PURPOSE:

To assist patients of Samaritan Medical Center (SMC), and its affiliates, who are uninsured or underinsured to qualify for a level of financial assistance, in accordance with their ability to pay; to comply with the New York State Public Health Law Subdivision 9-a of Section 2807-k.

Financial assistance may be provided in the form of free care for patients who qualify or a discount may be applied to inpatient and/or outpatient service charges (excluding cosmetic or self-pay flat rate procedures).

DEFINITIONS:

Bad Debt Expense: Uncollectible accounts receivable that were initially expected to result in cash received (i.e. the patient did not meet SMC's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectible accounts resulting from the extension of credit.

Catastrophic Financial Assistance: Assistance available to all uninsured patients who have a balance owed for medical care who do not qualify for the Medical Assistance program but have an extraordinary balance owed; a debt that is catastrophic to the family income base. Determination is made through the SMC Catastrophic Financial Assistance Committee on a case-by-case basis.

Financial Assistance: Financial Assistance (formerly known as charity care) is care that represents the uncompensated cost to a hospital of providing funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified as uninsured or otherwise financially indigent. Financial Assistance services are those that may not initially have been expected to result in cash received. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria. In this policy, the term "Financial Assistance" will be used rather than the term "financial Assistance".

Current Medical Debt: Self-pay portion of current inpatient and outpatient account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Internal and external collection agency accounts are considered as part of the current medical debt.

Family/Household: A group of two or more persons related by birth, marriage (including any legal common law spouse), or adoption who live together. All such related persons are considered as members of one family.

Living Expenses: A per-person allowance based on the Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. The allowance will be updated annually when guidelines are published in the Federal Register.

Payment Plan: When the patient is unable to pay his or her portion of healthcare costs all at one time, SMC will arrange to accept the amount due in regular installments over a defined period of time. Payment plans are expected to be resolved within one year. Payment plans extending beyond one year will be classified as bad debt expenses, and

forwarded to the Internal Collections Unit for processing.

Projected Medical Expenses: A patient's significant, ongoing, annual medical expenses, which are reasonably estimated to remain as non-covered by insurance carriers (e.g., drugs, co-payments, co-insurance, deductibles, and durable medical equipment).

Sliding Scale: An income-based scale that is adjusted to reflect the patient's ability to pay based on the income level of the household.

Spell of Illness: Medical encounters/admissions for treatment of a condition, disease, or illness in the same diagnosis-related group (DRG), or closely related DRG occurring within a 120-day period.

Supporting Documentation: Pay stubs, 1099s, workers' compensation documentation, social security letters, disability award letters, bank statements, brokerage statements, tax returns, life insurance policies, real estate assessments, credit bureau reports, and other documentation typically utilized to establish income levels and financial Assistance or Medical Assistance eligibility.

Take Home Pay: Patient's and/or responsible party's wages, salaries, tips, interest dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service after taxes and other deductions.

***Underinsured*:** SMC considers a patient underinsured when a patient's primary, secondary, and/or other insurance will not cover a specific service or procedure at any hospital or healthcare facility.

Uninsured: SMC considers a patient uninsured when the patient has no insurance coverage.

POLICY:

The Samaritan Medical Center's (SMC) core values of service, communication, personal excellence, interdepartmental relationships and teamwork call us to provide quality health care services to the people served by our organization. Patient and families are treated with dignity, respect and compassion during the provision of services and throughout the billing and collection process. Consistent with this commitment, SMC provides care, admits, and treats patients and provides all services without regard to age, race, color, creed, ethnicity, religion, national origin, culture, language, physical or mental disability, socioeconomic status, veteran or military status, marital status, sex, sexual orientation, gender identity or expression, or any other basis prohibited by federal, state, or local law or by accreditation standards. The determination of a patient's financial responsibility will be made according to a patient's ability to pay as indicated by the eligibility criteria established within the procedural guidelines of this policy. These guidelines include:

- Completion of the SMC income-based Financial Assistance Application

Financial assessments and the review of patients' financial information are intended for the purpose of assessing need as well as gaining an overall view of the patients' circumstances. SMC is committed to:

- Communicating with patients so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

In administering this policy, SMC will:

- Serve the health care needs of everyone, regardless of ability to pay
- Ensure the dignity of the patient/guarantor
- Encourage upfront financial counseling
- Be patient-centric and patient friendly
- Communicate collection procedures

PROCEDURE:

Identification of Potentially Eligible Patients:

1. An evaluation for Financial Assistance can be initiated in a number of ways, including the following but limited to:
   a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
   b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with the current or previous medical services.
   c. A physician or other clinician refers a patient for a financial assistance evaluation for potential admission. (Referral Form Attachment B)
2. When possible, prior to the admission or registration of the patient, SMC will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission or pre-registration interview is not possible, this interview should be conducted upon admission or registration, or as soon as possible thereafter. In the case of an emergency admission, SMC's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial patient interview, the following information should be gathered:
   a. Routine and comprehensive demographic and financial data.
   b. Complete information regarding all existing third party coverage.
3. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process (including bad debt collection).

4. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
5. Prior to authorizing the filing of a collection lawsuit on an account, a final review of the account will be conducted by the Patient Financial Services Director or his/her designee to ensure that no application of financial assistance was received. Prior to a lawsuit being filed, the Chief Financial Officer (CFO) approval is required.

Determination of Eligibility:

1. All patients identified as potential financial assistance recipients will be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Financial Counselor will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed or to act on behalf of the patient in this regard.
2. Requests for financial assistance may be received from:
    a. The patient or guarantor
    b. Physicians or other caregivers
    c. Various SMC clinics, practices, or other facilities
    d. SMC Administration
3. Other approved programs that provide for primary care of indigent patients
4. The patient should receive and complete a written application (Attachment A) and provide all supporting data required to verify eligibility
5. In the evaluation of an application for financial assistance, a patient's family income and medical expenses will be the determining factors for eligibility.

Screening Process:

The application should be completed by either the patient, a family member of the patient, the Financial Counselor, Collector, Customer Service Representative, or a Medical Assistance Eligibility Determination Representative

Financial Assistance:

Financial assistance will be granted, based on household income schedule associated with the sliding scale income table.

1. Upon the patient's completion of the application and submission of appropriate documentation, the Financial Counselor or Customer Service Representative will complete the SMC portion of the Financial Assistance Application using either the manual form (Attachment A) used by the patient or an electronic form (SMC Financial Assistance application). The

information shall be forwarded to the Patient Access Services Director or designee for determination, as required. Financial Assistance approvals will be made in accordance with the guidelines, and documented on the form used to complete the application.

2. Accounts for which the Financial Counselor, Customer Service Representative, or Patient Access Services Director identified special circumstances that affected the patient's eligibility for financial assistance will be referred to the SMC AVP of Fiscal Services for final determination.
3. Accounts that do not clearly meet the criteria will be reviewed by the Financial Counselor. The decisions and rationale for those decisions will be documented and maintained in the account file.
4. A scanned electronic record shall be maintained, reflecting authorization of financial assistance. These documents shall be kept for 10 years.
5. If, due to special circumstances, a patient refuses to cooperate, or if an incomplete application is submitted, the Financial Counselor may consider the patient for eligibility based on the recommendation of the representative working with the patient on the application process.

Financial Assistance shall be based on the following:

a. State and county residency
b. Individual or family income
c. Family size
d. Amount and frequency of bills for healthcare services
e. Other sources of payment for the services rendered

Financial Assistance Applications:

Applications for assistance should be submitted within 90 days of the date of service.

Charges incurred within 6 months of a financial assistance application may be considered for write-off.

Balances incurred before that date will be evaluated for inclusion in the financial assistance determination.

Collection Efforts:

Once a financial assistance application is received, SMC will discontinue all billing or collection efforts on the account pending review and determination.

f. The financial counselor is responsible to place accounts on collection hold in the system of the 3rd party self-pay collection vendor.

g. The financial counselor is responsible to enter account notes documenting the hold status suspending billing and collection efforts in the hospital's information system.

Determination of Eligibility for Financial Assistance:

h. Patients whose income is equal to or less than 300% of the Federal Poverty Level will be eligible for financial assistance through the program for emergency services for New York State residents, and for all other services, if they reside within the hospital's primary service area. The hospital's financial service area includes Jefferson, Lewis, Oswego and St. Lawrence Counties. The hospital voluntarily extends discounts to all eligible residents of New York State. Immigration status is not an eligibility criterion.

i. In the following situations, a patient is deemed to be eligible for a 100% reduction from charges (i.e. full write-off):

- If a patient is currently eligible for Medicaid, but was not eligible on a prior date of service. Instead of making the patient duplicate the required paperwork, the facility will rely on the financial assistance determination process from Medicaid up to 12 months prior to the eligibility date.
- If a patient states he or she is homeless and the facility, thru its own due diligence, does not find any evidence to the contrary. The due diligence efforts are to be documented.
- If a patient dies without an estate.
- If a patient is mentally or physically incapacitated and has no one to act on his/her behalf.

j. A sliding scale is used to determine the percentage of allowance afforded under financial assistance based on the Federal Poverty Level. The hospital calculates the patient responsibility amount using the fair price discount amounts of 43% of total charges for outpatient services and 50% of total charges for inpatient services.

POVERTY LEVEL	PATIENT RESPONSIBILITY
100% - 200%	0%
201% - 210%	5%
211% - 220%	10%
221% - 230%	15%
231% - 240%	20%
241% - 250%	25%
251% - 260%	30%
261% - 270%	35%
271% - 280%	40%
281% - 290%	45%
291%-300%	50%
300% and over	100%

Samaritan Health

2019 Poverty Guidelines - Annual

» 48 Contiguous States and D.C.

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Annual)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$12,490	$16,612	$17,236	$18,735	$24,980	$31,225	$37,470	$49,960
2	$16,910	$22,490	$23,336	$25,365	$33,820	$42,275	$50,730	$67,640
3	$21,330	$28,369	$29,435	$31,995	$42,660	$53,325	$63,990	$85,320
4	$25,750	$34,248	$35,535	$38,625	$51,500	$64,375	$77,250	$103,000
5	$30,170	$40,126	$41,635	$45,255	$60,340	$75,425	$90,510	$120,680
6	$34,590	$46,005	$47,734	$51,885	$69,180	$86,475	$103,770	$138,360
7	$39,010	$51,883	$53,834	$58,515	$78,020	$97,525	$117,030	$156,040
8	$43,430	$57,762	$59,933	$65,145	$86,860	$108,575	$130,290	$173,520
Add $4,320 for each person over 8								

2018 Poverty Guidelines - Monthly

» 48 Contiguous States and D.C.

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Monthly)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$1,041	$1,384	$1,436	$1,561	$2,082	$2,602	$3,123	$4,163
2	$1,409	$1,874	$1,945	$2,114	$2,818	$3,523	$4,228	$5,637
3	$1,778	$2,364	$2,453	$2,666	$3,555	$4,444	$5,333	$7,110
4	$2,146	$2,854	$2,961	$3,219	$4,292	$5,365	$6,438	$8,583
5	$2,514	$3,344	$3,470	$3,771	$5,028	$6,285	$7,543	$10,057
6	$2,883	$3,834	$3,978	$4,324	$5,765	$7,206	$8,648	$11,530
7	$3,251	$4,324	$4,486	$4,876	$6,502	$8,127	$9,753	$13,003
8	$3,619	$4,813	$4,994	$5,429	$7,138	$9,048	$10,858	$14,477
Add $368 for each person over 8								

Notification of Eligibility Determination:

a. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason for denial (if appropriate), will be provided, generally within 10 days of the Financial Counselor's decision after reviewing a completed application. Patients that do not qualify for assistance will be notified in the denial letter that will outline the appeal process if they so choose to execute.
b. If a patient chooses to appeal the denial, they must do so in writing within 45 days of the denial letter date. The Financial Counselor will again review the application, and

escalate it to the Director of Patient Access Services for a determination. The Director of Patient Access Services will escalate to AVP of Fiscal Services on a case by case basis as determined necessary for further review. Decisions reached will normally be communicated to the patient within 45 days, and will reflect the final executive review.

c. If a financial assistance determination allows for a percent reduction, but leaves the patient with a self-pay balance, payment terms will be established according to the patient's ability to pay.

d. If the patient complies with a payment plan to which SMC has agreed, the facility shall not otherwise pursue collection action against the patient. However, if a patient misses one monthly payment, the account may be referred to a Financial Counselor to determine the circumstances involved. The account may be referred to a collection agency if additional payments are missed.

e. A patient will be given a discount only if the account has an open self-pay balance. The determining factor for making refunds to the patient will be the date the patient becomes eligible. For example, if a patient is making payment arrangements on an account and part way through the agreed upon contract term the patient becomes eligible for financial assistance (e.g., they lose their job, etc.), then the amounts paid (before the date of job loss and financial assistance eligibility) will not be refunded. If a patient makes payments on an account, and during the time in which the payments were made the patient qualified for financial assistance, then those amounts will be refunded to the patient. The Patient Financial Services Director is authorized to make exceptions to these guidelines.

f. If the patient has a change in financial status, the patient should promptly notify the facility's Patient Financial Services Director or designee. The patient may request and apply for financial assistance or a change in their payment plan terms.

Availability of policy:

a. SMC will provide any member of the public or state governmental entity a copy of its financial assistance policy, upon request.

Application forms:

a. SMC will make available upon request a copy of the application used by the organization

Monitoring and Reporting:

a. SMC will maintain a computerized log of approved Financial Assistance accounts, reflecting the appropriate information to claim the adjustment of financial assistance (charity) for Disproportionate Share funding. A financial assistance log from which periodic reports can be developed shall be maintained, aside from any other required financial statements. The financial counselor is responsible to maintain the computerized financial assistance log. The financial counselor will log account detail upon receipt of the financial assistance application and will update the log daily to reflect any activity performed on the

associated accounts. The log will be provided to department leadership on a weekly basis and on request. Financial assistance logs will be maintained for ten years. At a minimum, the financial assistance logs are to include:

a. Account number
b. Date of service
c. Application mailed (y/n)
d. Application returned and complete (y/n)
e. Total charges
f. Self-pay balances
g. Amount of financial assistance approved
h. Date financial assistance was approved

b. Viewing capability of financial assistance logs will be utilized to exchange financial assistance information between SMC facilities if applicable. A patient who uses multiple facilities, services, or practices at SMC will be able to have his or her approved financial assistance documented by one facility; thereby preventing the need for the patient to reapply for assistance. The SMC facilities will be able to reference the log and note in the patient's account that the patient has already been approved for assistance. This will be considered sufficient documentation to extend that patient financial assistance.

c. The cost of financial assistance will be reported annually in the Community Benefit Report. Financial Assistance will be reported as the cost of care provided (not the charges for that care) using the most recently available operating cost and the associated cost-to-charge ratio, which is generated monthly.

Payment Plans (See Policy - Payment Plans):

a. SMC may provide care for a patient whose financial status makes it impractical or impossible to pay the patient portion balance in a single lump sum payment. In such circumstances, establishment of payment arrangements is consistent with, and essential to, the execution of our mission, vision, and values
b. To assist the patient in meeting his/her financial responsibilities, SMC allows patients to make payment arrangements when payment in full is not possible. SMC will provide long and/or short-term payment plans, based on patient/guarantor needs and financial situations. If the patient/guarantor qualifies for a payment plan, then the Customer Service Representative, Financial Counselor, or Patient Financial Services Representative will inform the patient about his/her responsibilities under the payment arrangement program, as detailed in the SMC "Payment Plans" policy.
c. All SMC registration representatives will inform eligible patients/guarantors of the SMC payment plan policy if a patient is unable to pay his/her self-pay amount in full.
d. Insured patients will not be referred to a collection agency unless first offered the opportunity to request a reasonable payment plan for the amount owed. SMC patients must be given the opportunity to assess the accuracy of their bill,

apply for financial assistance, and avail themselves of a reasonable payment plan prior to the pursuit of collection agency activity.

e. If the patient cannot meet the requirements of the payment arrangement program, the patient will be evaluated for financial assistance.
f. Payment plans on partial financial Assistance accounts need to be individually developed with the patient.

In administering this policy, SMC will:

a. Ensure the dignity of the patient/guarantor
b. Encourage upfront financial counseling
c. Be patient-centric and patient-friendly
d. Serve the healthcare needs of everyone, regardless of ability to pay
e. Communicate collection procedures

Exclusions: Medical expenses excluded from financial asssistance discounts:

a. Individuals eligible for administrative discounts
b. Elective cosmetic surgery services or other elective non-covered services for which a price has been negotiated
c. Accounts for which any third parties may be liable for services

2. Revenue Integrity/Quality Assurance Unit

a. Performs periodic audits of this process to ensure compliance with this policy.

b. Informs Patient Financial Services (PFS) management of discrepancies or variances with established procedures or protocols. Requests management action plans to eliminate variances.

c. Monitors and certifies the efficacy of PFS management action plans.

RELATED POLICIES:

Related SMC Policies	PAS Policy – Financial Practices
	PAS Policy – Financial Clearance
	PAS Policy – Discharge Clearance
	PAS Policy – Verification of Payer Coverage
	PAS Policy – Cash Collection
	PFS Policy – Payment Plans
	PAS Policy – Waivers of Co-Payments and Deductibles
	PFS Policy – Self Pay and Bad Debt Processing
	PAS Policy – Processing Elective Scheduled Encounters

RELATED FORMS:

- Financial Assistance Application (Attachment A)
- Financial Counseling Referral Form (Attachment B)

REFERENCES:

State Dept. of Health Reference	
Joint Commission Standard(s)	LD.04.02.03 (Leadership, Hospital Business Practices)
NFPA	
OSHA	
NCQA	
HIPAA	
CMS	Section 300 of the Medicare Provider Reimbursement Manual
OIG	
Anti-Kickback Statutes	
Other	Title VI of the Consumer Credit Protection Act (Fair Credit Reporting Act)
	Title VIII of the Consumer Credit Protection Act (Fair Debt Collection Practices Act)
	Title I of the Consumer Credit Protection Act (Truth in Lending Act)

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Title Date

_____ _____

Title Date