



Policy/Procedure

Title: Patient Financial Assistance	Date: 04/01//2016
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Category: SYS.MIS.FAP	Approved by: BSHSI Board

POLICY

It is the policy of Bon Secours Health System, Inc. (“BSHSI”) to be committed to ensuring access to needed healthcare services for all. BSHSI treats all patients, whether insured or uninsured, with dignity, respect and compassion throughout the admissions, delivery of services, discharge, and billing and collection processes. This policy is drafted with the intention of satisfying the requirements in Section 501(r) of the Internal Revenue Code of 1986, as amended, regarding financial assistance and emergency medical care policies, limitations on charges to persons eligible for financial assistance, and reasonable billing and collection efforts and should be interpreted accordingly.

SCOPE

This policy is to be used by all BSHSI acute care, and free standing emergency room facilities.

DEFINITIONS

Amounts Generally Billed (AGB) –Amounts Generally Billed means the amounts generally charged to patients for emergency and medically necessary services who have insurance for such services. Charges for patients who are eligible for financial assistance shall be limited to no more than amounts generally billed (“AGB”) for such services. These charges are based on the average allowed amounts from Medicare and commercial payers for emergency and other medically necessary care. The allowed amounts include both the amount the insurer will pay and the amount, if any, the individual is personally responsible for paying. The AGB is calculated using the look back method per 26 CFR §1.501(r).

Bad Debt – An account balance owed by a patient or guarantor which is written off as non-collectable.

Cosmetic – Surgery in which the principal purpose is to improve appearance.

Disproportionate Share Hospital (DSH) – A hospital that serves a high number of low-income patients and receives payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.

Eligible Services – The services provided by BSHSI facilities that are eligible under this financial assistance policy shall include:

- (A) Emergency medical services provided in an emergency room setting.
- (B) Non-elective medical services provided in response to life threatening circumstances in a non-emergency room hospital setting
- (C) Medically necessary services.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part.

Family Income – Gross cash or cash equivalents earned by or provided to an individual. Items not considered as income are noncash benefits and public assistance, such as food and housing subsidies, and educational assistance.

Federal Poverty Guidelines - The Federal Poverty Level is used by the U.S. government to define the poverty level of a patient and his/her family for purposes of this Policy. It is based on a family's annual cash income, rather than its total wealth, annual consumption or its own assessment of well-being . The poverty guidelines are updated annually in the Federal Register by the U.S. Department of Health and Human Services in effect at the time of such determination.

Flat Rate – A pre-determined fee for certain services patients elect to have that are paid for by the patient at the time the services are performed.

Guarantor – The patient, caregiver, or entity responsible for payment of a health care bill.

Head of Household– The individual listed on tax return as “Head of Household”.

Homeless - An individual without permanent housing who may live on the streets; stay in a shelter, mission, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if the person is “doubled up” with a series of friends and/or extended family members greater than 90 days.

Household Family Members (“Dependents”) – Individuals “residing” in household which are claimed on the tax return of the Head of Household.

Medical Eligibility Vendor/Medical Assistance Advocacy - Advocacy vendor contracted by BSHSI to screen patients for government programs and BSHSI Financial Assistance.

Medically Necessary Services – Health-care services needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. In any of those circumstances, if the condition produces debilitating symptoms or side effects, then it is also considered medically necessary to treat.

Non-Eligible Services - The following healthcare services are not eligible for financial assistance under this policy:

- (A) Services provided as a result of an accident. These charges are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, BSHSI will collect the balance owed from the third party payer. If third party coverage does not exist, patient may apply for financial assistance.
- (B) Elective non-medically necessary procedures such as cosmetic and flat rate procedures and patients with insurance who choose not to use their insurance, durable medical equipment, home care, and prescription drugs.

Regulatory Requirements

By implementing this policy BSHSI shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

PROCEDURE

The rationale for this procedure is BSHSI proactively screens to identify individuals and their family members who may qualify for federal, state or local health insurance programs or the Bon Secours Patient Financial Assistance Program (“FAP”). Application of this policy to any individual patient is contingent upon satisfactory completion of the application for financial assistance with all necessary documentation. Any patient who refuses to satisfactorily complete the financial assistance application including the supporting documentation is not eligible for financial assistance under this policy (provided the patient has received the notifications required by the regulations under Section 501(r)). .

BSHSI expects all patients to be screened for federal, state or local insurance programs prior to being screened for BSHSI FAP. Patients are expected to cooperate with and provide appropriate and timely information to BSHSI to obtain financial assistance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to broader health care services and for their overall personal health.

In certain situations, applicable state law may impose additional or different obligations on hospital facilities in such states. The intent of this policy is to satisfy both the Federal and state law requirements in such states. Accordingly, certain provisions are only applicable in certain states as noted below.

1. Eligibility Criteria

The granting of financial assistance will be based on an individualized determination of financial need and shall not take into account race, religion, color, gender, age, marital status, national origin, sexual orientation, gender identity, genetic information, veteran status, disability or any other characteristic protected by law.

2. Amounts Charged to Patients

The FAP provides 100% financial assistance for Eligible Services to uninsured and insured patients with an annual gross family income at or below 200% of the current Federal Poverty Guidelines (FPG) as adjusted annually. BSHSI also offers a discounted rate to patients whose family gross income is between 201% and 400% of the FPG (.

3. AGB

An FAP eligible individual or an uninsured individual will not be charged more than the AGB for emergency or other medically necessary care. BSHSI offers a reduction to uninsured patients who do not qualify for financial assistance. The reduction amount offered to these individuals is the AGB. The AGB is market adjusted annually and is based on the look back method utilizing Medicare and commercial rates, including co-payments and deductibles .

4. Presumptive Eligibility

There are instances when an uninsured patient may appear eligible for financial assistance but the patient has not provided supporting documentation needed to establish such eligibility. In these instances a patient's estimated income and/or Federal Poverty Level amounts can be provided through other sources, such as credit agencies, that would provide sufficient evidence to justify providing the patient with financial assistance. Presumptive eligibility is determined on a case by case basis and is only effective for that episode of care.

5. Eligibility Period

Patients can apply for financial assistance up to 240 days after the first billing statement date. If the patient is approved for financial assistance their coverage is valid for 240 days prior and 240 days post their application signature date. Patients approved for financial assistance that return for services during their 240 day approval timeframe will be screened for federal, state or local health insurance programs upon each visit. The BSHSI financial assistance program is not insurance.

Both non-citizens and permanent residents are eligible for financial assistance. However, patients in the United States on a Visa will be evaluated for financial assistance on a case by case basis. If a patient on a Visa is approved for financial assistance, the approval timeframe will only be for that episode of care, not 240 days prior to or post their application signature date. Patients are required to provide a copy of their Visa and any insurance, financial and/or sponsorship information.

6. Participating Providers

Certain medically necessary and emergency care services are provided by non-BSHSI providers who are not employees of BSHBI who may bill separately for medical services and who may not have adopted this financial assistance policy.

This policy is approved by the BSHSI Board of Directors.

For Billing and Collections please see our Billing and Collections policy.