LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL
POLICIES AND PROCEDURE MANUAL

POLICY/PROCEDURE NUMBER:	**6.2.1**
POLICY/PROCEDURE NAME:	**Financial Assistance**
APPROVED BY:	**Maggie Morgan-Lamb/Anthony K. Morris**
EFFECTIVE DATE:	**October 2010**
Revised	**April 2016**
Revised	**December 2017**
Revised	**February 2019**

RESPONSIBLE PARTY:

The Patient Accounting and Patient Access Departments at Levindale

PURPOSE: For medically necessary care, to assist uninsured and underinsured patients or any immediate family member of the patient living in the same household who do not qualify for Financial Assistance from State, County or Federal Agencies, but may qualify for uncompensated care under Federal Poverty Guidelines. Medically necessary care is defined as medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for purposes of this policy does not include elective or cosmetic procedures.

POLICY: To provide Uniform Financial Assistance applications compliant with IRS Section 501 (r) and in the manner prescribed by the Health Services Cost Review Commission (HSCRC) to patients experiencing financial difficulty paying for their hospital bill(s). Eligibility is based on gross household income and family size according to current Federal Poverty Guidelines or Financial Hardship Guidelines, as defined by the HSCRC.

IRS Section 501 (r) requires Financial Assistance Policy and related information be made available to the public through hospital websites, on billing statements, through advertisements, via letters sent to churches and schools, in writing summarized in plain language, as well as verbally at points of registration. Third parties collecting debt on the behalf of the hospital are required to provide related information on billing statements.

Financial Assistance information is made available to the public through multiple sources including:
1) HSCRC mandated Patient Information Sheet included in the admission packet, 2) signage and pamphlets located in Patient Access, Patient Accounting, as well as other patient access points throughout the facilities within Levindale, and 3) patient statements.

Financial Assistance eligibility determinations cover hospital and nursing home/facility patient charges only. Physicians and ancillary service providers outside the Hospital are not covered by this policy.

The Board of Directors shall review and approve the Financial Assistance Policy every two years. The Hospital may not alter its Financial Assistance Policy in any material way without approval by the Board of Directors.

IMPLEMENTATION/PROCEDURE: Implementation procedures are different for non-emergent and emergent services.

A. Inpatient and Outpatient Non-Emergent Post-Acute Services

Referrals for admission Insurance are verified for coverage and authorization by the Patient Access Department and the Financial Counselor. If Insurance does not cover all patient care charges the Medicaid Coordinator will verify assets as defined by the Department of Health and Mental Hygiene (DHMH) for Long Term Care Medicaid.

If patient is not financially eligible for Medicaid, the uninsured will be provided a verbal estimate (written upon request) of cost of care. Written estimates include the total charges for inpatient care charges that are reasonably expected to be provided and will state clearly that it is only an estimate and actual charges could vary. These estimates are written during normal business hours. The Admission Department or designee will be responsible for providing these estimates (verbal and written). The Hospital/Nursing Home is not required to provide written estimates to individuals shopping for services.

If there are extenuating circumstances regarding the patient, the patient's clinical condition, or the patient's financial condition, the patient or the physician may seek an exception from the COO and CNO. Patient Access will provide financial information that has been collected and will discuss business impact. Final determination will be made on a case-by-case basis**.**

If an agreement is made, the patient/responsible party signs the Installment Agreement Letter (Attachment #6). If the patient has the financial resources according to the Federal Poverty Guidelines, but fails to pay or sign the Installment Agreement Letter, the Director of Patient Financial Services is to be notified to determine next steps.

Financial Application is completed by the patient/responsible party or the Collections Coordinator if patient/responsible party is unable to complete. If the patient/responsible party does not complete the application or provide the required documentation, Financial Assistance is denied.

B. Outpatient Non-Emergent Post-Acute Services

Patient's Insurance is verified for coverage and authorization by the Outpatient Departments designee. If Insurance does not cover all patient care charges the case will be referred to Decco for Medicaid eligibility. If Insurance does not cover any patient care charges the case will be referred to the Director of the Outpatient Department to review the patient's clinical condition, or the patient's financial condition and may seek an exception from COO and CBO. Final determination will be made on a case-by-case basis**.**

If patient is not financially eligible for Medicaid, the uninsured will be provided a verbal estimate (written upon request) of cost of care. Written estimates include the total charges for inpatient care charges that are reasonably expected to be provided and will state clearly that it is only an estimate and actual charges could vary. These estimates are written during normal business hours. The Outpatient Department designee will be responsible for providing these estimates (verbal and written). The Outpatient Department is not required to provide written estimates to individuals shopping for services.

If an agreement is made, the patient/responsible party signs the Installment Agreement Letter (Attachment #6). If the patient has the financial resources according to the Federal Poverty Guidelines, but fails to pay or sign the Installment Agreement Letter, the Director of Patient Financial Services is to be notified to determine next steps.

Financial Application is completed by the patient/responsible party or the Collections Coordinator if patient/responsible party is unable to complete. If the patient/responsible party does not complete the application or provide the required documentation, Financial Assistance is denied.

Presumptive Eligibility and Other Financial Assistance Considerations

The Hospital/Nursing Home may apply Presumptive Eligibility when making Financial Assistance determinations on a case-by-case basis. Additionally, other scenarios may be considered. Note that a completed Financial Assistance application and/or supporting documentation may/may not be required. The Financial Assistance Presumptive Eligibility Determination Letter (Attachment #5) will be sent timely and include appeal process instructions. Appeals must be in written form describing the basis for reconsideration, including any supporting documentation. The Director of Patient Financial Services will review all appeals and make a final determination. The patient will subsequently be notified.

Presumptive Eligibility:

a. Eligibility covers services provided by all LifeBridge Health facilities (Health System Eligibility): Sinai Hospital, Northwest Hospital, Levindale and Courtland Gardens Nursing and Rehabilitation Center. Patients approved for Financial Assistance through another facility within the LifeBridge Health System must notify the Hospital of their eligibility, which is validated prior to Financial Assistance adjustment. Validation can be made by contacting the approving Hospital's Patient Financial Services Department (Attachment #8).
b. Maryland Medicaid 216 (resource amount) will be adjusted for patients eligible for Medicaid during their eligibility period.
c. Patients eligible for non-reimbursable Medicaid eligibility programs such as PAC (Primary Adult Care), family planning only, pharmacy only, QMB (Qualified Medicare Beneficiary) and SLMB (Specified Low Income Medicare Beneficiary), X02 Emergency Services Only or LTC Medicaid
d. Patients eligible for an out-of-state Medicaid program to which the hospital is not a participating provider.
e. Patients enrolled in State of Maryland grant funded programs (Department of Vocational Rehabilitation – DVR; Intensive Outpatient Psychiatric Block Grant; Sinai Hospital Addictions Recovery Program – SHARP) where reimbursement received from the State is less than the charge.
f. Patients denied Medicaid for not meeting disability requirements with confirmed income that meets Federal Medicaid guidelines.
g. Patients eligible under the Jewish Family Children Services (JFCS) (Y Card) program.
h. Households with children in the free or reduced lunch program (proof of enrollment within 30 days is required).
i. Eligibility for Supplemental Nutritional Assistance Program (SNAP) (proof of enrollment within 30 days is required).
j. Eligibility for low-income-household energy assistance program (proof of enrollment within 30 days is required).
k. Eligibility for Women, Infants and Children (WIC) (proof of enrollment within 30 days is required).

Note: An additional 30 days to provide proof of enrollment will be granted at the request of the patient or patient's representative.

Other Financial Assistance Considerations:

a. Expired patients with no estate.
b. Confirmed bankrupt patients.
c. Unknown patients (John Doe, Jane Doe) after sufficient attempts to identify.

1. Financial Assistance adjustments based on other considerations must be documented completely on the affected accounts. When appropriate, form: Qualifications for Financial Assistance (Attachment #7) must be completed. The Director of Patient Financial Services or designee will sign as Reviewer and obtain appropriate Approver/Denial signature(s) as directed. Authorizing signatures
are required for amounts $10,000.00 and greater –

$10,000.00 – 24,999.99	Director, Patient Accounting
$25,000.00 +	Corporate VP and Chief Revenue Officer

A. Collection Agency Procedures

1. The hospital will ensure third parties collecting on its behalf provide statements that contain Financial Assistance information including how and where to apply, where to find information including: on-line, in person at the hospital and by telephone.

2. The hospital will ensure third parties collecting on its behalf do not initiate Extraordinary Collection Actions (ECAs) until at least 120 days from the date the first post-discharge billing statement is provided.

3. Upon patient request and/or agency determination of inability to pay, agency will mail cover letter and Financial Assistance application with instructions to complete and return to the Hospital Patient Financial Services Department. Agency will suspend collection activities (ECAs) until a determination of Financial Assistance eligibility has been made by the hospital and the agency has been notified accordingly. Agency will request status from hospital 45 days after sending the Financial Assistance application. Agency will resume its collection activity only after receiving notification from the hospital.

B. Patient Refunds

1. Effective with dates of service October 1, 2010, the Hospital/Nursing Home shall provide for a full refund of amounts exceeding $25 in total, collected from a patient or the guarantor of a patient who, within a two-year period after the date of service, was found to be eligible for free care on the date of service.

2. The Hospital/Nursing Home may reduce the two-year period to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of service, if the hospital/nursing home documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information.

3. If the patient or the guarantor of the patient has entered into a payment contract, it is the responsibility of the patient or guarantor of the patient to notify the hospital/nursing home of material changes in financial status, which could impact the ability to honor the payment contract and qualify the patient for Financial Assistance.

4. The Hospital/Nursing Home must refund amounts paid back-dated to the date of the financial status change, or the date the financial status change was made known to the hospital/nursing home, whichever is most favorable for the patient. Previous amounts paid in accordance with a payment contract will not be considered refundable.

C. IRS Section 501 (r) requirements effective July 1, 2016:

1. Hospital shall post on websites in PDF format the following documents:
   a. Written summary of Financial Assistance information in plain language.

b. Financial Assistance Application and Cover Letter
c. Hospital Financial Assistance Policy
d. Hospital Debt Collection Policy

2. Hospital's website will display on home page and main billing page the following message: "Need help paying your bill? You may be eligible for Financial Assistance. Click here for more information →". Clicking the link will display a web page that includes the information described in #1 above.

3. The Hospital will provide on admission a plain language summary of the Financial Assistance Policy which provides eligibility criteria, how to apply and where to find information, including on-line, in person at points of Registration and in Customer Service and by telephone.

4. The Hospital's Registration Staff will verbally offer a copy of the Financial Assistance Policy to patients as they present for service. This will comply with oral notification requirements, as the patient will be notified at least 30 days before Extraordinary Collection Actions (ECAs) are engaged,

5. The Hospital's billing statements will explain where to find Financial Assistance information including how and where to apply and where to find information including: on-line, in person at points of Registration and in Customer Service and by telephone.

6. The Hospital will advertise the Financial Assistance Plain Language Summary in local newspapers and will mail a cover letter and the summary to area churches and schools.

7. The Hospital will ensure third parties collecting on its behalf provide statements that contain Financial Assistance information including how and where to apply, where to find information including: on-line, in person at the hospital and by telephone.

8. The Hospital will ensure third parties collecting on its behalf do not initiate Extraordinary Collection Actions (ECAs) until at least 120 days from the date the first post-discharge billing statement is provided.

9. The Hospital ensures the period allowed for submission of the Financial Assistance application is at least 240 days from the date the first post-discharge billing statement is provided.

DOCUMENTATION/APPENDICES:

Attachment #1 Maryland State Uniform Financial Assistance Application
Attachment #2 Financial Assistance Cover Letter
Attachment #3 Financial Assistance Calculation Sheet
Attachment #4 Financial Assistance Eligibility Determination Letter
Attachment #5 Financial Assistance Presumptive Eligibility Determination Letter
Attachment #6 Installment Agreement Letter
Attachment #7 Qualifications for Financial Assistance
Attachment #8 LifeBridge Health Patient Financial Services Contact Telephone Numbers

STATEMENT OF COLLABORATION:

Director, Patient Access
Director, Professional Practice Operations

SOURCES:

Health Services Cost Review Commission
Federal Register (Current Federal Poverty Guidelines)

Original Date: 7/99
Revised Date: 1/04, 1/05, 10/05, 1/06, 1/07, 11/07, 1/08, 1/09, 1/10, 10/10, 4/13, 4/16, 12/17

Approvals:

Name:	Title:
Deborah Graves	President and Chief Operating Officer
Nancy Kane	Vice President/Financial Reporting
Anthony K. Morris	Corporate VP and Chief Revenue Officer

Deborah Graves _____ _____
President and Chief Operating Officer Date

Nancy Kane _____ _____
Vice President/Financial Reporting Date

_____ _____
Anthony K. Morris Corporate VP and Chief Revenue Officer Date

Board of Directors Approval _____ _____
Date