SJHHC Financial Assistance Program

We are passionate healers dedicated to honoring the Sacred in our sisters and brothers.

Policy

Any patient at SJHHC will receive medical treatment whether or not the patient is insured or uninsured in accordance with the policy and the procedures herewith. SJHHC may reserve the right to refuse Financial Aid on pre-scheduled elective procedures only. It is the intent of the financial counseling representatives, to follow-up on every claim within a 30-day period, in an effort to provide financial assistance in accordance with the programs defined in our Financial Assistance Policy. The account will be noted each month as to the follow-up efforts made by the financial Counselors barring any unforeseen issues, delays with patient contacts, delays with the DSS, etc.

For those patients who are interested in financial assistance, patients will be contacted by a SJHHC Financial Counselor (FC) and instructed on the availability to enroll in Medicaid, Child Health Plus (CHP) and Family Health Plus (FHP), through a referral to those Medicaid Managed Care (MMC) Facilitated Enroller who has a Medicaid Managed Care contract with SJHHC, or a referral to the local County Department of Social Services depending on the patients demographics. Regardless of who completes the Medicaid application, the completion of one Medicaid application allows a patient access to enroll in Medicaid, CHP or FHP, depending on the combined income and assets of the patient and their family (if applicable). Other options to be discussed will be Financial Aid and Monthly Payment plans.

At all patient access points there will be FA pamphlets notifying patients and family members of the existence and availability of the Financial Counseling Unit. Patients and family members may discuss all programs offered either in person or by phone.

Note: Patients who may be eligible for Medicaid, Child Health Plus or Family Health Plus, who do not comply with the application requirements of their local Department of Social Services may not be eligible for Financial Aid. These patients may also be subject to bad debt, in accordance with the rules and regulations of the SJHHC Bad Debt Policy.

In addition, our data mailers being sent to patients for any amount they may owe on a bill now includes the phone number of our Financial Counseling Unit if the patient needs financial assistance. This section is also colorized for easy recognition.

Procedure for Uninsured Patients who are receiving Inpatient treatment (non ALC):

1. A daily report will be generated which will identify those patients who are currently an inpatient but presented for treatment the day before.
2. A SJHHC FC will make arrangements to visit the patient to discuss the need for financial assistance.
3. The SJHHC FC will refer the patient to a MMC Facilitated Enroller. Note: For those patients who do not wish to be seen by a FE, the SJHHC FC will advise the patient that they are responsible for payment on the bill and the account will be deemed self pay.
If a patient chooses to speak to a MMC Facilitated Enroller, the SJHHC FC will contact the MMC facilitated enroller chosen by the patient on the patient's behalf. The MMC Facilitated Enroller will contact the patient after discharge to set up a home visit to complete a Medicaid application. The SJHHC FC will continue to monitor the patient's account(s) throughout the application process. Should the patient be accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss Financial Aid (see Financial Aid Section) or Payment Plans (see Payment Plans Section).

Procedure for Uninsured Patients who are receiving scheduled outpatient treatment

1. There are two ways in which the SJHHC FC will be notified of uninsured patients receiving scheduled OP care.
   a. A daily report will be generated which will identify those patients who received outpatient treatment and presented for treatment the day before. A SJHHC FC will contact the patient after discharge to discuss the need for financial assistance, or
   b. An in-house referral will be made at the time of scheduling via phone call or e-mail advising the SJHHC FC that a patient needs to be contacted in advance of treatment to discuss how the patient is planning on reconciling their bill.

2. The SJHHC FC will offer to either assist in completing a Medicaid application, or refer the patient to a MMC Facilitated Enroller.
   a. If a patient chooses to speak to a MMC Facilitated Enroller, the SJHHC FC will contact the MMC enroller chosen by the patient on the patients’ behalf. The MMC Facilitated Enroller will contact the patient after discharge to set up a home visit to complete a Medicaid application. The SJHHC FC will continue to monitor the patients’ account(s) throughout the application process. Should the patient be accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss Financial Aid (see Financial Aid Section) or Payment Plans (see Payment Plans Section).
   b. If the patient chooses to have the SJHHC FC complete the Medicaid Application, the SHHHC FC will complete the application, and forward the application to the applicable County Department of Social Service depending on patients’ demographics. The SJHHC FC will continue to monitor the patients’ account(s) throughout the application process. Should the patient be accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss Financial Aid (see Financial Aid Section) or Payment Plans (see Payment Plans Section).

Procedure for Uninsured Patients who are receiving outpatient treatment in the ED

1. If a patient presents through the ED and is discharged (not admitted as an inpatient), the patient will be referred to the Discharge Desk
2. The patient will be given a form that identifies the various MMC payors who can assist the patient in obtaining Medicaid, CHP and FHP. The form also lists the Onondaga County DSS as a contact should patients want assistance directly through the DSS
3. The patient will make their selection on which agency they would like to be contacted by.
4. Once the form is read by the patient and explained (if necessary), the form will be signed by the patient and copied. The original will be given to the patient upon discharge, the copy will be sent to the FC Unit for follow-up
4. The SJHHC FC will continue to monitor the patient's account(s) throughout the application process. Should the patient be accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss Financial Aid (see Financial Aid Section) or Payment Plans (see Payment Plans Section).
Procedure for Uninsured Patients who are receiving outpatient treatment in the Clinics including the Dental Clinic:

1. If a patient presents through the clinics and is discharged (not admitted as an inpatient), the patient will receive a FC brochure that informs the patient about the FC Unit. An actual FE from one of the many Medicaid Managed Care Payors or a PCC Registrant may also counsel the patient.
2. All self-pay Clinic accounts incurred will be held 30 days, thus allowing the patient to contact our FC unit should they need assistance.
3. If the patient does not contact the FC unit within the 30 day allotted time, the account will be sent to our collection agency for follow-up.
4. If the patient does contact the FC unit with the 30 day allotted time, the Financial Counselor will advise the patient about facilitated enrollment and ask about a payor selection.
5. Once the patient decides which payor they would like to speak to about facilitated enrollment, the FC will place the current account on hold, then contact the chosen facilitated enrollee on the patients’ behalf to have the FE contact the patient directly.
6. The account will be1 diaried 30 days.
7. Once the 30-day period has been exhausted, the FC will contact the FE on the status of the enrollment.
8. If the patient has complied and is in the process of obtaining some sort of coverage but it Medicaid, Medicaid Managed Care, CHP, FHP, PCAP, or CHEP, the outstanding account(s) will be written off to Financial Aid in good faith. If the patient did not comply, the account will remain in a self-pay financial class and be released to be collected by our self-pay collection agency.

Procedure for Uninsured Patients who are on ALC:

1. A daily report has been created by Case Management to identify ALC patients. This report is sent to the SJHHC FC Unit and given to the ALC FC. Note: there are FC’s who are dedicated to ALC’s only.
2. A SJHHC ALC FC will make arrangements to visit the patient, family member or friend to discuss the need for financial assistance.
3. The SJHHC ALC FC, with the help of the patient, family or friends, will compile all the necessary paperwork to complete a Medicaid application on behalf of the patient. Note: Many nursing homes will not accept a transfer patient until the Medicaid application is completed and Medicaid has been approved.
4. The SJHHC ALC FC will send a completed application and all necessary paperwork to the Chronic Care Unit of the local Department of Social Services depending on the demographics. Note: if the nursing homes are aware that SJHHC has completed the application and obtained all the necessary documentation the patient can be transferred before Medicaid is approved.
5. The SJHHC FC will continue to monitor the patient’s account(s) throughout the application process. Should the patient be accepted for Medicaid, CHP or FHP the SJHHC FC will bill the appropriate program. Should the patient be rejected from any public programs, the SJHHC will contact the patient to discuss Financial Aid (see Financial Aid Section) or Payment Plans (see Payment Plans Section).

Procedures for Patients who are insured but are in need of Financial Assistance for out of pocket expenses they may incur and are unable to pay

1. Once a bill has been submitted to a primary, secondary or tertiary payor there may be a balance still due on the bill. In accordance with the SJHHC Bad Debt Policy a patient is sent 5 statements advising them of their patient responsibility. Our SJHHC FC phone number is listed on those statements. If a patient is concerned about their balance due and their inability to pay, the patient has the option to contact our Customer Service Department located in SJHHC Patient Accounting Services. If a Customer Service Representative (CSR) receives a call from the patient the CSR will either transfer the call the SJHHC FC Unit, or contact the SJHHC FC Unit and advise the SJHHC FC to contact the patient directly.
2. The SJHHC FC will review the particulars of each case to determine what avenue to take to assist the patient be it Financial Aid (see Financial Aid section) or Payment Plans (see Payment Plan...
Procedures for Payment Plans for all services

1. At the request of a patient or family member either by phone or in writing, a payment plan can be established for patient who has incurred an out of pocket expense(s). Requests can be made by contacting the SJHHC FC Unit or SJHHC Customer Service Department located in Patient Accounting Services. The monthly amount is determined based on the amount of money due on the account(s), using a sliding scale.

3. Once the amount of the monthly payment is established, the system is programmed to send out a monthly reminder that the agreed upon amount is due. This is the patient's billing cycle.

4. There will be no interest charged to the outstanding balance.

5. If the patient fails to pay the patient will be contacted either by phone or by mail to reevaluate the payment plan in case there has been a change on the income which may result in lowering the monthly payment.

6. Should the patient simply refuse to pay the monthly fee due on the open balance, the account will be sent to Bad Debt in accordance with the SJHHC Bad Debt Policy.

When assessing the monthly amount that will be due from the patient when setting up a payment plan use the following figures as a guide. However, there may be times when a patient is unable to pay the monthly amount requested based on the bill range. In those cases where there is a deviation, the amount due from the patient and the patients' financial circumstances should be discussed with the Director of Patient Accounting Services.

<table>
<thead>
<tr>
<th>Bill Range</th>
<th>Monthly Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 - $250</td>
<td>$25 per month</td>
</tr>
<tr>
<td>$250 - $500</td>
<td>$50 per month</td>
</tr>
<tr>
<td>$500 - $1,000</td>
<td>$75 per month</td>
</tr>
<tr>
<td>$1,000 - $2,000</td>
<td>$100 per month</td>
</tr>
<tr>
<td>$2,001 +</td>
<td>To be determined</td>
</tr>
</tbody>
</table>

Procedures for Financial Aid (documented aid) or Charity Care (undocumented aid). Note: SJHHC will use the current years FPL when determining FA but because the FPL published by the U.S. Government is not published until February we will use the current year FPL on applications starting March of that current year; i.e., in 2007 we will use the 2006 FPL until March 2007, in 2008 we will use the 2007 FPL until March 2008, and so on.

1. Our FA program is listed via our internet website, listed on our intranet website, listed in our hospital booklets given to all patients who are inpatient and outpatient, and is identified in brochures that are kept and available for distribution in every service area. Our brochures are printed in three primary languages used to communicate with at least 5% of the patients' visits per year by non English speaking patients. Note our data mailers to patients also list the FC Phone number in case a patient would like to call the FC Unit after a bill is received.

2. A patient is eligible for Financial Aid (FA) if they have met the necessary requirements while applying for Medicaid but have been denied. However, if a patients gross income and resources equate to less than 40% of the FPL, which means Medicaid would automatically deny the application, we will not send a Medicaid application to the DSS only to wait for a denial but will allow FA to avoid an unnecessary delay with the FA acceptance. A patient is also eligible for FA if they have applied for CHP or FHP, because these programs do not back date to allow coverage for a recently incurred bill. Note: there may be those rare occasions when Charity Care is granted because of extenuating circumstances, i.e. patient is homeless, because we are unable to locate the patient after discharge to complete a Medicaid application.

3. Financial Aid is offered to all patients regardless of where they reside (no limitation by zip code area).

4. Financial Aid is offered to patients who have urgent, emergent, and medically necessary procedures.
5. A patient will receive up to 5 data mailers throughout a 120 day cycle which will have the Financial Counseling Units phone number listed on our bill for all patients who seek financial assistance as well as an e-mail address which is a direct line to the FC unit.

6. Requests for FA can be made by contacting the SJHHC FC Unit or SJHHC Customer Service Department located in Patient Accounting Services. In addition, for those cases being monitored by a FC, the SJHHC FC's will automatically offer FA for those uninsured patients who have complied with the Medicaid, CHIP and FHP application requirements.

7. There is no time limit set on when a patient can apply for FA, as long as the data requested as to income, assets, etc., coincides with the time frame of the FA requested.

8. At the time we receive a request for FA, we will place the account (s) on hold using the FC 710 Financial Aid (FA) Pend. FA pend which will turn hold any and all bills from being sent to the patient.

9. The patient will complete a FA application and submit the form to the SJHHC FC Unit.

10. Proof of gross income and recourses will be required of the patient and all family members if applicable in order for a determination to be made by the SJHHC FC. The various types of proof of income are listed on the FA application form. The proof of income includes but is not limited to: income from wages, self employment, social security, pensions, compensation, alimony, child support, rental dividends, and V.A. benefits. The following assets are excluded: the patients primary residence (owned home), car used by the patient or patient's family, college savings accounts, and tax deferred or comparable retirement savings accounts.

11. Once the FA application is received, the SJHHC FC will evaluate the total income and assets which includes bank statements and investment statements for the individual or family.

12. Providing all the information requested to complete an application is received and we have the ability based on the data to determine FA, we will notify the patient within 30 days what percentage of FA was granted. If the information is incomplete the account will be placed in a FC 726 (ITT AID INCOMPLETE) and the account will be pended an additional 30 to allow time for the patient to acquire the additional data needed to complete our review. Note if after the 30 day period we do not receive the required information to complete the review, we will change the FA from 726 to 711 (REJECTED PAID), and the patient will receive up to 5 data mailers throughout a 120 day cycle. The patient will have the right to appeal; see #21.

13. The amount of income and assets will be matched to the current years US Poverty Guidelines to determine what percentage of FA can be given.

   A. Income less than or equal to 100% FPL: (100%) (use adjust code 9710152).
   B. Income between 101% and 150% FPL: (80%) sliding fee scale up to 20% of Medicare rate, (use adjust code 9710153).
   C. Income between 150% and 200% FPL: (60%) sliding fee scale up to 20% of Medicare rate, (use adjust code 9710154).
   D. Income between 201% and 250% FPL: (40%) sliding fee scale up to 20% of Medicare rate, (use adjust code 9710155).
   E. Income between 251% and 300% FPL: (20%) no more than Medicare rate, (use adjust code 9710156).

Note: For Inpatient claims we have chosen to use the Medicare DRG methodology. The adjustment code will be 9710157. As the DRG rates change we too will change our methodology. For Outpatient claims we will simply discount all OP bills by 50% before applying the discounts aforementioned using adjustment code 9710158. (Note: eventually we calculate OP claims using the APC grouper). The initial adjustment will be performed automatically by the system.

14. If granted we will change the Financial Class from FA pend to Financial Aid (FC 730 (primary), 702 (secondary), or 703 (tertiary).

15. If the FA granted is 101% FPL or more, we will first adjust the bill on file (which is at total charges) to either a Medicare DRG rate all inpatient claims on hold and (50%) off all outpatient claims on hold.

16. Once the adjustment is made we will then apply the appropriate approved percentage off the discounted bill.

17. The bills on file from the date the FA application was requested will be adjusted, and all future bills for 1 year will also be adjusted by the percentage of FA granted.
18. The amount of FA is granted for 1 year. If FA is still needed after one year has lapsed, the application process must be completed again.

19. A payment plan can be set up for any balance due after the FA percentage has been granted with no interest charged.

20. There are two reasons a patient may be declined FA.
   A. If the patient is denied FA because the patient was sent a FA application but after 30 days never returned the application we will change the FC from 710 (FA Pend) to 712 (REJ FA NO APP), and the patient will receive up to 5 data mailers throughout a 120 day cycle. The patient will have the right to appeal; see #21.
   B. If the patient is denied FA because of access income (over income), we will change the FC from 710 (FA Pend) to FC 713, REJ FA OINCOME. In this case the patient will be notified in writing and the letter will state the patient has the right to appeal; see #21.

21. To appeal the decision the patient may do so in writing addressing the appeal to the Director of Patient Accounting Services (note the appeal process is listed on the letter of decision).

22. If the patient should appeal and the appeals overturned then we will follow the steps aforementioned. However, should the patient be denied their appeal, thus denied FA, the patient will receive 5 statements of the amount due on their bills which extends over a 120 day period. The last statement will advise the patient they will be going to collections. Although a lien may be placed on the patients’ property while in the hands of our collection agent, the agent has been instructed not to foreclose on any primary residence.

Addendum: There may be instances where, based on file notes, that it would not be necessary to send out a FA application but allow a Charity Care adjustment because the account information does imply that the patient is underinsured. One example would be a patient who has Medicare as their primary insurance and Medicaid as their secondary insurance but there is a Medicaid spend-down on file. If the spend-down is less than $250 a FA application will not be necessary. A second example is those patients who have Medicaid as their primary insurance; they are inpatient and incur a deductible, currently averaging $25. This amount will be adjusted off as Charity Care. A third example would be those patients who have incurred outpatient bill/bills and are placed in a financial class of PE Pend. Once they are approved for Medicaid, CHIP, FHP, the bill/bills on hold will be adjusted off as Charity Care because their approval to one of these programs is proof the family is underinsured with limited income, and these programs will not backdate to cover OP bills. For those patients who have commercial insurance as primary and self pay secondary who may incur an out of pocket expense that they are unable to pay, we will screen the patient for Financial Aid if the patient requests us too, without making the patient apply for Medicaid. We will then follow the guidelines outlined in the Procedure for FA to see if eligible for FA.

It should be noted that we are looking into software products to help with the screening process and we should have an automated screening system in place by 2008.

Important message for patients accepted for FA in 2006. For those patients who were approved for 100% FA at any time in 2006 we will grandfather FA at 100% until the 1 year period ends in 2007. For those patients who were approved for less than 100% FA, we will review every application submitted in 2006 and apply the new 2007 guidelines for claims incurred 01/01/07 and after until their 1 year period ends.

True self pay accounts are sent to an outside agency for follow-up. Should a patient contact that agency requesting Financial Aid (charity care), I have asked the agency to contact the SJHHC Financial Counselors, and we will ask that that particular claim be returned to SJHHC for follow-up through the Financial Counseling Unit to ensure that we are adhering to the 01/01/07 NYS Legislation for all patients who request Financial Aid.

Procedures for Discounts:

The following is a summary of existing discounts afforded the various groups listed below. There may be an occasion where we may deviate from the policy. Authorization to deviate from the policy may only come from the President (or his designee), or the Vice President for Fiscal Affairs.
1. St. Joseph’s Active Hospital Employees Not Enrolled in the Self-Insured Plan. Note: effective 10/01/07 this will also include Dialysis Employees employed by Liberty. Allow a 25% discount on the self pay portion of a St. Joseph’s Hospital employee’s bill or the bill of a dependent of an employee, but only if they are not a participant in the self insured plan. Apply a 25% discount to any “true coinsurance” that may be due after the primary insurance carrier has made payment, i.e. usually 20% out of pocket remaining on the bill. Also apply a 25% discount to any self pay bills except for, cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits, telephone or private room charges, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

Do not apply a 25% discount to deductibles or co-pays as defined by another insurance plan, cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits, telephone or private room charges, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

2. St. Joseph’s Active Hospital Employees who are enrolled in the Self-Insured Plan.

Employees will be fully responsible for deductibles and co-pays as well as any non-covered services under the Blue Cross Self-insured plan. For questions as to whether or not a particular service is covered under the self-insured plan, this information can be obtained by contacting Blue Cross directly.

3. 3. St. Joseph’s Retired Hospital Employee. (Presently covered by Blue Cross Senior Care Health Plan). Allow a 25% discount on the self pay portion of a St. Joseph’s Hospital employee’s bill or the bill of a dependent of an employee, but only if they are a participant in the retiree plan.

Apply a 25% discount to any “true coinsurance” that may be due after the primary insurance carrier has made payment, i.e. usually 20% out of pocket remaining on the bill. Also apply a 25% discount to any self pay bills except for, cosmetic surgery, dental, foot care, eye and hearing exams, custodial care, any services excluded as a covered expense under Medicare, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

Do not apply a 25% discount to deductibles or co-pays as defined by another insurance plan, cosmetic surgery, dental, foot care, eye and hearing exams, custodial care, any services excluded as a covered expense under Medicare, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

4 Prompt Pay Discount for Uninsured Patients. Effective 03/01/07. Prompt pay discounts will be offered while accounts are in active status (not bad debt) as follows:

a. 25% discount if paid within 10 days of final bill date (9705237)
b. 20% discount if paid between 11 days and 30 days within 1st data mailer cycle (9710160)
c. 15% discount if paid between 31 and 60 days within 2nd data mailer cycle (9710159)
d. 10% discount if paid between 61 and 90 days within 3rd data mailer cycle (9710136)
e. 5% discount if paid between 91 and 120 days within 4th data mailer cycle (9710135)

5 Staff and Non-Staff Physicians. Allow a 25% discount for all Physicians spouse and children. All other requests for discounts on relatives such as, aunts, uncles, nieces, nephews, cousins, etc., will be reviewed on a case-by-case basis and will require Administrations approval.

6 Sisters of the Third Franciscan Order. 100% discount off all self-pay bills, including balances due after commercial insurance if applicable, co-pays, deductibles, etc.

7 Clergy. (Definition – Ordained priest, minister, etc.). Apply a 50% discount off all self-pay bills, including balances due after commercial insurance (if applicable), up to a yearly cap of $500.00 per individual, per calendar year. When commercial insurance is the primary payor, the discount only applies to “true coinsurance” (see # 1). Do not apply a 50% discount to deductibles or co-pays as defined by another insurance plan, cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits,
and other clinics operated by the Hospital which already have discounted structure, telephone or private room charges, nor does it apply to any service not provided by the hospital.

8. Sisters. (Other than those of the Third Franciscan Order): 50% discount off all self pay bills including balances due after commercial insurance (if applicable), up to a yearly cap of $500.00 per individual, per calendar year. When commercial insurance is the primary payor, the discount only applies to coinsurance (see # 1). Do not apply a 50% discount to deductibles or co-pays as defined by another insurance plan, cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits, and other clinics operated by the Hospital which already have discounted structure, telephone or private room charges, nor does it apply to any service not provided by the hospital.

3. Employees (only) of our Franciscan Corporation, i.e. Franciscan Health Support, Franciscan Management Services, and Health Care Management Administrators. Apply a 25% discount to any coinsurance that may be due after the primary insurance carrier has made payment, i.e. usually 20% out of pocket remaining on the bill. The 25% discount should be applied to health care products offered by Franciscan Health Support. Also apply a 25% discount to any self pay bills except for cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits, telephone or private room charges, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

Do not apply a 25% discount to deductibles or co-pays as defined by another insurance plan, cosmetic surgery, Dental clinic, outpatient Psych clinic, Family Practice and Ambulatory Care clinic visits, telephone or private room charge, other clinics operated by the Hospital which already have discounted structure, nor does it apply to any service not provided by the hospital.

Updated 12/20/09