**ST. JOSEPH HEALTHCARE**
**BANGOR, MAINE 04401**

☒ **HOSPITAL** ☐ **FOUNDATION** ☐ **STRAUSS** ☒ **ACI** ☒ **HOMEHEALTH**

**DEPARTMENT:** Organization Wide **POLICY: RI.018**

**POLICY:** Financial Assistance Program **EFFECTIVE: 4/6/1992**

**DEVELOPED BY:**_____ **REVISED: 1/1/2016**
Kathy Barry, MBA, CHFP
Director of Revenue Cycle Management

**AUTHORIZATION:**_____
Michael Hendrix, CFO

## I. POLICY:

Consistent with its mission to provide high quality health and wellness services for the community, it is the policy of St. Joseph Healthcare that an individual meeting qualified income guidelines may receive financial assistance in paying medically necessary bills without discrimination due to race, gender, age, sexual orientation, religious affiliation, social or immigrant status, or health insurance status. In accordance with the Affordable Care Act (ACA), any patient eligible for financial assistance will not be charged more for emergency or medically necessary care than the amount generally billed (AGB) to insured patients. St Joseph Healthcare follows all EMTALA regulations and no patient will be denied emergency services.

## II. PURPOSE:

To promote the mission of St. Joseph Healthcare through Compassion to those in the community who do not have the financial means to meet obligations in paying for necessary medical bills, St Joseph Healthcare offers both free care and discounted care, depending on individuals' family size and income.

## III. DEFINITION(S):

**Amount Generally Billed (AGB):** The amount generally billed is calculated using twelve months of Medicare and Commerical claims paid data and dividing the total payments received from all parties to the covered charges. The resulting percentage becomes the amount generally billed and is utilized as the maximum net charge (gross charge less discount) to patients qualifying under the Financial Assistance Policy. The AGB will be updated on an annual basis. The calculated AGB for the period beginning January 1, 2016 is 52% and a discount of 48% will be used as the maximum net charge to persons qualifying under the Financial Assistance Policy.

**Assets:** For categories B, C, D and E, the family's assets will be considered in approving the application. Assets under $15,000 are not considered and assets $15,000 and over are considered in the application approval process. Items not considered in the asset calculation include, but are not limited to:

1. the family's home and surrounding lot;
2. family vehicles and recreational vehicles greater than 10 years old;
3. property used to produce income such as boats, trucks, and machinery (refer to Schedule C from the Tax Return);
4. money in employer-owned pension plan or retirement plan;
5. money in IRA, 401K, 403B or similar plans up to $60,000 for a single person or $90,000 for a family of two or more;
6. loans that must be repaid;
7. cash value of life insurance the family has purchased; or
8. up to $10,000 in a Family Development Account (FDA) that can be spent only for education, home or school, small business start up, or to use for an emergency or other family need.

**Disability:** Persons 18 years of age and older who are on disability are considered their own individual. For children under 18 years on disability, both the child and the disability income must be included in the family income.

**Emergency Care:** Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any organs or body parts. Emergency care will be provided to all presenting persons regardless of ability to pay.

**Expiration Date:** The last day of the month, six months from the application's approval date. Notice of such expiration date shall be sent to the applicant in writing. For inpatient admissions which fall within the six month period, income qualification must be revalidated for patients who have Benevolence or Cost Share coverage.

**Family:** A family is a group of two or more persons related by birth, marriage or adoption who reside together for support; all such related persons are considered as one family. In the case of divorced/separated/joint custody parental relationships, dependent children may only be considered on one program application. Foster children may be included only if income associated with the care of the foster child is also included. Dependent adult members of the household other than the applicant and co-applicant should apply for Benevolence or Cost Share as an unrelated individual. If a household includes more than one family and/or more than one unrelated individual, the income guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole. Non-married adults living together in a significant other relationship may qualify as a family.

**Family Unit of Size One:** In conjunction with the income guidelines, a family unit of size one is an unrelated individual, that is, a person 15 years old or over who is not living with any relatives or a person who is 18 or older (even if living with relatives as a dependent adult). An

unrelated individual may be the sole occupant of a housing unit or may be residing in a housing unit (or in group quarters such as a rooming house) in which one or more persons also reside who are not related to the individual in question by birth, marriage, or adoption.

**Federal Poverty Guidelines (FPL):** The most current FPL are obtainable at http://aspe.hhs.gov/poverty or by contacting the Department of Health and Human Services office by calling 1-207-827-9368 or 1-800-321-5557 ext. 79368.

**Health Insurance Exchange (HIX):** Also known as the Affordable Care Act. Consumers with income greater than 100% of the FPL and equal to or less than 400% of the FPL are eligible to buy health insurance on the Exchange/Marketplace at a subsidized cost. Patients who are able to purchase affordable health insurance benefit by ensuring healthcare accessibility and can enhance overall well-being. We require that all persons applying for Benevolence Category B or Cost Share programs on or after October 1, 2014, attest that they have researched the cost of insurance on the Exchange. We do not require that they purchase health insurance from the Exchange.

**Inability to Pay:** A person is unable to pay for necessary medical bills when the family income of that person, as calculated in subsection D, is less than the income guidelines set forth in subsection E.

**Income:** Income shall be defined as total annual cash receipts before payment of appropriate social security and income taxes. Income sources shall include, but not be limited to, the following categories:

1. money wages and salaries before any deductions, exclusive of food or rent received in lieu of wages;
2. net receipts (as defined on Schedule C Adjusted Gross Income on Line 37) from self-employment, including farming activities, rental properties;
3. social security, railroad retirement, unemployment compensation, worker's compensation, strike benefits, veteran's benefits;
4. training stipends;
5. public assistance including aid to families with dependent children, supplemental security income and general assistance money payments;
6. alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household;
7. pensions and regular insurance or annuity payments, including IRA's and similar funded accounts;
8. income from dividends, interest, rents, royalties or payments from estates or trusts; and
9. net gambling or lottery winnings.

For eligibility purposes, income does not include the following:

1. capital gains;
2. any liquid assets, including withdrawals from a bank or proceeds from the sale of property;

3. lump-sum inheritances;
4. one-time insurance payment or other one-time compensation for injury, however, one-time insurance payments made for coverage of hospital services would limit the availability of free care to bills not covered by such payments;
5. tax refunds;
6. gifts and loans;
7. noncash benefits such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits;
8. the value of food and fuel produced and consumed on farms and the imputed value of rent from owner occupied non-farm or farm housing; and
9. federal non-cash benefit programs such as Food Stamps, school lunches, and housing assistance.

**Liability/MVA:** The terms Liability or Motor Vehicle Accident (MVA) will refer to those claims for which some liability or other non-health insurance is involved. The most common example is motor vehicle accidents in which car insurance is involved, but can include any situation in which a third party or other entity is considered to be responsible or liable. Any situation involving attorney representation would be included. This policy does not cover such claims unless all payments or settlements have been applied against the outstanding claim or until all benefits have been exhausted or denied.

**Medically Necessary Services:** Medically necessary services are generally defined as services which are ordinarily covered by healthcare insurance. Emergency Care and Urgent Care Services are always considered to be Medically Necessary under this policy. Services specifically not eligible under this policy are outlined in section IV. F. of the policy. Individual services which are not covered due to an insurance's medical coverage policies and for which an Advanced Beneficiary Notice was issued are not eligible for coverage under this policy.

**Presumed Eligibility:** The hospital may refer to or rely on external sources and/or other program enrollment resources in the case of patients lacking documentation that supports eligibility or individual circumstance. The hospital may provide free or discounted services if a patient is/has:

- Homeless
- Deceased and without an estate
- Filed for bankruptcy

**Presumed Ineligibility for MaineCare:** For the purposes of this policy, consumers are considered to fall into the MaineCare Non Categorical Coverage Group if they meet ALL of the following criteria:

- Over 21 years of age
- Under 65 years of age
- Not pregnant
- Not disabled

Any applicants who meet all of the above criteria will presumed to be denied MaineCare coverage under the Non Categorical Coverage Group and do NOT require a MaineCare denial to be submitted with the application.

**Providers:** Providers covered under this policy include any and all providers who are owned and operated under any of the St. Joseph Healthcare entities. This policy does not cover the fees for independent providers, surgeons, consultants, anesthesiologists, imaging interpretation services, pathology services and other professionals who may provide services and separately bill for those professional services. A listing of providers is available as Exhibit K of the Financial Assistance Policy and available on the SJH Website.

**Resident of Maine:** The term "Resident of Maine" refers to a United States citizen living in the state voluntarily with the intention of making a home in Maine. An individual who is visiting or is in Maine temporarily is not a resident. For individuals who reside in more than one state, residency will be determined by the state of residence identified on their Maine Income Tax Return. Students who are eligible to be considered a family unit of one under the above definition and who are attending a school, exclusive of correspondence courses, in Maine will be considered Maine residents. A copy of a State of Maine issued Driver's License or Photo Identification card, a current and valid school issued ID card or some other proof of residency will be required. Only U.S. citizens who are residents of Maine may qualify for the Category A free care under this policy. U.S. Citizenship is required, but residency is not a requirement for the other categories of free care or cost-sharing.

**SJH Website:** All references to the SJH Website or Website will refer to www.stjoeshealing.org. The Financial Assistance and Patient Collections policies, income guidelines and Financial Assistance application are available under the Billing/Benevolence tab.

**Urgent Care:** Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 to 24 hours. Urgent care will be provided to all presenting persons regardless of ability to pay.

## IV. PROCEDURE:

**A.** The organization will post a written plain language notice of the policy and income guidelines in all registration areas (Exhibit A). In addition, information about the benevolence and cost share program and the income guidelines are posted on the website and on the back side of all self pay billing statements. Staff and representatives will provide information about the programs during appropriate phone calls and follow-up communications with patients.

**B.** During the registration process, all patients will be provided with oral or written notice of the guidelines to participate in the Benevolence and Cost Share Programs as displayed in Exhibit A. If the patient has already qualified for the program and the eligibility period has not expired, the clerk will register the patient under a specific financial category as identified below.

1. St. Joseph Hospital – Category A 0052
2. St. Joseph Hospital – Category B 0059
3. St. Joseph Hospital – Category C 0056
4. St. Joseph Hospital – Category D 0057

5. St. Joseph Hospital – Category E 0058
6. St. Joseph Ambulatory Care, Inc. 0051
7. Alternative Health Services Benevolence Program

**C.** To apply for the Benevolence and Cost Sharing program, the patient must request an application for determination of eligibility from the registration representative or billing department or download it from the website and complete the application in its entirety. See Exhibits B and C "Request for Determination" and "Instructions".

**D.** The inability to pay shall be determined by one of the following methods and the application's calculated income cannot exceed the guidelines as set forth in subsection E to qualify:

1. Using the person's actual family income for the 12 months preceding the determination of eligibility.
2. Calculate an annualized family income as follows:
    a. Applications for working individuals submitted on or prior to March 31 will utilize the filed taxes, W2 information etc from the previous year.
    b. Applications for working individuals submitted after March 31 will utilize year-to-date salary information annualized by dividing the amount by the number of periods and multiplying by the total number of periods in a year.
    c. Applications for self-employed individuals submitted on or prior to March 31 will utilize the most recent filed Tax Schedule C or the 12 months of ledger information for the previous calendar year -- whichever is most recent.
    d. Applications for self-employed individuals submitted after March 31 will utilize year-to-date ledger information annualized by dividing the amount by the number of months and multiplying by 12 months.
3. For applicant's to qualify for the Category B benevolence or any of the Cost Share plans, the asset worksheet must be taken into consideration. Individual applicants may have assets up to $15,000 and family applicants may have assets up to $25,000. Assets in excess of these amounts will disqualify the applicant for the benevolence and cost share program. See the definition of Assets for clarification on what is and is not included in the Asset calculation.

**E.** Upon meeting the following income guidelines, the applicant will **qualify** for the Benevolence or Cost Share Program **for a period of six months**. Income qualification for inpatients must be revalidated with each admission (Exhibit I). This revalidation may occur in person or by phone. If the inpatient states that their income has changed from that represented on the most recent application, the account will be held until the proper determination can be made. Should any applicant's financial status change within the following guidelines, it may require a reapplication.

MaineCare applications are required where indicated below except if the applicant meets the Presumed Ineligibility for MaineCare guidelines as outlined in the definitions of this policy. In these instances, the MaineCare application requirement is waived.

Where indicated below, an attestation that the applicant has researched the cost of insurance

coverage on the Health Insurance Exchange is required for applications on or after October 1, 2014. We will offer to assist the applicant with navigating the HIX. Purchase of health insurance is not required.

Income eligibility requirements for participation shall be established using guidelines provided by the Department of Human Services and reviewed annually for compliance. See Exhibit D for a breakdown of category by family size.

1. Benevolence Program Category A: Income up to 150% of the Federal Poverty Guidelines qualify for a 100% discount – free care. This category meets the Maine State Free Care Guidelines. This category requires proof of Maine residency. This category requires that the applicant have no insurance coverage. This category requires a MaineCare application, but does not require an asset worksheet or application for health insurance on the HIX.
2. Benevolence Program Category B: Income up to 200% of the Federal Poverty Guidelines qualify for a 100% discount – free care. This category requires a MaineCare application and an asset worksheet and an attestation of application for health insurance on the HIX.
3. Cost Share Program Category C: Income up to 250% of the Federal Poverty Guidelines qualify for a 75% discount. This category does not require a MaineCare application, but does require an asset worksheet and an attestation of application for health insurance on the HIX. The remaining 25% is the patient's responsibility.
4. 
5. Cost Share Program Category D: Income up to 300% of the Federal Poverty Guidelines qualify for a 60% discount. This category does not require a MaineCare application, but does require an asset worksheet and an attestation of application for health insurance on the HIX. The remaining 40% is the patient's responsibility.
6. 
7. Cost Share Program Category E: Income up to 350% of the Federal Poverty Guidelines qualify for a 48% discount. This category does not require a MaineCare application, but does require an asset worksheet and an attestation of application for health insurance on the HIX. The remaining 52% is the patient's responsibility. This category uses the most recent AGB and represents the maximum net charge (gross charge less 48% discount) for persons who qualify under the Financial Assistance Policy.

**F.** The Benevolence and Cost Share program only applies to medically necessary services or services not covered under liability or MVA situations. A determination of medical necessity may require documentation from the physician. The program does not apply to elective services which are not deemed to be medically necessary, such as, but not limited to:

1. Cosmetic or aesthetic surgery;
2. Reverse sterilization procedure;
3. Gastric bypass (unless deemed to be medically necessary);
4. Migraine procedures (unless deemed to be medically necessary);
5. Off-label procedures (unless deemed to be medically necessary);
6. Phase III Cardiac Rehab program;

7. Pre-certification denials for medical necessity and an Advanced Beneficiary Notice (ABN) is issued;
8. Utilization Review denials for medical necessity and a Notice of Non-Coverage is issued; and
9. Services that the patient elects under the HIPAA Privacy Act to not have billed to his/her health insurance and instead elects to pay for the services in full. These services may be medically necessary, but would not be eligible for this program when another payer source is available, but the patient elects not to utilize it.

In liability or MVA situations, proof of valid insurance denial or exhaustion of benefits must be provided before claims will be considered for this program.

**G.** Processing of Application:

1. Upon receipt of an application, a search of the system will be made for all open accounts, including pre-registration accounts and any open accounts under a previous cost share eligibility.
2. Accounts that have already been sent to a Collection Agency will only be eligible for this program if the date of the application for financial assistance is within 240 days of the date of the first statement on each account in question.
3. If no accounts are found in the hospital system, the biller will contact the other entities (Ambulatory Care, Inc. and Alternative Health Services) to see if the patient has received or is scheduled to receive services.
4. If no accounts are found, the application will be returned to the patient with a notice of deferral stating that the patient is not eligible for financial assistance until services have been scheduled or provided.
5. The application will be reviewed for completeness of documentation and if found to be incomplete, the application will be returned with a notice itemizing the documents required to complete the application review process (Exhibit E). An application without a signature cannot be processed.
6. The completed application will be reviewed for approval and notice of final approval or disapproval will be sent to the applicant within Fifteen (15) business days of the receipt of the completed application. This notice will indicate all of the accounts in question and their disposition status as a result of the approval or disapproval of the application, see Section I. All accounts will be noted with the approval or disapproval date and placed in the appropriate financial class, see section B. above.
7. If the application is not approved, all accounts will be placed into the regular self pay billing cycle.
8. If the application is approved, all of the accounts will be adjusted per the approval category and a single write-off request will be generated. All accounts with remaining balances will be placed into the regular self pay billing cycle. In addition, the benevolence information will be provided to the other two St. Joseph Healthcare entities and the Spectrum Group will be notified via Secure Email at gale.shannon@mckesson.com with the patient name, medical record number and approval status.

**H.** Deferral of Determination:

Each application will be reviewed and based on the information submitted, deferral of approval of the application (Exhibit E) may be made for up to 60 days. The purpose of such delay shall be to require the applicant to obtain and provide evidence of ineligibility for medical assistance programs or to verify that the services in question are not covered by insurance, or other clarification.

If an applicant meets the income guidelines in subsection E and is not covered under any state or federal program for medical assistance, but meets any of the following criteria, qualification shall be deferred pending submission of additional information:

1. Age 65 or over;
2. Blind;
3. Disabled;
4. An individual is a member of a family in which a child is deprived of parental support or care due to one of the following causes, and the individual's income is less than the guidelines in subsection E:
    a. Death of a parent;
    b. Continued absence of the parent(s) from the home due to incarceration in a penal institute, confinement in a general, chronic or specialized medical institution, deportation to a foreign country, divorce, desertion or mutual separation of parents, or unwed parenthood;
    c. Disability of a parent; or
    d. Unemployment of a parent who is the principal wage earner;
5. Pregnant woman whose income is less than the guidelines in subsection E.1; or
6. A child up to the age of one year who is born to a woman who meets any of the above criteria.

**I.** Notification to Applicant:

1. A determination of eligibility (Exhibit F) must be completed on all applications received requesting participation in the Benevolence and Cost Share Program.
2. A letter of notification of Approval (Exhibit G) or Denial (Exhibit J) will be forwarded to the applicant within fifteen (15) business days of receiving a completed application. The letter will notify applicant of coverage or the reason for denial.
    a. The letter of notification to the patient shall include a list of all accounts being accepted as paid or discounted under the program at the time of acceptance.
    b. If a patient has made payments on any of the accounts prior to the date of their application, those payments will not be refunded. Only unpaid balances are eligible for the program.
    c. The notice must include the name and telephone number of the person who should be contacted should the applicant have questions regarding the notice; and state that the patient has a right to a hearing and how to obtain a hearing.
    d. Should the applicant be denied for failure to provide requested information within the timeframe, the applicant will be informed that he/she may reapply if

the required information can be furnished before the account goes to a Collection Agency.

**J.** Procedure to Request an Administrative Hearing:

An applicant for financial assistance may request an Administrative hearing if he or she is aggrieved by the action that denies the request for financial assistance. The Department of Health and Human Services may respond to a series of individual requests for a hearing by conducting a single group hearing. The applicant must follow the procedures described in this Section when requesting an administrative hearing:

1. An Administrative Hearing may be requested by an applicant or his/her representative.
2. Administrative hearings must be requested within sixty (60) days of the date of written notification to the applicant of the action the applicant wishes to appeal.
3. Request must be made by the applicant or his/her representative, in writing or verbally, for a Hearing to the Administrative Hearings Unit, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011.

## V. REPORTING AND RECORD KEEPING:

A. The billing department shall maintain records of the amount of free care and cost share care provided in accordance with this policy. Records for each category must be kept separately.
B. A summary of the amount of free care and cost share care and the number of individuals to whom each type of care was provided in each year must be reported to the Department of Health and Human Services.
C. A current copy of the Financial Assistance Policy and the posted guidelines must be submitted each year to the Department of Health and Human Services.

## VI. REFERENCES:

A. Department of Health and Human Services Office of MaineCare Services Chapter 150 Free Care Guidelines
B. Federal Poverty Guidelines
C. EMTALA
D. Affordable Care Act
E. IRS Code 501(r)
F. RI.024 Minors Consent Policy
G. RI.029 Patient Collection Policy

## VII. ATTACHMENT(S):

A. Exhibit A: Posted Notice of Benevolence and Cost Share Program Guidelines
B. Exhibit B: Request for Determination
C. Exhibit C: Instructions for the Request for Determination
D. Exhibit D: Benevolence and Cost Share Program Income Guidelines
E. Exhibit E: Notice of Return or Deferral of Application

F. Exhibit F: Determination of Eligibility
G. Exhibit G: Letter of Notification of Approval
H. Exhibit H: Benevolence Participation Card -- DISCONTINUED in 2014
I. Exhibit I: Category A Inpatient Admission Revalidation
J. Exhibit J: Letter of Notification of Denial
K. Exhibit K: Listing of Providers

## VIII. REVISIONS:

| DATE REVIEWED | DATE REVISED* | SIGNATURE AND TITLE |
|---|---|---|
| 3/18/2010 | 4/1/2010 | Kathleen K. Barry, MBA, CHFP<br>Director of Revenue Cycle Mgt |
| 1/8/2013 | 1/15/2013 | Kathleen K. Barry, MBA, CHFP<br>Director of Revenue Cycle Mgt |
| 2/7/2014 | 7/1/2014 | Kathleen K. Barry, MBA, CHFP<br>Director of Revenue Cycle Mgt |
| 9/3/15 | 1/1/16 | Kathleen K. Barry, MBA, CHFP<br>Director of Revenue Cycle Mgt |
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