

 Sheppard Pratt		Policy Number: HS-130.4
		Page 1 of 6
Manual: Sheppard and Enoch Pratt Hospital Administrative Manual		Effective: 1/26/2021
Section: 100 - Health System	Sub-section: 130 - Finance	Prepared by: Kelly Savoca
Title: Financial Assistance - Patient Financial Services		

POLICY:

Sheppard Pratt Health System ("Health System") is dedicated to providing patients with the highest quality of care and services. To assist our patients, financial assistance will be provided to patients who are unable to pay for services rendered and who meet the criteria established in this financial assistance policy ("FAP") regardless of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information or on the basis of disability.

PURPOSE:

To establish the eligibility criteria and process for application/approval of charitable assistance for Health System clients.

PROCEDURE:

1. Definitions

Amounts Generally Billed or AGB: The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, as further explained in Section 3 herein.

Code Section 501(r): Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder, as amended from time to time.

Emergency Care: Immediate care that is necessary to prevent putting the patient’s health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

Gross Charges: The full amount charged by the Health System for items and services before any discounts, contractual allowances, or deductions are applied.

Household: In determining the family/household income of a patient, a household shall consist of the patient and any of the following individuals: (i) a spouse, regardless of whether the patient and spouse expect to file a joint federal or state tax return; (ii) biological children, adopted children, or stepchildren; and (iii) anyone for whom the patient claims a personal exemption in a federal or state tax return. For a patient who is a child, the household shall consist of the child and the following individuals: (i) biological parents, adopted parents, or stepparents or guardians; (ii) biological siblings, adopted siblings; or (iii) stepsiblings; and (iii) Anyone for whom the patient’s parents or guardians claim a personal exemption in a federal or state tax return.

Medically Necessary Care: Services or care that is determined to be medically necessary following a determination of clinical merit by the admitting physician or other licensed physician.

Patient: Those persons who receive emergency or medically necessary care at the Health System and the person who is financially responsible for the care of the patient.

Presumptive Eligibility: The process by which the Health System may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.

Underinsured: Patients who have limited healthcare coverage, or coverage that leaves the patient with an out of pocket liability and therefore may still require financial assistance.

Responsible Party: With respect to services provided by the Health System, the patient, account guarantor or other person(s) responsible for paying for such services.

2. Financial Assistance Eligibility

A. General Criteria

Services eligible for financial assistance include: emergency care, services deemed medically necessary care by the Health System, and in general, care that is non-elective and needed in order to prevent death or adverse effects to the patient's health.

Certain services that are not otherwise considered emergency or medically necessary care, as determined by the Health System at its sole discretion, are not eligible for financial assistance under this FAP. Excluded services include, but are not limited to, elective services, Education Program(s), the Retreat, and the Ruxton House, as well as any ancillary services relating to the aforementioned categories.

In addition, the Quaker population may be eligible for separate and/or additional assistance under the Health System's separate Quaker Financial Assistance Policy. For further information regarding the Quaker Financial Assistance Policy, please contact the Patient Financial Services Department.

Absent extenuating circumstances, as determined by the Health System, financial assistance provided by the Health System under this FAP is secondary to all other third parties and financial resources available to the patient, including but not limited to worker's compensation insurance, Medicaid, and other local, state, or federal programs ("Third Party Assistance"). Any patient who fails or refuses to provide requested information to the Health System may be deemed ineligible for financial assistance under this FAP at the Health System's sole discretion. Similarly, a patient who furnishes false or misleading information in connection with this FAP may be deemed ineligible for financial assistance under this FAP at the Health System's sole discretion.

B. Financial Criteria

Patients who are uninsured or underinsured may be eligible for assistance based on certain financial criteria, limitations, and exceptions, as provided below:

- Patients who have a household income at or below 300% of the Federal Poverty Guidelines may receive free care (a 100% discount).
- Patients who have a household income below 500% of the Federal Poverty Guidelines and who are also experiencing a financial hardship may also receive a 50% discount as Reduced-Cost Care. For purposes of this provision, a financial hardship means medical debt (out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital) incurred by a family over a 12-month period that exceeds 25% of family income.

Notwithstanding the criteria above, Patients who have accumulated assets of \$10,000 per individual or \$25,000 per household (as adjusted for inflation annually beginning October 1, 2020 in accordance with the Consumer Price Index) may only be eligible for 50% assistance. For purposes of this asset test, the following assets shall be excluded from the aforementioned threshold: (i) equity in a primary residence not to exceed \$150,000; (ii) retirement assets to which the Internal Revenue Service 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; (iii) one (1) motor vehicle used for the transportation needs of the patient or any family member of the patient; (iv) any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and (v) prepaid higher education funds in a Maryland 529 Program account.

A patient whose income and assets exceed the established eligibility guidelines but state they are unable to pay all or part of their account balance(s) may be further evaluated on a case-by-case basis. Eligibility for full or partial financial assistance will be determined after giving consideration to the patient's total financial situation as well as a consideration of extenuating circumstances. Additional criteria used to determine eligibility status includes employment status, future earnings capacity, and other financial resources. Patients who have a household income between 300% and 500% of the Federal Poverty Guidelines shall be eligible for a payment plan pursuant to the Health System's separate billing and collections policy (See Section 9 below) in accordance with the Health System's mission and service area.

When determining patients' eligibility, the Health System does not take into account a patient's citizenship or immigration status. Furthermore, the Health System will not withhold financial assistance or deny a financial assistance application on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or disability.

C. Eligibility Determination Process

When reviewing a submitted financial assistance application, the Health System shall: (i) determine whether the patient has health insurance; (ii) determine whether the patient is presumptively eligible for free or reduced-cost care under Maryland law; (iii) determine whether uninsured patients are eligible for public or private health insurance; (iv) to the extent practicable, offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance; (v) to the extent practicable, determine whether the patient is eligible for other public programs that may assist with health care costs; and (vi) use information in the possession of the Health System, if available, to determine whether the patient is qualified for free or reduced-cost care under the hospital's financial assistance policy.

3. Determining the Financial Assistance Amount

Once eligibility for financial assistance is established, the Health System will not charge patients who are eligible for financial assistance more than the amounts generally billed, or AGB, to insured patients for emergency or medically necessary care (the "AGB limitation"). To the extent applicable, the maximum patient payment for Reduced-Cost Care shall be no greater than an amount equal to the Health System's charges less the Health System's mark-up for such care (see next paragraph for information concerning mark-up).

Pursuant to Maryland law, the charges to which a discount will apply are set by Maryland's rate regulation agency known as the Health Services Cost Review Commission ("HSCRC") and are the same for all payers. Thus, to the extent applicable, AGB is determined under the prospective method and is based on the rates established by HSCRC for the Health System. Furthermore, the Health System does not apply a mark-up or other fee on the rates established by HSCRC.

4. Applying for Financial Assistance

Determinations for financial assistance eligibility will require patients, including responsible parties, to submit a complete financial assistance application including all supporting documentation required by the application and may require appointments or discussion with a representative of the Health System's Patient Financial Services Department. Patients will be required to provide necessary information and documentation when applying for financial assistance. The information required is specified in the application and instructions thereto.

Financial assistance applications on file at the Health System may be used for a period of up to 12 months after the date of submission if financial circumstances have not changed.

Applications are accepted for financial assistance at any point in the billing cycle, including after placement with a collection agency or other third party. However, patients who have, or are eligible for, Third Party Assistance must first apply for and exhaust such Third Party Assistance before an application for financial assistance under this FAP will be processed/considered, as determined at the sole discretion of the Health System.

5. Notification of Approval or Denial for Assistance

The Patient Financial Services department will notify the patient in writing within 14 days of the receipt of a completed financial assistance application as to whether the application was approved or denied. If the application was approved, the letter will include the amount of assistance approved. If the application was denied, the denial reason will be provided in this letter. For incomplete applications, patients will be provided with a list in writing of the information and/or documentation still needed to complete the financial assistance application and where to submit the missing information.

Reasons for denial include:

- Incomplete application information.
- Excess income or resources.

6. Appeals

All patients determined to be not eligible for financial assistance or eligible for less than the most generous amount of assistance (100%) available under this Financial Assistance Policy (FAP) will be given 30 days to submit an appeal to request further financial assistance. The patient can present additional information at this time to support his or her request.

The Maryland Health Education and Advocacy Unit (HEAU) is available to assist patients in filing and mediation of a reconsideration request. The HEAU contact information is:

HEAU Hotline:
Mon-Fri 9am-4:30pm
410-528-1840
Toll free: 1-877-261-8807
FAX: 410-576-6571
heau@oag.state.md.us
www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx

Complaints concerning alleged violations of Maryland Code Sec. 19-214.1 or 19-214.2 can be filed by a patient or her/his authorized representative jointly with the HSCRC (Health Services Cost Review Commission) and the HEAU (Health Education and Advocacy Unit) via email at hscrc.patient-complaints@maryland.gov.

7. Presumptive Eligibility

In certain circumstances deemed reasonable and understandable, the lack of a financial assistance application and supporting documentation will not necessarily result in a denial for assistance. If a patient fails to supply sufficient information to support financial assistance eligibility, the Health System may refer to or rely on external sources and/or other program enrollment resources to determine if the patient qualifies for presumptive eligibility. Except as provided below, presumptive eligibility shall only cover the patient's specific date of service. A determination of presumptive eligibility will be based on the following criteria:

- Medicaid Eligible Patients. Balances for a patient who is currently eligible for full Medicaid coverage, but was not on the date of service.
- Patient is homeless.
- Patient with an adverse credit report or other third-party financial information.
- Deceased patient with no estate assets.
- Patient with out of state Medicaid eligibility currently residing outside of Maryland.

In addition, a patient who is not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program will qualify for presumptive eligibility if any of the following criteria apply:

- Lives in a household with children enrolled in the free and reduced-cost meal program.
- Receives benefits through the federal Supplemental Nutrition Assistance Program.
- Receives benefits through the State's Energy Assistance Program.
- Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children.
- Receives benefits from any other social service program as determined by the Maryland Department of Health and the HSCRC.

8. Publication of Financial Assistance Policy

The Health System's FAP, financial assistance application, and plain language summary (including translations) are available to patients upon request and free of charge. In addition, translation services for Spanish, Russian, Korean, Mandarin (Chinese), Tagalog, Urdu, Vietnamese, and French, as well as other languages can be requested for patients in need of language assistance (subject to availability and scheduling).

The FAP, financial assistance application form, and the plain language summary are available upon request in the following Health System locations:

- Patient Registration and Admission Locations
- Crisis Walk-in Clinic
- Patient Financial Services Department (Towson, Maryland)

During patient registration for inpatient hospital services, patients receive a packet with the plain language summary of the FAP.

The FAP, financial assistance application, and the plain language summary are distributed by mail when requested by telephone at the following numbers:

- Patient Financial Services Department – (410)-938-3370 or toll free at 1-(800)-264-0949
- Each collection agency with which the Health System places accounts

Patients can also find the FAP, the financial assistance application, and the plain language summary online at the Health System web site:

- www.sheppardpratt.org/patient-care-and-services/resources/financial-support/

In addition, the Health System communicates the availability of financial assistance in the following ways:

- Notification on all patient billing statements
- Signage posted in registration and admission areas
- Signage posted in the Crisis Walk-in Clinic
- Patient brochures summarizing the FAP and how to apply for assistance offered at hospitalization
- Additional public engagement efforts

9. Actions in the Event of Non-Payment

The collection actions the Health System may take if a financial assistance application and/or payment are not received are described in a separate billing and collections policy. In brief, the Health System will make certain efforts to provide patients with information about the FAP before certain actions are taken to collect a bill. Balances placed with a collection agency are still eligible for a financial assistance reduction if eligibility criteria are met. The billing and collections policy (including translations) can be obtained as in the same manner and the same locations provided in Section 7 above.

10. Eligible Providers

In addition to care delivered by the Health System, emergency and medically necessary care delivered by the providers listed below in the hospital facility is also covered by this FAP:

- Sheppard Pratt Physicians, P.A.

References:

HS-130.11 Patient Financial Assistance - Plain Language Summary

Attachments:

Revised Dates:

2/14, 6/18, 7/18, 11/19, 2/20, 11/20, 1/21

Reviewed Dates:

12/05, 5/08, 10/11, 3/14, 6/18, 7/18, 11/19, 2/20, 11/20, 1/21

Signatures:

Harsh Trivedi: 1/26/21

Kelly Savoca: 1/12/21