BURDETT BIRTH CENTER	**Effective Date:** 01/01/2016
Category: Finance	
Title: Financial Assistance to Patients Policy and Procedure	

TABLE OF CONTENTS

POLICY STATEMENT……………………………………………………………………………1
PROCEDURE……………………………………………………………………………....1
DEFINITIONS...9
LINKS

POLICY STATEMENT

Burdett Birth Center (BBC) is committed to minimizing the financial barriers to health care that exist for certain members of our community, in particular, those not adequately covered by health insurance or governmental payment programs. As such, financial aid to assist low income, uninsured or underinsured individuals with claims is available to all who qualify.

Accordingly, BBC shall offer Financial Assistance in accordance with this Financial Assistance Plan (FAP). This FAP was developed to comply with all federal and state rules and regulations, including IRS regulations §1.501r and NYS Public Health Law §2807-k.9-a.

PROCEDURE

I. Eligibility Criteria

1. A patient is eligible for financial assistance if his or her income is less than 400% of federal poverty guidelines.

2. Homeless patients, deceased patients with no known estate and patient bankruptcies are automatically eligible for financial assistance.

3. All medically necessary services will be eligible for financial assistance.

4. Services not provided and billed for financial assistance include:

   a. Services not provided and billed by the Hospital (e.g. independent physician services, ambulance transport).

   b. The Hospital will proactively help patients apply for public and private programs. The Hospital may deny financial support to those individuals who do not cooperate in applying for programs that may pay for their health care services, or those of its dependents.

5. The Hospital will provide financial assistance to patients residing within our defined primary service area and who qualify under the Hospital's FAP procedure. Primary Service Area consists of the following counties: Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

6. The Hospital will provide Financial Support to patients from outside their Service Areas who qualify under the Hospital's FAP and who present with an Urgent, Emergent or life-threatening condition.

II. Documentation for Establishing Income

1. Information provided to the Hospital by the patient and/or family should include earned household income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and income from any other source; number of dependents in household; and other information to determine the patient’s financial resources.

2. Supporting documents such as payroll stubs, tax returns, and credit history may be requested to support information reported and shall be maintained with the completed application and assessment. The Hospital will not deny Financial Support based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.

3. The Hospital will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. The Hospital may initiate Extraordinary Collection Actions (ECAs) if the patient does not submit the missing information and/or documentation within the 30 day resubmission period and it is at least 120 days from the date the Hospital provided the first post-discharge billing statement for the care. The Hospital must process the FAP application if the patient provides the missing information and/or documentation during the 240 day application period (or, if later, within the 30-day resubmission period.)

III. Presumptive Support

1. The Hospital recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted it is classified as “Presumptive Support”.

2. The predictive model is one of the reasonable efforts that may be utilized by the Hospital to identify patients who may qualify for financial assistance prior to initiating collection actions, *i.e.* write-off to bad debt and referral to collection agency, for the patient account. This predictive model enables the Hospital to systematically identify financially needy patients.

3. Examples of presumptive cases include:

- deceased patients with no known estate;
- homeless patients;
- non-covered medically necessary services provided to patients qualifying for public assistance programs; and
- patient bankruptcies

4. For patients who are non-responsive to the application process, other sources of information, if available, should be used to make an individual assessment of financial need. This information will enable the Hospital to make an informed decision on the financial need of non-responsive patients.

5. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record databases. These public records enable the Hospital to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

6. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within established timelines and be considered under the traditional financial assistance application process.

7. The Hospital will notify patients determined to be eligible for less than the most generous assistance available under the FAP that he or she may apply for more generous assistance available under the FAP within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, the Hospital may initiate or resume ECAs if the patient does not apply for more generous assistance within 30 days of notification if it is at least 120 days from the date the Hospital provided the first post-discharge billing statement for the care. The Hospital will process any new FAP application that the patient submits by the end of the application period or, if later, by the end of the 30-day period given to apply for more generous assistance.

IV. Timeline for Establishing Financial Eligibility

1. Every effort should be made to determine a patient's eligibility for Financial Support prior to or at the time of admission or service. Financial assistance applications will be accepted during the application period. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or either

    a. The end of the period of time that a patient that is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or

    b. The deadline provided in a written notice after which ECAs may be initiated.

2. The Hospital) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than $5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refunds of payments is only required for the episodes of care to which the FAP application applies.

3. Determination for Financial Support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted.

4. The Hospital will make every effort to make a Financial Support determination within 30 days of receipt of a completed application. If other avenues of Financial Support are being pursued, the Hospital will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

   a. If a patient's completed application is denied, the patient may appeal within thirty (30) days from the date of Financial Assistance determinations made under this policy, in writing to Burdett Birth Center, c/o St. Peter's Hospital, Financial Assistance Unit, 319 South Manning Blvd., 4th Floor, Suite 402 Albany, NY, 12208.

   b. Applications are approved for a period of one (1) year from the date of program determination. Failure to sustain insurance coverage through the Medicaid, New York State Health Exchange, publicly sponsored insurance programs or private insurer will result in revocation of current financial assistance status for all services provided on or after the date of cancellation notice.

   c. Patients may be asked to verify financial and/or demographic information periodically throughout their program approval period. Patients will be re-evaluated for publicly sponsored health insurance (i.e.; Medicaid, NY State of Health Marketplace) during a subsequent visit to the Hospital when their balance due is equal to or greater than $5,000 or they are admitted to the Hospital during their approval period.

V. Level of Financial Support

1. The Hospital will follow the Income guidelines established below in evaluating a patient's eligibility for Financial Support. A percentage of the Federal Poverty Level (FPL) Guidelines, which are updated on an annual basis, is used for determining a patient's eligibility for Financial Support. However, other factors will also be considered such as the patient's financial status and/or ability to pay as determined through the assessment process.

2. Family Income at or below 200% of the Federal Poverty Level Guidelines:

   A full discount off total charges will be provided for Uninsured Patients whose Family's Income is at or below 200% of the most recent Federal Poverty Level Guidelines.

3. Family Income between 201% and 400% of the Federal Poverty Level Guidelines:

Family income between 201% and 400% of the Federal Poverty Level Guidelines: A discount off total charges equal to the Hospital's average contractual adjustment for Medicaid/ Medicaid Managed Care payors will be provided for patient whose family income is between 201% and 400% of the Federal Poverty Level Guidelines. The Hospital's average contractual adjustment amount for Medicaid/Medicaid Managed Care will be calculated utilizing the look back methodology of calculating the sum of paid claims divided by the total of "gross" charges for those claims annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

4. Patients with Family Income up to and including 400% of the Federal Poverty Level Guidelines will be eligible for Financial Support for co-pay, deductible, and coinsurance amounts provided that contractual arrangement with patient's insurer do not prohibit providing such assistance

5. Medically Indigent Support/Catastrophic: Financial support is also provided for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their Family or household Income (for example, due to catastrophic costs or conditions), regardless of whether they have Income or assets that otherwise exceed the financial eligibility requirements for Free Care or Discounted Care under the Hospital's FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence/catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's Income, expenses and assets. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of Income will qualify the insured patient's co-pays and deductibles for catastrophic charity care assistance. Discounts for medically indigent care for the uninsured will not be less than the Hospital's average contractual adjustment amount for Medicaid/Medicaid Managed Care for the services provided or an amount to bring the patient's catastrophic medical expense to Income ratio back to 20%. Medically indigent and catastrophic financial assistance will be approved by the Hospital's Director of Finance.

6. While Financial Support should be made in accordance with the Hospital's established written criteria, it is recognized that occasionally there will be a need for granting additional Financial Support to patients based upon individual considerations. Such individual considerations will be approved by the Director of Finance.

VI. Assisting Patients Who May Qualify for Coverage

1. The Hospital will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Premium assistance may also be granted on a discretionary basis according to our procedure.

2. The Hospital will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the Hospital's FAP.

VII. Effective Communications

1. The Hospital will provide financial counseling to patients about their health care bills related to the services they received at the Hospital and will make the availability of such counseling known.

2. The Hospital will respond promptly and courteously to patients' questions about their bills and requests for financial assistance.

3. The Hospital will utilize a billing process that is clear, concise, correct and patient friendly.

4. The Hospital will make available for review by the public specific information in an understandable format about what they charge for services.

5. The Hospital will post signs and display brochures that provide basic information about their FAP in public locations in the Hospital. Information about FAP can be found in all patient registration areas and patient points of entry.

6. The Hospital will make available a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process. The Hospital will not have failed to widely publicize its FAP because an individual declines a plain language summary that was offered on intake or before discharge or indicates that he or she would prefer to receive a plain language summary electronically.

7. The Hospital will make the FAP, a plain language summary of the FAP and the FAP application form available to patients upon request, in public places in the Hospital, by mail and on the Hospital website. Any individual with access to the Internet must be able to view, download and print a hard copy of these documents. The Hospital must provide any individual who asks how to access a copy of the FAP, FAP application form, or plain language summary of the FAP online with the direct website address, or URL, where these documents are posted.

8. These documents will be made available in English and in the primary language of any population with limited proficiency in English that constitutes more than 5% of patient population or 1,000 individuals.

   a. Applications and/or confidential assistance with completion of the application are available on our website, www.burdettcarecenter.org from any patient Registrar, calling our Financial Assistance Unit by 518-525-1565 or emailing the Financial Assistance Unit at SPHPFAP@SPHP.COM.

9. The Hospital will take measures to notify members of the community served by the Hospital about the FAP. Such measures may include, for example, the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low income populations.

10. The Hospital will include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the Hospital's FAP and includes the telephone number of the Hospital's department that can provide information about the FAP, the FAP application process and the direct Web site address (or URL) where copies of the FAP, FAP application from, and plain language summary of the FAP may be obtained.

11. The Hospital will refrain from initiating ECAs until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient. The Hospital will also ensure all vendor contracts for business associates performing collection activity will contain a clause or clauses prohibiting ECAs until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patients.

12. The Hospital will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECAs that the Hospital (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided. The Hospital will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the Hospital's FAP and about how the patient may obtain assistance with the FAP application process.

13. The Hospital will provide written notification that nothing is owed if a patient is determined to be eligible for Free Care.

14. The Hospital will provide patients that are determined to be eligible for assistance other than Free Care with a billing statement that indicates the amount the patient owes for care as a FAP-eligible patient. The statement will describe how that amount was determined or how the patient can get information regarding how the amount was determined.

15. Physicians providing emergency or medically necessary care in the Hospital are not covered by this policy. A listing of these physicians is included in Appendix A of this policy.

VIII. Implementation of Accurate and Consistent Policies

1. Patient Financial Services and Patient Access will educate staff members who work closely with patients about billing, financial assistance, collection policies and practices.

2. The Hospital will honor Financial Support commitments that were approved under previous financial assistance guidelines. At the end of that eligibility period the patient may be re-evaluated for Financial Support using the guidelines established in this Procedure.

IX. Fair Billing and Collection Practices

1. The Hospital will implement billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations.

2. The Hospital will make available to all patients who qualify a short term interest free payment plan with defined payment time frames based on the outstanding account balance

3. The Hospital will have written procedures outlining when and under whose authority a patient debt is advanced for external collection activities that are consistent with this Procedure.

4. The following collection activities may be pursued by the Hospital or by a collection agent on their behalf:
    a. Communicate with patients (call, written, fax, text, email, etc.) and their representatives in compliance with the Fair Debt Collections Act, clearly identifying the Hospital. The patient communications will also comply with HIPAA privacy regulations.

    b. Solicit payment of the estimated patient payment obligation portion at the time of service in compliance with EMTALA regulations and state laws.

    c. Report outstanding debts to Credit Bureaus only after all aspects of this Procedure have been applied and after reasonable collection efforts have been made in conformance with the Hospital FAP.

    d. Pursue legal action for individuals who have the means to pay but do not pay or who are unwilling to pay. Legal action also may be pursued for the portion of the unpaid amount after application of the Hospital's FAP. An approval by the Director of Finance or the Director of Patient Financial Services must be obtained prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).

    e. Place liens on property of individuals who have the means to pay but do not or who are unwilling to pay. Liens may be placed for the portion of the unpaid amount after application of the Hospital's FAP. Placement of lien requires approval by the Director of Finance or the functional leader for Patient Financial Services for the Hospital. Liens on primary residence can only be exercised upon the sale of property and will protect certain asset value in the property as documented in each Hospital's Procedure. Burdett Birth Center will protect 50% of the equity up to $50,000.

5. The Hospital (or a collection agent on their behalf) shall not pursue action against the debtor's person, such as arrest warrants or "body attachments." The Hospital recognizes that a court of law may impose an arrest warrant or other similar action against a defendant for failure to comply with a court's order or for other violations of law related to a collection effort. While in extreme cases of willful avoidance and failure to pay a justly due amount when adequate resources are available to do so a court order may be issued; in general, the Hospital will first use its efforts to convince the public authorities not to take such an action and, if not successful, consider the appropriateness of ceasing the collection effort to avoid an action against the person of the debtor.

6. The Hospital (or collection agent on their behalf) will take all reasonably available measures to reverse ECA's related to amounts no longer owed by FAP-eligible patients.

7. Burdett Birth Center may have arrangement with a collection agency, provided that such agreement meets the following criteria:

    a. The agreement with a collection agency must be in writing;

b. Neither the Hospital nor the collection agency may at any time pursue action against the debtor's person, such as arrest warrants or "body attachments;"

c. The agreement must define the standards and scope of practices to be used by outside collection agents acting on behalf of the Hospital, all of which must be in compliance with this Procedure;

d. No legal action may be undertaken by the collection agency without the prior written permission of the Hospital;

e. All decisions as to the manner in which the claim is to be handled by the attorney, whether suit is to be brought, whether the claim is to be compromised or settled, whether the claim is to be returned to the Hospital, and any other matters related to resolution of the claim by the attorney shall be made by the Hospital in consultation with Legal Services;

f. Any request for legal action to collect a judgment (*i.e.,* lien, garnishment, debtor's exam) must be approved in writing and in advance with respect to each account by the appropriate authorized Hospital representative;

g. The Hospital must reserve the right to discontinue collection actions at any time with respect to any specific account; and

h. The collection agency must agree to indemnify Hospital for any violation of the terms of its written agreement with the Hospital.

X. Other Discounts

1. Prompt Pay Discounts: the Hospital may develop a prompt pay discount program which will be limited to balances equal to or greater than $200.00 and will be no more than 20% of the balance due. The prompt pay discount is to be offered at the time of service and recorded as a contractual adjustment and cannot be recorded as charity care on the financial statements.

2. Self-Pay Discounts: the Hospital will apply a standard self-pay discount off of charges for all registered self-pay patients that do not qualify for financial assistance (e.g., >400% of FPL) based on the highest commercial rate paid.

3. Additional Discounts: Adjustments in excess of the percentage discounts described in this Procedure may be made on a case-by-case basis upon an evaluation of the collectability of the account and authorized by the Hospital's established approval levels.

Should any provision of this FAP conflict with the requirement of the law of the State of New York, state law shall supersede the conflicting provision and the Hospital shall act in conformance with applicable state law.

a. If a patient is unable to resolve any concerns or issues after working with a Burdett Birth Center representative, the patient may call the New York State Department of Health at 1-800-804-5447.

DEFINITIONS

Application Period begins the day that care is provided and end the later of 240 days after the first post-discharge billing statement is provided to the patient or either –

1. The end of the 30 day period that patients who qualified for less than the most generous assistance available based up presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.

2. The deadline provided in a written notice after which ECAs may be initiated.

Amount Generally Billed ("AGB") means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, The Hospital's acute and physician AGB will be calculated utilizing the look back methodology of calculating the sum of paid Medicaid/Medicaid Managed Care claims divided by the total or "gross" charges for those claims by the System Office or Hospital annually using the twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

Discounted Care means a partial discount off the amount owed for the patients that qualify under the FAP.

Emergent medical services are those needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by Emergency Medical Treatment and Active Labor Act (EMTALA).

Extraordinary Collection Actions ("ECA") include the following actions taken by the Hospital (or a collection agent on their behalf):

- Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP. If a Hospital requires payments before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual's nonpayment of the outstanding bill(s) unless the Hospital can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.

- Reporting outstanding debts to Credit Bureaus.

- Pursuing legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).

- Placing liens on property of individuals.

Family (as defined by the U.S. Census Bureau) is a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility under the Hospital’s FAP.

Family Income - A person’s Family Income includes the Income of all adult Family members in the household. For patients under 18 years of age, Family Income includes that of the parents and/or step-parents, or caretaker relatives’ annual Income from the prior 12 month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be

determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Financial Support means support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by the Hospital who meet the eligibility criteria for such assistance.

Free Care means a full discount off the amount owed for patient that qualify under the FAP.

Income includes wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, child support, alimony, educational assistance, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity is defined as documented in each Hospital's state's Medicaid Provider Manual.

Plain Language Summary of the FAP means a written statement that notifies a patient that the Hospital offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand.

- A brief description of the eligibility requirements and assistance offered under the FAP
- A brief summary how to apply for assistance under the FAP,
- The direct Web site address (or URL) and physical locations where the patient can obtain copies of the FAP and the FAP application form.
- Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail.
- The contact information, including telephone number and physical location, of the department that can provide information about the FAP and provide assistance with the FAP application process.
- The statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.
- A statement that a FAP-eligible patient may not be charged more than AGB for emergency or other medically necessary care.

Service Area is the list of zip codes or counties comprising the Hospital service market area constituting a "community of need" for primary health care services.

Uninsured Patient means an individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which the Hospital is subrogated, but only if payment is actually made by such insurance company.

Urgent (service level) are medical services are those needed for a condition that is not life threatening, but requiring timely medical services.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Procedure may be obtained from the Director of Finance.

APPROVALS

Initial Approval:

Subsequent Review/Revision(s):

<table>
<tr><td>Approving Official: Board of Directors</td><td rowspan="2"></td><td rowspan="2">Effective Date: 10/1/11</td></tr>
<tr><td>Key Sponsor: Director of Finance</td></tr>
<tr><td>Reviewed By: Director of Finance</td><td rowspan="2"></td><td rowspan="2">Original Date: 10/1/11
Reviewed/Revised Date: 1/1/16

*Reviewed, No Revisions
**Revised without Full Review</td></tr>
<tr><td>Search Terms: Financial Assistance, Charity Care, FAP</td></tr>
<tr><td colspan="3">Replaces: 1101.1 Credit & Collection Policies for Self Pay
and
1101.3 Financial Assistance</td></tr>
<tr><td colspan="3"></td></tr>
</table>