FLUSHING HOSPITAL FINANCIAL ASSISTANCE NOTIFICATION TO PATIENTS POLICY & PROCEDURE	LAST REVIEW DATE 12/12/18

POLICY: To provide access to government assistance applications and/or Financial Aid Assistance for eligible patients.

PURPOSE: To provide a process by which accessible and affordable care is provided to eligible patients and to ensure that patients and/or family members are notified of the Flushing Hospital Medical Center Financial Assistance Policy.

PROCEDURE: **Notification to Patients:**

Flushing Hospital Medical Center (FHMC or Hospital) has a Financial Assistance Policy (FAP) written in plain language.

Patients treated in any FHMC facilities may be eligible for financial assistance as set forth in this policy. Patients are notified that financial assistance is available as follows:

- a summary description is provided to patients during the intake and registration process for inpatients and outpatients.
- all bills and statements include notification to the patient of the availability of the FAP.
- prominent display in public areas summary of the FAP and application, in a manner designed to attract patients' attention.
- posting on the Hospital website a summary as well as the complete policies and application The Hospital's FAP summary, policies and application are available online at www.flushinghospital.org, and can be accessed by selecting the "Financial Assistance" banner on the webpage.
- posting on the Hospital website the specific income levels used to determine eligibility for financial assistance, a description of the primary service area of the Hospital, and information about how patients can apply for assistance. FHMC notifies members of the community about the FAP in order to reach those individuals that are most likely to require financial assistance.

- FHMC's Community Health Needs Assessment (CHNA) describes how community members are notified of the FAP. The CHNA can be accessed via the hospital website at www.flushinghospital.org, and clicking on the "Community" link.

- FHMC provides the full FAP, summary and application in electronic and paper versions, into the language of any population that constitutes the lesser of 5% of the community served, or 1,000 individuals.

Financial Assistance Program Contact/Assistance Information

Information on the FHMC FAP is publicly available in the Hospital's 24-hour Emergency Department and Admitting Department.

Both departments are located on the Ground Floor of the main hospital building at 4500 Parsons Blvd, Flushing, NY 11355.

The contact number for the Emergency Department is:
1-718-670-5494.
The contact number for the Admitting Department is:
1-718-670-5435.

Paper copies of the FHMC FAP, FAP application, and FAP summary are available, upon request, and without charge in the ED and AD, and also by mail.

The FAP summary is offered to uninsured patients during the intake process in the Emergency and Admitting Departments.

The Financial Office is the department within the Hospital that can provide assistance with the FAP application process.

The Financial Office is located at:
14601 45th Avenue
Flushing, N.Y. 11355 – Suite 600.

The contact number for the Financial Office is:
1-718-670-5588 or 1-718-670-5589.

The office hours for the Financial Office are:
Monday – Friday, 9am – 4 pm.

Participating Physician Providers

The Hospital lists all its physician providers and identifies whether they participate, or do not participate, in the Hospital's FAP. The provider list is updated regularly.

The provider list can be accessed via our hospital website at www.flushinghospital.org by selecting the Financial Assistance option, and clicking on the link for "Providers".

A paper copy of the provider list is available, without charge, upon request, in the Emergency and Admitting Departments.

Services Covered:

FHMC offers the opportunity to apply for financial assistance to all patients for all medically necessary and emergency hospital services, including emergency transfers pursuant to the federal Emergency Medical Treatment and Active Labor Act (EMTALA). The Hospital provides emergency medical services to all individuals regardless of ability to pay

For outpatient care routine ancillary services are included in the financial assistance flat rate. Non-routine ancillaries, such as MRIs and/or cat-scans, are not included in the flat rate and billed separately.

Certain elective services are excluded from this program including non-medically necessary cosmetic services, and self-improvement services.

Co-pays, co-insurances and deductibles are not covered under the program, unless approved via the financial assistance appeals process.

Eligibility:

1. Presumptive eligibility

   The Hospital may provide financial assistance to patients without requiring that they complete a financial assistance application. This is called "presumptive eligibility" and is explained further in the next section.

2. Additional Assistance through FAP Application

   In addition, patients eligible for assistance under the presumptive eligibility screening process may also be eligible for additional assistance upon completion of a financial assistance application with designated financial counselors.

   To be eligible for this additional financial assistance the patient must be a resident of New York State, or the Hospital's primary service area and meet predetermined income limits. The patient must have received emergency or medically-necessary services and be uninsured or receive services that are not covered by his/her health insurance or have exhausted their health insurance benefits, and must be deemed ineligible for any other government assistance program by the financial counseling office of the Hospital.

Income and Assistance Levels

The level of financial assistance is dependent on family size and current income level.

The Hospital's Financial Assistance Grid details the amount of charitable discounting to be applied and covered services based upon the listing of income levels and family size.

There is no resource test for financial assistance eligible patients.

Eligibility determinations are subject to change if the patient experiences a life-event change, such as marriage, birth of a child, loss of employment, and/or change in income, or enrollment in third-party health insurance for covered services. Patients receiving financial assistance are required to notify the Hospital of any such change in status.

Financial assistance eligibility determinations are effective for one year, and applicants must reapply in order to renew their financial assistance.

FHMC's FAP ensures that any patient treated in the facility, or ancillary sites that has been deemed to be eligible is entitled to a global charitable discount (from total charges) for emergency and/or medically necessary services regardless of their ability to pay. The global charitable discount is based on expected reimbursement from Medicaid for covered services.

Presumptive Financial Assistance

All uninsured patients who reside in the state of New York and are treated for emergency or medically necessary services at FHMC are automatically eligible for presumptive financial assistance. Presumptive financial assistance provides patients with a reduction in payment responsibilities without requiring that they submit an application for financial assistance. Patients identified through the presumptive screening process will be billed at the rate that the hospital would have been reimbursed by Medicaid for those same services. In the event total charges are less than the expected Medicaid reimbursement for services rendered, the patient is responsible only for the lesser of the two amounts.

To determine eligibility for presumptive financial assistance, the Hospital reserves the right to review or use an agent to review patient financial information. The Hospital or contracted entity may utilize soft credit checks to establish patient income and family size. Presumptive eligibility for financial assistance will then be determined and applied if, or when, current income can be reliably established for the patient utilizing third-party means and the income falls within 300% of the federal poverty level.

If at any point in the process a patient decides to complete a full application after a presumptive determination has been rendered, the Hospital will require supporting documentation with specific income and/or expense documentation to support the patient's application for additional assistance.

A patient is given up to 20 days after submission of an application to submit additional documents and information needed to complete the application.

Timing:

Eligibility determinations regarding approval, or denial, of financial assistance applications are made within, at most, 30 days of receipt of a completed application. All eligibility determinations are provided to applicants in writing.

Under the FAP patients may apply for financial assistance up to 120 days after inpatient discharge or receipt of outpatient services, before the Hospital may refer unpaid accounts to a collection agency. However, patients may apply for financial assistance even if their accounts are in collection for up to 240 days from date(s) of service.

Financial assistance applicants are not required to pay their hospital bill(s) while the application for assistance is being considered until a determination is made.

Application and Review Process:

Hospital staff assists patients in the application process, including explaining the policies and procedures. Patients applying for financial assistance are required to provide all information necessary for determination of eligibility.

If, in the judgment of the Hospital, a patient may be eligible for Medicaid or another health insurance program Hospital policy requires that the patient apply for such coverage before being granted eligibility for financial assistance.

Whenever possible, a financial assistance eligibility determination is made concurrent to the submission of a Medicaid application. This is done in order to avoid creating any undue barriers to care while the Medicaid application is processing. In any event, a financial assistance determination will be rendered no later than 30 days from the Medicaid determination.

Applicants for financial assistance will be asked to establish and/or provide proof of current income and family size. Proof of income can be directly established by providing pay stubs, employment letters, or tax forms. Proof of income can be indirectly established if the applicant's current income has been verified by the New York State Department of Health via the NYS of Health marketplace website.

Required documentation may include self-attestations of income in appropriate circumstances.

Following a determination of approval for financial assistance, an FAP-eligible individual may not be charged more than the rate customarily paid by Medicaid for the identical service.

The eligibility determination is provided to the patient in writing and includes the method by which the patient can appeal a denial. The financial assistance denial letter explains the basis for denial and includes the process by which a patient can request a review of his/her eligibility determination.

Appeal:

Patients who disagree with their financial assistance eligibility determination may file an internal appeal through the financial assistance appeals process requesting a review of their eligibility determination. All appeals are reviewed by the Director of the Financial Office (or his/her designee), and a response provided in writing within 30 days of the appeal.

If the patient continues to disagree with the decision on the appeal, he/she can escalate the appeal for review by the Chief Financial Officer of the Hospital (or his/her designee).

During the appeals process the patient is not responsible for paying any applicable Hospital bills.

If a patient disagrees with an eligibility determination but does not want to appeal through the Hospital, he/she can contact the New York State Department of Health at 800-804-5447.

Billing and Collections:

Flushing Hospital Medical Center provides information about the availability of a financial assistance program on all bills and statements sent to patients.

Additionally, the Hospital requires outside contracted collections agencies to provide patients with, whenever possible, a plain language summary of the FAP and information about the availability of the financial assistance program.

Any accounts referred to collection in which a patient expresses interest in applying for financial assistance will be referred back to the Hospital for application processing.

The Hospital utilizes the "prospective" method established by the IRS for determining discounted fees for eligible individuals. Specifically, the Hospital bases all charitable discounting fees on the Hospital's highest volume payer rate – in compliance with IRS Financial Assistance Policy final rules.

In addition, the Hospital collects nominal payment amounts based on current income of eligible individual for emergency and medically necessary services – consistent with guidelines established by the New York State (NYS) Commissioner of Health.

Per NYS Financial Assistance Law, the maximum amounts that can be charged to patients whose incomes are at or below 100% of the FPL are as follows:

$150/discharge for inpatient services
$150/procedure for ambulatory surgery
$150/procedure for MRI testing
$15/visit for adult ER/clinic services
$0/visit for prenatal and pediatric ER/clinic services (pediatric patients are patients < 18 years of age)

All other covered services for eligible individuals at or below 100% of the FPL will be billed at 5% of the amount that the Hospital would have been reimbursed by its highest volume payer for the same services.

For eligible individuals with incomes between 101% and 150% of the FPL, all covered services will be billed at 20% of the amount that the Hospital would have been reimbursed by its highest volume payer for the same services.

For eligible individuals with incomes between 151% and 200% of the FPL, all covered services will be billed at 40% of the amount that the Hospital would have been reimbursed by its highest volume payer for the same services.

For eligible individuals with incomes between 201% and 250% of the FPL, all covered services will be billed at 60% of the amount that the Hospital would have been reimbursed by its highest volume payer for the same services.

For eligible individuals with incomes above 250% of the FPL, all covered services will be billed at 80% of the amount that the Hospital would have been reimbursed by its highest volume payer for the same services.

Where the highest volume payer does not provide a reimbursement methodology for a medically-necessary service rendered, financial assistance recipients will be billed at a percentage of the hospital costs based on financial aid discounting increments.

Please note that if its highest volume payer rate is greater than the Hospital's total charge for the service, the patient will be billed at the lesser of the two amounts.

The Hospital offers installment plans for payment of outstanding balances for patients approved for financial assistance.

The Hospital does not mandate that any monthly installment payment arrangement exceed 10% of the applicant's gross monthly income.

The Hospital does not charge an interest rate that exceeds the rate for a 90-day security issued by the US Department of Treasury, plus 0.5%. There is no accelerator or similar clause under which a higher rate of interest is triggered when a patient misses making a payment.

The Hospital does not engage in any extraordinary collection activities (ECAs).

The Hospital includes a written notice on patients' bills and statements at least 30 days prior to referring the account to collection.

The Hospital requires that any collections agencies with which it contracts follow the financial assistance policies of the hospital.

Collection is prohibited against any patient who was eligible for Medicaid at the time services were rendered.

The Hospital does not force the sale or foreclosure of a patient's primary residence to collect on an outstanding bill.

All contracted collections agencies on behalf of the Hospital must obtain the hospital's written consent before commencing a legal action.

Patients with account balances deemed their responsibility may be subject to the Hospital asserting a lien against any and all rights of action, suits, claims, counterclaims, demands or settlements of any nature that may be relating to or a result of personal injuries sustained prior to receiving treatment, care, and/or services at the Hospital, pursuant to Section 189 of New York States Lien Law, and any other applicable laws, rules or regulations.

Patient accounts to which a Hospital Lien has been filed are not eligible for coverage under this Program absent independent review, consideration, and subsequent settlement between the Hospital and the patient/guarantor.

The Hospital may require a deposit before providing non-emergent, medically necessary care, and it will be included as part of any financial assistance consideration.

Reporting and Compliance:

FH FAP, emergency medical policy, and billing and collections policies have been adopted by the authorized body of the organization (Board of Trustees).

FHMC, as a condition for participation in the Indigent Care Pools, certifies via attestation by an independent licensed public accountant that the Hospital is in compliance with reporting laws.

The Hospital's Finance Department submits financial assistance cost reporting on a yearly basis to the NYS Department of Health and Centers for Medicare and Medicaid Services.

Financial assistance cost reporting data is collected directly from registration reports generated from the Hospital's electronic medical records system.

Financial assistance cost reporting includes the following:

- The Hospital will provide the costs incurred and the uncollected amounts in providing services to eligible patients without insurance;
- The amount of care provided for a nominal payment amount;
- The hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;
- The number of patients organized by zip code, who applied for financial assistance;
- The number of applications approved, and the number denied;
- The reimbursement received for indigent care from the Indigent Care Pool;
- The amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose for providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;
- The number of applications for eligibility under Medicaid that the hospital assisted patients in completing and the number denied and approved;

- The hospital's financial losses resulting from services provided under Medicaid, and;
- The number of liens placed on the primary residences of patients through the collections process used by the hospital.

On a yearly basis, the Internal Auditing Department shall randomly select fifteen (15) self-pay/financial assistance accounts and analyze whether designated hospital staff have complied with all financial assistance policies and procedures in establishing eligibility and/or determining the account status. These reviews will be utilized to ensure compliance and to improve the financial assistance process – wherever necessary.

Staff Education:

FHMC trains on this policy all staff responsible for engaging or otherwise assisting in the applications for financial assistance.

The Human Resources Department includes education on the Hospital's financial assistance program in its new employee orientation training and in its annual staff re-orientation review.