ELLENVILLE REGIONAL HOSPITAL

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DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
APPROVED BY: BOB RUE, CFO	EFFECTIVE: 6/04
REVIEWED: 9/12, 7/14, 9/15, 7/17, 7/24	REVISED:1/07, 7/11, 06/13, 1/14, 9/16, 2/17, 7/18, 5/19, 6/19, 7/20, 11/21, 7/22, 11/24

STATEMENT & PURPOSE:

To establish guidelines for processing and approving requests for financial assistance.

POLICY:

Ellenville Regional Hospital ("ERH") recognizes the responsibility to provide access to quality health care services that reflects the community's needs. Patients who present themselves for emergency or urgent care will not be turned away because of their inability to pay. Financial Assistance will be made available for medically necessary services, which are defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Non-medically necessary services such as cosmetic surgery, patient convenience items or elective procedures are not covered under the policy.

Financial assistance is offered to all patients who reside in New York State for emergency services. For all other necessary medical services, assistance is offered only for patients whose primary residence is within ERH's primary service area (PSA). ERH's PSA is comprised of the following counties: Ulster, Dutchess, Orange, Sullivan, Delaware, Greene and Columbia.

Financial Assistance is defined as health care services provided at no charge or at a reduced charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. Partial or full Financial Assistance will be based solely on eligibility and will not be abridged on the basis of age, sex, race, creed, disability, national origin, or immigration status. ERH will provide care for emergency conditions regardless of financial status, without discrimination, in accordance with EMTALA regulations.

DEFINITIONS:

Uninsured: A patient who does not have any type of health insurance coverage. Eligibility is based on the patient's income scale, with discounts available up through 400% of the Federal Poverty Level (FPL).

Underinsured: A patient who does have health insurance coverage with cost share, such as co-pays, coinsurance and deductibles. Eligibility is based on the patient's income scale and whether the patient's medical cost share exceeds 10% of their gross income in the past 12 months. If this criteria is met, discounts are available up through 400% of the FPL.

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Availability of financial assistance is contingent upon the patient first applying for coverage under Medicaid or another publicly subsidized insurance program. Patients may contact and schedule an appointment with a Financial Counselor if needed.

The patient may apply for financial assistance at anytime during the hospital collection process, starting from the date of service. The patient may apply for financial assistance even if they have previously had a balance referred to a collection agency.

PROCEDURE:

1. All patients are provided financial assistance information at the time of registration as well as at the point of discharge. Financial assistance information is also posted in the Hospital, on patient statements, as well as our Hospital website. ERH uses the New York State Uniform Financial Assistance Application ("Financial Assistance application") which can be requested while at ERH or by phone.

2. Patient Accounting will review the patient's information for possible insurance coverage and other self-pay options, such as credit cards and payment plans. After all third party and personal resources have been exhausted, the patient will be evaluated for Medicaid or another publicly subsidized insurance program. Patient must cooperate in applying for coverage as a condition for applying for financial assistance.

    a. If Medicaid or another publicly subsidized insurance plan denies the application due to not qualifying, the patient/guarantor is responsible for supplying the Financial Counselor with a copy of the Medicaid denial letter.

    b. Upon receipt of the denial letter, the Financial Assistance application must be completed in a timely manner by the patient/guarantor.

    c. The patient/guarantor must provide proof of identification, address and income with their application.

        - Acceptable proof of identification includes: Driver license, passport, permanent resident alien card (Green Card), birth certificate, photo ID. At least ONE from this list must be supplied.
        - Acceptable proof of address/residency includes: utility bills, cell phone bills, cable television bill, rent receipt, copy of lease or mortgage papers, notarized

letter from person patient resides with or from landlord. At least ONE item from this list must be supplied.

- Acceptable proof of income includes, but is not limited to: Recent pay stubs (4 if paid weekly, 2 if paid bi-weekly), unemployment benefits, award letter from Social Security Administration / Pension / Annuities.

3. The Financial Counselor will receive the required information along with the Financial Assistance application. If the information is found to be untrue, the application will be immediately denied.

4. The Financial Counselor will evaluate the information provided in the application in conjunction with the Poverty Guidelines that are issued each year by the Department of Health and Human Services (HHS) to determine appropriate discount. Eligibility for financial assistance is determine solely on household income. A patient's assets, such as their house or car, may not be considered. Additionally, a patient's immigration status will not be considered when determining the patient's eligibility for financial assistance. The most current U.S. Federal Poverty Guidelines used to determine financial assistance eligibility can be found at:

   Link: https://aspe.hhs.gov/poverty-guidelines.

   The guidelines will be used in the sliding scale for uninsured and underinsured patients.

   Uninsured Guidelines:

   If applicant:

   - Is at 200% or below the FPL, they are entitled to a 100% discount.
   - Is between 201-300% of the FPL, responsibility will be 10% of Medicaid rate.
   - Is between 301-400% of the FPL, responsibility will be 20% of Medicaid rate.
   - Exceeds 400% of the FPL, no discount will be applied.

   Underinsured Guidelines:

   If applicant:

   - Is at 200% or below the FPL, they are entitled to a 100% discount.
   - Is between 201-300% of the FPL, responsibility will be 10% of all cost share.
   - Is between 301-400% of the FPL, responsibility will be 20% of all cost share.

- Exceeds 400% of the FPL, no discount will be applied.

5. Patients above 400% may still qualify for discounts, but will be reviewed on a case to case basis. Financial hardship and extenuating circumstances will be factored into decision. It is important to note that the hospital's Financial Assistance Policy covers only the hospital portion of the bill, and does not cover any provider services that are billed separately from one of our contracted provider groups. For a list of these groups, please visit:

   Link: https://erhny.org/patient-guests/paying-for-your-care/#tablinkid4

6. If the information supplied supports the fact that the patient qualifies, an "Adjustment Request" form is completed and sent to the appropriate authorization level for approval.

Authorization Level	Approval Range
Financial Counselor	$0.00 - $1000.00
Patient Financial Services Manager	$1000.00 and above

7. After review and determination, the original is returned to the Financial Counselor. The hospital must approve or deny within 30 days of the completed application:

   a. If patient/guarantor is approved for any level of assistance, they will be mailed an approval letter detailing the level of discount that they have received.

   b. For any level under the 100% discount, the patient/guarantor will be notified of the remaining balance on the approval letter. If the patient cannot pay the amount up front, a payment plan will need be established between the financial counselor and the patient/guarantor. Our payment plan guidelines state:

      - Not to exceed a monthly amount of 5% of their gross income.
      - Financial Counselor can ask for a deposit up front on reduced rates, but it cannot be "an undue obstacle".
      - That no acceleration clause will be enforced if the patient cannot fulfill their obligation.
      - In the event that the patient does not fulfill their obligation without notice to the billing office, the account(s) may be referred to a collection agency. The hospital will give notice at least 30 days prior to the referral to the agency.

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c. If denied, a denial letter will be mailed to the patient/guarantor. The denial letter will clearly outline the steps required to appeal. All applicants have the right to appeal. The patient/guarantor will have 30 days to file a written appeal disputing the decision. Appeals will then be reviewed by the Patient Finance Manager with the previous application and a written redetermination will be made within 30 days from receipt of the appeal.

8. Financial Counselors will notate all activity in the Electronic Medical Record system and will file the original documents in the current Charity file. The Financial Counselor will also adjust the affected account(s) based on the discount given upon approval.

9. Once an applicant has qualified for Financial Assistance, the approval is active for six months from the approval date. The patient/guarantor can then update their application once allotted time has passed.

10. Quarterly audits are performed on a sample of approved and/or denied application to ensure accuracy and fairness.

11. Collections of any amounts due from a patient shall be in accordance with ERH's Credit and Collections Policy.

ADDITIONAL INFORMATION

PARTICIPATING INSURANCES

The link provided in this section will show which insurance plans ERH participates with. You may call us at (845) 210-4930 with any specific questions you have. You can also contact your insurance plan to confirm participation with the hospital as well.

Link: https://erhny.org/patient-guests/paying-for-your-care/#tablinkid3

STANDARD CHARGES

The link provided in this section will provide you with a full transparent list of the hospital charges we use. All of these charges are uniform for all patients regardless of insurance. Out of pocket responsibilities will vary based on your insurance coverage with your carrier. If you have questions regarding charges or patient responsibility, we encourage you to contact us at (845) 210-4930.

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Link: https://erhny.org/patient-guests/paying-for-your-care/#tablinkid2

PROVIDER SERVICES

It is important to note that Provider services are billed separately and are not included in the hospital's standard charges. Providers may or may not participate in the same insurance plans as the hospital, so please check with the Provider arranging your hospital services to ensure they participate with your insurance. The link provided in this section includes all of the Provider groups that the hospital currently utilizes.

Link: https://erhny.org/patient-guests/paying-for-your-care/#tablinkid4