Cibola General Hospital **1016 E. Roosevelt Ave.** **Grants, NM 87020** **Phone: 505-287-4446 Fax: 505-287-5309**		**903076**
TITLE: Financial Assistance Policy		
Policy First Effective: **12/18/2013**	**Last Revised:** **2/20/2015, 8/22/2022**	**Last Reviewed:** **2/20/2015**

Policy Statement

The objective at Cibola General Hospital is for this charity policy to establish actions that will enable the hospital to implement practices that meet its goals of providing charitable services to the community. To accomplish providing specific charitable services, the criteria the hospital must follow in qualifying patients or programs for charity purposes is provided in this policy and is also reported in the Community Benefit Annual Report for Cibola General Hospital. The hospital has developed these policies in written form and will apply them consistently to all patients.

Those patients that currently do not pay for their medical bills because of an inability to pay are covered under this policy. The overall mission of the hospital is expressly demonstrated in this charity policy, everyday practices, and is consistent with Cibola General Hospital corporate office Charity Policy and Procedure guidelines. The Board of Trustees, demonstrating through their leadership and affirmation of the mission of Cibola General Hospital, which is to strive for excellence in the quality of health care services and education; competence and integrity in the professional, support and volunteer staff; and the maintenance of efficient and technologically current equipment and facilities, consistent with the needs of the community. As well as its vision to be recognized as a creative leader in the development and delivery of quality services that will improve the physical, mental and spiritual health of our community; and to become the organization of choice for community health care and health care education.

General Process and Responsibilities

All patients unable to demonstrate financial coverage by third party insurers will complete a financial screening form. This form is available in the two major languages spoken in our community, English and Spanish. It is our goal to have all elective admissions screened for ability to pay. Patients will be asked to complete this form if they are not covered by insurance. All patients, including those thought to be eligible for Medicaid, Victims of Crime, or any other third party coverage, but are not currently approved for coverage, must still complete the financial screening form. Completion of this form:

1. Provides the ability to determine if the patient has declared income and or assets making them capable to pay for the health services they are about to receive;

2. Provides the hospital permission to complete a credit check for this individual;

3. Provides a document to be reviewed by Patient Financial Services after the patient is discharged to determine financial class assignment; and

4. Provides an audit trail in documenting the hospital's commitment to providing charity care.

All patients not covered by third party insurance will be asked for a cash deposit from the patient or the patient's guardian, based on the estimated services to be received and the ability to pay. Insured patients who indicate that they are unable to pay patient liabilities may be screened at the time of admission, with follow up after insurance billing occurs. By completing the financial screening form, uninsured patients who have no means, uninsured patients with partial financial means to pay, and insured patients that are unable to pay patient liabilities will have all or part of the patient's bills covered by the charity care policy, if they are not eventually qualified for third party insurance. Patient Financial Services may give patients who were not subject to financial screening at the time of admission the financial screening form after discharge.

Before determining that a patient does not have the ability to pay, the financial screening process requires the hospital Financial Counselor to make a good faith effort to collect the following information:

- Individual or family income.

- Individual or family net worth including all assets, both liquid and non-liquid, less liabilities and claims against assets. Eligibility for Medicaid once some assets are depleted should also be considered.

- Employment status. This should be considered in the context of the likelihood future earnings will be sufficient to meet the cost of paying for these healthcare services within a reasonable period of time. A reasonable period of time is one year for repayment as a maximum for accounts greater than $1,000. Accounts less than $1,000 should be paid in a shorter time frame to be negotiated with the patient. Any balances not paid under these arrangements will be deemed charity care if unpaid because of the patient's inability to pay.

- Unusual expenses or liabilities.

- Family size. This is used to determine the benchmark for 100% charity, if income is at or below the established income levels.

This policy indicates that information will be based upon a signed declaration by the patient or patient's family, verification through credit checks, and/or other documentation provided by the patient or the patient's family. Additional information may be required only for special circumstances or as determined by management. Non-emergent patients will be asked to provide proof of income during pre-admission screening. It is understood that in some cases this information will not be available and therefore the admitting staff will indicate this on the screening forms and place them inside the patient's folder.

The attached forms are to be used in the financial screening process:

Form I: Hospital Screening Assessment form (this form also gives the Financial Counselor permission to obtain credit checks)

Form II: Income Certification form

Form III: Determination of Charity Care Status Income Levels

This policy will be available in the two primary languages spoken in the hospitals community area, English and Spanish. This form is for internal use only, and is not to be given to the patient or the patient's family or guarantor.

Approval or denial letters will not be required, as notification of payment obligations, charity assignment in full or in part, and payment plan options will automatically occur when financial classification assignment indicates what is to be printed on the patient billing form. Patient account folders are to include completed forms, credit check printouts, and financial counselor and other Admitting personnel notes.

This policy uses the current New Mexico minimum wage ($15,080) and federal poverty guidelines add-on for each additional dependent ($4,160) to determine eligibility for charity care. If the patient is at or below the guideline amount for his or her family size, 100% of the charges are to be written off as charity. If they are over the guideline rate, a partial charity write off will be made based on the cash payment option installment agreements. If the patient is at or above 350% of the guideline amount(s), no charity write off will be granted according to the policy standards, assuming some net worth or other ability to pay is identified.

Charity Determination, Forms and Record-keeping

The forms used for financial screening are attached to the charity care policy. The form requests annual income (plus verification of income) and annual expense information. Total assets less total liabilities (net worth) are requested. Family size and special circumstances are also requested. The form presents the income levels and the federal poverty guidelines.

Record-keeping will be recording services at full charges for revenue documentation, adjusting these amounts by payments from individuals or other third parties, and re- classifying all bad debt balances as charity write-offs when accounts are removed from receivable status. Documentation concerning the eligibility for charity status must be maintained in the patient's chart.

The adequacy of the established allowance for charity care levels in the hospital general ledger will be reviewed and adjusted for increases or decreases, based on actual experience at least quarterly.

Classification and Determination of Payment Shortfalls

Many government programs (Medicaid, Aid to Dependent Children, Medicare) and other assistance or third party coverage programs have been established to provide for or defray the healthcare costs for individuals that also may be considered needy. In the case where arrangements for payments to the hospital require the hospital to accept the payment amount as payment in full, the balances of these accounts written off are attributable to contractual

adjustments and will not be considered charity care. In cases where these programs require the patients to pay co-payments or deductibles and the patients do not have the ability to pay, these amounts will be considered charity care.

Administrative adjustments have historically included write-offs for bankruptcy, or special circumstances indicating the patient's inability to pay. These adjustments and write-offs should be reclassified as charity care as they meet the hospital's criteria for charity care.

Charity Determination Process

Financial Counselor Role

The Patient Financial Service department will establish programs to financially screen 100% of all self-pay patients. If there is no income claimed by the patient and no third party insurance, the patient will complete the multi-language screening forms. The forms provide financial information and patient or family approval to complete a credit check. The credit check will be completed to confirm financial status.

The charity financial classification should always be assigned when the income levels based on family size are equal to or less than the New Mexico minimum wage plus the federal poverty guideline add-on for each additional dependent.

This assumes the net worth and other income or asset tests show the clear inability to pay. If there is income claimed, verification of income should be attempted through requesting paycheck stubs, recent tax returns or W-2 forms. If the only income is General Relief, no hard copy verification is requested. There should always be a credit report run when a Social Security number and permission is obtained. Those patients meeting the hospital's charity care criteria will be assigned a charity financial classification.

Patient Financial Services Role

The patient financial services area is the focus of the charity determination at the hospital. Patients who are designated self-pay by the Financial Counselor and not classified as meeting the charity care criteria, will be contacted by staff and requested to complete the payment plan application. Those patients determined to have the ability to pay part or all of their bill will be requested to pay a deposit based upon the expected amount of the bill and will be offered a payment plan for a term of one year or less. If there is a cash discount, the payment must precede the service. There should be consideration of writing off a part of the bill as charity when appropriate in these circumstances.

Charity care status should be approved by staff consistent with the guidelines. The internal collection process by hospital staff to establish cash payments, payment plans, or any partial payment processes from self-pay patients should also be considered a potential charity write-off when appropriate.

Cash discounts identified prospectively at the time of discharge, should have the discounted balance applied to the allowance for charity care if the reason for the discount is the patient's inability to pay the full amount. They should not be included in the same category as courtesy discounts.

Charity Policy Compared to Charity Determination Process

Key points to this policy include:

- The identification of potential charity patients at time of admission.
- The financial screening form must be used and a credit check performed for all self-pay patients.
- Income and net worth are always routinely verified for non-emergent self-pay patients and should be used in all circumstances to determine charity status.
- The actual determinations are made based upon the criteria expressed in the hospital's charity policy.

Charity determination will be granted on an "all, partial, or nothing" basis. There is a category of patients who qualify for Medicaid, but do not receive payment for their entire stay. Under the hospital's policy definition, these patients are eligible for charity care write-offs. In addition, the hospital specifically includes as charity the charges related to the denied days for partial Medicaid denials, charges for denials when treatment is provided to a Medicaid patient, or the patient expected to be approved for Medicaid and the patient does not get approval for a particular date of service. These denials and any lack of payment for non-covered services provided to Medicaid patients are legitimate charity assignment designations. This classification of patient is receiving the service, and they do not have the ability to pay for it. In addition, Medicare patients that have Medicaid coverage for their co-insurance/deductibles, in which Medicaid does not make payment and Medicare does not ultimately provide bad debt reimbursement on the cost report, should also be included in the charity determination. Again, these are indigent patients receiving a service for which a portion of the resulting bill is not being reimbursed.

Cibola General Hospital Community Assistance Program

- For District and surrounding area residents
- As a critical access facility, we must offer financial assistance in compliance with Health and Safety Codes.
- Uninsured patients will first be offered referral to state and government programs.

- One application for both *full* and *discount* Charity Care.
- Applicants may be required to supply documentation of income, etc.
- Applications may be completed before, during, or after services (except for patients with Medicare – they must complete the application and be approved prior to services)

- FULL Charity Care = for non-elective services for patients with income below the current Federal Poverty Level (FPL) who are not insured or are underinsured and cannot pay their part.
- DISCOUNT Charity Care = for non-elective services for patients with income below 150% of FPL who are not insured or are underinsured and cannot pay their part.

- Assistance will apply to specific services on specific dates. If continued care is required due to the diagnosis, the ongoing care (given here) may be considered a single case for which assistance applies.
- Pre-existing patient balances may be considered for write-off.
- Share of Cost payments will not be waived.
- No-interest payment plans are available with a term no longer than 10 months,
- Documented as Homeless = automatically eligible.
- Patients on state aid programs such as New Mexico Health Department, etc. where the program does not pay in full - remaining balances are eligible for write-off.
- Patients whose income exceeds 150% of FPL and experience a catastrophic medical event ***may*** be eligible for partial Charity Care as decided by Management. on a case-by-case basis, usually on accts in excess of $30,000.
- Accounts returned by a collection agency where the patient can't pay may be eligible for Charity Care.

- Patients will be notified of determination by mail:
    - Approval letter describes level of approval and amounts outstanding if any.
    - Denial letter describes reason(s) for denial and amounts outstanding
    - Pending letter = incomplete application. It gives notice of what is still needed to make a determination.
- DISPUTES: Patient may file an appeal. Management will consider and decide. If patient still unsatisfied, they may request a review by the CFO or Director, PFS. After that, no further appeals.
- We retain the right to bill if fraudulent information is provided for the purpose of receiving Charity Care, as well as the right to seek civil/criminal damages.

ER/HOSPITAL: Patients eligible for Charity Care will not pay more than Medicare (MCARE) would typically pay. If patient has no other insurance, they pay a percentage of what MCARE would pay as follows: 101% to 125% of FPL = 25% of MCARE
126% to 150% of FPL = 50% of MCARE

- If patient does have other coverage and the amount paid by that insurance company exceeds what MCARE would have paid, then no further payment is due from the patient. If not, then the patient would pay the difference.

CLINICS: Clinic patients will complete the same basic application.

- Clinic patients will pay a reduced fee on a sliding scale:
  0% to 100% FPL = $20 flat fee
  101% to 150% FPL = 80% of what MCARE would pay

PROFESSIONAL: Professional fee charges are included in this policy, which includes:

- Hospitalist Care
- Surgeons
- Anesthesiologists
- Telemetry - neurology

To request information about eligibility, please contact Fiscal Services at (505) 287-6755

Serving Rural Communities
Principles and Guidelines for Community Service Discounts

POLICY:

Cibola General Hospital will process all patient accounts fairly and consistently. The discounts described in this policy will be extended to uninsured or underinsured patients receiving medically necessary services.

Eligibility Criteria for Community Service Discounting:

1. Any uninsured patient receiving medically necessary services.

2. Any medically necessary services for underinsured patients which are deemed non-covered by their health insurance.

3. Community service discounts are not intended to offset share of cost obligations, deductibles or coinsurance amounts under government or private health insurance programs.

4. In the event the patient and/or their family unit is determined to have assets exceeding $50,000, excluding the primary residence and any retirement funds, the patient may not be eligible for community service discounting or may qualify for a reduced amount.

5. Community service discounts are applied only in conjunction with full payment of the patient's portion.

6. Extended payment terms may be available at the discretion of Cibola General Hospital. Granting of such payment terms shall be free of interest but may result in a lower discount amount.

7. If any patient feels they may qualify for greater discounting based on income guidelines, they may apply for Cibola General Hospital's Financial Assistance and would thereby be governed by processes and documentation requirements outlined in that policy. Failure to qualify for Financial Assistance may still qualify the patient for the previously quoted community service discount amount.

8. Patients whose outstanding balance is greater than 50% of their family unit's gross annual income may also qualify for greater discounts under Cibola General Hospital catastrophic allowances detailed in its Financial Assistance Policy. Patient's falling into this category should be validated through Cibola General Hospital Financial Assistance process.

9. Patient's wishing to dispute charges on an account may do so for up to 60 days from the date of service and/or discharge. Quoted community service discount amounts will be valid from the date of the patient's inquiring for up to 45 days.

Cibola General Hospital
In-Patient and Out-Patient Discounting Matrix:

If the charges or estimate of charges exceeds $500 the following discounting tier is applicable.

Please note that if there are late charges on an account or if the charges exceed the estimated amount, the original discount of 25% will remain effective if the balance is paid in full upon receipt of the itemized statement and prior to 30 days from date of service and/or date of discharge.

Balance or Estimate of Acct:	Age of Acct from Discharge:	Discount Percentage:
>$500	Prior to or at time of service	25%
>$500	1-30 Days	20%
>$500	31-60 Days	20%
>$500	61-90 Days	15%
>$500	91-120 Days	15%
>$500	121-150 Days	10%

**Note: these percentages are subject to review and change each fiscal year.*

***If the combined balances of smaller accounts exceed $500 these patients will be considered eligible under the above discounting matrix. Note however the discount percentage will vary depending on the age of each individual account.*

If the charges or estimate of charges is less than $500 the following discounting tier is applicable.

Please note that if there are late charges on an account or if the charges exceed the estimated amount, the discount of 20% will remain effective if the balance is paid upon receipt of the itemized statement and prior to 30 days from the date of service and/or date of discharge.

Balance or Estimate of Acct:	Age of Acct from Discharge:	Discount Percentage:
<$500	Prior to or at time of service	20%

**Note: these percentages are subject to review and change each fiscal year.*

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