NEW LONDON HOSPITAL

Policy No: **22,251 HB/PB**	Page **1 of 5**
Subject: **Financial Assistance Policy**	Prepared by: **Director of Business Operations**
Manual: **Hospital and Physician Billing Manual**	Endorsed by: **CFO**
Effective Date: **1/2006**	Approved by: **CFO**

I. Purpose of Policy

To establish a policy for the administration of New London Hospital's (NLH) financial assistance for healthcare services program. This policy outlines the:

- 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
- NLH's measures to widely publicize the policy within the community served.

This policy is compliant with NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2009 and will be changed from time to time to maintain compliance.

II. Policy Scope

For purposes of this policy, "financial assistance" requests pertain to the provision of healthcare services by NLH.

III. Definitions

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

Presumptive financial assistance, excluding balances after Medicare, is the provision of financial assistance for medically necessary services to patients for whom there is not a completed NLH 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.

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 determination.

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- 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 abilities.

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

Emergency medical conditions are defined within the meaning of 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 by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

IV. Policy Statement

New London Hospital (NLH) is 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. NLH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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NLH 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 regardless of age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

NLH provides financial assistance 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.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with NLH 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 assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

NLH will not impose extraordinary collections actions such as wage garnishments; liens 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. Any exceptions must be approved by the chief financial officer.

A. Eligibility Criteria for Financial Assistance. Patients must:

- Be a resident of NLH's 15-town service area, or a non-resident who experiences a medical emergency, and/or be routinely cared for by a primary care provider employed by New London Hospital.
- Be uninsured, underinsured, ineligible for any government health care coverage for services provided, or are unable to pay for their care, based upon a determination of financial need.
- Demonstrate compliance with the requirements to apply for the Healthcare Exchange Program if eligible for these programs. Exceptions for good cause will be approved by management on a case by case basis and include:
    - Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
    - Cases where the patient feels that the financial burden to enroll in the marketplace is unaffordable.
- Be receiving a medically necessary service that is billed by New London Hospital.

If there is no interaction with the patient or the patient refuses to complete paperwork they may be deemed eligible under presumptive charity.

B. Method by Which Patients May Apply for Financial Assistance

1. Financial need is determined based on an individual assessment which includes, but is not limited to:
    - an application process, in which the patient or the patient's guarantor is required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. If NLH is unable to obtain an

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application from the patient or the patient's guarantor, NLH will consider whether the patient is eligible for presumptive financial assistance;
- the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);
- reasonable efforts by NLH Financial Counselors to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
- the patient's available assets, and all other financial resources available to the patient; and
- a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

2. It is preferred, but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated based upon the time limit associated with the approval of the last financial assistance application, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

3. It is the goal of NLH 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 NLH 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 Business Operations to explain why the decision made by NLH was inappropriate. The appeal letter will be reviewed by NLH 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.

The amount of financial assistance granted an individual is as follows:
- Patients whose family income is at or below 200% of the Federal Poverty Level (FPL) are eligible to receive free care; Patients whose family income falls between 201% and 400% of the FPL are eligible to receive reduction associated with that percentage, and
- Patients whose family income exceeds 400% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of NLH.
- Patients meeting Presumptive Financial Assistance eligibility criteria, will have a 100% write off of the account balance

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

- Referral of patients for financial assistance may be made by any NLH staff member or agent including physicians, nurses, financial counselors, social workers, case managers,

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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 NLH is:
  - on the NLH website,
  - available in patient care and registration areas,
  - available in other public spaces as determined by NLH,
  - provided in the primary languages spoken by the population serviced by NLH; translation services are utilized as needed.

Cross reference policy # 22,401