UR Medicine Finger Lakes Health
POLICY: FINANCIAL AID

PURPOSE:
UR Medicine Finger Lakes Health allows all patients, uninsured, underinsured, or individuals who do not otherwise have the ability to make full payment, the ability to apply for financial assistance. Patients applying for financial assistance will be evaluated using family size and income. The purpose of this policy is to document the guidelines for Financial Aid discounts available. In addition to financial assistance, an initial discount is provided to all self-pay (uninsured) patients determined to have no source of payment through any Federal, State, or Third-party insurer. We are committed to treating all patients in an equitable manner, with dignity, respect and compassion.

A. GENERAL GUIDELINES

UR Medicare Finger Lakes Health extends an overall initial discount to all self-pay (uninsured) patients. An application or other qualifying criteria are not required of the uninsured patient to receive the initial reduction in their total charges.

The initial discount applied to uninsured patients is a calculation based on an "Amount Generally Billed" for emergency and other medically necessary care. The Amount Generally Billed is intended to represent the amount the hospital generally receives as payment for services furnished to individuals who have insurance. FL Health has elected to use an average of Medicare Parts A and B and Excellus allowed payments (including coinsurance, copayments and deductibles) as the Amount Generally Billed. Information about the Medicare and Excellus allowed payment will be available upon request by our Patient Financial Services office by contacting us at (315) 787-4150. The representatives will be able to provide patients the amount the patient may be responsible for based on the reimbursement by Medicare Parts A and B and Excellus. A Financial Aid eligible individual cannot be charged more than the "Amounts Generally Billed" for emergency or other medically necessary care.

Financial Aid is applicable to all UR Medicine Finger Lakes Health services rendered at Geneva General Hospital and Soldiers and Sailors Memorial Hospital to include all hospital services, inpatient and outpatient, emergency room visits, associated physician practices, clinics, urgent cares, and FL Medical, PC. This program covers all medically necessary services regardless of where you live. Financial Aid is open to all patients, uninsured, underinsured, or who otherwise cannot afford their care. The provision of emergent healthcare is never delayed pending financial aid determination. The patient's medical condition is not a factor in financial aid determination. Immigration status in not considering for determining financial aid eligibility. Patient's assets are not considered when reviewing eligibility for financial aid. Specific questions about eligible services should be directed to the Patient Financial Services office by calling 315-787-4150.

Patients cannot be denied admission or treatment/services because of an unpaid medical bill.

If the patient feels they are unable to make full payment, financial aid may be requested. Financial aid can be applied for before you have an appointment, when you come to the hospital to receive care, or when the bill comes in the mail to include during the collection process. The Hospital will refrain from referring an account to a collection agency during financial aid eligibility determination.

Patients who wish to obtain Financial assistance are encouraged to cooperate with the Financial Counselors to: a) identify and pursue available assistance and coverage including Medicaid, Child Health Plus, HARP, victims' assistance, workers compensation, general liability, no-fault, Medicare, plans offered on the New York State of Health Exchange and any other available coverage; b) satisfy the prerequisites and requirements to secure such coverage; and c) cooperate in all efforts to secure payment through such coverage. However, the Financial Aid Review Team may waive a patient's obligation to pursue some or all third party coverage based upon a determination that the patient would be unlikely to qualify for it or in other appropriate circumstances.

To assist patients in their efforts to secure coverage, we provide information about the criteria that must be met to obtain public health benefits such as Medicaid, Child Health Plus and enrollment into Medicare or other health insurance programs. We will further assist patients with completing the application process for insurance and discounted fee programs. Patients can call 315-787-4150 with questions or to schedule a free confidential appointment. Certain situations may result in an amount being classified as financial aid without a formal application, such as the patient being deceased, crisis intervention referrals, bankruptcy, and non- participating out of state Medicaid plans.

Patients determined to be at or below 200% of the Federal Poverty Guidelines will be assessed based solely on their family size and income. Patients above 200% of the Federal Poverty Guidelines, who face extraordinary medical costs, or who have other unique circumstances may be considered for financial aid on a case-by-case basis.

Publicly available demographic and financial information may be used to determine whether a patient who has not submitted a Financial Aid application is presumptively eligible for Financial Aid and the level of Financial Aid the patient may be eligible to receive. This is not applicable to patients that have been determined to be at 200% or below of the Federal Poverty Guidelines or physician and clinic services. Patients determined to be at 200% or below of the Federal Poverty Guidelines will be assessed solely on their family size and income.

Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.

B. FINANCIAL AID GUIDELINES

Financial aid is available to qualified patients who are at or below 400% of the Federal Poverty Level (See Federal Poverty Guidelines), based on the responsible party's annual household income and the number of people in the family. The financial guidelines will be updated in conjunction with the Federal Poverty Level updates published in the Federal Register.

Patients who have been determined to have an income at or below 200% of the Federal Poverty Guidelines will receive a full discount. Those patients between 201% and 400% of the Federal Poverty Guidelines will receive a partial discount from the cost of care, depending on the percentage of the guidelines matched by the patient's household income, family size, and health insurance coverage status as described below.

The term uninsured is defined as patients who do not have health insurance coverage or have exhausted their health insurance benefit.

The term underinsured is defined as patients whose paid medical expenses have exceeded 10% of their income in the last 12 months.

- Income is assessed at the gross monthly income of the household, before expenses.
- Paid medical expenses refer to any out-of-pocket costs for emergency or medically necessary care (i.e. deductibles, copays, coinsurance, deposits, etc.), but do not include the cost of health insurance premiums.

Income Level	Payment
At or below 200% FPL	Waive all charges
201% - 300% FPL	**Uninsured patients:** Sliding scale up to 10% of the amount that would have been paid for the services by Medicaid.

	<u>Underinsured patients:</u> Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's cost sharing. **OR** Patients between 201% and 300% of the Federal Poverty Guidelines will receive a partial discount from the cost of care, depending on the percentage of the guidelines matched by the patient's household income and family size as described on the sliding fee schedule.
301% - 400% FPL	**<u>Uninsured patients</u>**: Sliding scale up to 20% of the amount that would have been paid for the services by Medicaid. **<u>Underinsured patients</u>**: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's cost sharing. **OR** Patients between 301% and 400% of the Federal Poverty Guidelines will receive a partial discount from the cost of care, depending on the percentage of the guidelines matched by the patient's household income and family size as described on the sliding fee schedule.

Any balance for those patients between 201% and 400% of the Federal Poverty Guidelines remaining after application of the financial aid discount is the responsibility of the patient. The patient will be assisted by the Hospital in making arrangements to satisfy any remaining balance on the account(s) by use of a payment plan. Monthly payment plans are available and will not exceed 5% of the patient's gross monthly income. Interest is not charged on the unpaid balance.

Financial aid applications are processed on a timely basis and written determinations are communicated to the patients within 30 days of receipt of the completed application. The responsible party may request reconsideration of a financial aid determination by providing additional information (such as explanation of extenuating circumstances) within 30 business days of receiving the initial notification. Contact information on how to file as appeal is as follows.
Directly to the hospital at 315-787-4150
Directly to New York State complaint hotline 1-800-804-5447 or Community Health Advocates 888-614-5400.

Requests for application forms will be accepted before, during, or after care to include during the collection process. The hospital will strive to assist patients receiving high-cost services as they occur. Patients may be asked to recertify their financial information when long term installment payment plans are being completed.

Patient statements will be put on hold during the application consideration process. Payment will not be expected until after the financial aid determination is made.

Once a Financial Aid determination is made, a discount will be applied to the patient account and any remaining balance will be billed to the patient.

When an eligible patient is approved for Financial Aid, the discount that they are eligible to receive will be applied to all services for a period on one year.

Further collection action will be taken on unpaid balances. Information regarding the billing and collection practices of FL Health is included in the Procedure for Hospital Billing and Collection. A copy of this policy may be obtained by contacting our Patient Financial Service Office by phone at 315-787-4150 or in writing to 196 North St, Geneva, NY 14456 and will be provided free of charge.

C. DEFINITIONS

Income: Income includes: gross wages, social security payment, unemployment compensation, disability payment, worker compensation, alimony, child support, dividends/interest, other miscellaneous sources. Gross income means before taxes are deducted.

Family Size: Family size are family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or dependents. This would include everyone listed on the same tax return.

Uninsured: Individuals with no private health insurance, Medicare, Medicaid, State Children's Health Insurance Program, state-sponsored, other government, or military health insurance coverage.

Underinsured: Patients whose paid medical expenses that have exceeded 10% of their income in the last 12 months. Individuals with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay would also be considered underinsured. .

Presumptive Eligibility: In cases where the patient has not submitted a Financial Aid application and therefore it cannot be determined whether the patient's income is at or below 400% of the Federal Poverty Guidelines, the hospital may utilize analytic services vendor to support presumptive Financial Aid processing. Presumptive eligibility is only applicable to hospital services (non physician/clinic). Presumptive eligibility will not be considered for patients in which Financial Aid has already been determined to be at or below 200% of Federal Poverty Guidelines.

D. SPECIFIC PROCEDURES

The following procedures describe the Hospital's implementation and management of its Financial Aid Program:

1. Training and Communication

a. *Public access staff- (*ambulatory, emergency, pre-admission, and admissions staff) these staff members are provided with in-depth knowledge of the program so that they may explain its general intent to patients and direct them to an appropriate Financial Counselor for further assistance.

. *Financial Counselors* - these staff members receive detailed training about all aspects of the Hospital's Financial Aid Program in order to prepare them to describe and implement the program in the course of their daily tasks.

b. The Hospital provides information about its Financial Aid Program in the following five distinct ways:

i. *Public Notices* – Notices and signage about the Financial Aid Program are available throughout the Hospital and all outpatient/affiliated practice sites in key public access areas and patient waiting rooms. Notices include instructions on how patients can access hospital staff to learn more about the program and/or apply. The Financial Aid policy, application, and summary are available in any Patient Access area and in addition on the Hospital's web site www.flhealth.org or by using the following link https://www.flhealth.org/patients-visitors/patient-financial-services/financial-aid-program. This information is available free of charge.

ii. *Hospital Publications* - Information about the Hospital's Financial Aid Program is included in the Hospital's Admission and Discharge Booklets that are available to all patients admitted to an inpatient care unit.

iii. *Patient Interviews* – reasonable efforts are made to have Financial Counselors interview all uninsured or underinsured inpatients and assist them in securing insurance coverage and explain the Financial Aid Program to the patients who do not qualify for coverage. .

iv. *Patient Billing Statements* - A brief summary of the Financial Aid Program and general income guidelines are provided on the patient billing statements.

v. *Translation Services* – Copies of the policy are available in Spanish. Multi-lingual interpretive services are available through the ATT Language Line Services.

2. Access to Financial Aid Program

a. Any patient may self-refer to a Financial Counselor to learn more about the Financial Aid Program. The procedure for contacting the Financial Counselors is outlined in all published material; in addition, all staff in key access areas are trained on how to refer the patient to the Financial Counselors. Financial Counselors make every effort to contact all patients admitted to the Hospital that may have a balance due. The Financial Counselor assesses the patient's current insurance, confirms existing coverage, and determines if the patient may need additional financial aid in order to pay for their health care service. Patients with insufficient insurance are told about the Hospital's services designed to assist them in making application for insurance and the Hospital's Financial Aid Program and are referred to the Financial Counselors. Patients unwilling to apply for insurance or pursue financial aid are informed that they will be responsible for full payment of their hospital bill (amount generally billed).

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3. Financial Aid Application

a. The Financial Counselor contacts patients seeking financial aid as soon as possible but typically within two business days of receipt of the application if indicated. If needed, a financial aid interview is then conducted (via personal or telephone interview, or via correspondence).

b. At the beginning of the interview, the patient is informed about: (a) the services covered

by the Hospital's Financial Aid Program; (b) steps in the application process; (c) the patient/family requirement to provide proof of current income as a basis for financial aid determinations (examples: pay stubs, rent income, Social Security payments, unemployment payments, disability payments, workers' compensation payments, alimony / child support, etc.) Self declaration can also be used as a mean of income verification.(d) the rules used in determining eligibility for financial aid; (e) the schedule used to determine fee discounts for eligible patients; (f) the process for patient request for reconsideration of a financial aid determination in light of additional information or change in circumstance; (g) patient responsibility for payment of charges remaining after a discount is applied; and (h) the hospital's billing and collection processes. At this point in the interview, patients are given the opportunity to decide if they wish to continue in the financial aid application process.

The applicant may also provide the eligibility determination page from the NY State of Health Marketplace.

Patients or their representatives who are unwilling to provide required documentation or comply with other aspects of the process are informed that they will not be eligible for financial aid and that they become immediately responsible for all hospital charges related to their care after the initial discount has been applied. Patients who elect to continue with the process participate in the financial assessment component of the interview.

In this segment of the interview, the Financial Counselor obtains additional information about the patient's household income and size. The patient is asked to provide documentation to submit verification of information provided during the interview within 20 days of the application.

c. Within 30 days of receiving the completed Financial Aid Application and all required documentation, the Financial Counselor shall determine: (a) the patient's eligibility for financial aid and (b) the discount percentage to which the patient is entitled. The Financial Counselor communicates this information to the patient in writing, and informs the patient of the amount that remains due after application of the indicated financial aid discount.

d. All submitted applications, approved or denied will be maintained and preserved in a secured electronic storage system. Applicants who have been approved for Financial Aid will be logged in the patient's electronic billing record. A weekly listing of all patients approved for Financial Aid will be sent to all outsourced billing companies and physician practices for application of the discount as indicated.

e. A patient or responsible party may request reconsideration of a financial aid determination if additional information is available that would change their status with regard to the financial aid eligibility guidelines. The request for reconsideration can be made by telephone or in writing to the Hospital's Financial Counselor. The reconsideration will be completed as soon as possible, and the patient/family will be informed of the review determination in writing within 30 business days of the request for reconsideration. If there is an issue that cannot be resolved with the hospital, the patient can contact the New York State Department of Health complaint hotline at 1-800-804-5447 or Community Health Advocates at 888-614-5400

f. After the Financial Counselor's initial determination or the determination rendered after an appeal review, the patient's hospital account is adjusted to reflect the amount of any financial aid deduction to be applied to it. The patient is billed for any remaining amount due, and is offered the telephone number of an individual within Patient Financial Services

who is available to assist the person in creating a self-payment plan that outlines patient re-payment steps over a specified period of time should the patient require such assistance. Monthly payments under a self-payment plan will not exceed 5% of the patient's gross monthly income.

g. Refusal to pay – Patients or their representatives who do not fulfill their payment obligations or refuse to pay (express verbally or otherwise) within specific time periods are informed of the delinquency status of their account and that failure to remit payment will result in their account being referred to a collection agency. Patients are notified on all subsequent statements that Financial Aid is available. Written Notification of referral to a collection agency, including notification on a patient bill, is made not less than thirty days prior to referral.

h. Only those hospital employees, who have specifically been delegated authority to do so, may release an account to a collection agency for processing. The Hospital maintains a written agreement with each collection agency it retains in which it defines the standards to be followed in pursuing payment of referred hospital accounts. Should the patient/family ask the collection agent about the possibility of pursuing financial aid at any point during the collection process, the agent is instructed to refer the patient to a Financial Counselor for an updated eligibility determination.

i. The Hospital's Chief Financial Officer and the Financial Aid Committee ensure that the Hospital's Financial Aid Program is audited at periodic intervals to assess the adequacy and fairness of its financial aid process and determinations. Changes are made in the process when audits indicate ways that it should be improved. The Financial Aid Committee consists of the CFO, Senior Director of Revenue Cycle, and the Director of Patient Financial Services.

j. Any exceptions to the above policy will be made on a case by case basis and will require the approval of the Senior Director of Revenue Cycle.

Approved By: _____ Title Treasurer & CFO

Printed Name Trisha Koczent

Date: _____

Approved By: _____ Title Director Patient Financial Services

Printed Name Kathi Finizio

Date: _____

Approved By_____ Title_____

Printed Name_____

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