NY DOWNTOWN HOSPITAL
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

TITLE: CHARITY CARE POLICY

EFFECTIVE: 01/01/2007 updated January 2010

1. Policy

All low income, uninsured patients who live in the hospital’s primary service area will have an opportunity to apply for financial assistance for emergent & non emergent services based on financial need. All low income, uninsured residents of New York State, but outside the hospital’s primary service area will have an opportunity to apply for financial assistance for emergent services, including EMTALA transfer patients. Eligibility for this program is based on the patient’s willingness to provide appropriate financial documentation, as well as the patient’s cooperation to apply for Medicaid, and other insurance programs.

I. Overview

A. Statement of Purpose

The NY Downtown Hospital has a thorough process for the financial evaluation of all patients with questions about their ability to pay for care. The primary objectives of this process are to:

- Maintain respect and compassion for our patient and their families
- Assist patients in accessing government and other insurance programs
- Assure the NY Downtown Hospital of the collection of appropriate reimbursement for the services it provides to patient, and
- Ensure patients have appropriate access to care.
- Provide clear information regarding the policy.
- Consistently apply this policy to all patients.
- Comply with all applicable laws, rules and regulations.

In those instances where there is a lack of insurance, and/or financial resources, the evaluation process then focuses on the services to be performed and whether or not the NY Downtown Hospital is in a unique position to provide those services. In addition, there are many instances where the verification of insurance and financial resources cannot be completed prior to making a decision as to whether or not to provide services to a patient. Again, in those instances, the NY Downtown Hospital evaluates the urgency of the medical need and its level of severity before rendering an opinion about providing services.

In all instances where the NY Downtown Hospital determination is that services should be rendered without regard to ability to pay, those services are provided. EMTALA standards for care of patients presenting to NYDH for emergency care, serve as the baseline for these decisions in emergency cases. The definitions of urgent, emergent, elective, waiting list patients are included in the Administrative Policy Manual under “ADMISSIONS - CLASSIFICATION OF PATIENTS”. During the provision of those services, and subsequently, the NY Downtown Hospital will continue to pursue its right to payment for those services if resources can be identified. However, often this process results in uncompensated care.

On an annual basis NYDH must accurately document charity care services provided to its patients, and distinguish these accounts from bad debt, or uncollected sums for services to those unable or unwilling to pay. In order to evaluate each case against criteria and accurately record the amount of charity care, the development of fair, consistent, and reasonable policy and procedures to support our objectives is required.
B. Accountability

The Charity Care Committee, chaired by the Director of Continuum of Care and reporting to the Chief Nursing Officer, administers the Charity Care policy. Representatives of Patient Financial Services, Administration, and Finance sit on this committee.

The committee is accountable to the NYDH Board of Trustees, through the Chief Executive Officer and Patient Financial Services, for developing, reviewing, implementing, and documenting the decisions of the committee and the charity care provided. This information is reported as necessary to external agencies, including the New York State Department of Health. NYDH will not take any action under this policy that might inhibit the hospital's compliance with their obligations under the Emergency Medical Treatment and Labor Act (EMTALA).

C. Regular re-evaluation of policy

The committee will review this policy, and any procedures and criteria developed in accordance with it, at least every two years.

II. Scope of Charity Care & Financial Aid provisions

A patient or family member of a patient may apply for financial relief for payment for any inpatient and outpatient services provided by NY Downtown Hospital. This policy does not cover discretionary charges (such as for private rooms, private duty nurses, telephone or television services.) For those low income, uninsured patients who reside in the hospital's primary service area, emergent & non emergent services are eligible, for financial assistance. For those low income, uninsured patients who reside in the State of NY, and are outside the hospital's primary service area, only emergency services are covered, as outlined in the statement of purpose.

A. When is the need for financial relief identified?

The need for financial relief may be identified

- During the pre-admission (inpatient) or pre-registration (outpatient) process, when the patient's coinsurance (co-payments and deductibles) and/or self-payment responsibilities are identified.
- At the time of admission
- During a hospitalization or episode of care
- During the process of providing recurring care
- During the process of billing or collections

The patient may request a referral for charity care, for government insurance programs (such as Medicaid, Child Health Plus, and Family Health Plus), for a discount on their payment responsibilities, or for a plan to pay over time. Any of these requests will trigger a referral to the Financial Counseling Office in the Credit and Collections Department. At any time, NYDH staff involved in billing, registering, or providing care may refer a patient or their family, when their ability to pay for care planned or NYDH or after discharge, is in question. All self-pay patients should be carefully evaluated as early in the pre-admitting process as possible to determine if a referral for Financial Counseling is needed.

This policy does not place a stringent timing requirement for the determination that the patient is eligible for charity care. This policy does, however, encourage early identification of eligible patients, as the most reliable information is more likely to be obtained before or during a
patient's stay. The identification of potential charity care cases should be made as early in the admission process as possible to minimize the allocation of unnecessary resources further in the cycle, ensure proper coding of charity care, and provide notice to Patient Financial Services such that the accounts receivable is not infested. Collection efforts can also yield critical information about the amount of charity service for which a patient is eligible. These efforts, including the use of outside collection agencies, are part of the information collection process and may appropriately result in a determination that a patient is eligible for charity services.

B. What forms of aid are available?

a. Application for insurance programs

   i) Medicaid, Child Health Plus, family Health Plus, or other options. Any patient or family member applying for financial relief must be evaluated for government insurance programs or other insurance options. Any applicant for financial relief must complete all paperwork and documentation requested to determine eligibility for those programs.

b. Charity Care Scale

   i) NYDH has developed a sliding scale, up to 300% of the latest federal poverty guide, based on documented ability to pay: income, family size, assets, liabilities & extenuating circumstances, to allow patients in need of financial relief to pay a percentage of Medicare reimbursement based on their ability to pay. The maximum fee is capped at Medicare reimbursement, using APC's, and fee schedules for outpatients, and DRG's for inpatients. This maximum fee is based on those low income uninsured patients who meet the financial aid criteria & have income of 250% to 300% of the Federal Poverty guidelines. For those low income, uninsured patients who meet the financial aid criteria, and have income below 250% of the federal poverty guideline, their charge is calculated on a percentage, ranging between 20% and 75% of the Medicare reimbursement. For those patients who's incomes are below the Federal Poverty Guidelines, per the NYS Public law, Chapter 57, Subdivision 9a to Section 280-k, paragraph b, the NOMINAL GUIDELINES APPLY. The current scale is available through the Credit Office. In addition to the objective measured incorporated into the sliding scale schedule, the Charity Care Committee may determine the application of this scale to patients presenting extenuating circumstances affecting their ability to pay, but with significant assets. Patients who have an income less than or equal to 150% of the federal poverty guidelines, but have significant assets, need approval from the Commissioner of health.

   ii) Assets may be considered in determining the charity care scale, excluding the following: patient's primary residence, tax deferred or comparable retirement savings accounts, college savings accounts, cars used regularly by the patient or the patient's immediate family.
c. Payment plans over time

i) Patients and family members may negotiate a plan to pay their balance over a period of months. Monthly payment is capped at 10% of the patient’s gross income. Assets may also be considered in addition to this cap.

ii) Interest is capped at the rate for a 90 day treasury security plus 0.5% and no accelerator clause which triggers higher payment if payment is missed.

iii) A payment plan may be negotiated with Credit and Collections Department during the pre-admission or pre-registration process, up to the time of discharge. The plan will be documented, noted in computerized and written financial systems, signed by the patient or legal representative, and submitted immediately to Patient Financial Services for their records.

iv) A payment plan may be negotiated with Patient Financial Services at any time during the collection and billing process after discharge, or as needed during a course of recurring care. The plan will be documented, noted in computerized and written financial systems, and signed by the patient or legal representative.

C. Referral from other facilities

a. Referrals from Non-Affiliated Hospitals

Tertiary referrals and/or transfers to NYCH from non-affiliated hospitals should also be recorded by the Admitting Department upon admission to ensure that this information is noted in the financial record, and in hospital information system, should the patient become a candidate for charity care eligibility.

b. Approval Process for Referrals from Affiliated & Non-Affiliated Hospitals

For elective admissions and transfers from other hospitals in which a potential need for charity care of financial relief is identified, review with Senior Hospital Administration should occur prior to admission.

III. Procedure for Applying & Determining Eligibility

A. Who, where, when

Implementation of this policy directly involves the departments of Continuum of Care, Admitting, Credit and Collections and Patient Financial Services. These guidelines primarily address the process of gathering information, and evaluation a patient's ability to fulfill their financial obligation to the hospital. Accordingly, information from referral sources (physicians, nurses, and therapists) should be used to form an opinion and this should be corroborated with data gathered during the ordinary course of business. Although the guidelines to recommend a case for eligibility under this policy. Each case will, however, received appropriate review as noted below.

The application process begin when the patient, family member, or other legal representative.
i) Meets with the Credit Office, located on the main floor (212-312-5104) The office is available Monday - Friday, from 9 AM through 5 PM, or

ii) Meets or communicates directly with Patient Financial Services about the need for charity care or financial relief.

Any patient or their representative seeking charity care or financial relief shall provide the hospital with any and all financial and other information needed to determine eligibility for charity care or financial relief. If the patient or representative does not cooperate with a timely application process or provides false information or conceals relevant facts during the application process, they may be found ineligible for any charity care or financial relief, other than emergency services and any stabilizing treatment necessary.

B. Identification and Verification of a Patient's Ability to Pay

The guidelines have four principal objectives as follow:

- Identification and verification of a patient's ability (inability) to contribute in whole or part for their care
- Identification and/or estimation of costs of services required
- Evaluation of Charity Care cases
- Review and approval of charity services

a. Patient Access

Upon review of exceptions to admitting policy, the Continuum of Care will notify the Credit Office, Admitting and Patient Financial Services (via telephone, e-mail, notification on HIS, and by reports and patient financial folder) that a patient was admitted as an exception, and may ultimately not be able to pay. In some cases, the need for charity care may be apparent resulting in an appropriate financial class change by communicating the information directly to patient Financial Services.

Methods of capturing and reporting this information may include:

1. Pre-Admitting/Pre-Registration units (for Inpatient & Day Surgery) will refer patients to the Credit Office who are admitted as self-pay patients or with co-insurance they are unable to pay before or upon admission.
2. ED Access will refer to the Continuum of Care and Credit Office, patients who are admitted from the Emergency Department as self-pay patients or with co-insurance they are unable to pay before or upon admission.
3. Transfers from other health care facilities will be referred to Continuum of Care by an Admitting Supervisor if they are self-pay patients or with co-insurance they are unable to pay before or upon admission.

Patient Registration will work with patients whose access to care may restricted by ability to pay, by counseling them about immediate options for care, by giving them written information about options for insurance though their state agencies, and by referring them to Social Work for further evaluation and referral when possible.

Once a decision about eligibility for charity care, and the specific arrangements made for a patient who remains under NYIHI's care, Patient Registration will ensure that the financial record is updated and any balance due is collected.

b. Continuum of Care

Many cases will require further information, and an evaluation of the patient's ability to pay by Continuum of Care while a patient is in-house should be performed. If not
possible, an evaluation may be performed after discharge by Social Work or Social Work may refer to Patient Financial Services and/or Credit and Collections for an evaluation, depending upon what charity care to form an opinion of the patient's ability to pay. This should be performed through routine interview, or as necessary, responding to an alert referral from any source. Typically, information arises from:

- Patient Registration as described above; or
- Patients that disclose financial difficulties; or
- Responses to high risk questionnaires (HIS screen); or
- Referrals from physicians, nursing and therapists.

Those patients who have a household income below 200% of the Federal Poverty Level should automatically be evaluated for charity care.

A recommendation specifying eligibility for charity care services should be sent to the Charity Care Committee along with documentation. In all cases, Social Work will assess the patient's financial ability to pay and will ensure that appropriate application to government-sponsored assistance program or agencies as well as to other philanthropic source are made. If certain, a notice to a Medicaid application in the future should be noted in the patient's record.

c. Patient Financial Services

Through its normal billing and collection process, the department may identify new or changed demographic and financial information, resulting in recommendations for charity service; this information should be combined with any documentation received from Patient Access, Social Work and/or any other source for evaluation of eligibility for charity care.

Once a decision about eligibility for charity care, and the specific arrangements made for a patient who has been discharged from NYDH's care, Patient Financial Services will ensure that the financial record is updated and any balance due is collected.

d. Financial Counseling Office

The Financial Counseling Office is responsible for determining if the patient or responsible party is eligible for government insurance programs. NYDH will supply an interpreter when needed. If eligible for government insurance, pursue the application, with the cooperation of the patient or the responsible party, until final determination of eligibility/coverage made by the appropriate government agency.

If the patient or responsible party, is deemed ineligible for government programs, and meets the residency requirements as described in the beginning of this policy, the financial counselor will collect all needed information to determine eligibility for the sliding fee scale. Charity Care applications will be printed in the primary language of the patients, when at least 5% of the visits per year by non English speaking patients. The process is simple and a patient has at least 20 days to submit a completed application, including all documentation, although in most cases the application is completed quicker with the assistance of the financial counselor. NYDH has 30 days after the receipt of a completed application to notify the patient in writing as to approval or denial of the application. The financial counselor reviews the completed application, income, assets & liabilities and determines the sliding fee percentage, according to NYDH sliding fee scale. Depending on the service & the expense of the procedure, may ask for a deposit. If the patient can make a full payment, directs patient to the cashier to make payment and to note patient's account.
b. Appeals

The patient or their representative may appeal any decision of the Financial Counselor, by sending a letter to the Charity Care Committee, describing why they need financial assistance. These will be reviewed and communicated in writing to the Patient or responsible party.

IV. Eligibility Criteria & Documents Required

1. Criteria
   The criteria for determining the amount of charity services for which patient is eligible for an occasion of services includes the following factors:

2. Individual of family Income
   Family earnings should be a measure of a patient’s ability to pay although family size and other significant liabilities should be considered.

3. FamilySize
   The evaluation of income, as noted above, should consider the adequacy of earnings in order to support a patient’s family.

4. Individual of family Net Worth
   Other liquid and non-liquid assets should be considered, less liabilities or claims against those assets.

5. Employment Status
   The likelihood of sustained or future earnings sufficient to meet the healthcare-related obligation within a reasonable period of time should be considered.

6. Other Non-Medical Financial Obligations
   Living expenses and other items of a reasonable and necessary nature should be considered.

7. Amount and Frequency of Bills
   Patient may incur or expect to incur significant healthcare expenses that would limit their ability to pay. A separate determination of the amount of charity service for which a patient is eligible should be made on each occasion of service.

8. Personal Charges
   Charges in a patient's ability to pay may occur over time, e.g., termination, exhaustion, or inadequacy of insurance coverage for medically necessary services, loss of employment, etc. These charges should be considered during the evaluation of the eligibility for charity services.

9. Eligibility for insurance programs
   Patients are expected to apply for public insurance programs, such as Family Health Plus, Child Health Plus, and Medicaid, or other private insurance options. Eligibility criteria for these programs will be reviewed for each patient, and they will be assisted in the application process. All applicants for charity care expected to cooperate with this application process.

A. Documentation

a. Documents will include, but may not limited to

(1) Identification:
   - Birth certificate
   - Baptismal Certificate
   - Driver's License
   - Picture ID
   - Passport
(2) Address:
- Current Utility Bill in patient’s name
- Driver’s License with patient name
- Picture ID
- Passport with patient’s name

(3) Income and Family Size:
- Previous Years’ Income Tax Return with W-2 form attached Pay stubs for most recent 4 weeks with the name and number of dependents indicated
- Unemployment insurance book
- Notarized letter from the employer or source of support

(4) Eligibility for other assistance
- Letter from the Social Security Administration, NYC or other local Department of Social Services, NYC Department of Health, or New York State Department of Labor

The amount of charity services, i.e., the difference between gross charges and the patient's identified resources, depends in large part on information supplied by the patient or someone acting on the patient’s behalf. In pursuing more reliable information and documentation the hospital should consider the timing and cost of its procurement versus the amount due to the Hospital. For example, extensive investigation in relation to a small balance due would not be cost-effective. Similarly, a single element of information may provide all the information necessary to make a reasonable determination, which would preclude the expenditure of additional effort.

An interview by qualified staff in Social Work or Credit and Collections, or staff otherwise identified and approved by the Charity Care Committee, a questionnaire or similar instrument, and any computer software designed for those purposes, may be used to provide additional data about a person’s eligibility for charity care. Permission to obtain a credit report may be requested as well.

The hospital will make every reasonable effort to verify the accuracy of information and to review all information necessary to make an appropriate determination of eligibility for charity care.

V. Maintaining documentation

A. Documentation and Reporting

a. Recording services at the full-established charges amount in revenue and receivables as services are rendered. Patient Access will ensure that patients approved for charity care are notified with the insurance/carrier Charity Care, and each plan, 20%, 50%, 75%, 100%, with notes recording their eligibility for charity care arrangements as approved by the Financial Counselor.

a. Selecting a plan will automatically adjust the patient’s account to what is due from the patient, and write off the excess charges to a charity care allowance.

b. Regularly evaluating the adequacy of the allowance for charity services, by Patient Financial Services.

c. Documentation concerning application, committee review, and final decisions about eligibility for charity service should be retained by the Financial Counseling Office, for the Charity Care Committee. Patient Financial Services will retain records of the charity care
arrangement made for each patient, as part of their financial record.

B. Collection

a. NYDH will not forward any claims to a collection agency if the patient completed the Financial aid application, and is waiting for a determination.

b. NYDH prohibits the forced sale or foreclosure of a primary residence, but placement of a lien is allowed.

c. NYDH will notify the patient or responsible party at least 30 days before the account is being forwarded to a collection agency.

d. NYDH will provide written consent to a collection agency before it begins legal action on the patient, or responsible party.

e. NYDH requires all its collection agencies to follow the hospital’s financial aid policies and procedures, including how to apply for financial aid.

f. NYDH will not collect any monies from patients eligible for Medicaid at the time of services, and the hospital is able to collect the Medicaid payment.

C. Reporting to DOH

a. Hospital costs incurred and uncollected amounts for services to the uninsured and Underinsured. (Included uncollected nominal payment, coinsurance & deductibles)

b. The amount of distribution from the indigent (BDCC) pool.

c. The amount spent from bequests or trusts established to provide financial aid.

d. The hospital’s gain or loss from services provided under Medicaid.

e. The number of patients who applied for aid, the approvals and denials, by zip code.

f. Where applicable the number of patients receiving assistance in applying for Medicaid.

g. The number of liens placed on a patient’s primary residence.

VI. Communication

A. To our patient

Prospective applicants for charity care or financial relief will be informed of this option by

- Telephone conversation with Pre-Admitting and Pre-Registration staff in Patient Registration when questions about ability to pay are identified
- Notices printed on the reverse side of patient bills

NYDH staff who may receive telephone inquiries about charity care or financial relief will be educated regarding the main provisions of this policy.
B. To the community

The community will be notified of this policy by communication with community boards, consumer advisory groups affiliated with NYDH and by posting of notices where appropriate, such as on our website or in NYDH publications.
POLICY
It is the policy of the Hospital to recognize patients in need of care that will have difficulty paying for services provided. The Hospital’s Charity Care program will provide discounts to qualifying individuals based on their income.

PURPOSE:
To assist patients with limited income and no health insurance.

PROCEDURE:

1. A financial counselor (CBIZ) will advise you of the required documents needed to complete a charity care application.
2. The documentation listing will be furnished to patients by a CBIZ financial screener and the patient will be informed of all documentation needed to fully complete a charity care application. (See attachment)
3. If the patient has an elective visit in the Hospital and the documentation is not completed, the patient will be made aware of the charity care application as (Pending Status) and will be given a copy of the signed pending application. (See attachment).
4. The patient will be directed to the registrar with approval to utilize services in the clinic for that specific date of service only.
5. A notation will be made in the comments in AMPFM system of the status of the charity care application and documentation missing in (expanded comments) for future reference for the registrar.
6. If the patient requires additional follow up in the clinic, then the patient will be referred to the CBIZ financial counselor for additional interviewing of the patient and collection of missing documents.
   a.) If patient does not meet the required documents for completion of charity care application then the patient will have 90 days to complete the process and continue to receive elective services.
b.) If the patient submits the required documents, the CBIZ financial counselor will advise patient of charity care discount and furnish patient with an acceptance letter and the patient will be given for clinic visits up to 90 days of coverage before being re-interviewed for future visits.

7. The patient can begin using their charity care discount at once, or make future appointments in the clinic.

8. The clinic registrar will inquire from the patient the charity care letter and register according to the status of the charity care application.