Catholic Health	POLICY AND PROCEDURE	
TITLE: Uninsured Expected Payment and Healthcare Assistance Policy	**POLICY NUMBER:** CHS-RMC-03	**PAGE #** 1 of 6
RESPONSIBLE DEPARTMENT: Finance	**POLICY LEVEL:** CHS	**EFFECTIVE DATE:** 5/1/2022
PREPARED BY: Craig Chase, Vice-President Patient and Resident Financial Services	**APPROVED BY:** Lisa Cilano, Senior Vice-President, Finance Bart Rodrigues, Senior Vice-President, Chief Mission Officer, CHS Corporate Leonardo Sette-Camara 3/11/22 Operational Policy Council 12/14/15	**MSMH:** 5/1/2022
This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its Associates for either employment or the provision of any benefit. This policy supersedes any policy previous to this policy for any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may be subject to disciplinary action up to and including termination.		

PURPOSE: Based on our mission, Catholic Health is committed to providing health care services to all patients based on medical necessity. However, we also recognize the need to provide financial assistance to those who find it difficult to manage the expenses incurred when receiving medical services at our facilities. The purpose of this policy is to define the Healthcare Assistance Program (HAP) and establish the necessary guidelines and criteria for eligibility.

APPLIES TO: Catholic Health extends discounts to uninsured and underinsured patients who receive medically necessary services. While Catholic Health primarily serves the five counties of Western New York, all patients who reside in New York State, contiguous states, or the state of Ohio, and whose household income is equal to or less than 400% of the most recent Federal Poverty Guidelines (as outlined in Attachment C) are eligible to apply. In addition, patients who reside outside of NYS, and Catholic Health is not a Medicaid provider in the state the patient resides, may apply. All other patients will be reviewed at the discretion of Catholic Health.

POLICY: The Healthcare Assistance Program, implemented in accordance with all applicable New York State and Federal laws, rules and regulations, considers a patient's ability to contribute to their healthcare costs and places no undue burden on the patient or the patient's family. Patients will be provided information and counseling regarding alternative programs or services within their community, in conformance with all applicable New York State and federal laws such as EMTALA. Catholic Health will make reasonable efforts to explain the benefits of Medicaid and other available public and private coverage programs to patients and assist them with the application process. A patient may apply for Medicaid, other insurances, and/or financial assistance at the same time, and may also be screened for presumptive eligibility as described below.

This policy covers all Catholic Health ministries and medically necessary services with the exception of the following: 1) non-medically necessary elective services, 2) provider services other than Catholic Health primary care provider services, Catholic Health employed providers, and others listed as Cover Providers (see attachment D), 3) sub-acute and skilled nursing long term care services and, 4) convenience items such as television, telephone and requested private room charges.

Only services performed by Catholic Health employed providers are covered by the Healthcare Assistance Program. Services performed by non-employed providers within a Catholic Health facility will not be covered by the program and will be billed separately. Instructions on how to obtain a list of both covered and non-covered providers can be found in Attachment D.

PROCEDURE:

1. General Procedure Expectations: all reimbursement and collection practices engaged in and observed by Catholic Health employees, contractors and agents will reflect Catholic Health's mission, values, and policies; patients on admission are given, and receive, prompt access to charge information for any item or services provided to them upon request; the program will be implemented in a manner consistent with all applicable New York State and Federal laws, rules, and regulations; and patients and their families are advised of Catholic

Health's policies, including the Healthcare Assistance Program and the availability of need-based financial assistance, in easily understood terms and any language commonly spoken by patients in the community.

2. An uninsured patient whose household income is equal to or less than 200% of the current Federal Poverty Guidelines qualifies for a 100% discount. If a patient's household income is greater than 200% and less than or equal to 400% of the current Federal Poverty Guidelines, then the patient qualifies for a partial discount as detailed in Attachment C. In compliance with Section 501(r) of the Internal Revenue Code, eligible patients will not be charged more than "amounts generally billed" ("AGB") to insured individuals. AGB is the average amount Catholic Health would receive from Medicaid for emergency or other medically necessary care. If in the event there is not a Medicaid fee for needed care, the New York State Medicaid fee schedule will be used to determine the uninsured self-pay rate.
3. Catholic Health uses third-party vendor presumptive eligibility tools to assist in determining an uninsured patient's qualification for a discount under the Healthcare Assistance Program. The assessment of a patient's ability to pay is based on a presumptive, objective, good faith determination that will be applied to all uninsured patients in the same manner. All income sources, the cost of living, family size and other financial considerations will be considered.
4. An uninsured individual receiving a discount of less than 100% may complete a Financial Assistance Application. Insured patients are also eligible for discounts under the Financial Assistance Program to offset the cost of coinsurance, deductibles, and other remaining patient balances. Patients interested in the Financial Assistance Program must complete, sign, and date an application form. In addition, the application must include one of the following forms of current income verification: Signed copy of the patient's most recent federal tax return; Copies of their last three pay stubs; Copies of their last three (3) unemployment payment stubs; Copies of their last two Social Security Payment Statements; self-employment business records of earnings and expenses; or a signed and notarized statement verifying no income sources. A copy of the application can be found in Attachment A.
5. The sliding scale for awarding financial assistance discounts for both uninsured and insured patients is outlined in Attachment C.
6. Patients have until the 240th day after the first billing statement to submit an application. Catholic Health will make determinations within 30 days of the receipt of a completed application and supporting documentation as outlined above. Awards will be granted for a period of six months prior and six months after the date of service requested on the Financial Assistance Application. Retro-eligibility may be extended back to 12 months at the discretion of Catholic Health. Patients will be notified of determinations in writing and any payments made in excess of the approved discount will be refunded in a timely manner. If applicable, collection agencies will be notified to cease collection efforts.
7. If an application is incomplete, Catholic Health will provide notice in writing of what additional information is needed. Patients will have 30 days from the date of the letter to comply with the request. If information is not received within the allowed time the case will be considered closed and regular collection efforts will begin.
8. Billing and collection efforts, as outlined in the Billing and Collections Policy CHS-RMC-08, will be suspended once a completed Financial Assistance Application has been received. A patient may disregard any bill from Catholic Health while the pending application is under review. If at any time during the application process it is determined a patient is eligible for Medicaid or other insurance programs, collection efforts will cease and the appropriate payer program will be billed.
9. Related collection practices from the Billing and Collections Policy CHS-RMC-08 are as follows:

    a. An uninsured patient account will not be forwarded to a collection agency if the patient has completed a Healthcare Assistance Program application or appeal and is awaiting response or determination.
    b. The forced sale or foreclosure of an uninsured patient's primary residence, in order to satisfy a patient account, shall be prohibited for all services with the exception of Community Based Care services.
    c. Uninsured patients who are participating in the HAP must be notified at least thirty (30) days before their account is forwarded to a collection agency.
    d. All collection agencies servicing Catholic Health accounts must obtain written consent from the Catholic Health before any legal actions is initiated on any patient account.

e. All collection agencies must agree in writing to follow all Catholic Health Uninsured Expected Payment and Collection Policies and Procedures.
f. Management is accountable to ensure that all collection policies are in accordance with the federal Fair Debt Collection Practices Act and all applicable New York State Law.
g. All collection agencies must provide information to patients on how to apply for Healthcare Assistance or appeal a Healthcare Assistance determination that is below their expectations.

10. All collection agencies are prohibited from making collections from any patient who was eligible for Medicaid at the time services were rendered.
11. Patients with balances remaining after a Healthcare Assistance Program award will be eligible for extended payment terms. Installment payments will be capped at 10% of gross monthly income of the patient's defined household in accordance with New York State Public Health Law.
12. Any and all determinations made under this policy may be appealed by phone or in writing as detailed in Attachment B. All reconsiderations will be made within 30 days of the date of appeal.
13. Information on the Healthcare Assistance Program is posted in key public access areas such as registration areas and Emergency Departments. In addition, the Catholic Health website contains information on how to apply as well as a plain language summary of this entire policy. Information is available in the primary languages spoken throughout the community. Patients are also offered the opportunity to have the material translated by a multi-lingual telephone translation service. All materials and information will be available to patients upon request and found on the website www.chsbuffalo.org/billing-insurance/financial-assistance.
14. Catholic Health associates engaged in making financial assistance determinations will be trained no less than annually and be kept abreast of procedural and, or regulatory changes.

REVIEW LEVEL:
This policy will be reviewed annually to ensure compliance with related state and federal regulations and any changes in Catholic Health's operational methodology or process.

ORIGINATION DATE: 1/1/2014

REPLACES (If applicable): NA

	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials
REVIEWED:	2/4/2014 SRK	1/29/2015 SRK	12/01/15 LS				02/14/18 BB	
REVISED:	2/4/2014 SRK	1/29/15 SRK	12/01/15 SRK	2/02/16 BB	03/24/16 BB	02/03/17 BB	02/14/18 SL	02/22/19 BB
REVISED:	6/13/19 SL	3/10/22 SL	4/28/2022 SL	2/20/24 SS				

CSC/OPC APPROVAL: 12/14/15, 3/30/16, 2/6/18, 6/26/19

REFERENCES: NA

Catholic Health

Attachment A: Healthcare Assistance Program Application

Thank you for choosing Catholic Health for your healthcare needs. We are pleased to offer you the opportunity to apply for financial assistance. To be considered for our Healthcare Assistance Program, please print this letter and provide the required information below:

Patient Full Name: _____

Patient Date of Birth: _____ Phone#: _____

Contact Phone: _____

Patient Address: _____

_____

Bill Account Number: _____

Number of People in Household (you, your spouse, and children under 18): _____

Additionally, please include one of the following forms of current income verification:

- A brief letter of hardship stating you would like to apply for healthcare assistance;
- One of the following forms of current income verification: Signed copy of the patients most recent federal tax return; Copies of their last three pay stubs; Copies of their last three unemployment payment stubs; Copies of their lst two Social Security Payment Statements; self-employment business records of earnings and expenses; or a signed and notarized statement verifying no income sources.

You have 240 days from your first billing statement to submit this application along with all required documents. While your application is being reviewed you may disregard bills you receive from Catholic Health. Please call us at 716-601-3600 or visit our website https://www.chsbuffalo.org/billing-insurance/financial-assistance for more information.

Signature: _____ **Date**: _____

Please mail required information along with this completed letter to:
Catholic Health/RMC.
144 Genesee Street, 3rd Floor
Buffalo, NY 14203
Attn: Supervisor, Credit & Collection Department

Attachment B: Appeal of Healthcare Assistance Determinations

Any financial assistance determination made under this policy may be appealed. A patient may call the Patient Financial Services team at (716)-601-3600 or appeal in writing at:

Catholic Health Administration & Training Center
Patient Financial Services Team
144 Genesee Street, 3rd Floor
Buffalo, NY 14203

All decisions regarding an appeal will be completed within 30 days of the receipt of the request. Patients will be notified of any appeal outcome in writing. If, after reviewing the decision, a patient is not satisfied they may request a final appeal in the same manner. The review of final appeals will also be held to the 30 days from the date of the request.

All final appeals will be reviewed by the Vice President of Patient Financial Services or their delegate. A written determination of the final appeal signed by the deciding party or parties will be mailed to the applicant.

With the exception of extraordinary circumstances, such as additional or revised information that would impact the original decision received after the date of the final appeal decision) all decisions rendered on appeals will be final. The written notification of determination of a final appeal will not contain any further notice of right of either further review or appeal

Attachment C: Federal Poverty Guidelines as of February 2024

Attachment D: Providers covered and not covered by the Healthcare Assistance Program:

You may find a list of Covered and Non-Covered Providers on the Catholic Health website:

- Covered Providers: https://www.chsbuffalo.org/providers/employed
- Non-Covered Providers: https://www.chsbuffalo.org/providers/non-employed

Covered Providers are only covered under this policy when performing services at the noted location noted.

You may also confirm if a provider is covered under this policy by contacting Patient Financial Services at 716-601-3600

% Federal Poverty Level	FAMILY SIZE										HealthCare Assistance Discount
	1	2	3	4	5	6	7	8	9	10	
Less Than 200%	30120	40880	51640	62400	73160	83920	94680	105440	116200	126960	100 % of balance after Fixed HAP Discount
200%	30120	40880	51640	62400	73160	83920	94680	105440	116200	126960	100% of balance after Fixed HAP Discount
210%	31626	42924	54222	65520	76818	88116	99414	110712	122010	133308	90% of balance after Fixed HAP Discount
220%	33132	44968	56804	68640	80476	92312	104148	115984	127820	139656	80% of balance after Fixed HAP Discount
230%	34638	47012	59386	71760	84134	96508	108882	121256	133630	146004	70% of balance after Fixed HAP Discount
240%	36144	49056	61968	74880	87792	100704	113616	126528	139440	152352	60% of balance after Fixed HAP Discount
250%	37650	51100	64550	78000	91450	104900	118350	131800	145250	158700	50% of balance after Fixed HAP Discount
260%	39156	53144	67132	81120	95108	109096	123084	137072	151060	165048	40% of balance after Fixed HAP Discount
270%	40662	55188	69714	84240	98766	113292	127818	142344	156870	171396	30% of balance after Fixed HAP Discount
280%	42168	57232	72296	87360	102424	117488	132552	147616	162680	177744	20% of balance after Fixed HAP Discount
290%	43674	59276	74878	90480	106082	121684	137286	152888	168490	184092	15% of balance after Fixed HAP Discount
300%	45180	61320	77460	93600	109740	125880	142020	158160	174300	190440	10% of balance after Fixed HAP Discount
350%	52710	71540	90370	109200	128030	146860	165690	184520	203350	222180	5% of balance after Fixed HAP Discount
400%	60240	81760	103280	124800	146320	167840	189360	210880	232400	253920	Fixed HAP Discount*

ORIGINATION DATE: 1/1/2014

REPLACES (If applicable): NA

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CSC/OPC APPROVAL: 12/14/15, 3/30/16, 2/6/18, 6/26/19, Going to 3/30/22 OPC

REFERENCES: NA