CERNER encounters upon receipt of a return address will be reviewed utilizing the established process in place. If an address is not obtained encounters with a balance over $2500 will be eligible for placement with a collection agency.

- BANKRUPTCY ACCOUNTS will be closed regardless of the balance and placed on a Bad Debt Report and placed with our licensed collection agency.

- Based on their review of the account at the conclusion of this activity, a recommendation is made to adjust the account to a Bad Debt status and refer the account to an outside collection agency.

5. Based on this recommendation, the account is adjusted to reflect a $0.00 balance utilizing a Bad Debt Allowance Code. The account is also manually changed to reflect Phase 8 (CENTRICITY), which allows the account to be referred to a collection agency. CERNER Accounts move automatically through the dunning cycle and placed in a bad debt placement file 15 days after receiving an SP4 (final) statement.

6. The account remains with the agency until requested or returned. Accounts returned from our agency are deemed uncollectible and no further activity takes place.

7. Based on the nature of circumstances, both medical and financial, the necessity of promoting a positive public/community image and as well as patient satisfaction, the manager as well as Senior Management can make exceptions on a case by case basis. Exceptions would include but not be limited to changes in the dunning cycle as well as placement conditions and/or requirements. Such exceptions will be documented in the Comments Field of the account as well as part of established reporting appropriate for the changes initiated.

Reviewed & Updated: 10/21/15

Item #1

ST. VINCENT'S MEDICAL CENTER
PATIENT FINANCIAL SERVICES

Subject: Collection - Judgment

Effective Date: 03/11/08 Category: Financial

Policy: All patients receiving services are given the opportunity to make payment within a reasonable amount of time. The Medical Center reserves the right to file a judgment/lien when patients choose not to pay an amount determined to be their responsibility.

Purpose: To utilize legal options in the form of a judgment/lien to collect outstanding balances from patients as a result of deductibles, co-payments or services rendered within a reasonable time-frame.

1. Upon review our licensed collection agency makes a determination the patient is eligible for judgment based on the following conditions:
   - Patient must be a property owner.
   - Patient must be gainfully employed for at least 6 months
   - Patient's credit record reflects current activity and a pattern of regular payments to other creditors.
   - Patient's mortgage must be no more than one payment in arrears.
   - Combined debt to The Medical Center must exceed $2,000.00.

2. The agency will complete an Approval to File Form and send it to the Accounts Receivable Manager who is responsible for the agency as a vendor. A copy of the debtor's credit report and all applicable documentation including all agency notes are to accompany the form.

3. Upon review the Accounts Receivable Manager will determine if legal activity will be pursued.
   - Legal activity will be limited to filing a judgment/lien only.
   - Judgments/liens will be filed against homeowner property only.
   - Wages are not to be garnished nor are bank accounts to be frozen.
   - No foreclosure will be initiated.

4. The Approval to File Form will be returned to the agency with all documents maintained by the Accounts Receivable Manager.

Reviewed 12/2/13

ITEM #2

ST. VINCENT'S HEALTH SYSTEM
ADMINISTRATIVE POLICY MANUAL

Subject:	Financial Assistance (Charity Care)	Classification: 700-1
Effective Date:	February 3, 1992 January 1, 1998	Category: Financial
Revision Date:	August 22, 1994, April 16, 1996, March 9, 1998, May 20, 2002, August 2, 2004, June 5, 2006, November 29, 2010, April 18, 2011, May 17, 2013	
Reference Material:	Finance Department Ascension Health System Policy #16	Administrative Approval:

Policy: St. Vincent's Medical Center has established the provision of health care to all members of the Community as an integral part of its Mission. In an effort to ensure medical care is available to all segments of the community without regard to the ability to pay, the Medical Center offers as part of its mission, medically necessary care to those individuals not covered under a third party insurer or government programs or who do not have resources to pay all or a portion of their bills. For the benefit of our patients and our Community, the Medical Center has established a Financial Assistance Policy, whereby, uninsured and underinsured patients are provided with an opportunity to apply and be considered, for needs based financial assistance.

No person is turned away based on their inability to pay; however, it is expected that each patient will contribute to the cost of their health care in a manner befitting their individual financial circumstances. Furthermore, it is the policy of SVMC to differentiate between uninsured patients who are unable to pay, from those who are unwilling to pay for all or part of their care. SVMC will provide Charity Care to those uninsured patients who are unable to pay based upon the eligibility criteria set forth in this policy and will seek payment from uninsured patients who do not qualify for Charity Care. While qualification for Financial Assistance is ideally determined at the time of service, SVMC will continue to review such determinations as potential insurers or other financial resources are discovered during the billing and collection process.

Purpose: To provide guidelines for decision making regarding the provision of health care based on the patient's ability to pay for care. These guidelines will be developed and updated periodically for all services at the Medical Center.

Financial Counselor. An individual trained to assist patients in identifying sources of healthcare coverage, determining eligibility for such coverage, and assisting in completing necessary applications. Financial counselors may either be employees of SVMC or a third party engaged by SVMC to assist in its billing and collections processes.

Financial Assistance can take the form of:

(a) **100% Charity Care.** Which is defined as free care provided to patients who are uninsured for the relevant, medically necessary service and who are ineligible for governmental or other insurance coverage.

(b) **Assistance.** Assistance is provided to patients who are financially unable to meet the full cost to pay for medically necessary services, but do not qualify for full Charity Care.

(c) **Free Bed Funds** – are gifts provided to SVMC to endow a "free bed" that can be used to provide medical care to those who can not afford it. It is not a governmental program but a charitable donation administered by SVMC.

(d) **Other Assistance Funds** such as, but not limit to, Grants. St. Vincent's Medical Center Foundation (SWIM), etc.

(e) **Self-Pay Patient Discount.** Those patients who are uninsured patients (as defined below) and who are not eligible for Charity Care, will be provided a Discount on eligible care in accordance with SVMC's policy and Public Act 03-266 (Section 19a 509(b) of the Connecticut General Statutes.

The Term **"Charity Care"** as used in this policy shall refer collectively to the above programs.

Family Income: (As defined by *the US Census Bureau*) Family income based on pre-tax and includes wages, self-employed earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non cash benefits (such as food stamps and housing subsidies) do not count and excludes capital gains or losses. If a person lives with a family, add up the income of all family members.

Family Members – mother, father, and/or children (including foster children) under the age of 19, children over the age of 19 and who are disabled or are full time students, or other related individuals classified as dependents on federal income tax filing. Non-relatives such as housemates do not count.

Federal Poverty Level ("FPL") the poverty guidelines issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for determining financial eligibility for certain federal programs.

Immediate Service Area. For the purposes of this policy, SVMC's immediate service area is defined as those zip codes (Attachment 1) that comprise the primary area of St. Vincent's Medical Center. Emergent services will be

considered regardless of residence and will be considered per visit.

Uninsured Patient is a patient who does not have any third party health care coverage by either (a) a third party insurer, (b) an ERISA plan, (c) A federal health care program (including without limitation Medicare, Medicaid, SCHIP, and TRICARE), (d) Worker's Compensation, Medical Savings Account, or other coverage for all or any part of the bill, including claims against third parties but only if payment is actually made by such third party. In addition, Financial Assistance under this Policy shall also include (a) services if a person with insurance has exhausted his or her insurance benefit, (b) services which are not covered benefits on the patient's insurance policy and are not considered Service Exclusions, or (c) is deemed fully responsible for payment of their bill.

Governmental Health Care Coverage. Any health care program operated or financed at least in part by the federal, state or local government.

Service Exclusions: Charity care will not be available to patients for services that are not medically necessary, considered elective, or cosmetic surgery. In addition, non-essential services and services that are not appropriate for a hospital setting may also be excluded from this policy. This Policy will not apply to payment obligations classified as patient responsible in cases in which a person is insured.

II. ELIGIBILITY

Financial Assistance eligibility will be determined by the applicant's unadjusted family gross income as stated on the most recently 4-consecutive weeks prior to requesting Financial Assistance application or as stated on the most recently filed Federal and State Income Tax Return in relationship to total family size. Or in the case the patient does not file Income Tax Returns; the patient shall be required to sign an Income Tax Exception Statement, or a signed statement from their employer attesting to wages. Patients receiving Social Security or disability benefits shall provide copies of their most recently 4-consecutive weeks prior to requesting the Financial Assistance application, a benefit letter, or bank statement showing the direct deposits, if applicable. In addition to the noted documentation, the patient's and/or significant other's Social Security Number will be used to verify stated income.

The following documentation and verification is required to be considered for financial assistance.

A. Proof of Identity
   1. Photo identification
   2. Proof of address (utility bills, rent receipt, mail- including post mark, etc.)
   3. Copies of social security cards of all family members listed on the application
   4. Copies of birth certificates, resident cards, visas, or passports

B. Proof of Income
   1. Pay stubs for the most recent 4 weeks for each working family member
   2. Unemployment or Workers Compensation Statement
   3. Social Security benefit letter or bank statement, if Direct Deposit
   4. Pension statement

5. Self Declaration letter for each working family member
6. Most recent tax return filed. If patient had a Low Income Tax Exemption, and did not have to file a return, patient will be required to sign a statement at the time of application
7. Medicaid denial letter or Medicaid Spend down letter.

C. Applicants that have not applied for State Medicaid must complete an application and provide copies of all supporting documentation.

Other Requirements

- **Non-Citizens.** In accordance with the Department of Social Services, non-citizens must submit sponsor information.
- **Non-CT Residents.** Non-CT residents will be encouraged to apply for Medicaid in their home state. If the Medicaid application is denied, they will be considered for financial assistance.
- **Assets.** There is no asset limit. We will consider income from a 401K as documented by a tax return.
- **Lawsuits.** St. Vincent's Medical Center may recover the cost of accident-related medical services paid by St. Vincent's from the proceeds of a lawsuit.

III. LEVELS OF FINANCIAL ASSISTANCE

(a) 100% Charity Care – unadjusted gross income less than or equal to 200% of the Federal Poverty Level ("FPL") which may be adjusted by the hospital for cost of living utilizing the wage index for Fairfield county compared to national wage index, will be eligible for 100% Charity Care write off of the charges for services that have been provided to them. FHC patients are required to pay a nominal office visit co-pay. (Attachment 1)

(b) Financial Assistance –Uninsured patients with unadjusted gross income above 200% of the FPL but below 400% of the FPL will receive a discount on services based on a sliding scale.

(c) Free Bed Fund and Other Assistance Funds – must meet the specific criteria of the fund (Attachment 2).

(d) Self-Pay Patient Discount – Uninsured patients with unadjusted gross income exceeding 400% of the FPL (which may be subject to the wage index adjustments noted above) will receive a discount on services in accordance with SVMC policy governing Self-Pay Patient Discounts and Public Act 03-266. Such discount is based on total billed charges.

(e) Catastrophic Events. Patients who qualify for financial assistance will not be required to pay more than 10% of their adjusted annual gross income per year, for a maximum of three years. All financial payments shall be capped at this level.

IV. PROCESS FOR FINANCIAL ASSISTANCE

Confidentiality: The need for Financial Assistance may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of the individual's dignity shall be maintained for all who seek Financial Assistance. Orientation of staff and the selection of personnel who will implement this policy and procedure should be guided by these values. No information obtained in the patient's Financial Assistance

application may be released unless the patient gives expressed permission for such release, except to bona fide governmental agencies requesting aggregate data.

1. At the time of registration all patients without insurance are to be informed that the Medical Center has a policy entitling them to a possible reduction in their liability for services rendered by the Medical Center. If the patient requests to speak with someone to discuss Financial Assistance they will be referred to a Financial Counselor for an initial screening. The Financial Counselor will assess the patient's needs and begin the appropriate Financial Assistance process.
2. After the initial screening, Applications who only qualify for the Self-Pay Patient Discount, do not need to complete an application and they shall be informed at the time about the discount program. If the patient appears to qualify for Charity Care and the patient requests financial relief from their bill they will be provide with an application for Financial Assistance (Attachment4) along with all necessary application materials and instructions. Ideally the application should be taken in-person by the Financial Counselor however, the application can be completed and returned with all required documentation to the Financial Counselor's office.
3. Applicants are required to complete and apply for State Medicaid. If an applicant has applied within 6 months of requesting consideration for financial assistance, they must provide a copy of the determination letter. Applicants which meet the income threshold equal to or below State and City welfare standards shall also complete the agency's application. Applicants who may qualify based on income threshold criteria but do not meet other State and City welfare qualifications such as residency, spend-down requirements, etc. shall be exempt from this requirement.
4. Patients who do not provide the requested income information necessary to completely and accurately assess their financial situation in a timely manner and/or who do not cooperate with efforts to secure governmental health care coverage may not be eligible for Charity Care.
5. The Medical Center will notify the patient of its determination in writing within thirty (30) days of receipt of a completed application. If the application is granted the applicant will be assigned a case number, all family members shall be provided an ID card. If the application is declined, an explanation will be provided as to the reason(s). The applicant shall also be advised as to their appeal rights.
6. All appeals shall be made in writing by the applicant within 60 calendar days of the date of the determination letter. Appeals will be referred to the Review Committee consisting of representatives from Mission Services, the Patient Family Advocacy Committee, and other hospital areas. A hearing shall be scheduled to review the appeal in a timely manner and a decision rendered within 2-weeks of the monthly meeting.
7. Applicants awarded either Charity Care or Assistance shall be granted into the program for one (1) year. Patients who are approved and reside outside of the St. Vincent's primary service area will be granted on a per visit basis. Annually, the applicant shall be required to complete an application update in order to continue under the program. If circumstances change, the patient may request earlier re-consideration. In addition, patient demographics may be verified at time of registration for services.
8. All applications and documentation shall be maintained in accordance with appropriate record keeping criteria.

V. SPECIAL CIRCUMSTANCES

All patients requesting financial assistance must follow standard procedures as outlined in this policy. It is understood that there may be special circumstances such as, but not limited to the following, which shall be considered by SVMC in making a final determination.

Special Financial Needs. Patients who do not initially qualify for Charity Care during the general application process but have indicated they have special circumstances such as, but not limited to, significant financial issues, shall be referred to the Review Committee for consideration. After review by the Review Committee, a determination shall be made to award a level of Financial Assistance at pre-qualification level or to issue a higher level by assigning an Administrative Approval Waiver at an adjusted level determined by the special circumstances. The applicant shall be notified in writing of the determination and the patient has a right to appeal such determination as afforded in item 6 above.

Patients Without Adequate Supporting Documentation. Patients without adequate supporting documentation shall be referred to the Review Committee for consideration and Administrative Approval of 100% Charity Care. The application for financial Assistance although required, may be signed by a duly authorized SVMC staff member on behalf of the patient. SVMC will accept a written statement attesting to identity and income if it is signed by the patient and a witness. No notary is required.

Insurance Denials Due to Patient's Actions. Insurance denials due to patient's actions should not be eligible (failure to respond to request for information, leaving against medical advice, etc.)

VI. PROCESS FOR SELF PAY DISCOUNTS

Self Pay Discount: At the time of registration, all patients without insurance are to be informed that the Medical Center has a policy entitling them to a reduction in their liability for services rendered by the Medical Center. If the patient requests to speak with someone to discuss Financial Assistance they will be referred to a Financial Counselor for an initial screening. The Financial Counselor will assess the patient's needs and begin the appropriate Financial Assistance process. All patients who register as self pay but do not quality for Financial Assistance are automatically granted the Self Pay discount in accordance with SVMC policy.

***Penalty cause for tampering with the Charity Card:** Any evidence of tampering with the information on the Charity Card will result in a suspension of Charity Assistance for 6 months, and the patient will have to re-apply again for Financial Assistance.

Attachments: Free Bed Funds
Reviewed: March 28, 1994, June 10, 1996, January 24, 2000, March 3, 2004, January 5, 2009

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Attachment 1

Financial Assistance Eligibility Matrix
Based on Federal Poverty Guidelines (FPL)

	Hospital Based Inpatient & Outpatient

Monthly Income	100%a	200%	250%	275%	300%
Family Size	Charity Care		325%	350%	
1	931	1,862	2,327	3,258	
2	1,261	2,522	3,152	4,413	
3	1,591	3,182	3,977	5,568	
4	1,921	3,842	4,802	6,723	
5	2,251	4,502	5,627	7,878	
6	2,581	5,162	6,452	9,033	
7	2,911	5,822	7,277	10,188	
8	3,241	6,482	8,102	11,343	
Annual Income			(C)		
Income as a % of FPL	100%a	200%	250%	350%	
Family Size					
1	11,170	22,340	27,925	39,095	
2	15,130	30,260	37,825	52,955	
3	19,090	38,180	47,725	66,815	
4	23,050	46,100	57,625	80,675	
5	27,010	54,020	67,525	94,535	
6	30,970	61,940	77,425	108,395	
7	34,930	69,860	87,325	122,255	
8b	38,890	77,780	97,225	136,115	
SVHS Discount	100%	100%	80%	60%	

Attachment 2
St. Vincent's Medical Center
Free Bed Funds

Below is a listing of the six Free Bed Funds listing of St Vincent's Medical Center.
If you believe you may qualify for one of the Free Bed funds listed below, you may request to have your case for financial assistance presented to St. Vincent's Medical Center. The Director of Patient Financial Services has the authority to grant free bed funds based on financial and personal need. To obtain further information, including an application, please contact a Financial Counselor at 203-576-5911 or 203-576-5829.

Baker Fund

Available to Bridgeport Fire & Police Departments. The patient must present verification that he/she is a member of the Bridgeport Fire or Police department.

Harral Fund

Member of St. Augustine's Parish. The patient must present a letter from St. Augustine's Parish (Bridgeport, CT) confirming patient's membership status.

Hubbell Fund

Alumni of St. Vincent's College or Bridgeport Hospital School of Nursing, who reside in Bridgeport and are active in the Nursing of the Sick.

Klein Fund

Funds to assist pediatric patients. Must provide a copy of patient's birth certificate or Baptismal certificate.

Ladies of Charity Fund

Letter verifying membership in the Ladies of Charity organization.

Conlin Fund

Assistance for low-income patients. Must provide proof of income and assets and a letter of denial from available third party sources.

Brodbeck Fund

Emergency room services. Must provide proof of income and assets and a letter of denial from available third party sources.

Item # 3

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Patients With No Medical Insurance	Classification: 700-12
Effective Date:	May 18, 1977	Category: Fiscal
Revision Date:	May 26, 1987, October 30, 1989 October 29, 1990, March 16, 1992 December 18, 1995, August 9, 1999 December 11, 2000, June 17, 2002 June 7, 2004, June 5, 2006	
Reference Material:	Patient Access Services Manuals Admission Policy (600-1) Financial Assistance Policy (700-1) Ascension Policy #16 (Billing and Collecting for the uninsured)	Administrative Approval: Susan L Davis

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Policy: Outpatients and Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their bill. Uninsured patients with the ability to pay will be provided a discount per Ascension Policy #16. This discount will be adjusted annually.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implementation Procedures:

I. Elective Patients

A. The physicians' offices shall schedule patients in accordance with St. Vincent's Medical Center policies and procedures. (600-1 and 600-18)

B. When a physician schedules a self pay patient, the arrival date is to be held in a pending status until the Patient Access Services Financial Counselor is able to establish a financial source.

C. Prior to the pending arrival date, the Financial Counselor will do the following in accordance with hospital procedures to establish a payment plan:
- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Financial Assistance Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.

D. Once a financial source is determined the pending date will be finalized and detailed information provided to the physician's office.

E. If a financial source cannot be determined, the physician's office will be notified of this and the patient will be held in pending status until a financial source has been determined.

F. In the event a financial source cannot be established, the decision to treat the patient will be made by Senior Management of the Medical Center.

II. Urgent or Emergent Patients

A. Emergent or urgent services will never be refused to a patient due to the inability to pay the Medical Center.

B. The Financial Counselor will interview the patient or appropriate family member either after initial screening and stabilization or by the next business day in accordance with hospital procedures to establish a payment plan:

- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Financial Assistance Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.

C. If a financial source cannot be established, the Director of Patient Financial Services and Patient Access will refer the account over to the Collection agency utilized by the Medical Center.

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

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ASCENSION HEALTH

SYSTEM POLICY#: 16 **SUBJECT: Billing and Collection for Those in Need of Financial Assistance**

BOARD APPROVAL DATE: 12/10/03
EFFECTIVE DATE: 07/01/04
12/08/10
8/1/15

President/CEO, Ascension Health

POLICY

It is the policy of the System to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). This policy is specifically designed to address the financial assistance eligibility and billing and collection practices for patients who are in need of financial assistance and receive care within the System.

This policy is intended to ensure consistent treatment of patients across all of Ascension, regardless of place of service. This includes extension of the policy to all services including employed physician practices, joint venture operations where Ascension is the controlling member, and billing-under-arrangement bills.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder and shall be interpreted and applied in accordance with such regulations.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "Patient" shall mean those persons who receive care at a System Health Ministry and the person who is financially responsible for the care of the patient and includes racial minorities, immigrants, undocumented persons, and refugees.
- Patient in need of financial assistance is defined as follows:
  - Qualify for charity care as defined in Ascension Health System Procedure M-1,
  - Do not otherwise qualify for or cannot reasonable access any governmental or private program that provides coverage for any of the services rendered,
  - Do not qualify for charity care but do qualify for some discount of their charges for Health Ministry services based on a substantive assessment of their ability to pay ("Means Test"), or
  - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided in the health ministries, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures as defined by each Health Ministry and determined by a licensed physician.

3. Each Health Ministry must ensure that:

    a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

    b. Patients receive prompt access to charge information for any item or service provided.

    c. Patients and their families are advised of the Health Ministries' applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community. HMs will translate the financial assistance policy, application form, and plain language summary for populations with limited English proficiency (for any group that constitutes the lesser of 1,000 individuals or 5% of the community served).

    d. Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the Patient's financial status.

    e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.

    f. Financial counselors are available to all Patients.

    g. Information regarding financial assistance and charity care policies is widely publicized including posted information in the all admitting and registration areas, including the Emergency Room.

    h. Following a determination of financial assistance, an individual eligible for charity care will not be charged more than amounts generally billed (AGB) to insured patients for emergency or medically necessary care.

    i. Health Ministry programs that include nominal payments by patients qualifying for charity care designed to encourage patients to participate in their care are permissible.

    j. Health ministries may apply medical necessity as a criteria for financial assistance. Medical necessity determination must include the determination of clinical merit by a licensed physician in consultation with the admitting physician.

k. Local policies regarding residency requirements and geographical determinants for access to financial assistance are defined local, consistent with Community Health Needs Assessments, and are consistently administered within a Health Ministry. At a minimum, services should never be declined for patients within the defined communities included in the Community Health Needs Assessment.

l. Health ministries will provide a list of any providers delivering care in the health ministry that specifies which are covered by the financial assistance policy and which are not.

4. Charity Care (Minimum Standards)

   a. At a minimum, patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services which the patient is responsible following payment by an insurer that have been provided to them in accordance with Ascension Health Procedure M-1. HMs may adjusted the 250% threshold higher for cost of living utilizing the local wage index compared to national wage index,

   b. At a minimum, patients with demonstrated financial needs with incomes above 250% of the FPL but not exceeding 400% of the FPL, subject to market adjustments as described in Section 4(a), will receive a sliding scale discount on that portion of the services provided which the Patient is responsible following payment by an insurer. The sliding scale will be determined by each Health Ministry and/or Health Ministry in accordance with guidelines established in Ascension Health Procedure M-1 and will limit amounts charged for emergency and other medically necessary care provided to individuals eligible for charity care to not more than AGB.

   c. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application

   d. Eligibility for charity care write-off must be determined for any balance for which the patient with financial need is responsible.

5. Financial Assistance

   a. Patients with demonstrated financial needs with income greater than 400% of the FPL, which may be adjusted by the Health Ministry for cost of living utilizing local wage index compared to national wage index, may be eligible for consideration for some discount of their charges for Health Ministry services based on a substantive assessment of their ability to pay.

   b. The assessment of a patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.

      1) The Means Test will be determined by each Health Ministry in accordance with guidelines established in Ascension Health System Procedure M-1.

      2) Each Health Ministry must establish a process for patients and families to appeal decisions of the Health Ministry regarding eligibility for financial assistance.

3) Eligibility for financial assistance may be determined at any point in the revenue cycle.

4) Eligibility for financial assistance must be determined for any balance for which the patient is responsible

6. Limitations on Charges

   a. Patients eligible for charity care will not be charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to not more than AGB. Each health ministry must determine AGB in accordance with IRS Reg. Sec. 1.501(r)-1(b)(1).

   b. Uninsured patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Health Ministry.

   c. The highest paying payor must account for at least 3% of the Health Ministry's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Health Ministry business for that given year.

   d. A prompt pay discount must be provided to all of patients for balances owed with the exception of payor contracted co-payments.

7. Collection Practices

   a. HMs will not engage in extraordinary collection actions (ECA) against an individual before making reasonable efforts to determine whether the individual is eligible for financial assistance. ECAs include taking actions that require legal or judicial process; selling debt to third parties; reporting adverse information to credit agencies or bureaus; and deferring or denying (or requiring a payment before providing) medical necessary care because of nonpayment of previously provided care that is covered under the financial assistance policy.

   b. Liens on personal residences are permitted only in the following circumstances:

      1) The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the Health Ministry and the Patient.

      2) The lien will not result in a foreclosure on a personal residence.

      3) Liens pursued by a collection agency or other representative of the Health Ministry have had prior review and approval from executive management of the Health Ministry

   c. Garnishments of wages are permitted only if:

      1) The Patient does not qualify for charity or financial assistance under Section 4 or 5 of this Policy, and a court determines that the Patient's wages are sufficient for garnishment.

      2) Garnishment pursued by a collection agency or other representative of the Health Ministry has had prior review and approval from executive management

of the Health Ministry.

d. No Health Ministry will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts.

e. No Health Ministry, collection agency, or other representative working on behalf of the Health Ministry may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.

f. Interest charges on outstanding balances may only be assessed if:

   1) The financing plan offered is one of several options offered to the patient.

   2) The interest rate is fair (i.e., less than that charged by standard credit cards).

   3) The amounts financed include only those amounts due after charity or financial assistance has been given.

   4) The amount of interest anticipated to be charged by the financing entity must be netted against the balance the patient is deemed able to pay.

   5) Consistent with Catholic social teaching regarding healthcare as an act of charity, not a commodity, Health Ministries will not charge interest on outstanding balances for those individuals identified with financial need wo are accessing charity care or financial assistance per this policy.

g. All Health Ministry collection agency agreements will incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for patients in financial need including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] all patients.

2. A copy of the Policy has been provided to [the Collection Agency].

3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving [Health Ministry] patients. Such activities include, but are not limited to, the following:

   a. All communications with any [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and

   b. All legal proceedings, of whatever kind or nature, against any [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].

4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

LIST OF PROVIDERS

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F), this list must specify whether any providers of emergency and medically necessary care delivered in the hospital facility follow the Financial Assistance Policy (FAP).

Providers covered by FAP	Providers not covered by FAP

ASCENSION HEALTH

SYSTEM POLICY #: 9 **SUBJECT: Care of Persons Living in Poverty and Other Vulnerable Persons**

BOARD APPROVAL DATE: 09/06/00
EFFECTIVE DATE: 09/06/00
REVISION DATE: 03/12/03
12/08/10

President/CEO, Ascension Health

POLICY

In accordance with Catholic Social Tradition, it is the policy of Ascension Health that each Health Ministry, providing services in an inpatient, outpatient, clinic, ambulatory setting or physician practice, guided by the Mission, Vision, Values, and Philosophy of the System, will plan for care of persons living in poverty and other vulnerable persons and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. Ascension Health desires to express commitment to this principle through a unified system of planning and accountability.

2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their integrated strategic, operational and financial planning.

3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.

4. Annually Ascension Health will produce an aggregate report highlighting the best practices and innovative programs in the System.

APPLICABILITY TO AFFILIATES

It is expected that all organizations with which Ascension Health Ministries are affiliated will adopt a policy that is consistent with and supportive of this System policy. Such organizations also will be expected to comply with System reporting requirements regarding care of persons living in poverty and other vulnerable persons and community benefits.

SYSTEM PROCEDURES

Guidelines and Procedures for planning and reporting on Care of Persons Living in Poverty and Other Vulnerable Persons and Community Benefit and unreimbursed care can be found in the System Procedure #M-1 and M-2.

Item #5

St Vincent's Medical Center
Financial Assistance Eligibility Matrix
Based on Federal Poverty Guidelines (FPL)

Hospital Based Inpatient & Outpatient Services					
					All Uninsured Patients regardless of Income (d)
Monthly Income	100%a	200%	250%	350%	44% OP/ 44%IP Discount
	Charity Care				
Family Size	981	1,962	2,452	3,923	
2	1,328	2,655	3,319	5,310	
3	1,674	3,348	4,185	6,697	
4	2,021	4,042	5,052	8,083	
5	2,368	4,735	5,919	9,470	
6	2,714	5,428	6,785	10,857	
7	3,061	6,122	7,652	12,243	
8	3,408	6,815	8,519	13,630	
Annual Income			(C)		
Income as a % of	100%a	200%	250%	350%	
Family Size	$11,770	$23,540	$29,425	$47,080	
2	$15,930	$31,860	$39,825	$63,720	
3	$20,090	$40,180	$50,225	$80,360	
4	$24,250	$48,500	$60,625	$97,000	
5	$28,410	$56,820	$71,025	$113,640	
6	$32,570	$65,140	$81,425	$130,280	
7	$36,730	$73,460	$91,825	$146,920	
8b	$40,890	$81,780	$102,225	$163,560	
SVHS Discoun	100%	100%	80%	60%	

a) Federal Register, Vol. 80, No. 14, January 22, 2015 Federal Poverty Guidelines.
b) For each additional person after 8 add $3,960
c) St Vincent's Charity Care % exceeds OHCA's requirement that care be provided at cost for income between 200% and 250% of FPL. Also CT Public Act #03-266
(d) Note: All uninsured patients with the means to pay are eligible for an additional prompt pay discount per Ascension. We have determined a 2% prompt pay discoun