# NEW YORK HOSPITAL QUEENS
Flushing, New York 11355

**DEPARTMENT/UNIT:** Administration

**POLICY/PROCEDURES**

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<tr>
<th>Effective Date: December 11, 2006</th>
<th>Title: DISCOUNT/CHARITY CARE POLICY</th>
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<tr>
<td>Original Date: 1/1/93</td>
<td>Policy Number: 8611-053</td>
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**This policy/procedure supersedes: 8611-053**

## PURPOSE:

1. To establish policy and define responsibility for the Medical Center Charity Care and Discount Protocol. The Discount Protocol relates to employees and voluntary attending physicians. The Charity Care Protocol relates to patients unable to make payment of their hospital bills. New York Hospital Queens provides care to all without regard to financial condition or mode of payment. Appropriate notice will be placed at strategic registration stations to advise the public that New York Hospital Queens is able to assess, and if necessary, approve a self pay or underinsured patient’s request for reduced fees.

2. Individuals eligible for discounts include the following:
   - Employees
   - Voluntary Physicians
   - Volunteers
   - Interns and Residents
   - Board of Trustees

Along with the above individuals, any immediate family member is also covered by the discount policy. An immediate family member is defined as spouse or unmarried child under the age of 19 unless the unmarried child is a full-time student. Such full time students must be under the age of 23.
3. Individuals eligible for charity care and other allowances are individuals presenting for medically necessary services and include:
Uninsured New York State residents with incomes below 400% of the Federal Poverty Guidelines as issued each year. The annual FPL rates change each January, and the new rate schedule will be attached to this policy at issuance.
All New York State residents under 400% FPG are eligible for emergency Hospital services.
New York State residents under 400% FPG who reside in our primary service area are eligible for assistance for non-emergent services. Our service area as determined by the Department of Health includes the five boroughs of New York City, as well as the county of Nassau.
Our Financial Coordinators may also consider ambulatory care patients unable to pay full charges, patients with inadequate insurance coverage and patients making payment arrangements which fall within settlement guidelines.

PROCEDURE:

4. New York Hospital Queens provides care to all without regard to financial condition or mode of payment. Our EMTALA policy clearly states that all patients presenting to Emergency or Ambulatory Care sites are to be treated without questions of a financial nature being raised until patient is deemed stabilized. Appropriate signage will advise patients residing in the New York Hospital Queens service area that we have a Charity Care Policy. Such signage is posted at all relevant access points, Admitting, ED, Ambulatory Care etc, and is in six languages. We are a culturally diverse community and at this time, in addition to English, we service large Chinese, Korean, Spanish, and to a lesser extent, Russian and Greek, speaking populations. In accordance with our language needs assessment required by 10NYCRR Section 405.7, we identify our primary languages as those used by patients during 5% of annual patient visits and monitor this by the use of quarterly system prepared preferred language reports. Since 2007, these reports show that in addition to English, more than 5% of our patient preferred languages are Chinese, Spanish and Korean, in that order.
On in-patient cases, we will request the indigent patient make application to the New York State Medicaid Program if preliminary discussion indicates they may be eligible. We will begin our assessment for aid at the same time.
In the case of out-patients, our Ambulatory Care Registrars will be provided with information necessary to advise patients of the policy and how financial assistance can be requested. In the case of out-patients requesting assistance, we will provide treatment to the patient beginning assessment for aid upon the completion of our application and refer the patient to their local medical assistance office so they may make application for assistance in such form as they may be entitled, Medicaid, Family Health Plus, Child Health Plus and so forth.
5. The vast majority of our patients are covered by some form of insurance. It may be Medicare, Medicaid or any one of the myriad commercial insurers or health maintenance organizations (HMO’s). Virtually all these payers reimburse us on “contracted rates” and not our charges. These contracted rates are negotiated by our Managed Care Department and the contracting staff of the commercial carriers and HMO’s. Our Medicare and Medicaid rates are fixed by federal and state regulatory authorities based upon costs of operation. Eligible patients as listed above at or below 400% FPG will have their payments for services capped at the rate paid by Blue Cross, our highest volume health plan payer. Blue Cross rates will be listed on a separate schedule as they will change from time to time and the schedule will have to be updated as required. Additional payment limits are as follows.

For eligible In Patient and Ambulatory care services.

Patients under 100% FPG-Minimum payment within New York State guidelines to be set annually by the New York State Department of Health.

Patients between 101% and 125% FPG-10% of Blue Cross rate.
Patients between 126% and 150% FPG-20% of Blue Cross rate.
Patients between 151% and 200% FPG-40% of Blue Cross rate.
Patients between 201% and 250% FPG-60% of Blue Cross rate.
Patients between 251% and 300% FPG-80% of Blue Cross rate.
Patients between 301% and 350% FPG-90% of Blue Cross rate.
Patients between 351% and 400% FPG-Blue Cross Cap Fee.

As Blue Cross does not issue a “Clinic” type rate we will continue to “scale” such eligible patients based on the capped fee which will be the published New York State “clinic” rate.

Patients under 100% FPG will pay the State published minimum rate.
Patients between 101% and 125% FPG-State published minimum rate.
Patients between 126% and 150% FPG-20% of MA rate.
Patients between 151% and 200% FPG-40% of MA rate.
Patients between 201% and 250% FPG-60% of MA rate.
Patients between 251% and 300% FPG-80% of MA rate.
Patients between 301% and 350% FPG-90% of MA rate.
Patients between 351% and 400% FPG-MA Cap Fee.

For other self pay patients unable to make full payment of their bills we will offer them one of our contracted rates for services as payment in full.

In price based cases, as with Blue Cross, the cost of implants and non-standard medical equipment we must purchase for the patient will be added to the requested payment at cost.

Patients requesting charity care before or during service shall complete our simple application form which is printed in four languages, English, Chinese, Spanish and Korean which will be forwarded to the staff members designated “Charity
Care Coordinators”. The application will list any information which will be required to assess the need for charity care such as recent pay stubs, and other asset information as may be necessary to perform the assessment, as well as expenses which may support the patient’s request for financial aid. We are permitted to consider assets in determining how much a patient should pay. Asset levels may only be used to upgrade patients with incomes up to 150% of the FPL. Asset levels to be disregarded are amended annually by the State. However the following four assets are always to be excluded when evaluating payment scales. Patient’s primary residence Tax-deferred or retirement savings accounts College savings accounts Cars used by the patient or immediate family An appointment will be set up and the patient will bring their completed application to the meeting with the Charity Care Coordinator where the request will be discussed and reviewed. Based on the review and patient affirmation of the application submitted, the Charity Care Coordinator may assign the patient the legal settlement rate as defined in the schedule. We will require the applicant to present photo ID to confirm New York State or New York City-Nassau County residence status as well as to conform to Federal “Red Flag” laws. Charity Care for necessary services can also be extended to eligible patients residing in our service area based on needs of varying degrees such as loss of employment, illness, major medical expenses, substantial debt and so forth. Necessary services are defined as those services which would be covered by the Medicare program if they were the payer. Some, but not all services, such as cosmetic surgery, dentistry, phase 4 cardiac rehab are not eligible for financial aid or discount.

6. Patients will have 90 days from the date of discharge to apply for financial assistance. Once a bill is created and sent to the patient, applications and scaling for financial aid will be done by our billing/collection service, Network Recovery Services. Applicants will be advised by mail and phone that NRS will be handling and evaluating their request. Whether receiving application at New York Hospital Queens or NRS, the patient has 20 days to submit a completed application. NRS or our Financial Coordinators then have 30 days from receipt to respond in writing either approving or denying the application. We will need to document the reason for decision. In the case of denial we will advise the patient they can appeal our decision by submitting further information. The request for appeal must be made within 30 days of the denial. During the application and appeal process, no bills are to be generated and patients are to be advised to disregard any such bill should one accidentally be sent.

7. As noted in item 6, prior to or at an admission, or at any point post discharge up to actual billing, the process resides at the Hospital with our Financial Counselors and Financial Aid Coordinators. Should a patient apply for aid after the billing process has begun, they will do so with Network Recovery Services, our Network self pay billing service, which will employ their procedures to make
determinations on financial aid requests. In addition to patients who have made financial aid applications, NRS will initiate their presumptive eligibility criteria to evaluate all self-pay patients with balances over $250 per encounter. This involves submitting all such accounts to credit reporting agency Equifax for a “soft touch” evaluation of the patient’s presumptive eligibility. The use of the agency cannot be used to deny an application for financial aid. Accounts returned by Equifax with income scores below “43” ($43,000) will then be automatically scaled by NRS in accordance with the current fee scale schedule and Charity Care allowance ANFA will be applied to the account.

8. We are also able to review cases where patients are unable to pay large balances due to low insurance payments. We can, and do, in cases of hardship apply pro-rated discounts to these balances based upon our settlement guidelines. It should be noted however that federal law has prohibited the discounting of Medicare deductibles and co-payments in all but the most extreme cases, so we cannot reduce these fees, which are specific to service and set by law, except in the case of medically indigent patients qualifying for discount under this charity care policy. Medicare deductibles and co-pays are based on Medicare calculations for out-patients and flat deductible amounts for in-patients and bear no relationship to our actual charge for service.

9. We will continue to maintain “sliding scale” fee schedules in our ambulatory care clinic sites for patients without health care coverage. These schedules are based on federal poverty level (FPL) calculations set each January and are categorized according to the most current income and resource levels by family size. Patients will be interviewed and scaled as noted in point number six at fee scales of State defined minimum fee to capped MA rate for this service by the site registrars. Those patients applying for “sliding scale” fees must present affirmed application to the registrar or other intake person assigning the scale. The most recent income schedules will be made available to all intake personnel. The intake person will request copy of most recent pay stub and will also require photo or other ID to confirm residency in our assigned service areas.

10. Employees and staff eligible for discount under this policy will have the following obligations waived by the Hospital.
Co-pays for inpatient or out-patient services required by a managed care plan.
Any deductible required by a managed care plan.
50% of the private room differential if done at request of patient.
Any out-of-network charge if the plan is one that the hospital offers to employees and the hospital does not have a contracted rate for the specific service with the carrier.
Again, no Medicare deductibles or co-pays are eligible for these discounts.

MONITORING:

11. Every effort shall be made during the registration process to ascertain
whether or not a patient is eligible for allowance or discount under this policy. We are flexible and when a patient cannot meet their obligation within the settlement or sliding scale guidelines, will judge such inability to pay on a case by case basis.

12. There are four different allowance codes to be used for discounts or charity care.
   - Employee allowance
   - Administrative adjustment
   - Charity care allowance
   - ANFA financial aid allowance

   The current sliding scale allowances will point to the charity allowance code ANFA.

   Both ANFA and CHAR can be used for charity care. At this point in time to allow us to monitor and report on Financial Aid to the State, we will use CHAR for an allowance's granted when we have full Financial Aid application and the allowance is processed by NYHQ personnel. NRS staff will continue to use ANFA for patients from whom they have received an application for Aid. NRS also will be using three new codes in the following circumstances.

   Patients who have made application and have residual balance -FARB
   Patients self pay and presumptively eligible-PEPS
   Patients residual balance and presumptively eligible-PERB

   The Charity Care Coordinator or other staff member, or manager, either hospital based or at NRS performing any of the above adjustments should select the proper allowance to be used. Use of sliding scale is intended for clinic and ambulatory care patients and is input by proper category selection. Use of employee allowance is clearly limited to staff. The use of administrative adjustment and charity care, however must be clearly defined for bad debt charity care reporting purposes. As a rule of thumb, "ANFA" and "PEPS" will most commonly be used for sliding scale and similar poverty level charity care fee reductions by NRS. "CHAR" will be used as noted above when NYHQ Financial Aid Coordinators receive and approve a financial aid application. “Administrative Adjustment” is to be used for courtesy or similar situations.

13. Under New York State laws we are required to meet the following criteria with respect to the follow up collection process, which predominantly resides with Network Recovery Services.

   While liens on primary residences are permitted, forced sale or foreclosure initiated by the hospital is not.

   No account may be sent to collection while the financial aid application process is still pending.

   We must provide written consent to a collector beginning a legal action for collection.

   Network Recovery or Financial Counseling will provide minimum 30 days notice to a patient for submitting an account for collection. Collection activity during Medicaid process is not allowed.

   Collection vendors must conform to our financial aid policy.
14. Our financial aid policy is in writing and notice is to be made available in summary for the public upon request. All of our hospital bills include a statement that financial assistance is available with telephone number to call to make such application. Our language appropriate signage in the Emergency Room and all other intake points makes it known that financial aid is available. All hospital staff who interact with patients on intake or financial matters as well as those responsible for billing and collection have and will continue to receive annual training in the hospital financial aid, charity and discount policy.

15. On Tuesday mornings, reports are printed of all In-patient and ASU admissions for the week. On alternate Tuesday mornings the OnTrac monitoring committee meets and discusses cases including those of the indigent, uninsured and underinsured patients and options we have which can help the patient and hospital secure satisfactory reimbursement for the encounter. We will also review the status of applications for charity care at this meeting. When we are unaware of a patient's indigence or difficulty in meeting payment obligation at point of service a bill will be generated by our network billing office or Network Recovery Services (NRS). NRS generates day one self pay billing on our behalf. NRS will maintain a copy of this policy, and as noted is permitted to initiate applications for financial aid with patients. We must maintain a record of the number of patients, organized by zip code, who applied for financial assistance as well as number by zip code of those approved and those denied, as well as results of appeals.

APPROVALS:

__________________________
Stephen S. Mills, President CEO
Date

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John E. Sciortino, Sr.Vice President COO
Date

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Kevin J. Ward, Sr. Vice President CFO
Date

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Lorraine Orlando, Vice President H.R.
Date

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Peter J. Siriani, Director, PFS
Date