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Financial Assistance Policy, FN 100

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:

Frederick Health is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, color, national origin or creed. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in the day-to-day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and has been adopted by the Frederick Health Board of Directors.

POLICY:

This policy applies to all patients seeking emergency or other medically necessary care at Frederick Health. This policy also applies to patients seeking treatment at any Frederick Health owned physician practice. These entities are hereinafter collectively referred to as “FH.”

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

PROCEDURE:

A. OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within thirty (30) days.
    a. For purposes of this policy, “financial assistance” refers to healthcare services provided without charge or at a reduced charge to qualifying patients.

b. A list of our health care service providers is available at. https://www.frederickhealth.org/Find-a-Doctor.aspx. Only providers employed by FH are covered under this policy and are indicated on the provider list.

c. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.

d. Should a patient need assistance applying for Financial Assistance; help is available at our physical location 400 West Seventh St. Frederick, MD 21701. Patients can also call 240-566-4214 with any inquiries regarding the Financial Assistance application process.

2. Notice of the Availability of Financial Assistance:

   a. FH will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within FH locations.

   b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.

   c. A statement on the availability of financial assistance will be included on patient billing statements.

   d. A Plain Language Summary of the FH Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.

   e. The FH Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at FH, through mail (postal service), and on the FH website at https://www.frederickhealth.org/billing.

   f. The FH Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.

      i. On an annual basis, FH shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: FH retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

   a. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

   b. All patients presenting for emergency services will be treated regardless of their ability to pay.

      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

   a. The FH rate structure is governed by the HSCRC rate setting authority. As an "all- payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

   b. Charges are developed based on a relative predetermined value set by the HSCRC at the

approved unit rate developed by the HSCRC.

B. **PROGRAM ELIGIBILITY**

1. FH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. FH reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or returned mailed with no forwarding address.
2. Patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care may be eligible for the FH Financial Assistance Program.
3. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:
    a. Emergency medical services provided in an emergency room setting;
    b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual;
    c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
    d. Medically necessary services.
        i. A medically necessary service is one which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.
        ii. A service or item is not medically necessary if there is another service or item that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all.
        iii. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary.
4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
    a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
        i. Exceptions to this exclusion may be made, in FH' sole discretion, considering medical and programmatic implications.
    b. Unpaid balances resulting from cosmetic or other non-medically necessary services;
    c. Patient convenience items.
5. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:
    a. After being notified by FH, refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).
    b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to FH

due to insurance plan restrictions/limits.

c. Failure to pay co-payments as required by the Financial Assistance Program.

d. Failure to keep current on existing payment arrangements with FH.

e. Failure to make appropriate arrangements on past payment obligations owed to FH (including those patients who were referred to an outside collection agency for a previous debt).

f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless FH can readily determine that the patient would fail to meet the eligibility requirements.

6. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

7. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section C.2 below).

   a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership for approval.

   b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

8. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in ***Appendix 1.***

C. PATIENT ASSISTANCE GUIDELINES

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section; additionally, payment plans based on patient's ability to pay are available on an individual basis.

2. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services. Below is an example of the sliding scale Frederick shall use to determine patient eligibility for financial assistance. Please visit our website at: https://www.frederickhealth.org/billing

   a. Patients whose family income is at or below 200% of the Federal Poverty Level (FPL) are eligible to receive free care.

   b. Patients whose family income is above 200% but not more than 250% of the FPL are eligible to receive a discount of 80% of their account balance.

   c. Patients whose family income is above 250% but not more than 300% of the FPL are eligible to receive a discount of 60% of their account balance.

   d. Patients whose family income is above 300% but not more than 350% of the FPL are eligible to receive a discount of 40% of their account balance.

   e. Patients whose family income is above 350% but not more than 400% of the FPL are eligible to receive a discount of 20% of their account balance.

D. PRESUMPTIVE FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance form and/or

supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining financial assistance eligibility.

a. In the event there is no evidence to support a patient's eligibility for financial assistance, FH reserves the right to use outside agencies, or propensity to pay modeling in determining financial assistance eligibility.

b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service.

2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage;

b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);

c. Homelessness;

d. Maryland Public Health System Emergency Petition patients;

e. Participation in Women, Infants and Children Programs ("WIC");

f. Food Stamp eligibility;

g. Eligibility for other state or local assistance programs;

h. Deceased with no known estate; and

i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.

4. Exclusions from consideration for presumptive eligibility include:

a. Purely elective procedures (e.g., cosmetic procedures).

b. Uninsured patients seen in the Emergency Department under Emergency Petition unless and until the Maryland Behavioral Health Administration (BHA) has been billed.

E. **MEDICAL HARDSHIP**

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Medical Hardship program.

a. Patients may qualify under the following circumstances:

i. Combined household income less than 500% of the Federal Poverty Guideline; or

ii. Having incurred collective family hospital medical debt may be at FH exceeding 25% of the combined household income during a 12-month period.

a. Medical debt excludes co-payments, co-insurance and deductibles.

2. FH applies the criteria above to a patient's balance after any insurance payments have been received.

3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of this sliding scale is provided at our website; https://www.frederickhealth.org/billing.
4. If determined eligible, patients and their immediate family qualify for reduced-cost, medically necessary care, for a 12 month period effective on the date the medically necessary care was initially received.
5. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, FH is to apply the greater of the two discounts.
6. Patient is required to notify FH of their potential eligibility for this component of the financial assistance program.

F. **ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES**: FH reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management level review and approval.

G. **ASSET CONSIDERATION**

1. Assets are generally not considered as part of financial assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. The following assets are exempt from consideration:
    a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
    b. Up to $150,000 in primary residence equity.
    c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

H. **APPEALS**

1. Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: FH 400 West Seventh Street Frederick, MD 21701 Attn: Financial Counseling Team.
2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
3. Appeals are documented and reviewed by the next level of management for additional reconsideration
4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.
6. Patients who have formally submitted an appeal will receive a letter of the final determination.

I. **PATIENT REFUND**

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under FH' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where FH' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for financial assistance after FH has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, FH will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

J. **OPERATIONS**

1. FH will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        i. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. FH will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
        i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
            a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
            b. Proof of disability income (if applicable);
            c. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
            d. Proof of social security income (if applicable);
            e. A Medical Assistance Notice of Determination (if applicable);
            f. Reasonable proof of other declared expenses; and
            g. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, a letter will be sent reminding the patient that financial assistance is available and informing the patient of the collection actions that will be taken if no documentation is received.

a. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.

b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).

c. If documentation is received after collection actions have been initiated, but within the 240 day after patient receipt of the first post discharge billing statement, FH shall cease all collection actions and determine whether the patient is eligible for financial assistance.

4. A Plain Language Summary of this policy shall be included with the letter and FH staff must make a reasonable effort to orally notify the individual of FH's financial assistance program.

5. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on FH guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

   b. For complete applications, the patient will receive a letter notifying them of approval/denial within 30 days of submitting the completed applications.

   c. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information

      i. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

      ii. If a patient is determined to be ineligible after receiving services, a payment arrangement will be obtained, subject to FH' approval, on any balance due by the patient.

6. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective as of the date treatment is received and the following six (6) calendar months.

   a. For those who qualify for reduced-cost care due to financial hardship, such qualification will apply for a twelve (12) month period.

   b. Presumptive Financial Assistance cases which will apply to the date of service only.

   c. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

7. The following may result in the reconsideration of Financial Assistance approval:

   a. Post approval discovery of an ability to pay; and

   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to FH.

8. FH will track patients' qualification for financial assistance or financial hardship. However, it is ultimately the responsibility of the patient to inform FH of their eligibility status at the time of registration or upon receiving a statement.

K. **CREDIT & COLLECTIONS POLICY**

1. FH maintains a separate Credit & Collections Policy that outlines what actions FH may take in the

event a patient fails to meet their financial responsibility.

2. A copy of the Credit & Collections policy may be obtained by requesting a copy from FH staff or by visiting FH website.
3. FH maintains a list of all non-FH providers who may care for patients while at FH. Non-FH providers bill separately for their services and not all participate in FH' Financial Assistance Program.
4. A copy of this list may be obtained by requesting a copy from FH staff or by visiting FH' website at https://www.frederickhealth.org/Find-a-Doctor.aspx.

Attachments

No Attachments