Status **Active** PolicyStat ID **18111420**

| | |
|---|---|
| Origination | 11/2017 |
| Last Approved | 05/2025 |
| Effective | 01/2024 |
| Last Revised | 05/2025 |
| Next Review | 05/2028 |
| Owner | Eric Hardy: COV VP FINANCE |
| Policy Area | Covenant Revenue Cycle |
| Applicability | Covenant Health |

# Financial Assistance Policy

COPY

## POLICY/PURPOSE:

Consistent with its mission to provide high quality health and wellness services for the community, it is policy, that an individual meeting qualified income guidelines may receive financial assistance in paying medically necessary self-pay bills, without discrimination due to race, gender, age, sexual orientation, religious affiliation, social or immigrant status, or health insurance status. In accordance with the Affordable Care Act (ACA), any patient eligible for financial assistance will not be charged more for emergency or medically necessary care than the amount generally billed (AGB) to insured patients. Covenant Health follows all EMTALA regulations, and no patient will be denied emergency services.

## SCOPE:

St. Joseph Hospital, Bangor Maine; St. Joseph Hospital, Nashua, NH; St. Mary's Health System, Lewiston, ME

## DEFINITIONS:

- **Amount Generally Billed (AGB):** The amount generally billed is calculated using the prior twelve months of Medicare and Commercial, hospital, and professional claims paid data and dividing the total payments received from all parties to the covered charges. The resulting percentage becomes the amount generally billed and is utilized as the maximum net charge (gross charge less discount) to patients qualifying under the Financial Assistance Policy. The AGB will be updated on an annual basis for each entity. Contact the Business Office at each entity for the detailed calculations.
- **Covenant Health:** Covenant Health is an innovative, Catholic regional health delivery network, and a leader in values based, not-for-profit health and elder care. Covenant consists of

hospitals, skilled nursing and rehabilitation centers, assisted living residences, and community-based health and elder care organizations throughout New England. We are committed to the health and the individuals and communities we serve, and strive to offer a continuum of high quality care. The facilities partnering in the Financial Assistance Program within Covenant are St. Joseph's Hospital-Bangor, Maine, St. Joseph's Hospital-Nashua, New Hampshire and St. Mary's Regional Medical Center-Lewiston, Maine.

- **Disability:** Persons 18 years of age and older who are on disability are considered their own individual. For children under 18 years on disability, both the child and the disability income must be included in the family income.
- **Emergency Care (Emergency Department Patients):** Patients who present to the Emergency Department (ED) for treatment in compliance with current Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. Emergency Services is defined as "those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in: (1) placing the enrollee's physical and/or mental health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part."
- **Expiration Date:** The last day of the month, **six months** from the application's **approval date**. Notice of the approval period shall be sent to the applicant in writing. For inpatient admissions, which fall within approval period must be revalidated. Approval period exception is for those who are between 150% - 200% of the FPG and receive fixed-recurring income, who have no other wages and/or salaried spouse or family members. Individuals falling within the exception, may be eligible for one year.
- **Financial Assistance**: Health care services provided free or at a reduced rate for individuals who meet certain criteria.
  Financial assistance is that portion of patient care services provided by a hospital for which a third-party payor is not responsible, and a patient has the inability to pay. Any portion of costs that a patient is unable to pay can count as financial assistance. Financial assistance includes the portion of total charges for patients with coverage from a third-party payor that does not have a contractual relationship with the Hospital. Financial assistance does not include bad debt, contractual adjustments, or unreimbursed costs (payment shortfalls). Financial assistance may include unpaid coinsurance, deductibles, and non-covered services if the patient meets the hospital's financial assistance eligibility criteria. Denial of payment by Medicaid for any reason for medically necessary services provided and any lack of payment for medically necessary non-covered services provided to a Medicaid patient shall be considered financial assistance. This includes non-covered charges for days exceeding Length of Stay limits set forth by individual states.
- **Family:** A family is a group of two or more persons related by birth, marriage or adoption who reside together and among whom there are legal responsibilities for support; all such related persons are considered as one family. (If a household includes more than one family and/or more than one unrelated individual, the income guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole.)
- **Family Unit of Size One:** In conjunction with the income guidelines, a family unit of size one is an unrelated individual, that is, a person 15 years old or over who is not living with any relatives or a person who is 18 or older (even if living with relatives as a dependent adult). An unrelated

COPY

individual may be the sole occupant of a housing unit or may be residing in a housing unit (or in group quarters such as a rooming house) in which one or more persons also reside who are not related to the individual in question by birth, marriage, or adoption.

- **Federal Poverty Guidelines (FPL):** The most current FPL is obtainable at http://aspe.hhs.gov/poverty or by contacting the Department of Health and Human Services office.
- **Income & Asset Testing:** Income means total annual cash receipts before taxes from all sources except capital gains, any liquid assets, including withdrawals from bank or proceeds from sale of property, tax returns, gifts, loans, lump-sum inheritances, and non-cash benefits. Both income and asset testing will be completed to determine indigency.
- **Liability/MVA:** The terms Liability or Motor Vehicle Accident (MVA) will refer to those claims for which some liability or other non-health insurance is involved. The most common example is motor vehicle accidents, in which car insurance is involved, but can include any situation in which a third party or other entity is responsible or liable. Any situation involving attorney representation would be included. This policy does not cover such claims unless all payments or settlements have been applied against the outstanding claim, or until all benefits have been exhausted or denied.
- **Medically Necessary Services:** Medically necessary services are generally defined as services which are ordinarily covered by healthcare insurance. Emergency Care and Urgent Care Services are always considered to be Medically Necessary under this policy. Services specifically not eligible under this policy are outlined within the policy. Individual services which are not covered due to an insured medical coverage policy and for which an Advanced Beneficiary Notice or a Financial Responsibility Notice was issued are not eligible for coverage under this policy.
- **Presumed Eligibility:** The hospital may refer to or rely on external sources and/or other program enrollment resources in the case of patients lacking documentation that supports eligibility or individual circumstance. The hospital may provide free or discounted service's if a patient is/has:
    - Homeless
    - Deceased and without an estate
    - Filed for bankruptcy
    - Mental incapacitation with no representation to act on the patient's behalf
    - Patient liability is in excess of 25% of their annual income
    - Current Medicaid eligibility but not at the time of service or for non-covered service
    - A minor seeking confidential services in the state of Maine
    - Enrollment in WIC, SNAP benefits, STATE free lunch and breakfast programs, Low Income Home Emergency Assistance Program (LIHEAP) or another community-based program providing access to medical care.
- **Provider Group:** Provider group covered under this policy includes any and all providers who operate under Covenant's three hospitals. This policy does not cover the fees for independent providers, surgeons, consultants, anesthesiologists, imaging interpretation services, pathology services and other professionals who may provide services and separately bill for those professional services. A listing of providers is available within this policy and is located on each of the facility's Websites.

COPY

- **Resident of Facility State:** The term "Resident of Maine or New Hampshire" refers to a person living in the state voluntarily with the intention of making a home in the state. An individual who is visiting or is in that state temporarily is not a resident. Individuals who are a resident or have the intention of making a home in the state are required to provide proof of residency during the Financial Assistance application process. For individuals who reside in more than one state, residency will be determined by the state of residence identified on their Federal or State Income Tax Return. A copy of a State issued Driver's License or Photo Identification card or other proof of residency may be required. Individual granted asylum may be required to present a copy of the "A" Asylum card or another immigration of asylum status form of proof when applying for Financial Assistance.
- **Self-Pay Discount:** All self-pay (uninsured) patients are automatically eligible to receive a self-pay discount without submitting Financial Assistance Application. This includes insured patients who were determined uninsured for the entire hospital stay. Self-Pay patients are charged the lesser of AGB or 70% of cost as the self-pay discount.

# PROCEDURE:

A. The organization will post a written plain language notice of the policy and income guidelines in all Patient Access Areas. In addition, information about the Financial Assistance and cost share program and the income guidelines are posted on each facility's website and a notice of Financial Assistance is provided on the self-pay billing statements. Staff and representatives will provide information about the programs during appropriate phone calls and follow-up communications with patients.

B. If a patient at the time of pre-admission, admission or during the billing cycle indicates the inability to pay a self-pay balance, the Patient Access (front-end) staff or the Patient Financial Services staff will pursue the possibility of Financial Assistance.

C. To apply for the Financial Assistance program, the patient must request an application for determination of eligibility from the facility, or download it from the website and complete the application in its entirety. A verbal application may be completed in the event that the patient is unavailable to sign. All verbal applications must be signed by a representative of the hospital.

D. A person is determined to be unable to pay for hospital services when the family income of that person, as calculated by either of the following methods, is not more than the applicable income guidelines set forth in subsection C, (if one method does not apply, the other must be applied before determination of ineligibility is made):

    1. Multiplying by four the person's family income for the 3 months preceding the application date; or
    2. Using the person's actual family income for the 12 months preceding the application date.

E. Upon meeting the following income guidelines, the applicant will qualify for the Financial Assistance for a period of six months. Income qualification for inpatients must be revalidated with each admission. This revalidation may occur in person or by phone. If the inpatient states that their income has changed from that represented on the most recent application, the account will be held until the proper determination can be made. Should any applicant's financial status change within the following guidelines, it may require a reapplication. Approval period exception is for those who receive fixed-recurring income who have no other wages

COPY

and/or salaried spouse or family members. Individuals falling within the exception and whom are between 151%-200% of the FPG may be eligible for one year.

Income eligibility requirements for participation shall be established using guidelines provided by the Department of Health and Human Services and reviewed annually for compliance. See Exhibit A for a breakdown of category by family size.

Charity Care/Uninsured: Covenant Health will provide discounted hospital services to uninsured patients. The discount amount will be specific to the patient's economic condition and based on the Federal Poverty Guidelines.

Financial Assistance: Income up to 200% of the Federal Poverty Guidelines qualifies for a 100% discount. Income 201-400% of Federal Poverty Guidelines qualifies for a 70% discount.

Self-pay Discount Policy: Patients who are uninsured will receive an initial discount based on AGB of each hospital facility, which is currently calculated as 70%. The discount off of the billed charges will be reflected on the first statement.

Patients determined to have presumptive financial assistance eligibility will be provided 100% financial assistance. Presumptive determinations for financial assistance will not require a completed application or be required to provide income or asset information. Available resources such as technology solutions, may be used to obtain an FPL score to determine if a patient is presumed eligible.

COPY

The Financial Assistance program only applies to medically necessary services or services not covered under liability or MVA situations. The program does not apply to services that are found not to be medically necessary, including but not limited to:

- Acupuncture
- Admission Not Certified by Utilization Review
- Breast Pump Rental
- Cardiac Rehab Phase III
- Cat Scans for Lung Screening
- Child Birth Class
- Circumcision
- Cosmetic or Aesthetic Surgery; Breast Reconstruction/Mastopexy, Removal of Excess Skin and Subcutaneous Tissue of Abdomen, Skin Tag Removal for Cosmetic Purposes, EVLT (Endovenous Laser Treatment) for Cosmetic Purposes
- Gastric Bypass, Gastroplasty, Gastric Banding (unless deemed to be medically necessary)
- Infertility Services
- IOP/Intensive Outpatient Behavioral Program(s)
- Medicare Care by Mail, Telephone or Internet
- Migraine Procedures (unless deemed to be medically necessary)
- Off-label procedures (unless deemed to be medically necessary)
- Pre-certification Denials for Medical Necessity and an Advanced Beneficiary Notice (ABN) is

issued

- Preparation and Duplication of Records, Forms and Reports
- Private Room(s)
- Procedures to alter gender
- Reversal of Sterilization Procedures
- Services Not Covered by the Primary Insurance/Payer due to Services Not Being Authorized
- Services received at d/b/a St. Mary's d'Youville Pavilion
- Unauthorized Days Awaiting Placement
- Utilization Review denials for medical necessity and a Notice of Non-Coverage is issued
- Services that the patient elects under the HIPAA Privacy Act to not have billed to his/her health insurance and instead elects to pay for the services in full. These services may be medically necessary, but would not be eligible for this program when another payer source is available, but the patient elects not to utilize it.
- Weight Management

Maine Hospital(s): If not noted, the hospital(s) reserves the right to follow the Medical Necessity and Medically Necessary rules as outlined in the Maine Department of Health and Human Services 10-144, Chapter 101, MaineCare Benefits Manual.

New Hampshire Hospital: If not noted, the hospital reserves the right to follow the Medical Necessity and Medically Necessary rules outlined as such; Health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluation, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, disease, or its symptoms;
- Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- Not experimental, investigative, cosmetic, or duplicative in nature

In liability or MVA situations, proof of valid insurance denial or exhaustion of benefits must be provided before claims will be considered for this program.

**Processing of Application:** These steps are procedural and will be defined in each of the facilities own policies as they are system driven

1. Upon receipt of an application, a search of the system will be made for all open accounts, including pre-registration accounts and any open accounts under a previous cost share eligibility.
2. Covers dates of service in which the initial claim to the patient is within 240 days preceding

COPY

the date of application. The determination for eligibility is effective for 6 months up to a 1 year based on the nature of the income and determination level.

3. Accounts that have already been sent to a Collection Agency will only be eligible for this program if the date of the application for financial assistance is within 240 days of the date of the first statement on each account in question.
4. If no accounts are found, the application will be returned to the patient with a notice of deferral stating that the patient is not eligible for financial assistance until services have been scheduled or provided.
5. The application will be reviewed for completeness of documentation and if found to be incomplete, a notice requesting the documents required to complete the application review process. An application without a signature cannot be processed, application must be signed by the patient or hospital representative.
6. The completed application will be reviewed for approval and notice of final approval or disapproval will be sent to the applicant within thirty days of the receipt of the completed application. This notice will indicate the approval or disapproval of the application; see Section I. All accounts will be noted with the approval or disapproval date and placed in the appropriate financial class, see section B. above.
7. Accounts with a patient liability of $5,000 or more will adhere to the following QA process:
   Associates call approve account balance $0-4,999.99
   Supervisor can approve account balance $5,000-24,999.99
   Manager can approve account balance $25,000-49,999.99
   Director can approve account balance from $50,000 and above
   If the application is not approved, all accounts will be placed into the regular self-pay billing cycle.
   If the application is approved, all the accounts will be adjusted accordingly.
8. Third party scoring may be used in absence of an application for financial assistance. A 3rd party FPG score less than or equal to 200% of the FPL will result in a presumptive discount of the patient responsibility. The adjustment is applicable to the scored account only.

COPY

**Deferral of Determination:** Determination of eligibility is to be made as close to the date of service or as close to the application date as possible. A determination for qualifications for Financial Assistance may be deferred up to 60-days, for the purposes of requiring the applicant to obtain the present evidence of ineligibility for medical assistance programs or to verify that the services in question are not covered by insurance.

**Notification to Applicant:**

1. A Financial Assistance application determination of eligibility must be completed on all applicants requesting participation in the Financial Assistance Program.
2. A favorable decision that the applicant is qualified for Financial Assistance will be completed with an approval letter that will include the following:

- That the hospital will adjust charges for services rendered
- That the date on which services were or will be first provided to the applicant

- That the date of determination of eligibility was made

1. A non-favorable decision that the applicant does not qualify for Financial Assistance will be completed with a denial letter that will include the following:

- That the hospital will provide the applicant with a denial letter
- That the applicant has the right to appeal the decision, in writing, to the facility. The written appeal must include a reason for the appeal not included in the original Fee Care application. All appeals will be reviewed by the Patient Financial Services and written appeal decision with 30-days.

**Procedure to Request an Administrative Hearing (State of Maine only**): An applicant for financial assistance may request an Administrative hearing if he or she is aggrieved by the action that denies the request for financial assistance. The Department of Health and Human Services may respond to a series of individual requests for a hearing by conducting a single group hearing. The applicant must follow the procedures described in this Section when requesting an administrative hearing:

- An Administrative Hearing may be requested by an applicant or his/her representative.
- Administrative hearings must be requested within sixty (60) days of the date of written notification to the applicant of the action the applicant wishes to appeal.
- Request must be made by the applicant or his/her representative, in writing or verbally, for a Hearing to the Administrative Hearings Unit, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011.

COPY

# REPORTING AND RECORD KEEPING:

- The billing department shall maintain records of the amount of free care and cost share care provided in accordance with this policy. Records for each category must be kept separately.
- A summary of the amount of free care and cost share care and the number of individuals to whom each type of care was provided in each year must be reported to the Department of Health and Human Services.
- A current copy of the Financial Assistance Policy and the posted guidelines must be submitted each year to the Department of Health and Human Services.

# REGULATORY RESPONSIBILITIES:

- No extraordinary collection action will be pursued within 240 days of the initial claim to the patient, should you apply and then qualify for financial assistance. Accounts will be removed from the collection agency if an account is at a collection agency at the time of approval.
- Policy to be approved by Board of Directors

# REFERENCES:

- Department of Health and Human Services Office of MaineCare Services Chapter 150 Free Care Guidelines
- Department of Health and Human Services Office of New Hampshire
- Federal Poverty Guidelines

- EMTALA
- Affordable Care Act
- IRS Code 501(r)

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Covenant SVP & CFO | Stephen Forney: SVP AND CHIEF FINANCIAL OFFICER | 05/2025 |
| | Stephen Forney: SVP AND CHIEF FINANCIAL OFFICER | 05/2025 |

COPY