St. Mary's Healthcare Amsterdam Care You Can Trust **St. Mary's Organizational Policy Manual**	**Policy #**	**PR 4.7**
	Title:	**Financial Assistance Policy**
	Replaces Policy:	**PR 4.5**
	Policy Originator:	Rick Henze, Vice President of Finance
	Concurrence:	Lori Mucilli, Director-Patient Financial Services
Chapter **Patient Rights**	**Effective Date:**	July 1, 2016
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	Approval:	
	Date:	

I. POLICY/PRINCIPLES

It is the policy of St. Mary's Healthcare (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to, and reverence for, individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to care that is not emergency care or otherwise medically necessary.

3. Attachment A provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

II. DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.

- "**Community**" shall have the same definition as included in the Community Health Needs Assessment completed by Professional Research Consultants, Inc. for St. Mary's Healthcare in January 2019, and shall primarily mean Fulton and Montgomery Counties, New York.
- "**Emergency Care**" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.
- "**Medically Necessary Care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician/ referring physician.
- "**Organization**" means St. Mary's Healthcare.
- "**Patient**" means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

III. PROCEDURE

A. Financial Assistance Provided

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), shall be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.

2. At a minimum, Patients with incomes above 250% of the FPL, but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges or the amounts generally paid for the same services by Organization's highest volume commercial payor, Capital District Physicians Health Plan.

    2.1 The sliding scale discount for the Organization's services is as follows:

    - Patients with income less than 300% and greater than 250% of the FPL will receive a 75% financial assistance write off.
    - Patients with income less than 350% and greater than 300% of the FPL will receive a 70% financial assistance write off.
    - Patients with income less than 400% and greater than 350% of the FPL will receive a 64.9% financial assistance write off.

2.1 A The following are required national approval levels for financial assistance write offs:

- $0-$499.99 Financial Counselor
- $500-2999.99 Supervisor
- $3000-4999.99 Manager
- $5000-9999.99 Director
- $10,000-24999.99 VP
- $25,000 + VP or Designee

The financial counselors will not approve the applications they process; but will review one another's applications and approve or deny based on the national approval guideline. The following canned text will be used to document on the patient's account(s) as applicable:

- Financial assistance application approved and sent to financial counselor for processing.
- Financial assistance application reviewed and returned to financial counselor for corrections and/or updated information.

2.2 Patients who cannot pay their balance in full may be offered a payment arrangement option that is based on guidelines which include a minimum monthly payment based on the balance owed. Monthly payments will not exceed 10% of the gross monthly income of the applicant.

2.3 An uninsured Patient eligible for the sliding scale discount may also receive a prompt pay discount of 10% if the balance due is fully paid prior to 30 days after the date of the first billing statement.

3. For a Patient that participates in certain insurance plans that deem the Organization to be "out of network", the Organization may reduce or deny the financial assistance that would otherwise be available to Patient for non-Emergency Care services, based upon a review of Patient's insurance information and other pertinent facts and circumstances.

4. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application.

5. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:

5.1. If the applicant can demonstrate extenuating circumstances that prevent payment of their account beyond proof already provided in the application process, this information may be taken into consideration. Once reviewed, a new letter of determination shall be sent to the applicant with a decision to approve or deny the application based on the additional information provided.

5.2 All appeals shall be considered by St. Mary's Healthcare's Charity Care and Financial Assistance Appeals Committee, and decisions of the Committee will be sent in writing to the Patient or family that filed the appeal.

B. Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here – although they are not need-based and are not intended to be subject to 501(r), but are included here for the convenience of the communities served by St. Mary's Healthcare.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount afforded to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.

2. Uninsured Patients who are not eligible for financial assistance may receive a prompt pay discount of 20% if the balance due is fully paid prior to 30 days after the date of the first billing statement. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

C. Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB, or the amounts generally paid for the same services by Organization's highest volume commercial payor, for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization will calculate an AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation and percentage may be obtained from St. Mary's Healthcare, Finance Department, 518-841-7434.

D. Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP. The FAP Application and FAP Application Instructions are available from a Financial Counselor or Patient Registration representative of the Organization.

E. Informing and Notifying Patients about the Financial Assistance Policy

1. Information regarding financial assistance will be available and posted in all registration areas, including the Emergency Department, of the Organization. Financial Counselors will be available to discuss Patient-specific financial options in a confidential setting. A financial assistance summary will be available to all Patients.

2. Financial Counselors are available to all Patients Monday through Friday from 8:00AM to 4:30PM. Patients that would like to call for a specific appointment may do so.

3. Organization will maintain a conspicuous link to the FAP summary and application on Organization's website's home page.

4. All bills and statements sent to Patients shall include a statement regarding the availability of financial assistance and a contact number to call to obtain further assistance.

F. Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate Billing and Collections Policy. A free copy of the Billing and Collections Policy may be obtained by contacting a Financial Counselor. All staff that interact with Patients or have a responsibility for billing and collections must be trained and educated on the Organization's Financial Assistance Policy.

G. Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r), except where specifically indicated.

IV. APPENDIX

Exhibit A – List of Providers Covered/Not Covered by the Financial Assistance Plan
Exhibit B – AGB Calculation

Exhibit B

ST. MARY'S HEALTHCARE

AMOUNT GENERALLY BILLED CALCULATION

January 1, 2021

St. Mary's Healthcare calculates an AGB percentage for inpatient and outpatient services using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of that calculation and AGB percentage are described below.

The AGB percentages for St. Mary's Healthcare are as follows:

Inpatient/Outpatient Services: 35.1%

These AGB percentages are calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12 month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).