PATIENT ASSISTANCE PROGRAM

PURPOSE:

Onslow Memorial Hospital (OMH) is committed to providing charity care, through the Patient Assistance Program, to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, OMH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. OMH will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance – free care after a $10 co-pay
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital

Charity care is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with OMH's procedures for obtaining charity care or other forms of payment or financial assistance, in order to qualify for 100% coverage after a $10 co-pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow OMH to provide the appropriate level of assistance to the greatest number of persons in need, the Hospital Authority establishes the following guidelines for the provision of patient charity.

I. **Definitions**

For the purpose of this policy, the terms below are defined as follows:

Amounts Generally Billed ("AGB"): The most recently determined average percentage of gross charges the Hospital generally bills for the year to insured individuals for the category of services.

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- 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;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis
- Excludes capital gains or losses
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient is not covered under a health insurance policy or otherwise entitled to benefits payable by a third party as a result of the services provided by the Hospital. Uninsured status will be determined without regard to the Hospital having a contract with the third party payor responsible for coverage of the patient or the Hospital's status as a participating provider in the patient's health insurance or health plan network.

Underinsured: The patient is covered under a health insurance policy or is otherwise entitled to benefits payable by a third party, but the amount due from the patient after third-party payment exceeds his/her financial ability to pay. If the Hospital is considered "out-of-network" or a non-participating provider under the network of the patient's third party health insurance policy or plan, the patient cannot not qualify as "underinsured."

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. § 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

II. **Procedures**

A. Services Eligible Under this Policy. For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by Onslow Memorial Hospital, Inc. without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis at OMH's discretion.

B. Eligibility for Charity. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. OMH shall determine whether or not patients are eligible to receive charity for deductibles, co-insurance, or co-payment responsibilities.

The Hospital will calculate an AGB for three categories of medical services on an annual basis: (1) outpatient services, (2) inpatient services, and (3) emergency department services. The AGB for each category of medical services will be determined by dividing the sum of allowed amounts (including co-pays, co-insurance and deductibles) for all claims billed to third-party payers (including governmental payers) for the twelve (12) months preceding the annual review date by the sum of the associated Gross Charges for those services.

$$\frac{\text{Total of Allowed Amounts Billed to Third Party Payors}}{\text{Total of Gross Charges for same services}} = \text{AGB}$$

When an individual is determined to be eligible for Charity Care under this Policy, the Hospital will determine the maximum amount that may be charged to the patient for each episode of care by multiplying the actual Gross Charges for medical services the patient received by the applicable AGB percentage. The resulting product is the maximum financial responsibility of the patient (taking into consideration all co-pays, co-insurance, and deductibles due from the patient) for the account in question.

In situations where the patient is determined to be "underinsured" pursuant to this Policy, the combined total payments on the account (including payments from third party payors) may exceed the AGB; however, in no instance will the Hospital hold the patient personally responsible for payment in excess of the maximum amount of charges determined above.

C. Method by Which Patients May Apply for Charity Care.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

   - Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
   - Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);
   - Include reasonable efforts by OMH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
   - Take into account the patient's financial resources available to the patient.

- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
- Include a review of all financial information submitted to OMH including but not limited to credit card information, social security number, income information, pay stubs, bank account information, and tax returns or applications for exemption.

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six months prior or 240 days from first statement date, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. OMH's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and OMH shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for charity care, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, OMH could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Involuntary commitment.
4. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down and out of state Medicaid) or Medicaid programs with limited coverage (e.g. MAFD/MQBB/MQBE)
5. Medical care provided prior to booking/incarceration.
5. Low income/subsidized housing is provided as a valid address; and

6. Patient is deceased with no known estate.
7. A review of all financial information lawfully obtained by OMH including but not limited to credit card information, social security number, income information, pay stubs, bank account information, and tax returns or applications for exemption.
8. Mail return from homeless shelters
9. Self-pay Veterans Administration non-emergency care for post-traumatic stress disorder (PSTD) service related

E. Eligibility Criteria and Amounts Charged to Patients. Services eligible under this Policy will be made available to the patient in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. The basis for the amounts OMH will charge patients qualifying for financial assistance is as follows: Patients whose family income is at or below three hundred percent (300%) of the FPL are eligible to receive free care. When a patient who's been accepted to receive Charity Care under the aforementioned guidelines, presents to receive any kind of medical treatment or services, they will be required to pay a $10 co-pay for that patient encounter.

F. Communication of the Charity Program to Patients and Within the Community. Notification about charity available from OMH, which shall include a contact number, shall be disseminated by OMH by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, admitting and registration departments, Patient Financial Services office and at other public places as OMH may elect. OMH also shall publish and widely publicize a summary of this charity care policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital as OMH may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by OMH Referral of patients for charity may be made by any member of the OMH staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, Chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

G. Relationship to Collection Policies. OMH management shall develop policies and procedures for internal and external collection practices. OMH will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the hospital; or
2. Documentation that OMH has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements; or
3. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

In the event of non-payment of all or a portion of a patient's charges for services rendered that have not determined to be Charity Care, OMH will bill and collect on the patient's account in accordance with OMH's billing and collections policy listed below.

1. Prompt Pay Discount Policy, Organization Policy No. 122
2. Point of Service Cash Collections Policy, Organization Policy No. 123
3. Emergency Department Cash Collection Policy, Organization Policy No. 126
4. Credit and Collection Policy, Organization Policy No. 156-A
5. Bad Debt Policy, Organization Policy No. 159

A copy of each policy is available in English and Spanish and can be obtained by requesting a copy free of charge to OMH Patient Financial Services. A copy of each policy in English and Spanish, including this Policy, is available on the OMH website.

H. Regulatory Requirements. In implementing this Policy, OMH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.