Cuba Memorial Hospital, Inc.
140 West Main Street
Cuba, N. Y. 14727

DEPARTMENT: Patient Accounting **Date Issued:** 01/01/07
FORMULATED BY: Chief Financial Officer **Date Revised:** 01/18/2018
APPROVED BY: Administration **Date Reviewed:** 03/19/2018
SUBJECT: Financial Assistance Plan For Uninsured and Underinsured Patients (Charity Care/Financial Assistance Policy)

Distributed To: Registration, Patient Accounting, Fiscal Services

1) Statement of Policy:

a) Cuba Memorial Hospital, Inc. 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, Inc. 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. Charity Care is provided by CMH without the exception of payments. Charity Care does not include bad debt or contractual shortfalls from government programs, but may include insurance copayments or deductibles, or both. 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 services provided, but has demonstrated by his/her actions an unwillingness to pay for these services.

d) This policy applies to services provided by CMH and its employed professionals. It does not apply to services provided by and billed separately by contracted physicians (i.e. radiologists, durable medical equipment, ect.)

2) Procedure:

a) Eligibility:

i) Uninsured or underinsured patient will be provided a Self Pay discount. The source used is 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 the 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 or have exhausted their insurance benefits; have family income below 400% the Federal Poverty Guidelines, may also be eligible for additional Financial Assistance. These patients may also be eligible if they are responsible for payments to the Hospital which exceeds 50% of the sum of their combined income and net assets calculated on an annual basis. Exceptions to this criterion may be authorized by either the hospital's Chief Executive Officer (CEO) or Finance Director.

iv) Uninsured patients with incomes below 400% of the Federal Poverty Guidelines (FPG) are eligible for financial assistance. The FPG for 2018 are as follows:

Persons in Family or Household	100% of the FPG
1	$12,140
2	16,460
3	20,780
4	25,100
5	29,420
6	33,740
7	38,060
8	42,380
For each additional person, add	4,320

Source: https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines

Thus, a single person at 400% of the FPG with income/resources less than $48,560 ($12,140 X 400%) per year, a family of four at 400% of the FPG with income/resources less than $100,400 ($25,100 X 400%) per year, and so on.

v) Presumptive eligibility: In certain situations where the documentation may not be available, Cuba Memorial Hospital, Inc. 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 Finance Director 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 (i.e. hospital admissions, urgent care visits, and ancillary services).
   ii) This policy does not apply to any non-medically necessary cosmetic surgery. Questions concerning urgency will be addressed by Care Management in conjunction with attending physician.
   iii) Patient will receive separate bills for physician services.
   iv) Patient 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 Federal Poverty Guidelines or FPG) and assets. The patient will be responsible for payment at the following percentage of the Applicable Rate:
      (1) Financial Class P5: Up to 100% of FPG: 0% off 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 P1: 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.
   iv) The New York State self-pay surcharge of 9.63% will be added to fee scale amount for services.

e) Procedures:
   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:
      - Financial Screening Document Checklist
      - Application Form
   ii) Patients have 90 days from the date of discharge or services 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 completed 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 only be made in writing (or in person, by appointment) to the Director or Manager of Patient Access Department. The Patient Access Department will make reasonable efforts to issue an appeals decision with 15 business days of receipt of a patient appeal (i.e. after receipt of letter or an in-person appeal). The Patient Access 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 Access Department will be responsible for reviewing appeals based on additional documentation 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 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 payments plan may be worked out, not exceeding one year in duration.

f) <u>Collection Practices:</u>

i) Applicable payment, based on this policy for all non-emergent outpatient services are <u>payable in full upon each visit/registration</u> 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 the 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 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 written consent prior to starting legal action for collection.

vii) CMH will train 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 patients 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 Access 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 collection.

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 the most 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 Finance Director may waive such conditions in situations where the patient is not capable of meeting these requirements.

h) Reporting Requirements:
   i) CMH will report the following:
      (1) Cost 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 for 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 helps 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 it's compliance with these requirements either through the certification of its outside auditor or through an attestation by its CEO or Finance Director.
   ii) In order to comply with New York State reporting requirements, the Patient Accounting Department will ensure that the copies of applications and determination notices are maintained for a period of 7 years.