CHESHIRE MEDICAL CENTER
DARTMOUTH-HITCHCOCK • KEENE

# Free Care Policy

| Date: 07/2015 | Policy ID: 004 | Status: Active |
|---|---|---|

**I.** **Purpose**: To provide guidelines for the processing of financial assistance requests for patients and Patient Financial Services (PFS).

**II.** **Responsibility**: The Patient Financial Services Department is responsible for processing all financial assistance requests.

**III.** **Policy Scope:** For purposes of this policy, “financial assistance” requests pertain to the provision of healthcare services delivered by Cheshire Medical Center-Dartmouth Hitchcock Keene (CMC/DHK). This policy is limited to charges billed by CMC/DHK and does not include any physician, anesthesiologist or professional charges not billed by CMC/DHK such as those professional charges billed by the Dartmouth-Hitchcock Clinic.

**IV.** **Definitions:**

**Financial assistance** (also known as “Charity Care”) is the provision of healthcare services at no charge or at a discounted rate to individuals who meet established criteria.

**Family** is defined by the U.S. Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption.

- The state law regarding marriage or civil union and the federal guidelines are used to determine who is included in a family.
- In the case of applicants who earn income by caring for disabled adults in their homes, the disabled adult will be counted as a family member and their income included in the determination.
- The Internal Revenue Service rules that define who may be claimed as a dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

**Family Income** is calculated using the federal poverty guidelines which are based on:

- earnings, unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- noncash benefits (such as food stamps and housing subsidies) do **not** count;
- pre-tax income;
- capital gains or losses evaluated on a case by case basis; and
- the income of all family members (Non-relatives, such as housemates, do **not** count).

An **uninsured patient** has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

An **underinsured patient** has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial ability to pay.

**Gross Charges** are the total charges at the organization's full established rates for the patient’s healthcare services

**Emergency medical conditions** are defined by section 1867 of the Social Security Act (42 U.S.C. 1395dd) as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

- serious impairment to bodily functions, or

- serious dysfunction of any bodily organ or part, or

- with respect to pregnant woman:
    - That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

**Medically necessary** is defined as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve functioning.

## V. Policy Statement:

All patients have the ultimate responsibility for the payment of their medical bills. A financial responsibility statement will be signed upon admission to certify recognition of this fact. However, there are instances where a patient, due to the lack of funds or third party coverage, will not be able to meet this obligation. CMC/DHK is committed to providing care to patients regardless of their ability to pay. Although it is recognized that the financial solvency of the Medical Center requires the recovery of operating expenses by charging for services provided, CMC/DHK recognizes our legal and ethical obligation to cover uncompensated care from endowment income in order to meet our designation as a tax-exempt organization.

CMC/DHK provides care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay or eligibility for financial or government assistance. Services are provided regardless of age, gender, race, social or immigrant status, sexual orientation, disability, or religious affiliation. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), no patient shall be screened for financial assistance or payment information prior to the rendering of services for emergency medical conditions.

As a general rule, CMC/DHK does not routinely discount charges for health care items or services, nor routinely grant a waiver of a patient’s co-payment and/or deductible. With this policy, CMC/DHK intends to establish the appropriate procedures for the limited circumstances in which a discount, compliant with all federal, state or local laws, might be appropriately offered to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care or emergency medical conditions based on their individual financial situation.

CMC/DHK does not provide financial assistance for purely elective services or patient convenience. The determination of which services are considered elective resides solely with CMC/DHK. Examples of services that are ineligible for financial assistance are set forth on **Exhibit F** (Services Not Covered Under Financial Assistance) as updated by CMC/DHK from time to time in its sole discretion.

CMC/DHK will not impose extraordinary collections actions such as wage garnishments, leins on primary residences or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance.

## VI. Requirements & Procedures

### A. Referral to Patient Financial Services

All patients who are unable to pay their medical expenses will be encouraged to apply for financial assistance and referred to PFS for an application and instructions.

### B. Financial Assistance Application Process

As part of the financial assistance application process, CMC/DHK shall assess each patient's eligibility for health insurance coverage through federal or state programs such as New Hampshire Medicaid or the health insurance marketplace exchanges to ensure exhaustion of all other sources of reimbursement prior to approval of financial assistance. If eligible for coverage under one of these programs, PFS at CMC/DHK will assist the patient with the application process.

CMC/DHK utilizes the New Hampshire Health Access Network's (NHHAN) income guidelines (**Exhibit A**) to determine a patient's ability to meet their financial obligation. Patients who do not meet the income guidelines for NHHAN or who cannot produce all NHHAN documentation are reviewed on a case by case basis to determine eligibility for financial assistance according to CMC/DHK's internal financial assistance guidelines. (**Exhibit B**- CMC/DHK Income Guidelines).

In order to be considered for financial assistance, the patient or their representative will work with a PFS representative to complete and sign a financial assistance application (FAA) similar to the one found on **Exhibit C** (NHHAN Application Form) and provide information and documentation that supports their financial need.

In certain circumstances, CMC/DHK does not require the FAA form to be completed:

1. NH Health Access Network approval has been granted by another hospital.
2. CMC/DHK accepts NH Medicaid's eligibility determination. Should Medicaid coverage become inactive, the patient will be required to complete a FAA form.
3. The patient is considered presumptively eligible for financial assistance based on their income alone under the CMC/DHK Income Guidelines (**Exhibit B**).

C. Determination of Eligibility for Financial Assistance based on FAA Form

The Manager of Patient Financial Services has the authority to make a determination of a patient's financial assistance eligibility according to the documentation available from patients. If, upon review, information is missing from the FAA form, PFS shall contact the patient or their representative and request that additional information be provided. Eligibility for financial assistance may be determined by CMC/DHK at any time upon receipt of all information needed to determine a patient's eligibility for CMC/DHK's financial assistance programs.

In reviewing the application, consideration is given to the following factors:

1. All means of payment, including government and non government programs, available must be applied for and exhausted. A determination may be based on a patient's ability to pay insurance premiums on some or any of the following plans or programs:
    a. Medicare
    b. Medicaid
    c. Marketplace Plans (Affordable Care Act)
    d. Catastrophic Illness Programs
    e. Vocational rehabilitation
    f. Veterans Programs
    g. Other programs that may become available.
2. Local charitable or endowment funds must be applied for.
3. All third party coverage must be exhausted (e.g., coordination of benefits issues).
4. Residence. Does the patient reside in a community serviced by CMC/DHK (see **Exhibit E**- CMC/DHK Service Area). If not, is the care required not otherwise available in the patient's community?
5. If the patient is a non-resident, did the care result from an emergency situation while in a community served by CMC/DHK?

The application is reviewed for gross income and asset levels in comparison to the FPL to determine if the patient qualifies for a partial or full reduction (see, Asset Considerations chart in Section VII). The patient may not qualify because their assets and/or gross income exceed guidelines. In these cases the following applies:

- When income is less than three times the FPL, but assets exceed one hundred percent of FPL, the bill will be capped at ten percent of the assets after the sheltered amounts are subtracted.
- When income is greater than three times the FPL, the bill will be capped at ten percent of twenty-four months of gross income.
- If the patient/family has assets over three times the FPL, their responsibility will be a minimum of ten percent of the assets over the sheltered amount, plus ten percent of 24 months of income.
- When a patient between the ages of 55 and 78 disqualifies based on liquid assets, the assets are divided by 60 months and this amount is added to the existing monthly gross income. This new total is used to determine if the patient now qualifies or not.

D. Determination of Eligibility for Financial Assistance based on Individual Circumstances

The following categories of patients are reviewed on a case by case basis to determine eligibility for financial assistance:

i. Patients who have not applied for Medicare Part B benefits or for insurance through the affordable care marketplace must demonstrate a financial hardship in order to be exempt from this requirement. These patients will be assessed on an individual basis.

ii. Patients for whom CMC-DHK does not have a completed FAA form on file because the patient refuses to complete the form, provide supporting documentation, or is non-responsive to follow-up requests from PFS. These patients are assessed on a case by case basis taking individual life circumstances into account, such assessment of circumstances is documented by PFS.

E. Approval.

Once approved, PFS shall issue a financial assistance approval letter to the patient.

Patient balances classified as charity care will be approved for 1 year prior to the approval date and 6 months greater for future service dates. Patients with a high deductible of >$1,000 with no contractual adjustment will be eligible for a 42% reduction from charges owed to CMC/DHK until they have met their deductible.

Authority to approve financial assistance is as follows:
- Manager, PFS >$1,000
- Director, PFS>$10,000
- CFO >$25,000
- President >$50,000

If financial assistance is awarded based on current employment status, the application will be reviewed in 6 months. If the patient is a Social Security beneficiary and income is fixed, the application will be reviewed annually.

## VII. Asset Considerations

- Savings and CD's are sheltered up to 100% of FPL based on family size.
- The first $ 100,000 of retirement funds (that hold penalties and specific timeframes to access) are excluded from the asset calculation. Any other funds will be considered savings and be subject to the sheltering rule for savings.
- A home equity allowance is applied of up to $200,000 for those under age 55 and up to $ 250,000 for those age 55 and older. (NH Health Access Network guidelines allow $150,000 for those under age 55 and up to $ 200,000 for those age 55 and older.)
- Patients may pay their portion of the medical bill over a 24-month period. Exception to this time frame may be made by the Free Care Committee.
- In cases where the patient is unable to provide documentation to complete the application or cannot be located, the application information, a credit report and scoring the account(s) for

collectability is applied. If these avenues indicate low collectability then the account will be presumed charity and will be adjusted accordingly, otherwise it will move to bad debt.

## VIII. Financial Assistance Denials & Appeals

If a patient does not qualify for financial assistance under NHHAN or CMC-DHK's internal financial assistance guidelines but the individual has a large balance (e.g., $10,000 or more for a single episode of care), PFS shall assist the patient with completing the Catastrophic Charity Care Worksheet (**Exhibit D**) to determine whether financial assistance is available for the episode of care.

Patients /legal representatives who are denied financial assistance may request an appeal by calling the Patient Financial Services office phone number listed in the denial letter. The PFS Manager will request a written appeal letter; however, this requirement may be waived if the patient is unable to comply. Additional supporting documentation will be reviewed, if available. Should the Manager of PFS determine that the denial continues to be warranted, and the patient/legal representative continues to disagree, the final determination will be made by the Free Care Committee, comprised of the Chief Financial Officer, the Controller, the Manager of Patient Accounts and the Director of Patient Financial Services. A clinical leader from the patient's Primary Care (or other provider's) office will be consulted in making the determination. The decision of this Committee is final, although the patient/legal representative will be encouraged to reapply should circumstances change.

## IX. Communication Regarding the CMC/DHK Financial Assistance Policy to Patients and the Community

- Referral of patients for financial assistance may be made by any CMC/DHK staff member or agent including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

- Information regarding financial assistance from CMC/DHK is:

  i. on the CMC/DHK website,
  ii. posted in patient care areas,
  iii. available on Information Cards and brochures in the registration and admitting departments,
  iv. available in other public spaces as determined by CMC/DHK,
  v. provided in the primary languages spoken by the population serviced by CMC/DHK; translation services are utilized as needed.

**References**: NH RSA 358-C; NH RSA 151:12; 26 U.S.C. § 501(r). **Revision**: 07/01/2015 **Next**

**Review Date**: 07/01/2017

Exhibit A: NH Health Access Network Sliding Fee Schedule

Exhibit B: CMC/DHK Financial Assistance Guidelines

Exhibit C: NH Health Access Network Application Form

Exhibit D: Catastrophic Charity Care Worksheet

Exhibit E: Service Area

Exhibit F: Services not covered by financial assistance.