CLIFTON-FINE HOSPITAL

POLICY TITLE: Financial Assistant Program ☐ DEPARTMENTAL
DEPARTMENT OWNERSHIP: Business Office ☐ MULTI-DEPARTMENTAL
LAST REVISION DATE: 3/6/2023 ■ ORGANIZATIONAL
Approval dates tracked electronically in MCN Policy Manager

POLICY: Clifton-Fine Hospital's (CFH) core values of service, communication, personal excellence, interdepartmental relationships and teamwork call on 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, CFH 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 CFH 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.

CFH 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
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment

In administering this policy, CFH 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:

Financial Counseling Services

As part of the Financial Assistance Program, CFH will provide patients with information about the criteria that must be met under Federal and NYS regulations in order to obtain insurance through Medicaid or the NYS Marketplace other health insurances. Patients are assisted in making applications for any of these programs or discounted fee plans.

Patients may remain self-pay and be responsible for full payment of their medical bill, if they;

- Elect not to make application for insurance coverage for which they may qualify; or
- Elect not to make application for Financial Assistance;
- Do not comply with insurance company requirements
- Have the ability to pay

Financial Assistance Discounts

Services Eligible for Discounts

The FAP covers Hospital and Employed Physician services that are determined to be Medically Necessary by a Physician; including both inpatient and outpatient services.

Notice 2015-46, Section 03.02 allows a hospital facility to specify providers by reference to a department or a type of service. All departments in the hospital follow the financial assistance policy except for hospitalist and radiology interpretation services.

For National Health Service Corps (NHSC) approved sites, as well as those sites which are applying to become NHSC approved, a sliding fee discount program is offered so the amount owed for services by eligible patients is adjusted based on the patient's ability to pay. Services are rendered regardless of the patient's ability to pay. The sliding fee discount program is applicable to all individuals and families with annual incomes at or below 200% of the most recent Federal Poverty guidelines. Eligibility for discounts is based on income and family size and no other factors, (e.g. assets, insurance status, participation in the Health Insurance marketplace, citizenship, population type).

The Financial Assistance Program does not cover, cosmetic services, convenience items, such as television and special request private room charges, or any services billed by non-employed physicians and providers performing services in the hospital, which will be billed separately.

Discount Eligibility Requirements

Financial Assistance discounts are available for uninsured and underinsured patients who reside in New York State and whose household income, as determined by the income patients provide in the Financial Assistance Application, is equal to or less than 400% of the most recent Federal Poverty Guidelines. Further information on income eligibility requirements is detailed in Appendix B.

CFH will use discretion on a case by case basis to process financial assistance for all non-NYS resident patients who may be deemed medically indigent due to a catastrophic illness or injury.

Discount Levels and Patient Payment

A patient whose household income, as determined by the application income worksheet, is equal to or less than 200% of the most recent Federal Poverty Guidelines qualifies for 100% coverage at CFH.

A patient whose household income is greater than 200% and less than 400% of the most recent Federal Poverty Guidelines qualifies for a partial Financial Assistance discount, based upon a sliding scale. The

percent of the partial FAP discount decreases as household income increases as illustrated in Appendix A.

Financial Assistance discounts are also available to eligible patients to decrease the cost of coinsurance, co-payments and deductibles, also illustrated in Appendix A.

The Financial Assistance discount and amount of payment CFH accepts from a patient shall be capped at the average amount the hospital would normally receive from Medicare for inpatient and outpatient services – this is referred to as the Amount Generally Billed (AGB). The calculation methodology of the AGB discounts to the Medicare rate is described in Appendix A, along with further regulatory details, and, the applicable AGB discount percentages.

Discount Application Process

CFH will make available, upon request and without charge, the Financial Assistance Program policy, application and plain language summary to patients. The aforementioned policy, application and summary are also available on the Clifton-Fine Hospital website, under For Patients – Financial Information – Financial Assistance Program. Applications can also be obtained by calling (315) 848-8000.

If there is sufficient information to identify that a patient is potentially eligible for a Financial Assistance discount, CFH may consider the patient to be Presumptively Eligible. CFH may utilize analytic software or an analytic services vendor to support such presumptive Financial Assistance discount, the discount amount will be reflected on the patient's next billing statement.

Patients can submit FAP applications prior to or on the day their care is provided up to the 240th day after the first post-discharge billing statement is provided.

If a submitted application is deemed incomplete, CFH will provide written notice of what additional information is needed. Patients will have 30 days to provide the requested information after which time CFH will close the application review process. Once the application process is closed, normal collection efforts may begin, as outlined in Appendix C.

Once a completed application is received, the patient will be notified of approval determination within 30 days. The Financial Counselor will, upon approving a patient for a FAP discount, include any and all covered services accounts with open balances up to 240 days back from the date the patient completed the application and up to a maximum of 12 months forward. Accounts older than 240 days prior to the application date by be approved at the discretion of the Director of Revenue Cycle or designee.

See Appendix B for detail on the application and information required.

Billing and Collection Efforts for Patients Applying for Financial Assistance Program Discounts

Patients may receive multiple bills for the healthcare services provided at CFH. One bill will contain the costs for the facility (i.e., hospital stay, medicine given during patient stay, etc.). A separate bill may include the professional fee for the physician that provided care to the patient during their stay.

Once a patient has submitted a completed application for FAP consideration, the patient may disregard any bill from CFH that might be sent until such time as CFH has rendered a determination on the pending application.

If approved for Financial Assistance Program discount, the patient will receive a new bill with the new amount due and illustration of how the new amount was calculated by the billing office. CFH will notify any collection agencies, as applicable, if any adverse information needs to be removed from the patent's credit report.

Approved applications for a Financial Assistance Program discount will be honored for a period of 1 (one) year. In the event a patient returns for additional medically necessary services within that time period and the patient's financial status has not changed, no new application will need to be completed.

Installment payment plans may be established for patients who qualify for a Financial Assistance discount. Monthly installment payment will be capped at 10% of gross monthly income of the patient's defined household in accordance with NYS Public Health Law 2807-k. CFH prohibits the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill for hospital or employed physician services.

Any payments made by patients during the application period that are in excess of the approved Financial Assistance adjusted amount due on open accounts will be applied to other open balances or refunded upon approval of FAP application.

Depending on the age of a bill, CFH may refer a patient account to a Collection Agency.

Further detail on Billing and Collection procedures can be found in Appendix C.

Appeals Process

Any Financial Assistance Program discount determination made under this policy may be appealed in writing within 45 days of the denial letter date to Clifton-Fine Hospital Attention: Business Office; Financial Counseling 1014 Oswegatchie Trail Road Star Lake, NY 13690.

The Financial Counselor will review the application and any additional information provided, and escalate to the Director of Revenue Cycle or designee for a determination. If necessary the appeal will be escalated to Chief Financial Officer or designee on a case by case basis if determined necessary for further review. The reconsideration will be completed and communicated within 30 days of receipt of the request.

Implementation & Staff Training on Financial Assistance Program

Detail on CFH procedures regarding Financial Assistance, including training of staff, is illustrated in Appendix D.

Exceptions to this policy require CFO approval.

MONITORING:

REFERENCES:
New York State Public Health Law 2807-k
26 U.S.C. 7805 Section1.501(r) 1-6

Related Materials:

APPENDIX A

Financial Assistance Discounts and Patient Payment Detail

A patient whose household income, as determined by the application income worksheet, is equal to or less than 200% of the most recent Federal Poverty Guidelines qualifies for 100% coverage at CFH.

Sliding Scale Discounts
Patients whose household income is greater than 200% and less than 400% of the most recent Federal Poverty Guidelines, may qualify for a discount, whether uninsured or underinsured. The scale below illustrates the discounts

	Household Income Percentage of Federal Poverty Guidelines			
	0%-200%	**201%-225%**	**226%-250%**	**251%-400%**
CFH Medically Necessary Services (*For Uninsured)*	*100% discount of patient responsibility*	*40% discount of patient responsibility*	*20% discount of patient responsibility*	*Discounted to the Medicare Rate*
CFH Medically Necessary Services (*For Underinsured)*	*100% discount of patient responsibility*	*40% discount of patient responsibility*	*20% discount of patient responsibility*	*0% discount*

In compliance with the 26 CFR, Section501(r)(5)(b)(3), each hospital will calculate the Amount Generally Billed (AGB) based on Medicare claims for a 12-month period ending no earlier than 180 days prior to the beginning of the year it is utilized for. The AGB for Medicare Fee for Service claims was calculated based on prior year claims by dividing the Allowed Amount by the Total Allowed Charges for Inpatient and Outpatient claims.

For Uninsured Patients the calculation of the Medicare Amount Generally Billed (AGB) is calculated by multiplying Total Patient Charges by the following discount Percentage.

	AGB Discount to Medicare			
Inpatient Services	*50%*			
Outpatient Services	*48%*			

APPENDIX B

Financial Assistance Application and Information Required

Household Income Criteria and Verification

The evaluation of a patient's eligibility for the Financial Assistance Program discount will be based upon a combination of the patient's household size and income. Household size is the number of family members/persons occupying the same household who are identified as dependents.

Income is defined as annual earnings and cash benefits from all sources before taxes and deductions for the patient and anyone in the patient's defined household. Income will include wages, interest, dividends, rents, pensions, Social Security, VA benefits, unemployment benefits, workers' compensation, disability, child support, alimony and any other types of income that may accrue to the patient or any individual in the patient's defined household.

CFH may require that income be determined and verified by documentation or through the use of a self-attestation form. Income may also be determined by annualizing the pay of the patient and others in the patient's defined household, at the patient's current monthly earnings rate.

See the attached FAP Application.

APPENDIX C

Billing and Collection Efforts for Patients Applying for Financial Assistance Program

CFH will not send patient accounts, for which an application for a Financial Assistance Program discount is pending, to an external collections agency until CFH has rendered a determination on the pending application.

In some cases, a patient eligible for assistance under the FAP may not have been identified prior to initiation of external collections efforts. Patients whose accounts have been sent to CFH's outside collections agent may still apply for a Financial Assistance discount, providing the patient had not previously requested an application for the program, had not failed to complete a previous application

and/or had not had a completed application previously rejected. In the case of such late application for a FAP discount, the eligibility of the patient and the amount of any Financial Assistance discount for which the patient might be eligible will be based on the CFH Financial Assistance Policy and guidelines that were in effect on the date of service to the patient.

Installment payment plans may be established for patients who qualify for a Financial Assistance discount. Monthly installment payment will be capped at 10% of gross monthly income of the patient's defined household in accordance with NYS Public Health Law 2807-k. CFH prohibits the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill for hospital or employed physician services.

Any unpaid patient balances remaining 120 days after the first post-discharge billing statement will be referred to a collection agency. CFH will notify the patient in writing 30 days prior to sending an account to a collection agency. CFH will make every attempt to determine if a patient is eligible for Medicaid and bill accordingly. However, if a patient's Medicaid coverage validation is received past the Medicaid timely filing limit, CFH will cease all collection activity and close the account.

All collection agencies utilized by CFH will comply with this CFH Financial Assistance Program policy and have applications readily available should a patient wish to apply. If the collection agency decides to commence with legal action, written consent form CFH is mandatory.

APPENDIX D

I. Procedure for Implementation of the Financial Assistance Program Policy

The following describes the procedures followed regarding the implementation and management of the Financial Assistance Program policy:

A. Communication Methods of the Financial Assistance Program

1. *Posted Public Notices.* Notices regarding the CFH's Financial Assistance Program are posted throughout the Hospital and Medical Groups in key public access areas. Contents include a general description of the CFH Financial Assistance philosophy and program, together with instruction for how patients can access Financial Counselors to learn more about programs available and how to apply for these programs. In addition, a description of the Financial Assistance program is available on the Clifton-Fine Hospital website. Language used in the website material is in "plain language" format. In addition, material is available in Spanish, and patients who speak other languages are offered the opportunity to have the material translated.

2. *Publications Available for Patients.* Brochures describing the Financial Assistance Program

are available in all registration offices for ambulatory, emergency and inpatient areas of the Hospital and Medical Group sites. Information about the CFH Financial Assistance Program is described in the Hospital's admission booklet that is given to all patients admitted to an inpatient care unit.

Common language and information regarding availability of translated documents and multi-lingual interpretive services are featured in these publications. Information on how patient may inquire about financial assistance is printed on all bills and statements sent to the patient. If a patient account has been referred to a collection agency, the agency shall provide information to the patient on how to apply for Financial Assistance when appropriate.

3. *One-on-One Discussions.* Financial Counselors are available to interview uninsured inpatients and assist them in securing commercial, Medicaid or other insurance benefits to cover the cost of their care. When patients do not have insurance and do not qualify for public benefits, the Financial Counselor will explain the Financial Assistance Program to these patients and assist them in applying for discounted care.

B. Patient Access to the Financial Assistance Program

1. *Initial Contact*

Any patient may self-refer to a Financial Counselor to learn more about the Financial Assistance Program. The procedure for contacting the Financial Counselor is outlined in all published material, and Patient Access staff as well as Billing staff are trained on how to refer patients.

The Financial Counselor will make every effort to contact all uninsured patients admitted to the Hospital. They may access the patient's current insurance, identify any existing coverage and anticipate if patients will require additional financial assistance in order to pay for their health care services.

2. *Assessment for Financial Assistance*

A Financial Counselor is available to assist uninsured patient in conducting a financial assessment and in securing insurance for health care.

Through this process, if a patient appears to be qualified for Medicaid Insurance, the Financial Counselor will assist in applying for this public insurance program, if the patient wishes.

Patients who are unwilling to apply for Medicaid, or who do not comply with all application requirements in a timely manner may still be eligible for Financial Assistance discounts on a case by case basis review.

The Financial Counselor will inform the patient about:

a. The services covered by the Financial Assistance Program
b. Steps in the application process
c. The patient/family requirement to provide full and accurate financial information as a basis for determination, including pay stubs or required income documents *(assets are not considered in determining eligibility)*
d. The factors used in determining eligibility for FAP (including application to Medicaid, if applicable)
e. The sliding scale used to determine fee discounts for eligible patients
f. The process for a patient to request reconsideration of a Financial Assistance Program determination in light of additional information or change in circumstances
g. Patient responsibility for payment of the balance remaining after a discount is applied, including copays, deductibles and coinsurances
h. Samaritan Medical Center's billing and collections procedures

After all information is provided, patients are given the opportunity to decide if they wish to continue pursuing the Financial Assistance Program process.

Patients or their representatives who are unwilling to provide required documentation or comply with other aspects of the process are informed that they may not be eligible for FAP discounts and that they become immediately responsible for all Hospital charges related to their and/or their dependents care.

3. *Application Determination and Appeal Process*

Once a completed Financial Assistance Program application and all required documentation is received, a determination regarding the patient's eligibility is made within 30 days and if eligible, the amount of discount to which the patient is entitled. This information is communicated to the patient in writing and an updated bill with deductions is sent by billing.

A patient or responsible party may request reconsideration or an appeal of a Financial Assistance determination/denial if additional information is available that would change their status as outlined in the FAP eligibility guidelines.

The appeal can be made in writing to Clifton-Fine Hospital Attention: Business Office; Financial Counseling 1014 Oswegatchie Trail Road Star Lake, NY 13690. The reconsideration will be processed within 30 days of receipt of the request. A determination letter will be sent to the patient notifying them of the outcome of the appeal.

Definitions:

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

Bad Debt/Financial Assistance Distinction: Bad debts result from the ***unwillingness*** of a patient to pay, whereas financial assistance is provided to a patient with demonstrated ***inability*** to pay. Bad debt expense is reported on financial statements as an expense. Financial Assistance is neither reported as revenue nor as receivables.

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.

Elective: Those services that, in the opinion of a physician, are not medically necessary or can be safely postponed.

Emergency care: Immediate care that is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organ or body part.

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.

Financial Assistance Program: Financial Assistance (formerly known as charity care) is the policy describing how CFH will provide financial assistance at our hospital and facilities. This includes free or discounted health services provided to persons who meet our criteria for assistance and are unable to pay for all or a portion of the services.

Household Income: As measured against annual Federal Poverty Guidelines includes, but is not limited to the following:

- Annual household pre-tax job earnings
- Unemployment compensation

- Workers' Compensation
- Public Assistance
- Social Security and Supplemental Security Income
- Veteran's payments
- Pension or retirement income
- Interest, dividends, or royalties
- Other applicable income to include, but not limited to rents, alimony, child support, and any other miscellaneous source

Medically necessary service: A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.

Payment Plan: When the patient is unable to pay his or her portion of healthcare costs all at one time, CFH 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.

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 (most recent 8 weeks), Social Security benefit statements, pension statements, monthly benefit statements from all other income sources, if self-employed, an income attestation and cash flow statement.

Underinsured: Patients covered by a source of third-party funding, but at risk of high out-of-pocket expenditures due to their plan benefits package. This may include, but is not limited to, high deductible plans, high coinsurance/copay plans, low per diem policies, etc.

Uninsured: Patients who are not covered under an insurance health plan, Workers' Compensation, governmental plans such as Medicare and Medicaid, state/federal agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

- CFH extends discounts to those uninsured patients not otherwise covered in this policy by applying a discount to medically necessary services provided at the hospital. Exclusions include: non-employed physicians and the following elective services: cosmetic surgery.

APPROVAL:
Policy will be reviewed and approved at least every 2 years, unless otherwise stated in regulation or policy. Initial review, approval and revision details are documented below. Revision history will be updated below, however all future approval/review dates are electronically documented in MCN Policy Manager.

Approved by:

Name: Linda Sharrow, Business Office Supervisor	Date: 11/22/2022

Revision History:

Date	Description	Revised By
11/17/2022	Policy made and placed in CFH updated policy format	Destiny Law Executive Assistant
3/6/2023	Added reference to specify which providers follow the policy	Rodney Teribury, CIO