ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM
POLICY AND PROCEDURE

TITLE: PATIENT FINANCIAL ASSISTANCE POLICY

DEPARTMENT: PATIENT FINANCIAL SERVICES

Effective Date:	7/1/16	Number:	
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Reviewed:		Approval Date:	

Signature:

Vice President, Finance	Director of Patient Financial Services
Approver	Author

Policy:

It is the policy of Atlantic General Hospital/Health System (AGH/AGHS) to provide medically necessary services without charge or at a reduced cost to all eligible patients who lack health care coverage or whose health care coverage does not pay the full cost of their hospital bill. Financial Assistance (FA) is granted after all other avenues have been exhausted, including, but not limited to Medical Assistance, private funding, grant programs, credit cards, and/or payment arrangements. FA applies only to bills related to services provided by the AGH/AGHS. Fees for healthcare and professional services that are not provided by AGH/AGHS are not included in this policy. Emergent and urgent services may be considered for FA; elective care services are excluded. A roster of providers that deliver emergent, urgent, and other medically necessary care is updated quarterly and available on the hospital website at www.atlanticgeneral.org, indicating which providers are covered and which are not under the FA policy. This information is also available by calling a Financial Counselor at (410) 629-6025. The patient must have a valid social security number, valid green card or valid visa. A patient's payment for reduced-cost care for AGH shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission (HSCRC).

Definitions:

- Emergent Care: An emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of

such severity that the absence of immediate attention may result in serious medical consequences.

- Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate nursing or physician representative will be contacted for consultation in determining the patient status.

- Medical Necessity: Inpatient or outpatient healthcare services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated, would pose a threat to the ongoing health status. Services must:
  - Be clinically appropriate and within generally accepted medical practice standard.
  - Represent the most appropriate and cost effective supply, device or service that can be safely provided and readily available with a primary purpose other than patient or provider convenience.

- Immediate Family: A family unit is defined as all exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household must be submitted.

- Post-Discharge Billing Statement: The first billing statement after the discharge date of an Inpatient or the service date of an outpatient.

- Medical Hardship: Medical debt incurred by a family over the course of the previous twelve months that exceeds 25% of the family's income. Medical debt is defined as out of pocket expenses for medical costs billed by the health system. The hospital will provide reduced-cost, medically necessary care to patients with family income at or below 500% of the Federal Poverty Level.

- Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

- Plain Language Summary: A summary of the Financial Assistance Policy which includes information on how to apply and how to obtain additional information.

- Income: The amount of income as defined on the tax returns.

Procedures:

The Maryland State Uniform FA application, (Attachment 1) the AGH/AGHS FA policy, Collection policy and the Plain Language Summary are available in English and Spanish. No other language constitutes a group that is 5% or more of the hospital service area based on

Worcester County population demographics as listed by the U.S. Census Bureau. The policies can be obtained free of charge in English and in Spanish by one of the following ways:

1. Available upon request by calling (410) 629-6025.
2. Picked up in the registration areas
3. Downloaded from the hospital website: www.atlanticgeneral.org/FAP
4. The Plain Language Summary is inserted in the Admission packet
5. FA language is included on all statements that include the telephone number to call and request a copy and the website address where copies may be obtained.
6. FA notification signs are posted in the main registration areas
7. An annual notification is posted in the local newspaper, and presented at area events
8. Patients who have difficulty in completing the application can orally provide the information

No ECA will be taken within 120 days of the first post-discharge billing statement. A message will be on the statement thirty days prior to initiating ECA notifying the patient. During the 120-day period, the patient will be reminded of the FA program during normal collection calls. If the application is ineligible, normal collection actions will resume, which includes notifying the agency if applicable to proceed with ECA efforts. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all ECA until the application and all appeal rights have been processed. A list of approved ECA actions may be found in the Collection Policy. The patient may appeal a denied application by submitting a letter to the Director of Patient Financial Services indicating the reason for the request.

If the FA application is submitted incomplete, any ECA efforts that have been taken will be suspended for 30 calendar days and assistance will be provided to the patient in order to get the application completed. A written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

If the FA is approved, service three months before the date of the original approval date and twelve months after the approval day will be included in the adjustment. For patients that have been approved for 100%, any amount exceeding $5.00 that has already been collected from the patient or guarantor for approved dates of service at 100% shall be refunded to the patient if the determination is made within two years of the date of the FA approval.

Eligibility determination will be provided in writing within two business days of receipt of a completed application by the FA Committee.

Automatic Eligibility:

If the patient is enrolled in a means-tested program, the application is approved for 100% FA on a presumptive basis, not requiring supporting financial data. Examples of a means-tested program are reduced/free school lunches, food stamps, energy and housing assistance, out of

state Medicaid, Qualified Medicaid Beneficiary Program and the Specified Low Income Beneficiary Program. The patient is responsible for providing proof of eligibility.

FA will be granted for a deceased patient with no estate.

Patients approved under any Federal or State Grant are eligible for FA for the balance over the grant payment.

FA may be approved based on their propensity to pay credit scoring.

Eligibility Consideration:

Generally only income and family size will be considered in approving applications for FA. Liquid assets such as rental properties, stocks, bonds, CD's, and money market funds will be considered if one of the following scenarios occurs:

1. The amount requested is greater than $20,000
2. The tax return shows a significant amount of interest income
3. The patient has a savings or checking account greater than $10,000
4. If the patient/guarantor is self-employed, a profit and loss statement may be required

The following assets are excluded:

1. The first $10,000 of monetary assets
2. Up to $150,000 in a primary residence
3. Certain retirement benefits such as a 401K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potentially could pay taxes and/or penalties by cashing in the benefit.

FA approval is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care
- Between 201% and 225% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%
- Between 226% and 250% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 251% and 300% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

Medical Hardship is based on the following income level:

- 0% to 200% of the Federal Poverty Guideline – 100% reduction for Medically Necessary care
- Between 201% and 300% of the Federal Poverty Guidelines – Reduced cost Medically Necessary care at 75%

- Between 301% and 400% of the Federal Poverty Guidelines - Reduced cost Medically Necessary care at 50%
- Between 401% and 500% of the Federal Poverty Guidelines - Reduced cost care Medically Necessary care at 25%

If the patient qualifies for both reduced cost-care and Medical Hardship, the reduction that is most favorable to the patient will be applied. The Federal Poverty Guideline, family size, and income level can be referenced on Attachment 2.

This policy may not be changed without the approval of the Board of Trustees. Furthermore, this policy must be reviewed by the Board and re-approved at least every two years.