PATIENT FINANCIAL ASSISTANCE PROGRAM

Policy:

Any patient at SJHHC will receive medically essential services irrespective of their ability to pay. Financial Assistance is offered to patients who have urgent, emergent, and medically necessary procedures in accordance with the procedures outlined below, consistent with Subdivision 9-a to Section 2807-k of the New York State Public Health Law.

Service Area:

St. Joseph’s will extend financial assistance to all eligible patients within our primary service area which includes Onondaga, Cayuga, Cortland, Madison, Oswego, Jefferson, Lewis and St Lawrence Counties. Any patient requiring emergency care may be considered for financial assistance independent of their county or state of residence.

Guidelines:

St. Joseph’s considers eligibility for financial assistance at any point before or after services are rendered and/or any time during the billing and collection cycle. A patient’s eligibility for financial assistance is based upon the size of the applicants family and is limited to those families whose income is less than or equal to 342% of the current poverty level income guidelines as determined by the Department of Health and Human Services. Applicants for financial assistance may be screened for any available insurance options including Medicaid eligibility by a financial counselor. Income verification for the time frame in which the patient received services will be needed to determine whether a state sponsored insurance application should be completed.

Procedure:

1. Outpatients (OP) - uninsured
   a. Outpatients arriving to registration who have not been pre-registered and are identified as self pay are provided with a Financial Assistance Brochure. The patient has the option to complete form # 12779 for a referral to a Medicaid Managed Care facilitated enroller (FE) or Onondaga County Department of Social Services. The form identifies the various MMC providers who can assist the patient in obtaining Medicaid, CHP (Child Health Plus) and FHP (Family Health Plus). The referral form is electronically scanned or mailed via interoffice to the financial counselor who will refer the patient to the FE. The account is placed on hold from being billed. If a MMC FE is on site in the clinic the patient may meet with the FE at that time.
   b. The FC monitors the patient’s account(s) throughout the application process. If the patient is accepted for Medicaid, CHP or FHP the FC will bill the appropriate program. If the patient is rejected from any public programs, the patient accounts will be transferred to a financial aid pending category and the patient is sent an FA application to complete. If the FE was unable to contact the patient following the referral, the patient will be billed for services.
c. ED outpatients are provided with this information as outlined above at the Discharge Desk during their discharge process.

d. An uninsured scheduled surgical or diagnostic procedure identified during the pre-registration process and an in-house referral is sent to the FC unit via email. The FC will attempt to contact the patient and offer to assist the patient in completing a Medicaid application, refer the patient to a MMC Facilitated Enroller or begin an FA application if the patient will not qualify for Medicaid.

e. The FC will monitor the patients’ account(s) throughout the application process. If the patient is accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss financial assistance or a payment plan.

f. Patients who may be eligible for Medicaid, Child Health Plus or Family Health Plus, who do not comply with the application requirements of their local Department of Social Services may not be eligible for Financial Aid.

2. **Inpatients-uninsured**

a. The FC will visit the patient to discuss the need for financial assistance. Depending on the patient’s or guarantors income level the FC will either complete a Medicaid application with the patient or mail the patient a FA application to be completed after discharge. If a patient does not wish to meet with the FC, the FC will advise the patient they will be responsible for the bill and the account will be deemed self pay. The FC will monitor the patient’s account(s) throughout the application process. If the patient is accepted for Medicaid, CHP or FHP the FC will bill the appropriate program. If the patient be rejected from any public programs, the SJHHC will contact the patient to discuss financial assistance.

b. Patients placed on ALC (Alternate Level of Care) will be visited by the FC who will meet with the patient, personal representative to discuss the need for financial assistance and assist in compiling necessary documentation to complete a Medicaid application. The FC will send a completed application and supporting documentation to the Chronic Care Unit of the local Department of Social Services depending on the demographics. Note: the FC can determine, based on the information provided from the patient, if the patient will qualify for Medicaid. That information will be provided to case management who will decide on the patient disposition to nursing home. The FC will continue to monitor the patient’s account(s) throughout the application process and bill the appropriate program once the ALC patient has been approved for Medicaid.

3. **Insured, Underinsured, Benefits Exhausted and Denied Coverage patients – inpatient/outpatient**

a. A patient may be insured but in need of financial assistance for account balances as a result of out of pocket expenses, benefits exhausted, and denied insurance payment they may incur and are unable to pay.

b. Once a bill has been submitted to a primary, secondary or tertiary payor there may be a balance still due. In accordance with the SJHHC Bad Debt Policy a patient is sent 5 statements advising them of their patient responsibility. The SJHHC FC phone number is listed on these statements. If a patient is concerned about their balance due and their inability to pay, the patient has the option to contact Patient Accounting Services or Financial Counseling. Calls received by the patient accounting are referred to an FC who will review the particulars of each case to determine if patient qualifies for financial assistance based on the federal poverty levels and income.
Filing the FA application:

1. Brochures and signage in multiple languages are available at registration sites to notify patients and family members of the existence and availability of the Financial Counseling Unit. Our hospital website, billing data mailers includes the phone number of our Financial Counseling Unit. Both inpatient and outpatient handbooks display information regarding financial counseling and contact information for the financial counseling unit.

2. The FA application form is also available on the hospital website sjhsyr.org

3. To facilitate the compilation of documentation for FAP application processing and/or the financial screening process, St Joseph’s may utilize soft credit inquiries that are transparent to creditors and have no impact on the patient’s credit status or FICO scores. Such inquiries may be used to:
   a. Reduce the patient’s burden of compiling documentation
   b. Determine presumptive eligibility for patients or their guarantor that do not establish contact with the hospital during the billing and collection cycle.

4. Proof of income and resources is required of the patient and all family members if applicable. The various types of proof of income are listed on the FA application form. The proof of income includes but is not limited to: income from wages, self employment, social security, pensions, compensation, alimony, child support, rental dividends, and V.A. benefits. The following assets are excluded: the patients’ primary residence (owned home), car used by the patient or patient’s family, college savings accounts, and tax deferred or comparable retirement savings accounts.

5. A patient is eligible for Financial Aid (FA) if they have met the necessary requirements while applying for Medicaid but have been denied.

6. St. Joseph’s utilizes NYSDOH guidelines regarding the consideration of liquid assets and may review a patient’s liquid assets if they fall within the income levels and family size approved by the state. (less than 189% FPL). A patient whose annual income is at or below 138% of FPL will not have the liquid asset test applied. An asset test cannot be used to deny financial assistance, but only to upgrade the patient’s level of obligation, up to the legal maximum permitted under the NYS law. The following assets are not included: primary residence, cars used by the patient’s family, college saving accounts, tax deferred retirement accounts, college saving accounts. The liquid asset test may not be applied unless the patient’s liquid assets are above the amounts stated on chart below:

<table>
<thead>
<tr>
<th>2014 Household Size</th>
<th>2014 Asset Levels (NYS)</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
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<td>9</td>
<td>$29,315</td>
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<tr>
<td>10</td>
<td>$31,460</td>
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<tr>
<td>Each additional person</td>
<td>$2,145</td>
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**FA application review**

1. The patient is expected to complete the application and provide supporting documentation 90 days after the date of service/discharge. Accounts are not billed until a decision is rendered by the hospital in reviewing the application. Applications must be reviewed by the FC within 30 days of receipt of the completed application and supporting documentation. Where the FC finds the patient eligible for financial assistance the appropriate discount will be applied:

   - Income less than or equal to 138% FPL: (100%)
   - Income between 139% and 189% FPL: (80%)
   - Income between 190% and 240% FPL: (60%)
   - Income between 241% and 291% FPL: (40%)
   - Income between 292% and 342% FPL: (20%)

   Inpatient claims will be adjusted to the Medicare rate before the FA discount is applied. Outpatient claims will be discounted 50% before FA discount is applied.

   Accounts on file from the date the FA application was requested will be adjusted, and all future bills for 1 year will also be adjusted by the percentage of FA granted. If FA is still needed after one year has lapsed, the application process must be completed again.

2. The patient will be notified of the decision in writing. If the application is denied the reason for the denial will be provided to the applicant, in addition to instructions for the patient of the appeals process. There are two reasons a patient may be declined FA:

   a. The patient did not return the application with 30 days. In this case the patient will receive five data mailers throughout the 120 day billing cycle for their patient liability.
   b. The patient is over the income limits to qualify for FA.

3. The written appeal may be filed within 30 days of the patient’s receipt of the decision and the FC will review the appeal and notify the patient in writing of the determination within 30 days of receipt of appeal from patient. The appeal process is noted on the decision letter sent to the patient. If the appeal is denied the patient will be sent five data mailers throughout the 120 billing cycle. The last statement will advise the patient the account will be sent to collections.

4. An appeal may be based on the following:
   a. Change in patient’s financial status has occurred
   b. Incorrect information was provided
   c. Extenuating circumstances

**Payment Plans**

Extended interest free installment plans for payment of patient’s liability are available. Monthly payments should not exceed 10% of the patient’s gross monthly income. Any deposits collected on an elective medically necessary procedure may be considered in the application for financial assistance. Patient may also be eligible for a 10% prompt pay discount.

**Collection Practices**

St Joseph’s does not send an account to collection if a decision on a FA application is pending or if the patient was determined to qualify for Medicaid at the time of service. Patients receive five data mailers in a 120 day billing cycle before an account is sent to collections. Although an account may be sent to collection the patient may be provided the opportunity to apply for financial assistance. The hospital does not seek foreclosure on the patient’s primary residence (although a lien may be obtained as a result of legal action for unpaid charges)
**Title:** Patient Financial Assistance Program  

**Forms #:**

**Document Owner:** Director for Patient Access  
**Department:** Patient Access

**Reviewed by the following:**

<table>
<thead>
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<th>Role</th>
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<td>Chief Financial Officer</td>
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<tr>
<td>Director of Patient Accounting</td>
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**Administrative Approvals:**

- Sandra Sulik, M.D.  
- AnneMarie Walker-Czyz, RN, Ed.D  
- Vice President for Medical Affairs  
- Sr. VP of Operations COO/CNO

**Education:**

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<tr>
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**Revisions:**

- 6/06 Memorandum from Michael Scherr  
- 1/07 Memorandum from Michael Scherr/Staff Education/Service Area Education  
- 7/13 Process review for financial counseling unit by unit co-ordinator

- 6/06 Discounts to self pay patients will be offered after Financial Aid approval  
- 1/07 Added information from NYS Legislation effective 1/1/07 on Charity Care  
- 8/10 No revisions  
- 3/11 Updated hospital mission  
- 7/13 Summarize patient application process/review; clarify service area, use of presumptive eligibility; NYS guidelines for assets; prompt pay discount revised  
- 10/14 Revised % based on new FPL guidelines

**List References:**

- R = Research  
- L = Literature  
- N = National Guidelines  
- E = Expert Opinion

- 6/06 & 1/07 NYS Legislative Bill

**Original Date:** 1/03  
**Reviewed/Revision Dates:** 3/04 6/05 1/06 6/06 1/07 8/10 3/11 9/12 7/13 10/14

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