ELIZABETHTOWN COMMUNITY HOSPITAL
POLICY/PROCEDURE

TITLE:	**Financial Assistance Program**	
DEPARTMENT:	**Revenue Cycle**	
SECTION:		**NUMBER:**
Page 1 of #		☐ **Attachments**
☒ **New -effective date -** ☐ **Reviewed/Revised -effective date - upon Administrative approval**		☐ **Name Change- formerly**

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Responsible Department(s): Revenue Cycle	
Administrative Approval:	Date:
All other related polices/procedures/protocols:	

SEE LAST PAGE FOR REVIEW HISTORY

I. PURPOSE:

To establish a policy and procedure for the administration of ECH's Patient Financial Assistance Program.

II. POLICY STATEMENT:

ECH is a committed to treating all patients equitably, with dignity and respect regardless of the patient's health care insurance benefits or financial resources. Further, ECH is committed to providing financial assistance to persons who have essential healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission, ECH strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with ECH's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow ECH to provide the appropriate level of

assistance to the greatest number of persons in need, the following policies and procedures have been established for the provision of patient financial assistance.

VI. PROCEDURES:

Patient Financial Assistance

Healthcare Service Eligibility:

The following services are eligible for financial assistance

- Emergency medical services provided in an emergency room setting;
- Urgent services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
- Elective medically necessary services for patients who meet established program guidelines

Services not eligible for financial assistance:

- Cosmetic services unless medically necessary based upon physician review
- Services deemed not medically necessary
- General Dentistry

Patient Eligibility: Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation, gender identity or expression, or religious affiliation.

Eligibility for financial assistance is based on an income test

- Income Test: Patients whose household income is at or below 200% of the Federal Poverty Level Guidelines (FPLG), as adjusted for household size, pass the income test and are considered for charity care assistance

    - Non-custodial parents may have their income adjusted for child support when supporting documentation of payment is provided.
    - Patients may have their income adjusted for alimony when supporting documentation of payment is provided.
    - Students between the ages of 18 – 21 may be included within the household when more than 50% of the support is provided by the parent. To qualify for this household extension, the student must be listed as a dependent on the Federal Income Tax return.

Exclusions:

- Accounts already referred to a collection agency greater than 120 days from placement to agency, unless referred in error;
- Services reimbursed directly to the patient(s) by an insurance carrier or already covered by another third party.

Residency Criteria: Patients must reside within the ECH service area, unless medical services were urgent or emergent in nature. Eligibility for patients residing outside of the ECH service area will be determined on a case by case basis. Financial assistance for residents outside of the ECH service area may be granted with appropriate approval.

Proof of residency may be established by one of the following:

- Service area driver's license, tax bill with Service area address, lease for Service area property or a Service area utility bill;
- Potential exceptions may be considered on an individual case-by-case.

Health Insurance and Liability Payments: Services rendered at an ECH facility will be billed to patient's primary coverage, a private medical insurance, an employer occupational health plan, workers' compensation, or pending by medical pay/third-party liability carriers. In cases where there is a potential liability payment pending at a future date, ECH may file a lien to protect its financial interests, excluding Medicare/Medicaid recipients. After the lien is filed, financial assistance may be granted assuming that the patient otherwise qualifies. If there is a future time when liability payments are distributed, lien will allow ECH to recover some or all of the financial assistance initially granted to the patient.

Public Health Care Program/Healthcare Exchange Criterion: Patients applying for financial assistance are reviewed for their potential eligibility for state or federal healthcare program benefits and/ or benefits offered through the NY healthcare exchange programs. Any patient identified with potential to be granted such assistance will be instructed to apply. For those patients identified as candidates for eligibility for the NY Healthcare Exchange Program; application for and compliance with those program guidelines is a pre-requisite for patient assistance.

Exclusions: A patient who's religious or cultural belief system prohibits seeking or receiving financial assistance from a government entity may be excluded from the public health care program criterion. The patient will, however, be required to assume a portion of financial responsibility to be assessed by the Patient Assistance Program Administrator.

Determination of Financial Need: Financial need will be determined in accordance with procedures that involve an individual assessment of financial need which may include the following: (Note, in the case of presumptive charity, the application process may be excluded).

- An application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
- Include reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
- Include a review of the patient's ECH outstanding accounts receivable for prior services rendered and the patient's payment history.

It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. A patient must have a current patient balance that is due to ECH, an expectation that an account currently pending insurance will leave a balance that is due to ECH, or a future scheduled service at ECH that is expected to leave a patient balance. However, the determination may be done at any point in the billing cycle.

The need for charity assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation is greater than one year.

Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance application on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide sufficient evidence to provide the patient with financial care assistance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
- Food Stamp Eligibility
- Participation in Women, Infants and Children programs (WIC)
- Transient (homeless)
- Patient is deceased with no known estate (documented by probate court)
- Patient is incarcerated with no health care coverage
- Patient has qualified for charitable assistance at another organization, e.g. hospitals, etc.
    - Copies of other organization "approved" applications will be required to process a presumptive grant under this clause. CVPH will review the determination against our policy and grant / deny as appropriate.

Patient Financial Assistance Guidelines: In accordance with financial need, eligible services under this policy will receive financial assistance based upon the federal poverty guidelines. The amount of assistance provided to a patient will vary based upon their income level and the grant awarded shall ensure the patient is not responsible for more than the Amount Generally Billed (AGB) to an insured patient and the Maximum Amount Paid (MAP) by the Highest Volume Payer (HVP) (see definitions for AGB, MAP, HVP).

As defined by the IRS, eligible patients cannot be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. The amounts generally billed (AGB) to patients is calculated using the "Look-Back method"; actual claims paid to the organization by Medicare together with all private health insurers, including any associated portions of these claims paid by beneficiaries. Additionally, as provided for in NYS PHL 2807, eligible patients cannot be charged more for emergency or other medically necessary care than the Maximum Amount Paid (MAP) by the Highest Volume Payer (HVP).

ECH uses the combined Amounts Generally Billed and the Maximum Amount Paid by the Highest Volume Payer method calculations. The minimum grant percentage awarded to patients who qualify for assistance will be greater than the AGB & MAP HVP calculated for the period.

Based upon the patient's FPL, additional assistance has been provided for up to 100% of gross charges. The percentages and the policy may need to be adjusted annually based upon the AGB & MAP HVP for the previous fiscal year.

Elizabethtown Community Hospital Financial Assistance Grid for 2015:

FPLG	200%	250%	300%	350
Grant	100%	75%	50%	25%

The patient grant is applied against all current balances (i.e. hospital and medical group) and extends for a coverage window of one year. When the grant period has closed, patients will be required to re-apply for financial assistance and based upon their financial status, may have their grant category adjusted.

Individual Case Reviews and Appeals Process: ECH acknowledges that extenuating circumstances may exist where an individual's income or assets exceed program eligibility guidelines. The program administrator, on an as-needed basis, will review unusual or catastrophic cases that do not meet established program guidelines but present unusual hardship.

Patients whose applications for charity are denied may appeal the denial decision. Requests for appeal should be sent to the Patient Assistance Program (PAP) administrator, in writing, within 30 days of receipt of the denial decision and must clearly indicate the reason for the appeal. All cases will be reviewed in preparation for the Director of Revenue Cycle Services to review. The patient will be notified of the final grant/deny decision.

Communication of the Charity Program to Patients and the Public: Notification about patient assistance charity care available from ECH shall include a contact number and shall be disseminated by various means, which may include, but are not limited to:

- Reference to the charity program printed on each patient statement
- By posting notices in emergency rooms, admitting and registration departments, and patient financial services offices that are located on facility campuses
- By providing a copy of the plain language policy summary at the point of Registration on the facility campuses and making available the summary at our satellite clinics. Providing copies of the policy and application upon request
- Information shall be available on the ECH website, including the policy, a plain language summary, the application, FPLGs and contact information for follow-up assistance
- Referral of patients for charity assistance may be made by any member of the ECH staff or medical staff. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

Relationship to Collection Policies: ECH management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from ECH, and a patient's good faith effort to comply with his or her payment agreements with ECH. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, ECH may offer extended payment plans to eligible patients.

Regulatory Requirements: In implementing this policy, ECH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

Document Retention: Completed applications for the Financial Assistance Program will be maintained for a period of six years after the date the application was approved or denied.

Monitoring Plan: Compliance with this policy will be through annual review of Financial Assistance Program applications.

V. DEFINITIONS For the purpose of this policy, the terms below are defined as follows:

- **AGB:** Amount generally billed to insurance payers for services provided. The look-back method is used to calculate the AGB, reflecting a combination of fully adjudicated claims for Medicare fee for service and all private health care plans, including the portions paid by the beneficiaries.
- **HVP:** Per NYS PHL 2807, "highest volume payer" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payer, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.
- **MAP:** Maximum Amount Paid per NYS PHL 2807 is the greater of the amount that would have been paid for the same services by the "highest volume payer" for such general hospital, or for services provided pursuant to title XVIII of the federal social security act (Medicare), or for

services provided pursuant to title XIX of the federal social security act (Medicaid), and provided further that such amounts shall be adjusted according to income level.

- **Medical Indigence:** There are instances when individuals are financially unable to access adequate medical care without depriving themselves and their dependents of food, clothing, shelter and other essentials of living. A patient will generally be considered Medically Indigent if the balance of a hospital bill exceeds 30% of the person's annual household gross income and he or she is otherwise unable to pay all or a portion of the bill balance resulting from a catastrophic illness or injury.
- **Medical Necessity:** Services or items that are: (1) appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease or injury; (2) provided for the diagnosis or the direct care of the condition, illness, disease or injury; (3) in accordance with current standards of good medical practice; (4) not primarily for the convenience of the patient or provider; and (5) the most appropriate supply or level of service that can be safely provided to the patient.
- **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. An uninsured patient is ineligible for any government healthcare entitlement program (Medicare, Medicaid, "exchange plans", etc.) during the dates of service provided by CPI.
- **Underinsured:** The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

V. DISTRIBUTION

This policy is available in Policy Medical for all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.

All recipients of this policy must acknowledge their receipt and understanding of the policy by attesting in Policy Manager. Refer any questions with the policy within ten days of the issue date to your immediate supervisor. If no question or problems are stated, it will be deemed that the policy has been read and understood.

Does the draft/revised policy involve federal, state or local regulations? Yes No If yes, please describe in research/reference section below ↓					
DATE:	DRAFTED/REVISED BY:	NEW √	No Change √	REVISION (S): state reason for revisions	INITIALS

	Creation date				

Research/References:
