Mt. Ascutney Hospital & Health Center

AFFORDABLE CARE POLICY AND PROCEDURE

*(Old Title: **Requests for Financial Assistance**)*

Initiated by: Chief Financial Officer
Dept.: Billing and Customer Service
Approved by Dept. Head/Committee: Chief Financial Officer

Date Effective: January 1, 2005
Date Reviewed: 03/07, 09/08, 10/11, 08/13, 02/14, 02/15, 04/16
Date Revised: 10/11, 08/13, 02/14, 02/15, 04/16

Purpose

MT. Ascutney Hospital and Health Center recognizes that some patients do not have the ability to pay for their medical care. MT. Ascutney Hospital and Health Center is committed to extending Affordable Care to individuals and families with limited financial resources. Individuals and families who have received services from MT. Ascutney Hospital and Health Center, which have resulted in outstanding financial obligations to the hospital, may apply for assistance through this program. Applications will be processed and approval will be determined based on specified criteria. If approved, their obligation to MT. Ascutney Hospital and Health Center will be reduced in full or in part. Approval is based on the criteria set forth in this document and the ability of the patient/guarantor to demonstrate the need and limited resources. MT. Ascutney Hospital and Health Center will not discriminate in the determination of Affordable Care eligibility on the basis of race, color, creed, sex, age, or handicap.

Policy

MT. Ascutney Hospital and Health Center will offer Affordable Care if an individual's or family's income is within the specified parameters, their assets or lack of assets meet established standards, and all other means of reimbursement have been exhausted. These standards must be clearly documented and confirmed. Availability of Affordable Care will be consistent with MT. Ascutney Hospital and Health Center's ability to provide such care as determined by Administration and the Board of Directors.

All patients and guarantors who request or require Affordable Care should be referred to the Financial Counselors in the Revenue Cycle Department of MT. Ascutney Hospital and Health Center or to the Patient Navigator in the Community Health Program.

Affordable Care will be applied to elective and non-elective services that are medically necessary or emergent. Medically necessary services are defined as services that are reasonable and necessary for the diagnosis and treatment of an illness or injury. Non-medically necessary services are defined as cosmetic, patient convenience, or non-urgent services that would not put functional capacity or life at risk if not rendered. Further, experimental treatments, treatments that do not improve the patient’s condition and services that do not functionally prevent further degradation of the condition shall not be covered under this policy. The medical center has defined policies addressing the Emergency Medical Treatment and Labor Act (EMTALA) and this policy shall not conflict with these EMTALA-related policies.

Affordable Care may be provided to patients who have not filed a formal application. These allowances can be authorized, by Administration, based on extenuating circumstances or through outside sources with similar criteria and approval processes. Additionally, applications of other healthcare providers and agencies can be accepted if they provide the necessary information and documentation as outlined in this policy. These provisions are not intended to be used as an alternative to the application process, but to provide the necessary administrative flexibility in certain situations and to provide reasonable customer service and operational efficiencies. Additionally, MT. Ascutney Hospital and Health Center may use its discretion to administratively approve or deny Affordable Care, based on circumstances relative to the patient's or guarantor's ability to make payment

Procedure:

1. The patient shall be referred to the Financial Counselor or Patient Navigator if they request or indicate a need for Affordable Care.
2. MT. Ascutney shall periodically perform a preliminary review of the needs of scheduled and treated patients based on available patient information to initiate an application from patients with Affordable Care needs.
3. All applicants will be counseled by the Financial Counselor as needed and as appropriate. Availability of assistance from other sources will be investigated. The Affordable Care Program will be considered to be secondary to all other sources of reimbursement. All other means of reimbursement must be exhausted and documented as such. Pending third party liability claims are not eligible for the Affordable Care Program until written confirmation is received denying the claim in whole or part and all appeals have been adjudicated and sufficient funds are not available to resolve the patient’s obligation. This includes Worker’s Compensation, Auto Accidents, Torte Feasors, etc.
4. Upon determination that all other sources of assistance have been exhausted the patient must complete an Affordable Care Application (Attachment A). This completed form must be submitted to the Financial Counselors along with documentation of current income and proof of denial from other sources of assistance. The application must be complete and accurate.

   A. Household size and income. Income may be documented by:

      1. Copy of most recent tax form
      2. Copy of most recent income statement(s)
      3. Copy of most recent pay stub(s)
      4. Signed statement of income from employer(s)
      5. Copies of benefit statements; i.e. Social Security, A.F.D.C., Worker's Compensation, Pensions, etc.
      6. Other records as required

   B. Full names and ages of patients concerned

   C. Assets and liabilities

   D. Required demographic information; i.e. address, telephone number, social security number, etc.

E. Guarantor's dated signature

F. Household Size

5. Income includes salaries, wages, tips, earned interest, dividends, pensions, alimony, or any source of income recognized by the Internal Revenue Service or Federal Government.

6. Upon receipt of the completed form and required documentation, the Financial Counselor will organize and evaluate the applications and the related bills.

7. The Financial Counselor will perform the review of the applications a minimum of once a month. The application and documentation will be utilized to determine eligibility. Eligibility is based on the following:

   A. Affordable Care will only be extended to patients who reside within the service area of MT. Ascutney Hospital and Health Center (Attachment B). Applicants who are not citizens of the United States will not be considered for this program. Patients who live outside the service area may be considered for the program if the services rendered were emergent or unavailable in their residential area.

   B. An applicant's total household income must fall within the guidelines established by MT. Ascutney Hospital and Health Center (Attachment C). These guidelines are based on the Federal Income Poverty Guidelines. These guidelines will be updated annually. The guidelines are set up with a prorated scale of assistance based on income.

   C. Liquid Assets such as cash, investments, and others will be considered for resolution of obligations less than $10,000.

   D. Ownership, Liquid Assets and Assets with limited liquidity will be considered for each application for assistance totaling over $10,000. Ability to satisfy the obligation through these assets will be determined. Assets such as Retirement Accounts, Trust Accounts, Real Estate, and others will be considered to be available resources.

   E. Household size and dependent status will be based on Federal Standards. Full time students who have been claimed as dependents on their parent's tax return will not be considered to be independents.

   F. The patient was not directly reimbursed for the services concerned, by any other source.

   G. The outstanding balance(s) are not the result of a penalty assessed for failure to comply with the provisions set forth in the insured's insurance contract.

8. Based on the above referenced eligibility requirements, the Financial Counselor will approve or deny each application. The Financial Counselor may approve all adjustments for Affordable Care under $5,000.00 for a given applicant. For adjustments greater than $5,000.00 per applicant, the Financial Counselor must present these recommended adjustments and their related applications to the Revenue Cycle Director. Adjustments greater than $10,000 must be approved by the C.F.O./Vice President of Finance.

9. Once the determination has been made and all required signatures/approvals have been received, a list of approved adjustments will be given to the Customer Service in the Revenue Cycle Department. The Customer Service Staff will post the appropriate write-off transactions on the appropriate patient accounts. Written verification of approval and denial will be sent to the applicants within two (2) weeks of determination. The Financial Counselor is responsible for generating this notification.

10. All qualified services that are rendered to a patient previously approved for Affordable Care, are covered under the previous approval, if these additional services were rendered within one hundred and eighty (180) days of the and their financial situation has not materially changed. Medicare patients, whose situation tends to be more static, shall be granted one year. All previously mentioned eligibility requirements are required to be met for services provided within this window of approval. A new application and updated documentation will be required after this time period window has expired or if their financial situation has significantly changed.

11. The Revenue Cycle Director and/or the Financial Counselor are required to produce necessary statistics and reports for internal and external needs.

12. Other considerations:

    A. The application and approval can occur before, during, or after the treatment so long as the account has not been written off to bad debt prior to receipt of completed application and necessary documentation. Accounts sent to bad debt after required information has been received can be returned from collections for processing without penalty to the applicant if Financial Counselor deems the patient has been cooperative or that the medical center mistakenly referred the account(s) to bad debt. MT. Ascutney Hospital and Health Center encourages the application process to begin as early as possible.

    B. Patient receiving benefits from certain programs through Medicaid, may have already had comparable income and asset tests completed through that program. Accordingly, their approval can be expedited with proof of coverage under those programs.

    C. Balances after insurance, not inclusive of balances designated as penalties for non-compliance with policy coverage requirements, are eligible for Affordable Care.

    D. Balances remaining after partial Affordable Care write-offs shall be handled according to the Credit and Collections Policy.

13. MAHHC sponsors the Windsor Community Health Clinic (WCHC) as an integrated service for the uninsured and under insured members of our community. Staff from all departments are encouraged to refer eligible patients. WCHC provides case management, as well as, assistance in the application process for insurance, medication and medical equipment

Attachment B.

2015 MAHHC Service Area

	Place of Service				
Residence	**Windsor**	**Woodstock**	**Wilder**	**Hanover**	**Lebanon**
VT					
Barnard	X	X	X		
Bridgewater	X	X			
Brownsville	X	X			
Cavendish	X	X			
Hartford	X	X	X	X	X
Hartland	X	X	X	X	X
Ludlow	X	X			
Norwich			X	X	X
Pomfret	X	X	X		
Queechee	X	X	X	X	X
Reading	X	X			
Sharon			X	X	X
Taftsville	X	X	X	X	X
Thetford			X	X	X
Weathersfield	X	X	X		X
White River Junction	X	X	X	X	x
Wilder	X	X	X	X	X
Windsor	X	X	X	X	X
NH					
Canaan			X	X	X
Claremont	X		X	X	X
Cornish	X		X	X	X
Enfield			X	X	X
Etna			X	X	X
Hanover			X	X	X
Lebanon	X		X	X	X
Lyme			X	X	X
Plainfield	X		X	X	X

Note:

- Inpatient Rehabilitation Unit has no service area restrictions.
- Emergency Care has no service area restrictions
- Patients receiving services not available in their service area are eligible for those services
- Only larger towns have been listed as a general guide. Small towns and villages normally associated with these larger towns should be considered as well.

Attachment C.

MAHHC
2016 Income Guidelines
Affordable Care Program

Eligibility is determined by measuring family income against the Income Poverty Guidelines established by the Department of Health and Human Services (DHHS).

Household Size	INCOME EQUAL TO OR LESS THAN			
	225%	250%	275%	300%
1	$26,730	$29,700	$32,670	$35,640
2	$36,045	$40,050	$44,055	$48,060
3	$45,360	$50,400	$55,440	$60,480
4	$54,675	$60,750	$66,825	$72,900
5	$63,990	$71,100	$78,210	$85,320
6	$73,305	$81,450	$89,595	$97,740
7	$82,643	$91,825	$101,008	$110,190
8	$92,003	$102,225	$112,448	$122,670
Each add'l Person	$9,360	$10,400	$11,440	$12,480
	100% FREE CARE	75% DISCOUNTED CARE	50% DISCOUNTED CARE	25% DISCOUNTED CARE