Dartmouth-Hitchcock

Policy Title:	Financial Assistance for Healthcare Services Policy	Policy ID:	179
Keywords	patient financial assistance, charity care, needed services, NSA, Excluded, Financial Assistance Exclusions, FAA		

I. Purpose of Policy

To establish a policy for the administration of Dartmouth-Hitchcock (D-H) and Cheshire Medical Center's (CMC) financial assistance for healthcare services program. This policy outlines the following with respect to all emergency or other medically necessary care provided by all D-H/CMC facilities:

- eligibility criteria for financial assistance
- method by which patients may apply for financial assistance
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care, and
- D-H/CMC's measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be changed from time to the extent required by applicable law.

II. Policy Scope

This policy applies to any D-H/CMC provider working in any D-H/CMC facility responsible for providing emergency and any other medically necessary care and billed by D-H/CMC provider.

For purposes of this policy, "financial assistance" requests pertain to the provision of emergency and other medically necessary care provided in any D-H facility by D-H or any provider employed by D-H.

III. Definitions

Financial assistance (also known as "charity care"): The provision of healthcare services free or at a discounted rate to individuals who meet the criteria established pursuant to this Policy.

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.

Presumptive financial assistance: The provision of financial assistance for medically necessary services to patients for whom there is not a completed D-H/CMC Financial Assistance Form due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), and parents claimed on adult child's claim on a tax return.

Family Income: As defined under the federal poverty level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services 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;
- the income of all family members (non-relatives, such as housemates, do **not** count).

Uninsured patient: A patient with no insurance or other third-party source of payment for his/her medical care.

Underinsured patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay in as determined according to this Policy.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Emergency medical conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), 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
- serious dysfunction of any bodily organ or part
- with respect to a pregnant woman:
    - inadequate time to effect a safe transfer to another hospital before delivery
    - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Medically necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Elective: Healthcare items or services which are not considered medically necessary.

Financial Assistance Exclusions: Services, which are not considered medically necessary or are considered elective. This policy applies to care provided in any D-H facility by D-H or any provider employed by D-H. In addition, providers may provide care in D-H space as part of a non D-H entity. These service are not covered by the D-H/CMC Financial Assistance policy.

IV. Policy Statement

Dartmouth-Hitchcock (D-H) and Cheshire Medical Center (CMC) are committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay for services or balances that are their responsibility. D-H strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided, including after an account has been referred to an outside collection agency.

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

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with D-H/CMC procedures for obtaining financial assistance or other forms of payment, 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 are required to do so, as a means of ensuring access to health care services, for their overall personal health, and for the protection of their individual assets.

D-H/CMC will not impose extraordinary collections actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Chief Financial Officer. For information on actions D-H/CMC may take in the event of nonpayment, please refer to our credit and collections policy. Copies of the Credit and Collection Policy is available online or can be requested at the Patient Financial Services Offices or can be mailed to you by calling 844-808-0730.

A. Eligibility Criteria for Financial Assistance. In order to qualify for financial assistance under this Policy, a patient must meet the following criteria:

- Be a resident of NH or VT, or a non-resident who receives emergency treatment at D-H/CMC.

- Be uninsured or underinsured, ineligible for any government health care benefit program, and unable to pay for their care as outlined in the Credit and Collections Policy, based upon a determination of financial need under this Policy.

- Have Gross Family Income, inclusive of all members of the patient's household, during the past 12 months of less than 300% of FPL.

- Have Family Income exceeding 300% of FPL and aggregate balances owed for services performed at D-H/CMC in excess of 10% of 2 years Family Income, plus 10% of the value of household assets in excess of sheltered amounts (as described below).

- For purposes of determining value of assets, assets include, but are not limited to: savings, alimony, certificates of deposit, IRAs, stocks, bonds, 401Ks, and mutual funds. In calculating the amount of assets for purposes of qualifying a patient for charity above:

    - Savings (which includes savings accounts, alimony, or certificate(s) of deposit) are sheltered up to 100% of FPL

    - Retirement accounts (which includes IRAs, stocks, bonds, 401Ks and mutual funds) are sheltered up to $100,000, equity in a primary residence is sheltered up to $200,000 for applicants up to age 54, and equity in a primary residence is sheltered up to $250,000 for applicants age 55 or older.

    - When dividends are noted on a tax return, the source of the dividends will be requested along with a recent market value statement.

    - Documentation of all trust fund payments and ability to access funds is required.

- Demonstrate compliance with the requirements to apply for qualified health plan coverage the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs. Exceptions to this requirement may be approved by senior leadership for good cause on a case-by-case basis. "Good cause" will depend on facts and circumstances, and may include:

    - Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.

    - Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this Policy, such patients may nevertheless be considered for eligibility for presumptive financial assistance.

B. Method by Which Patients May Apply for Financial Assistance

1. D-H/CMC will explore alternative sources of coverage and/or payment from federal, state, or other programs and assist patients in applying for such programs. With respect to any balances remaining after such other sources have been exhausted, D-H/CMC will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:
    - A patient or guarantor is required to submit an application on a form approved by D-H/CMC management, and provide such personal, financial, and other information and documentation as required for D-H/CMC to determine whether such individual qualifies for assistance, including, but not limited to, documentation to verify Family Income and available assets or other resources. If D-H/CMC is unable to obtain an application or any required supporting documentation from the patient or the patient's guarantor, D-H/CMC may consider whether the patient is eligible for presumptive financial assistance.
    - In lieu of an application and supporting documentation from the patient, staff may use any of the following to support a recommendation for approval of a financial assistance application:
    - D-H/CMC may utilize one or more vendors to screen individuals for eligibility using publicly available data sources that provide information on a patient's or guarantor's capacity and propensity to pay.
    - Current eligibility for Medicaid.
    - Current statement from a Federal or State housing authority.
    - Verification from a homeless shelter or a Federal Qualified Health Center.
    - Verification of incarceration with no source of payment from the correction facility; or
    - For an individual patient, a patient's verbal attestation of income and assets, in lieu of a written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than $1,000.

2. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies to all balances for which the patient has applied for charity, in addition to emergency and other medically necessary care provided for a period of time, dates of service prior to receipt of the financial assistance application, including balances placed at a collection agency, and any services provided before or on the expiration date listed on the acknowledgement letter as long as the service is not listed below. After that time, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known, D-H/CMC will re-evaluate the individual's financial need in accordance with this Policy.

   D-H/CMC recognizes decisions made by the following assistance programs without requesting copies of applications. D-H/CMC reserves the right to accept or deny decisions made outside D-H/CMC guidelines made by the organizations listed below. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

- NH Health Access Network Card for insured patients only
- Good Neighbor Health Clinic
- Manchester Community Health Center
- Nashua Area Health Clinic
- Mobile Community Health
- Teen Health Clinic
- Current Medicaid eligibility if not retroactive to cover past services
- Deceased patient with no estate (as confirmed by executor or state)

3. It is the goal of D-H/CMC to process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application.

4. **Appeals Process**: If D-H/CMC denies partial or total financial assistance then the patient (or his/her agent) can appeal the decision within 30 days. The patient must write a letter to the Director of Eligibility and Enrollment to explain why the decision made by D-H/CMC was inappropriate. The appeal letter will be reviewed by D-H/CMC and a final decision will be sent to the patient within 30 days of the receipt of the request for appeal.

C. Determination of Amount of Financial Assistance

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied. See D-H/CMC Uninsured Patient Discount Policy: Revenue Management Division (linked below)

If an individual is approved for financial assistance, the amount of such assistance to be provided for applicable care will be as follows:

- Family income at or below 225% of FPL will receive 100% financial assistance
- Family income between 226% - 250% of FPL will receive a 75% discount
- Family income between 251% - 275% of FPL will receive a 50% discount
- Family income between 276% - 300% of FPL will receive a 25% discount.
- As discussed above, patients whose family income exceeds 300% of FPL may be eligible to receive a discount based on the self-pay balance. Discounts will be granted such that the total self-pay bill does not exceed 10% of 2 years' gross income, plus 10% of assets in excess of the sheltered asset calculation described earlier in the Policy. Any discounts other than those described above must be approved by the Financial Assistance Appeals Committee based on a written appeal from the patient or responsible party.
- Patients meeting criteria for Presumptive Financial Assistance, will receive 100% financial assistance.

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Dartmouth-Hitchcock applies a discount against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay. The discount is based on the "prospective Medicare" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any

financial assistance adjustments. This discount doesn't apply to any copayments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

For fiscal year 7/1/2017-6/30/2018, the following discount rates apply:
Dartmouth-Hitchcock Clinic 62.8%
Mary Hitchcock Memorial Hospital 62.8%
Cheshire Medical Center 64.7%

Presumptive Eligibility for Financial Assistance:
D-H/CMC may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for Dartmouth-Hitchcock.

Information from the predictive model may be used by D-H/CMC to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Presumptive financial assistance is not available for balances after Medicare.

Presumptive screening is used, without respect to outstanding balance, on accounts greater than 120 days after statements and notices to collect the debt and prior to referral of the account to an outside collection agency to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application. Probate accounts that have exceeded time limits are eligible for presumptive screening.

Refunds:
If a patient has paid an outstanding balance and subsequently submits a competed Financial Assistance Application which is approved for financial assistance through the application process, the hospital will refund any amount the individual has paid for the care.

D. Communication Regarding the D-H Financial Assistance Policy to Patients and Within the Community

- Referral of patients for financial assistance may be made by any D-H/CMC 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 D-H/CMC, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning D-H/CMC's patient collection policies and procedures, will be available to the public and to D-H/CMC patients through at least the mechanisms described below:
  - On the D-H/CMC website,

- Posted in patient care areas,
- Available on Information Cards in the registration and admitting departments,
- Available in other public spaces as determined by D-H/CMC,
- Provided in the primary languages spoken by the population serviced by D-H/CMC; translation services are utilized as needed.

- If the balance is approved, the patient is sent a letter indicating approval.

E. Assistance in Completing the Applications

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock Medical Center	Dartmouth-Hitchcock Concord	Dartmouth-Hitchcock Manchester	Dartmouth-Hitchcock Nashua	Dartmouth-Hitchcock Keene
One Medical Center Drive	253 Pleasant Street	100 Hitchcock Way	2300 Southwood Drive	580-590 Court Street
Lebanon, NH 03756	Concord, NH 03301	Manchester, NH 03104	Nashua, NH 03063	Keene, NH 03431
(603) 650-8051	(603) 229-5080	(603) 695-2692	(603) 577-4055	(603) 354-5454 ext: 4444

You will continue to be financially responsible for any services you receive until you r completed application is received.

Additional options can be obtained through New Hampshire Health Access Network (https://www.healthynh.com/nh-health-access-network.html)

F. Financial Assistance Appeals Process

- If the balance is not approved, the patient will be sent a denial letter or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction.
- A committee of three D-H Leaders not involved in the original process will review the appeal and make recommendations on all denial appeals.

G. Charity Determination Levels

- Approval levels are as follows:

Position	**Dartmouth-Hitchcock**	**Cheshire Medical Center**
Vice President/CFO/President	>$350,000	>$100,000
Director Revenue Management	>$50,0000	>$50,0000
Director – Conifer	Up to $50,000	Up to $50,000
Manager – Conifer	Up to $5000	Up to $5000
Supervisor – Conifer	Up to $1000	Up to $1000
Account Rep – Conifer	Up to $500	Up to $500

H. Financial Assistance Exclusions-Services

A. Special Considerations

- The below medical procedures are not meant to be all inclusive.
- Non-medically necessary services, as deemed by the Provider could be excluded.
- All best efforts will be made to inform the patient prior to service of any new treatments not covered under the Financial Assistance Program.

B. Elective Cosmetic Procedures (not covered)

- Bariatric Surgery
- Breast Capsulectomy w/implants
- Mastpexy (Breastlift)
- Gynecomastiz (Male Breast Removal)
- Mastectomy (Transgender or cosmetic)
- Ryhtidectomy (Face Lift)
- Blepharoplasty (Eyelids)
- Brow Lift (fat/wrinkles on forehead)
- Augmentation Mammaplasty (breast implants)
- Reduction mammaplasty (breast reduction if not covered by insurance)
- Rhinoplasty (nose)
- Dermatology Procedures
- Abdominoplasty (tummy tuck)
- Lipectomy of any kind (liposuction) - can also be listed as removal of excess skin or fat which is not deemed a medical necessity

  Note: Above procedures are usually screened and identified by the Financial Information Coordinators

C. Artificial Insemination

- Microreanastomosis (tubal reversal)
- Vasovasostomy (vasectomy reversal)
- Laparoscopy for treatment of infertility (IUI - IVF - GIFT Programs)
- Infertility treatment - need to research: is it diagnostic or treatment of

D. Other

- Acupuncture
- Chiropractic Services
- Hearing aids and repairs
- Eye glasses
- Massage therapy
- Pharmaceuticals-prescription and over the counter medication
- Travel Clinic
- Blood Cord Study
- Gender disorder
- Retail Sales
- Services provided by Renaissance Psychiatry of New England, LLC

E. Manchester and Nashua Divisions Only

- **Routine Eye Exams**
  - Only covered if determined to be medically necessary and/or there is an underlying medical condition.
  - In cases where these conditions do NOT exist the scheduler will inform the patient that financial assistance will not apply.
  - Keene and Lebanon Opthamology write these off

F. Exemptions

A. Some services fall under the elective and not medically necessary category, may be covered under the D-H/CMC Financial Assistance Policy for all or some services related to the episode of care.
B. Policies and procedures will be outlined for known services and maintained by the Patient Access Resource Team.
C. These will be reviewed annually for needed revisions.
D. Individual cases will be reviewed by Patient Access leadership and the Vice President of Revenue Management for approval of the exception.

I. Financial Assistance Exclusions – Non D-H Providers

- Cheshire – Radiology Associates of Keene
- Cheshire-Surgicare Medical Equipment
- Cheshire-Monadnock Family Services
- Manchester – Foundation Medical Partners
- Manchester – Amoskeag Anesthesia
- Manchester – Dietician Services
- Manchester-Alliance Health Services/Catholic Medical Center
- Bedford- Alliance Health Services/Catholic Medical Center
- Nashua – Greater Nashua Mental Health Center (Social Worker)
- Nashua – Nashua Anesthesiologist Group
- Nashua – St. Joseph's Hospital (PT/Rehab Services)
- Concord – Riverbend Community Mental Health
- Concord-services provided Concord Hospital
- Lebanon-Orthocare medical equipment

V. References N/A

Responsible Owner:	Finance Division Corporate	**Contact(s): email**	Kimberly Mender
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Related Polices & Procedures:	Uninsured Patient Discount Policy: Revenue Management Division Credit and Collections Policy Budget Payment Policy		
Related Job Aids:			