Catholic Health Services of Long Island At the heart of health	**CATHOLIC HEALTH SERVICES** **Rockville Centre, New York** **POLICY & PROCEDURE MANUAL**	Effective Date: December 18, 2019 Review Date: November 1, 2019 Supersedes Issue of: December 15, 2015 January 27, 2014 November 20, 2006
	Subject: CHS Financial Assistance Policy	
	Distribution: Revenue Cycle Departments, Finance, Entity Leadership and Compliance	
	Responsible Department: Revenue Cycle and Entity Leadership	

I. Introduction:

As Catholic healthcare providers and consistent with Catholic Health Services of Long Island and its System Hospitals (collectively, CHS) mission of providing care to needy and underserved persons in a manner that preserves the dignity of the individual, this CHS Financial Assistance Policy (Policy) describes the policies and procedures relating to the provision of financial assistance to persons who are unable to pay for all or a portion of their bill. No individual will be denied medically necessary medical services based on a demonstrated inability to pay for those services.

System Hospitals are designated as charitable organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order for a hospital to maintain its tax-exempt status, it is required to adopt and widely publicize its financial assistance policy.

The purpose of this Policy is to establish standard policy and procedures within CHS for identifying and recording financial assistance services and other discounts and to address how System Hospitals calculate amounts charged to patients. Other discounts include self-pay discounts for uninsured patients with the ability to pay for services provided and third-party discounts for non-contracted payors.

The CHS Revenue Cycle Team, along with Entity Leadership, is responsible for the implementation of this Policy.

II. Definitions:

System Hospital – A hospital within the CHS System that is required by New York State to be licensed or registered or similarly recognized as a hospital, including Good Samaritan Hospital Medical Center, Mercy Medical Center, St. Catherine of Siena Medical Center, St. Charles Hospital St. Francis Hospital and St. Joseph Hospital.

Family Income – Family income includes earnings, unemployment compensation, workers compensation, Social Security, supplemental security income, public assistance, veterans payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as food stamps and housing subsidies) do not count. Family income is calculated before taxes and excludes unrealized capital gains or losses.

Financial Assistance – Financial assistance is defined as healthcare provided to patients without expectation of payment for services, in whole or in part, as a result of a patient's financial inability to pay.

Guarantor – An individual who is legally and financially responsible to provide payment on a patient's medical bill.

Liquid Assets – Liquid assets include investments that could be converted into cash within one year; these assets shall be evaluated as cash available to meet essential living expenses and should be consistent with what is reported to the New York State Department of Health.

Medical Necessity – Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life; cause suffering or pain, result in illness or infirmity; threaten to cause or aggravate a handicap; or cause physical deformity or malfunction; if there is no other equally effective, more conservative or less costly course of treatment available.

Medically Indigent Patients – Patients whose health insurance does not provide full coverage for all of their medical expenses, in relationship to their income, and would become indigent if they were required to pay full charges for their medical expenses.

Self-Pay Discounts for Uninsured Patients – The discount extended to those patients/guarantors that provide evidence that no health insurance coverage exists either through an employer-provided program, health insurance exchange or a governmental program such as Medicare, Medicaid or other state and local program to pay for healthcare services rendered to the patient.

Settlement – An agreement for payment between a payor or patient and a System Hospital on an outstanding balance owed by the payor or patient for the purposes of foregoing additional collection activity.

Third Party Discounts – Discounts offered to third-party payors who do not have an existing contract in effect with the System Hospital. Such discounts are offered for various reasons including expediting payments (payment in a specified number of days) or in lieu of an audit.

Uninsured Patients – Patients without insurance coverage for their medical expenses.

Underinsured Patients – Patients with health insurance coverage, however, after adjudication of benefits, large balances remain (e.g. high deductible health plans).

III. Policy:

As Catholic healthcare providers, CHS is called to meet the needs of patients and others who seek care, regardless of their financial ability to pay for services provided. As part of its mission and under this Financial Assistance Policy, System Hospitals may provide free or discounted emergency and other medically necessary care to those eligible individuals not covered under a third party insurer or government program or who do not have resources to pay for all or a portion of their bill. In addition, CHS is committed in assisting eligible patients obtain available health insurance so they may maintain continued coverage for services provided within or outside of CHS.

This Policy applies to hospital services provided at a System Hospital for emergency or other medically necessary care. It does not include physician and other provider services provided at a System Hospital. Such services are typically billed separate and independent of the hospital claim. In addition, dental, occupational, physical and speech therapy services are also not covered by this Policy.

1. **Eligibility Criteria – Medical Necessity:** Emergency services, including emergency transfers, pursuant to the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) are always provided to all CHS patients in a non-discriminatory manner, regardless of their ability to pay, insurance status, national origin, race, creed or color.

   In addition, CHS shall extend free or discounted care to eligible individuals, residing in the United States, for non-emergent medically necessary services. The medical condition of the patient shall not be a factor in determining eligibility.

   While patients visiting from out of the country and requiring emergency services are eligible for financial assistance, patients visiting the U.S. with the intent of receiving non-emergent care within CHS are not generally eligible for financial assistance. Special hospital/physician programs may exist for these types of services; however, for services not provided for under such special programs, arrangements must be made by the patient/guarantor to pay for medical care prospectively.

2. **Eligibility Criteria – Financial Ability:** Financial assistance for medically necessary services is available on a sliding scale of up to 100% of charges, and up to a full waiver of co-payments and/or deductible after third-party insurance proceeds, based on financial need (i.e. uninsured and underinsured patients). Patients qualify for 100% financial assistance if their family income is at or below 300% of the Federal Poverty Level Guidelines (FPL). FPL Guidelines are updated annually by the U.S. Department of Health and Human Services.

   Lesser discounts are available for patients with a family income between 301% and 400% of the Federal Poverty Level Guidelines. Please refer to the current financial assistance income guidelines (attached Exhibit 1) for sliding scale eligibility percentages.

   CHS is committed to assisting patients without health insurance obtain coverage from available resources (i.e. Medicare, Medicaid, workers' compensation, health insurance exchange) so they may maintain continued coverage for healthcare services provided within or outside of CHS. In order to evaluate whether a patient qualifies for available third-party coverage and/or financial assistance from CHS, certain financial information may be required to be provided by the patient/guarantor. Such information and/or documentation are described below.

   a. Presumptive Eligibility – Patients are presumed to be eligible for financial assistance discounts on the basis of individual life circumstances (e.g. homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.) CHS shall grant 100% financial assistance discounts to patients determined to have presumptive financial assistance eligibility.

      Therefore, under certain circumstances, CHS may provide financial assistance prior to, or without, any application being made for such assistance; through a screening process. CHS will screen

unpaid accounts using commercially available income predictor software to assist in determining whether a patient is presumed eligible for financial assistance based on variables such as address, age and gender. The presumed eligibility process shall not negatively affect an individual's credit score. In addition, this process shall not be utilized to deny financial assistance to an individual.

While CHS strives to make determination of financial ability as close to the provision of service as possible, there are times when information is not provided or unavailable. Therefore, determination of financial assistance, including presumed eligibility, may occur subsequent to billing a patient for services rendered.

b. Other Asset Exemptions – There are situations where individuals may not have reasonable recorded income, but have significant other assets available to pay for healthcare services. For situations in which patients have such other assets, these assets shall be evaluated as cash available to meet essential living expenses, which includes healthcare expenses. Assets, subject to the exclusions listed below, may be considered for individuals with income greater than or equal to the federal poverty level to 'upgrade' the amount owed, up to the maximum payment amount, but not to deny financial assistance. Therefore, CHS will convert available assets to income for comparison to poverty guidelines, on a dollar for dollar basis; however, it will exclude from consideration the following assets in considering whether the patient meets the financial assistance criteria:

- Savings accounts and other liquid assets with balances of less than six months of income
- Assets held in a tax-deferred or comparable retirement savings account
- College savings accounts
- All personal property, including but not limited to, household goods, wedding/engagement rings and medical equipment
- Available business equity below $50,000
- Automobiles used regularly by a patient or immediate family members
- Other assets at CHS' discretion that is believed to be in the patient’s best interest to exempt

For those individuals where income is greater than 150% of the FPL, liquid assets will not be considered when determining eligibility for financial assistance.

c. Deposits – Although CHS may request payment of co-insurance and deductibles at the time of service, it does not request patients provide a financial deposit prior to the date of service.

d. Amounts Charged to Individuals Eligible for Financial Assistance – Federal and New York State regulations indicate that hospitals may not use gross charges when billing individuals who qualify for financial assistance. More specifically, the Federal Affordable Care Act (ACA) indicates that amounts billed to those who qualify for financial assistance shall be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates (calculated annually). The ACA also indicates that hospital policy must indicate which of these two methods the hospital will use in calculating the amount to be charged, and must either describe how the hospital arrived at the amount, or explain how the public may obtain such information free of charge. Furthermore, the ACA provides that a hospital facility may change the method it uses to determine Amounts

Generally Billed (AGB) at any time. However, it must update the policy to describe a new method before implementing it.

In accordance with regulation, CHS will not use gross charges when billing individuals who qualify for financial assistance when such eligibility is known at the time of billing. In addition, CHS will not charge individuals for medically necessary services who are eligible for 100% financial assistance. Furthermore, for those who qualify for a prorated discount under this Policy, CHS will limit such charges for emergency or other medically necessary care to not more than the Medicare rates which are published annually in the Federal Register and are one of the lowest amounts charged to insured patients (the prospective method).

3. **Medical Indigence – Financial Ability:** Patients may also be extended financial assistance based upon medical indigence. A determination as to a patient's medical indigence takes into consideration significant and/or catastrophic medical bills not covered by insurance in addition to the patient's family income level and liquid assets.

   For example, a patient suffering a catastrophic illness may have a reasonable level of family income, but a low level of liquid assets such that the payment of medical bills would be seriously detrimental to the patient's basic financial (and ultimately physical) well-being and survival. Such a patient may be extended discounted or free care based upon the patient's facts and circumstances.

   Approval for financial assistance due to medical indigence may require documents evidencing income as follows:

   - Confirmation of medical necessity of service provided
   - Copies of unpaid patient/guarantor medical bills
   - Information related to patient/guarantor drug costs
   - Evidence of multiple instances of high-dollar patient/guarantor co-pays, deductibles, etc.
   - Other evidence of high-dollar amounts related to healthcare costs
   - Information concerning available insurance coverage
   - Information concerning available liquid assets

4. **Specific Exclusions:** Procedures inconsistent with the Ethical and Religious Directives as interpreted and applied by the Bishop of the Diocese of Rockville Centre are specifically excluded from the CHS Financial Assistance Policy. In addition, physician and other provider services are excluded from this Policy.

IV. *Procedures:*

1. Applying for Financial Assistance:

a. Confidentiality – The need for financial assistance may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for all those who seek charitable services. Orientation of staff and the selection of personnel who will implement this Policy and its procedure should be guided by those values. No

information obtained in the patient's financial assistance application may be released unless the patient provides expressed permission for such release.

b. Completion of Financial Assistance Application – Determination of eligibility for financial assistance discounts shall occur as closely as possible to the time of the provision of service to enable CHS to properly record the related revenues, net of financial assistance allowances. The objective is to provide financial relief for those people who are truly in need. When financial assistance is not identified at the time of service, CHS will generally accept applications within 12 months of the first "post-discharge" billing statement. The financial assistance eligibility is assessed as of the date the application was received.

   In general, patients requesting financial assistance will be required to complete the CHS Financial Assistance Application Form (attached Exhibit 2). Instructions for the completion of the financial assistance application shall be provided along with the application. A completed application should be submitted within thirty (30) days of its receipt to establish financial assistance eligibility. Assistance shall be made available to patients in understanding this Policy and with the financial assistance application process.

   Financial assistance application materials shall include a notice to patients indicating that collection activity will be suspended on all accounts, and the patient may disregard any bills, where a completed application has been received until a determination has been made.

c. Documentation – In order to evaluate whether a patient qualifies for available third-party coverage and/or financial assistance from CHS, certain financial information may be required to be provided by the patient/guarantor.

   Currently, CHS considers the following as sources of income during the evaluation process:

   - Income from wages or self-employment
   - Unemployment compensation
   - Social Security benefits
   - Workers Compensation benefits
   - Disability benefits
   - Pension/IRA/Annuity
   - Income from investments
   - Alimony/Maintenance
   - Rental income
   - Government income
   - Veterans' benefits
   - Public assistance
   - Strike benefits

   The patient/guarantor shall provide information about immediate family members and/or dependents residing with the patient/guarantor, including name, age and relationship.

   The System Hospital may obtain information from an individual in writing or orally (or a combination of both) in order to consider a financial assistance application complete. Financial assistance may not be denied based upon the omission of information and or documentation if such was not specifically required by this Policy or the CHS Financial Assistance Application Form.

   Individuals will be notified when financial assistance applications are deemed incomplete. Such notification shall include the information needed to complete the application, the timeframe the

information is requested and contact information to provide missing information and to obtain information about assistance in completing the financial assistance application.

2. **Review and Processing Financial Assistance Applications:** An established financial assistance assessment methodology, applied consistently, shall be adopted by each System Hospital.

Available financial resources shall be evaluated before determining eligibility for third party health insurance coverage and/or financial assistance. CHS shall consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g. the parent of a minor child or patient's spouse). The patient/guarantor may be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs.

a. Establishing Amount of Financial Assistance Discount – Eligibility for financial assistance discounts shall be determined based on a percentage of the Federal Poverty Level Guidelines, available assets and any relevant circumstances. Thus, the standards of eligibility for the application of financial assistance discounts should consider assets as well as family income (see Other Asset Exemptions – Section III.2. b. above). Any patient whose income is equal to or less than 300% of FPL guidelines is eligible for a full (100%) financial assistance write-off, provided that the individual does not have significant assets.

The Affordable Care Act provides greater opportunity for individuals to obtain healthcare coverage. To ensure an individual is not eligible for other forms of insurance coverage (Medicare, Medicaid and Health Insurance Exchange Plan), confirmation of continued financial assistance eligibility shall be updated every ninety (90) days.

b. Waiver of Co-Payments and Deductibles –

- Medicare and Medicaid – CHS shall not routinely waive co-payments and deductibles for Medicare or Medicaid patients. Medicare and Medicaid patients are eligible for financial assistance on those co-payments if they qualify as underinsured. CHS may consider patients with Medicare primary and Medicaid secondary as eligible for presumptive financial assistance if no application or payment in full is made after the 120 day statement cycle prior to sending to collections.

- Third-Party Insurance – CHS shall not routinely waive co-payment and deductibles for third party insurance. There may be a requirement within a managed care agreement to pursue patients for their portion of the payment amount (i.e. co-payments). Patients with third party insurance are eligible for financial assistance on co-payments and deductibles if they qualify as underinsured. Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and co-payments (i.e. the patient has insurance coverage for the remainder of the patient's bill).

c. Authorization to Provide Determination of Financial Assistance – The authorization of financial assistance discounts shall be provided pursuant to the following:

- Up to $1,000 – Financial counselor/representative level
- Up to $5,000 – Director level
- Over $5,000 – CFO/Vice President of Finance

d. Pending Financial Assistance Applications – CHS shall suspend all collection activity if the patient has submitted a completed application for financial assistance and the eligibility determination is pending.

e. Approved Financial Assistance – Patients/guarantors shall be notified in writing within thirty (30) days of receipt of a completed application or a determination of presumed eligibility, the amount, if any, the patient is responsible to pay, the amount of financial assistance discount eligibility related to services provided by CHS, and how these amounts were derived. Patients/guarantors shall be advised that such eligibility does not include physician services (i.e. independent physicians, physician practices, anesthesiologists, radiologists, pathologists, etc. depending on the circumstances). The patient/guarantor shall also be informed that periodic review of financial status shall be required in the event of future services.

f. Denied Financial Assistance – Patients/guarantors shall be informed in writing within thirty (30) days of receipt of a completed application if financial assistance is denied and a brief explanation for the determination shall be provided. In addition, the denial notice shall include information on the CHS denial appeal process, including contact name, phone number, e-mail and mailing address to which the request for appeal must be directed. Please refer to Section 3 – Appeals Process, below, for information on CHS' appeals process.

g. Record Retention – CHS shall retain a central file, in paper or electronic form, for each patient/guarantor who has applied for financial assistance. Documentation shall include the patient's application and other supporting materials, copies of written financial assistance approval and/or denial letters, including reason for denial. Files shall be maintained for seven (7) years from the date of approval or denial.

3. Appeals Process: While only a small number of applications are ever denied, CHS' financial assistance program provides patients the opportunity to appeal a previous denied application for financial assistance.

a. Within thirty (30) days of a financial assistance denial notice, patient/guarantor shall inform CHS in writing of their intent to appeal such decision. Patient/guarantor's notice of appeal shall include the circumstances that CHS should consider during its review of the appeal. In addition, the notice of appeal shall include the patient's account number and dates of service.

All appeal requests shall be directed to the following:

Catholic Health Services of Long Island
Financial Assistance Appeals
320 South Service Road
Melville, New York 11747

b. Each CHS Hospital shall establish a financial assistance review process to review patient/guarantor appeals. In addition, reviews shall include the evaluation of information related to patient accounts that do not clearly qualify under the basic financial assistance discount eligibility criteria, including, but not limited to, the following:

- Patients who have been initially denied assistance or provided less than 100% assistance and are requesting reconsideration;
- Patients with extenuating circumstances that were not known at the time of the initial application;
- Patients who appear to have, or are known to have, excessive discretionary spending;
- Patients who have significant non-liquid assets;
- Patients whose eligibility exceeds 300% of the FPL Guidelines and thus are not eligible for financial assistance discounts on the sliding scale, but whose cumulative medical bills are so large that they are unable to pay; and
- Any questionable situations.

c. Within thirty (30) days of CHS' receipt of an appeal request, patient/guarantor shall be informed in writing of the appeal determination. The determination shall state the specific reasons for the denial being upheld or overturned and shall clearly state the amount due from the patient.

4. <u>Publicizing Availability of Financial Assistance</u>: Every CHS patient shall be made aware that financial assistance may be available and how to obtain further information.

a. Notification of and information about the CHS Financial Assistance Policy shall be provided to patients during the intake and registration process.

b. Each System Hospital is required to maintain a CHS Hospital Financial Assistance Summary (Policy Summary), in English and Spanish, which includes information explaining that it provides care that is deemed medically necessary, without regard to ability to pay, to individuals with limited financial resources, and shall explain how patients/guarantors can apply for financial assistance. In addition, the Policy Summary shall contain a contact number to call to obtain further information and assistance with the application process and a direct website address where copies of the CHS Hospital Financial Assistance Policy, Summary and Application may be obtained. The Policy Summary document shall be offered to patients during the intake and registration process as well as provided upon request.

c. Paper copies of the full CHS Hospital Financial Assistance Program documents (policy, policy summary and application, including instructions) shall be provided upon request and without charge, at points of intake and registration and by mail.

d. CHS shall clearly post signage (in English and Spanish) through conspicuous public displays or other measures reasonably calculated to attract visitors' attention, including (at a minimum, the emergency room and admissions/registration areas, to advise patients of the availability of financial assistance. Every effort will be made to ensure that, for patients speaking languages other than those for which the financial assistance guidelines are printed, policies are clearly communicated.

e. CHS and System Hospitals shall publish the Policy Summary on its website, along with a link to the CHS Financial Assistance Application Form and Application Instructions. The Policy Summary shall provide information on financial assistance eligibility, income levels used to determine eligibility and how to apply for assistance. The Policy Summary must be published in English and Spanish and shall be published in other languages as deemed necessary.

f. CHS and System Hospitals shall notify and inform residents of the community served by the System Hospital about the CHS Hospital Financial Assistance Policy in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance.

g. All bills and statements sent to patients shall include a statement regarding the availability of CHS' financial assistance program and a contact number to call to obtain further information and assistance with the application process. In addition, all bills and statements shall include a direct website address where copies of the CHS Hospital Financial Assistance Policy, Summary and Application may be obtained. This information shall be available at or below a sixth grade reading level.

h. In addition to English and Spanish, CHS Hospital Financial Assistance Program documents (policy, policy summary and application, including instructions) shall be translated for language groups that consist of 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. CHS may use any reasonable method to determine such populations. Furthermore, in instances in which patients not proficient in reading and writing, additional assistance shall be made available to complete necessary forms.

V. ***Collections Practices:***

It is CHS' intent to determine financial assistance eligibility prior to services being performed. There are times, however, when financial information is not known or available and patient accounts become delinquent and collection efforts are necessary. CHS utilizes both in-house staff and third parties to perform collection activities in order to be reimbursed for services performed. As tax exempt hospitals, CHS cannot and does not take "extraordinary collection actions" (lawsuits, arrests, liens, or other similar actions) until it has made reasonable efforts to determine whether a patient is eligible for financial assistance.

This CHS Hospital Financial Assistance Policy incorporates CHS' policy and procedures surrounding its collection practices and therefore does not have a separate collection policy. Therefore, the following includes CHS' collection practices.

1. In-House Collection Practices: In-house collection agents are to follow the following practices:

a. Training and Education – All staff that interact with patients or have a responsibility for billing and collections must be trained and educated on the CHS Financial Assistance Policy.

b. Collection Practices – All patient/guarantor accounts shall be pursued fairly.

c. Ethics and Integrity – All collection activities shall consistently reflect the highest standards of ethics and integrity, and be consistent with the mission of CHS with respect to the dignity of each individual.

d. Medicaid Eligibility – Collection activity is prohibited for individuals determined to be eligible for Medicaid.

e. Reasonable Payment Terms – Reasonable payment schedules (installments) and terms (no interest is assessed) shall be offered to each patient/guarantor with self-pay balances.

f. Annual Collection Limits – Annual amounts collected from an uninsured individual shall not exceed ten percent (10%) of that individual's gross monthly family income.

g. Cooperating Efforts – No unpaid self-pay account shall be sent to a third-party collection agent as long as the patient/guarantor is cooperating to settle the account balance.

h. Eligibility for Assistance – CHS will not take "extraordinary collection actions" (lawsuits, arrests, liens, reporting of adverse information to credit agencies, or other similar actions) against individuals until it has made reasonable efforts to determine whether a patient is eligible for financial assistance; but not before 120 days from the first post-discharge billing statement. A reasonable review shall be performed prior to turning an account over to a third-party collection agent and prior to instituting any legal action for non-payment, to assure that the patient/guarantor is not eligible for any assistance program (i.e. governmental coverage) and do not qualify for coverage through the CHS Financial Assistance Policy. After having been turned over to a third-party collection agent, any account that subsequently is determined to meet the financial assistance criteria shall be returned immediately by the third-party collection agent for appropriate follow-up.

   System Hospitals shall suspend extraordinary collection actions taken against an individual to obtain payment for the care at issue who submits a financial assistance application. If cases of incomplete applications, System Hospitals shall suspend extraordinary collection actions until (a) the individual completes the application and the System Hospital determines whether the individual is eligible for assistance or (b) until the individual has fails to respond to requests for additional information and/or documentation within a reasonable period of time (not a period of at least 240 days from the first post-discharge billing statement).

i. Notification to Patient – Patients shall be notified thirty (30) days before their account is sent to a third-party collection agent. In addition, CHS shall provide written notification to individuals of its intent to initiate one or more extraordinary collection actions. Such written notification shall include a plain language summary of the CHS Hospital Financial Assistance Policy. Extraordinary collection activities may not be initiated earlier than thirty (30) days from the date the written notification was provided (date of mailing). Furthermore, CHS shall also make reasonable efforts to orally notify an individual, at least thirty (30) days before the initiation of extraordinary collection actions, about its financial assistance policy and how they may obtain assistance with the financial assistance application process.

System Hospitals may provide any of the written notices or communications electronically (e.g. email) to any individual who has indicated he/she prefers to receive the written notice or communication electronically.

j. Reporting – System Hospitals shall report whether and how they made reasonable efforts to determine financial assistance eligibility before engaging extraordinary collection activities on their Form 990 and are for responsible for maintaining records to substantiate any information required by the Form 990.

2. Third-Party Collection Practices: Third-party collection agents are to follow the following practices:

a. Standards and Scope of Practices – Third-party collection agents shall follow the same standards as the CHS patient financial services.

b. Financial Assistance – The third-party collection agent shall advise the patient/guarantor of the CHS Financial Assistance Policy and return the account to CHS immediately if it is determined that the qualifications are met.

c. Approval Policy – The Hospital's Financial Lead (Vice President or Assistant Vice President) shall consider and must first approve, in writing, any legal actions (i.e. garnishments, liens, etc.) that may be pursued by the third-party collection agent. Such approvals shall be reported to the CHS Vice President Revenue Cycle.

d. 210-Day Limit – Unsettled accounts shall be returned to CHS as uncollectible after 210 days. Under certain circumstances (i.e., when or if a payment or resolution is expected within 60 days), a third-party collection agent may manage an account beyond 210 days from the date assigned to the third-party collection agent.

e. Annual Collection Limits – Annual amounts collected from an uninsured individual shall not exceed ten percent (10%) of that individual's monthly gross family income.

f. Annual Adherence Attestation – The CHS Revenue Cycle Team shall send the current CHS Financial Assistance Policy and an attestation to each collection agent for them to sign that they will act in compliance with this Policy. In addition, each third-party collection agent shall be reviewed at least annually by the CHS Revenue Cycle Team for adherence to these standards (i.e. rate of success and compliance with these terms and conditions).

3. Specific Prohibitions:

a. Unemployed Without Significant Income/Assets – No legal action shall be pursued for non-payment of any bills against any patient/guarantor who is unemployed and without other significant income or assets.

b. Principal Residence – No legal action against any patient/guarantor by seeking a remedy that would involve foreclosing upon the principle residence of a patient/guarantor, or taking any other

action that could result in the involuntary sale or transfer of such residence or informing any patient/guarantor that he/she may be subject to any such action.

c. Collection Tactics – Tactics such as charging interest, requiring patients/guarantors to incur debt or loans with recourse to the patient/guarantor's personal or real property assets (recourse indebtedness), or so called 'body attachments' (i.e. the arrest or jailing of patients in default on their accounts, such as for missed court appearances) are strictly prohibited.

VI. Discounts Other than Financial Assistance:

CHS shall not offer any patient discounts in a manner prohibited by law (e.g., discounts used in connection with marketing healthcare services to potential patients or discounts that may influence patients to select a CHS facility or related entity) or prohibited by contract (e.g., prohibitions contained in managed care organization contracts).

Consistency shall be essential in the definition, communication, distribution and implementation of self-pay and third-party discounts standards among all System Hospitals and within their functional areas (e.g., patient access, patient accounting, collection agents, satellite clinics, outpatient diagnostic, therapeutic and surgical centers, etc.)

1. **Self-Pay Discounts:** Self-pay discounts shall be provided to all (a) patients with accounts that are 100% self-pay and who are uninsured patients with the ability to pay or (b) patients who have insurance but whose services are 100% non-covered by that insurance. Those patients with a health spending account without third-party health insurance coverage shall qualify for self-pay discounts.

   The self-pay discount amount shall be based on the current Blue Cross PPO rate for the respective System Hospital, which is each Hospital's highest volume payor.

2. **Emergency Department Prompt-Pay Discounts:** Prompt-pay discounts may be provided to uninsured patients who make a full payment within 48 hours of discharge. This discount shall only apply to those patients who are treated and released from a CHS Emergency Department. The Prompt-Pay rate shall include payment for services provided by the CHS Hospital, Emergency Room Physician as well as Radiology and Laboratory physician services. It does not include other physician services (e.g., specialists – orthopedic, plastic surgeon, neurologist, etc.).

3. **Third-Party Discounts:** Third-party discounts, for accounts in which there is no contract between the insurers and the System Hospital shall be permitted only under certain circumstances. However, third-party discounts to non-contracted secondary payors (e.g., Medigap, etc.) shall not be permitted.

   - Discounts to non-contracted primary payors may be made available only if the balance is paid in full within thirty (30) days of the initial billing date or agreed upon date with the System Hospital and the payor does not dispute the charges and services rendered. If charges are found by the System Hospital to be in error, the payor will be allowed 30 days from receipt of a corrected claim to pay; payments past the agreed upon time frame may not be eligible for the third-party discount.
   - Discounts applied to payments received within the applicable time frame shall be allowed up to the self-pay discount rate. This discount will be made in conjunction with the managed care

department. As part of the discount with a non-contracted provider, the patient will only be responsible for in-network benefits.

New York State has a clean claim statute that requires payment within 45 days of receipt by the payor of a clean claim. These state statutes shall mitigate the need to discount billed charges for non-contracted payors.

Cases in litigation shall be considered settlements and amounts due to CHS as a result of that litigation shall not qualify nor be considered for third party discounts.

4. **Package Programs:** Hospital services, procedures and programs for which (a) third-party payors in general do not cover the services/procedures (e.g., cosmetic surgery, clinical research trials, bariatric surgery, etc.) and (b) the patient is self-pay, the patient shall not be extended a self-pay discount on the package procedures.

   Any package offer shall be provided to all patients who receive the service, irrespective of payor category, subject to the limitations noted above.

   To the extent that a patient receiving services under a package program is uninsured or underinsured and the procedure has been determined to be medically necessary, the patient should be considered for a financial assistance discount pursuant to this Policy.

VII. Annual Review, Monitoring and Reporting:

1. The CHS Board of Directors' Mission & Ministry Committee, as part of an annual mission report, shall review the CHS Financial Assistance Policy annually. In addition, the CHS Compliance and Audit Committee shall review the Policy from a regulatory compliance perspective. The CHS Board of Directors shall approve all revisions.

2. The CHS Revenue Cycle Team shall develop a mechanism to measure CHS' compliance with this Policy and make an annual report to each respective Board of Trustees' Mission and Ministry Committee.

3. Compliance with this Policy will be monitored annually by each System Hospital's Mission and Ministry Committee, and be reported to the CHS Mission and Ministry Committee of the Board of Directors.

4. The CHS Financial Assistance Policy shall be provided to the Nassau and Suffolk County Departments of Health Services, the New York State Department of Health as well as any other regulatory agency, upon request.

5. Each System Hospital shall comply with all governmental reporting requirements.