TITLE:	FINANCIAL ASSISTANCE PLAN FOR UNINSURED AND UNDERINSURED PATIENTS (CHARITY CARE/FINANCIAL ASSISTANCE POLICY)			POLICY #:	1A.2900.00	
Department or Hospital-Wide Section Name:	REGISTRATION, PATIENT ACCOUNTING, FISCAL SERVICES		Revision Date:	04/06/2022	Revision #:	
Committee approvals – see meta data information			Original Effective Date:		02/25/2004	

1) **STATEMENT OF POLICY:**
   a) Cuba Memorial Hospital (CMH) recognizes that there are unfortunate occasions when a patient is not financially able to pay for their medical care. Since provision of emergency/urgent medical care at CMH is not dependent on a patient's ability to pay, CMH has established guidelines in which a patient may apply and qualify for charity care. The Hospital will continue to ensure that all patients, regardless of ability to pay, are treated in a manner that reflects the policies and values of Cuba Memorial Hospital. Cuba Memorial Hospital is required to comply with EMTALA.

   b) Charity Care is provided to patients who have demonstrated an inability to pay for medical care provided by CMH. These patients may be uninsured or underinsured. The program is available to all patients who express and can demonstrate a financial burden associated with their patient responsibility. Patients who do not qualify for the hospital assistance program may be offered extended payment options to satisfy the balance within a mutually agreed upon timeframe. Medical Care includes inpatient and outpatient medical treatment and diagnostic services. Charity care is provided by CMH without the expectation of payment. Charity Care does not include bad debt or contractual shortfalls from government programs, but may include insurance coinsurance, copayments or deductibles, uninsured (self-pay) discounts, charges for patients with coverage from an entity that does not have a contractual relationship with CMH, charges for non-covered services provided to patient eligible for Medicaid or other indigent care programs, charges for patients that have exceeded the length of stay for Medicaid of other indigent care programs, charges for otherwise insured patients that have exhausted their benefits and are liable for the charge for any remaining amount, and use of any sort of presumptive scoring or other methodology to determine eligibility for charity care/financial assistance. Charity care may also be referred to as financial assistance.

   c) Bad Debt is defined as the expense resulting from medical care services provided to a patient and/or guarantor who has the ability to pay for the services provided, but has demonstrated by his/her actions an unwillingness to pay for these services.

   d) This policy applies to services provided by Cuba Memorial Hospital and its employed professionals. It does not apply to services provided by and billed separately by contracted physicians (i.e. radiologists, emergency room physicians, anesthesiologists, etc.)

2) **DESIGNATED PERSONNEL**: Registration, Patient Accounting and Fiscal Services

3) **PROCEDURE**:
   a) <u>Eligibility:</u>
      i) Uninsured or underinsured patients will be provided a Self-Pay discount. The source used in determining the Self-Pay discount amount is current facility specific Medicare rate of reimbursement for that service. This applies to all uninsured or under insured patients prior to, and not dependent, upon their Financial Assistance application filing status.

ii) Eligible individuals will not be charged more than the “amount generally billed” to insured individuals (AGB) for emergency or other medically necessary care. The facility will not charge FAP-eligible individuals gross charges for any medical care.

iii) Patients who are uninsured, under insured; have family income below 400% of the Federal Poverty Guidelines, may also be eligible for additional Financial Assistance. Exceptions to this criterion may be authorized by either the hospital’s Chief Executive Officer (CEO) or Chief Financial Officer (CFO).

iv) The services under this Policy are discounted to the patient on a sliding fee scale in accordance with financial need as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination.

v) Presumptive eligibility: in certain situations where the documentation may not be available, Cuba Memorial Hospital reserves the right to extend financial assistance on a case-by-case basis. Presumptive eligibility may be determined on the basis of individual life circumstances that may include: homeless or received care from a homeless clinic, no permanent address, state-funded prescription programs, participation in Women, Infants and Children (WIC) program, food stamp eligibility, participation in subsidized school lunch program, eligibility for other state or local assistance programs that are unfunded (i.e. Medicaid spend-down, rental assistance, cash assistance), low-income/subsidized housing provided as a valid address, patient is deceased with no known address, etc. Patient attestation to their financial need is also acceptable. Patient Account manager and/or the Regional Director of Revenue Cycle must approve all adjustments for presumptive eligibility.

vi) Patients must present acceptable insurance coverage at the time of service, or they will be responsible to pay the designated fee. This includes non-covered services provided to insured patients. Patients who do not wish to apply for insurance, a government sponsored program, or financial assistance will be required to pay the discounted rate *at the time of service*.

b) Installment Plans:

i) CMH offers installment plans for eligible patients. Monthly installments are capped at 10% of a patient‘s gross income.

ii) Installments will not be accelerated for a missed payment.

iii) CMH may ask for a deposit.

c) Service Coverage:

i) This policy applies to inpatient and outpatient services (i.e. hospital admissions, emergency room visits, ambulatory surgery, primary care, and ancillary services). For emergency and non-emergency services, Cuba Memorial Hospital offers financial assistance as follows:

ii) This policy **does not** apply to any **non-medically necessary cosmetic surgery.** Question concerning urgency will be addressed by Care Management in conjunction with the attending physician.

iii) Patients will receive separate bills for physician services.

iv) Patients with insurance coverage will be responsible for all co-payments and deductibles for each episode of care, unless the patient can demonstrate an inability to pay.

d) Fee Schedules:

i) The hospital has developed a self-pay discount using facility specific Medicare as the base rates for the determination of discount amounts.

ii) The hospital has developed a sliding fee scale for its services, based upon an "Applicable Rate" or AR, which will be the current reimbursement rates Medicare or Medicaid, as a base rate for each service. When a patient has been determined to be eligible for Financial Assistance, the patient will be assigned a financial class based upon their level of income (percentage of the Federal Poverty Guidelines or FPG) and bank statements. The patient will be responsible for payment at the following percentages of the Applicable Rate:
   (1) Financial Class P5: Up to 100% of FPG: 0% of Applicable Rate (nominal fee)
   (2) Financial Class P4: Up to 175% of FPG: 20% of Applicable Rate
   (3) Financial Class P3: Up to 250% of FPG: 40% of Applicable Rate
   (4) Financial Class P2: Up to 325% of FPG: 60% of Applicable Rate
   (5) Financial Class P 1: Up to 400% of FPG: 80% of Applicable Rate
   (6) Financial Class P (Self Pay): No financial assistance (Self Pay Discount)

iii) For all non-emergent outpatient services, specific sliding fee scales have been established. These are detailed in an attachment to this policy.

e) <u>Procedures:</u>

i) Patients who are not covered, or receive services not covered by a third-party insurer will be given an educational package by the Patient Access Registrar. This educational package will include information regarding the self-pay discount applied to all uninsured or under insured patients as well as information on the Financial Assistance program. The package will include:
   * Patient Notice Letter which states the due date to return documents
   * Financial Screening Document Checklist
   * Application Form

ii) Patients have 90 days from date of discharge or service to apply for financial assistance and at least 30 days to submit completed application.

iii) CMH will respond, in writing, approving or denying the application within 30 days after receipt of a complete application.

iv) If an applicant for Financial Assistance is determined not to be eligible, the patient has the right to appeal the decision within 30 days of the notification of non-eligibility. Appeals can only be submitted based on the following:
   * Incorrect information was provided; OR
   * A change in the patient's financial status occurred; OR
   * Due to extenuating circumstances

v) Appeals should be made in writing (or in person, by appointment) to the Director or Manager of the Patient Accounting Department. Patient Accounting will make reasonable efforts to issue an appeals decision within 15 business days of receipt of a patient appeal (i.e. after receipt of letter or an in-person appeal). The Patient Accounting Department may, at their discretion, request that an application be filed for government sponsored benefits as part of the appeal process.

vi) The Director or Manager of the Patient Accounting Department will be responsible for reviewing appeals based on additional documents to support such claims. All decisions made at this time are considered final.

vii) CMH may require that a patient first apply for Medicaid or another program, such as workers' compensation or no-fault, if we believe the patient may be eligible for these programs.

viii) Financial assistance is contingent upon a patient's cooperation in following CMH's application requirements. This includes providing the necessary information to permit CMH to make a determination of eligibility for financial assistance.

ix) If a patient is deemed not eligible, the patient will be billed for payment for services at the self-pay discounted rate. A payment plan may be worked out, not exceeding one year in duration.

f) Collection Practices:

i) Applicable payment, based on this policy for all non-emergent outpatient services are payable in full upon each visit/registration prior to services rendered at the self-pay discounted rates or rates determined by the patient's financial class. The discounted rate for the first episode of care may be billed to the patient, as they may not be aware of our upfront payment policy.

ii) After applying the self-pay discount and/or after being approved and assigned to the appropriate financial class, the patient will be billed for the balance due for all other outpatient services: If the patient's account remains unpaid after appropriate billing attempts, the account may be sent to a collection agency.

iii) CMH will not cause the forced sale or foreclosure on a patient's primary residence.

iv) CMH will not send account to collection if the patient has submitted a completed application for financial assistance, including the required documentation, while an application is pending.

v) CMH will provide written notification to a patient at least 30-days before an account is sent to collection. This written notice may be included on a bill.

vi) CMH requires that a collection agency have its written consent prior to starting legal action for collection.

vii) CMH will train all general hospital staff who interact with patients or have responsibility for billing and collection.

viii) CMH will measure our compliance with these polices.

ix) CMH requires any collection agency under contract to follow our financial assistance policy and provides information to patient's on how to apply, where appropriate.

x) CMH does not allow collection activity if the patient is determined eligible for Medicaid for the services that were rendered and CMH is able to collect Medicaid payment.

xi) Once an application is approved for Financial Assistance, all outstanding accounts with the hospital may be included in the Financial Assistance determination. Accounts with litigation pending will not be included in the Financial Assistance decision.

xii) If a patient cannot pay the balance on an account, Patient Account representatives will attempt to negotiate a payment plan with the patient. Once an agreement is made, the patient must adhere to its terms or accounts may be considered for collections.

g) Application Documentation and Standards:

i) Applicants may be asked to provide documentation including but not limited to the following:

(1) Household income for the most recent three months;
(2) Household income for a recent twelve-month period;
(3) Number of people in household and relationship to applicant;

(4) Form 1040 (US Individual Income Tax Return) or any other documentation that can be used to substantiate household income, in the absence of Form 1040.

ii) It is an expectation that the patient will cooperate and supply all necessary information required to make a determination of Financial Assistance eligibility. Either the CEO or CFO may waive such conditions in situations where the patient is not capable of meeting these requirements.

iii) Financial Assistance approvals will be valid for **one year** from date of application. When appropriate the need for Financial Assistance may be reevaluated. Circumstances which may justify such reevaluation include:
(1) Change of income
(2) Change in household size
(3) Reopening of a closed account
(4) Completion of a financial evaluation more than a year ago
(5) Any other change subsequent to rendering of services, which may affect ability to pay.

h) Reporting Requirements:
i) CMH will report the following:
(1) Costs incurred and uncollected amounts in providing services to the uninsured and underinsured, including uncollected coinsurance and deductible amounts.
(2) The number of patients, by zip code, who applied for financial assistance. This report will also include the number of approved and denied applications by zip code.
(3) The amount of distributions from the New York State Hospital Indigent Care Pool.
(4) The amount spent from charitable funds or bequests established for the purpose of providing financial assistance to eligible patients as defined by such bequests.
(5) If permitted to help patients complete Medicaid applications, the number of Medicaid applications CMH helped complete and the number approved and denied.
(6) CMH's gain/loss from providing services under the Medicaid program

i) Compliance Certification:
i) CMH will certify its compliance with these requirements either through the certification of its outside auditor or through an attestation by its President/CEO or Vice President Finance/CFO.

ii) In order to comply with New York State reporting requirements, the Patient Accounting Department will ensure that copies of applications and determination notices are maintained for a period of 7 years.

j) NHSC Participating Sites:
i) NHSC Participating sites will offer sliding fee scale discounts on the basis of family size and income only.
ii) Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. CMH will also accept non-related household members when calculating family size.
iii) Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.
iv) The patient/responsible party must complete the application in its entirety. Staff will be available, as needed, to assist patient/responsible party with applications. By signing the Sliding Fee Discount Program application, persons are confirming their income to CMH as disclosed on the application form.

v) Nominal fees will not be assessed for any qualifying patient into the program.
vi) Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, CMH will work with the patient and/or responsible party to establish payment arrangements. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.