

DEPARTMENTAL POLICIES AND PROCEDURES		Page(s):	1 - 12
		Saved As:	Policy #: 22.01
MANUAL:	Patient Financial Services	Formulated:	1/1/2016
SUBJECT:	Patient Financial Assistance 501R Policy	Reviewed:	01/24
Governing Board Approval Date: 02/16/2024		Revised:	3/18, 3/20, 3/21, 6/21, 01/24

I. Policy:

Each hospital owned by Prime Healthcare Services, Inc. (each, a “Hospital”), offers a financial assistance program for those patients who meet the eligibility tests described in this policy. Prime Healthcare provides Charity Care and self-pay discounts adhering to the requirements of federal and state law. The intent of this Financial Assistance Policy (the “Policy”) is to satisfy applicable federal and state laws and regulations; all provisions should be interpreted accordingly.

A significant objective of Prime Healthcare nonprofit facilities is to provide care for patients in times of need. Prime Healthcare nonprofit facilities provide Charity Care and a Discount Payment Program as a benefit to the communities we serve. To this end, Prime Healthcare facilities are committed to assisting low-income and/or uninsured eligible patients with appropriate discount payment and Charity Care programs. All patients will be treated fairly, with compassion and respect. Notwithstanding anything else in this Policy, no individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care. Accompanying this Policy are the following addendums, as referred to through this Policy:

- Plain Language Summary of Financial Assistance
- Charity Care Program
- Financial Assistance Discount Payment Program
- Notice to be included in all post-discharge billing statements.
- Notice to be included in post-discharge billing statements to patients who have not provided proof of insurance.

II. Definitions:

“Amounts Generally Billed”: The amounts generally billed (“AGB”) for emergency or other medically necessary services to individuals eligible for the Discount Payment Program. The Hospital calculates the AGB for a patient using the prospective method as defined in the Treasury Regulations. Under the prospective method, AGB is calculated using the billing and coding process the Hospital would use if the individual were a Medicare fee-for-service beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.

“Emergency and Medically Necessary”: Any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely cosmetic for patient comfort and/or convenience.

“EMTALA”: The hospital complies with the requirement of the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act. There is nothing contained in this policy, which will preclude such compliance. This is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay.

“Extraordinary Collection Actions”: An Extraordinary Collection Action means any collection action involving certain sales of debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual’s nonpayment of one or more bills for previously provided care covered under the hospital’s Financial Assistance Policy, or any action requiring a legal or judicial process, including placing a lien, foreclosing on real property, attaching or seizing of bank accounts or other personal property, commencing a civil action against an individual, taking actions that cause an individual’s arrest, taking actions that cause an individual to be subject to body attachment, and garnishing wages, in each case as further described in [IRS Section 501\(r\)\(6\)](#).

“Family”: the patient, the patient’s spouse (regardless of whether they live in the home) and all the patient’s children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the “family” shall include the patient, the patient’s natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)’ children, natural or adoptive, under the age of eighteen who live in the home. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute to income to the family, determination of eligibility shall proceed with the available income information. If the patient is the child of a minor parent who still resides in the home of the patient’s grandparents, the “family” shall include only the parent(s) and any of the parent(s)’ children, natural or adoptive, who reside in the home.

“Plain Language Summary”: The summary of the Financial Assistance Policy in the addendum “Summary of Financial Assistance”, intended to comply with [IRS Section 501\(r\)\(4\)](#).

III. Applicability of the Policy:

This Policy applies to all emergency and other medically necessary care provided by the Hospital or a substantially related entity working in the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an emergency, inpatient or outpatient basis. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance. The Hospital is not responsible for the administration of any financial assistance program offered by the Hospital’s non-employed medical staff physicians or such physicians’ billing practices.

Financial assistance policies must balance a patient’s need for financial assistance with the Hospital’s broader fiscal stewardship. Financial assistance through discount payment and Charity Care programs is not a substitute for personal responsibility. It is the patients’ responsibility to actively participate in the financial assistance screening process and where applicable, contribute to the cost of

their care based upon their ability to pay. Outside debt collection agencies and the Hospital's internal collection practices will reflect the mission and vision of the Hospital.

IV. Procedure:

1. Eligibility for Financial Assistance

A. Self-Pay Patients

A patient qualifies for **Charity Care** based on the conditions discussed in the addendum "Charity Care Program". Please see this addendum for additional details on the Charity Care program.

A patient qualifies for the **Discount Payment Program** based on the conditions discussed in the addendum "Financial Assistance Discount Payment Program". Please see this addendum for additional details on the Discount Payment Program.

B. Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for Charity Care, but may qualify for the **Discount Payment Program** based on the conditions discussed in the addendum "Financial Assistance Discount Payment Program". Please see this addendum for additional details on the Discount Payment Program. Charity Care and discounts from the Discount Payment Program may apply to patient liability amounts, including coinsurance amounts, copayments, and deductibles.

C. Other Circumstances

The Hospital may use an outside agency or determination from the Director of the Hospital's Patient Financial Services, (PFS) Department to extend Charity Care or the Discount Payment Program to patients under the circumstances as listed below (presumptive eligibility). Presumptive eligibility does not convey an entitlement for future services. The hospital also may not disclose presumptive eligibility determination and may not have access to the data utilized by an outside agency. The circumstances below are considered forms of Charity Care and may be documented as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to Charity Care, self-pay discounts, non-covered services and denials.

(i) The patient qualifies for limited benefits under the state's Medicaid program, *i.e.*, limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital. This includes non-covered services related to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (*i.e.*, patients that may only have pregnancy or emergency benefits, but receive other care from the Hospital);
- Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for Charity Care;
- Medicaid or other indigent care program denials;
- Charges related to days exceeding a length of stay limit; and

- Any other remaining liability for insurance payments.

(ii) The patient qualifies for a county-level medically indigent services program but no payment is received by the Hospital.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the Hospital's PFS Director has reason to believe that the patient would qualify for Charity Care or the Discount Payment Program, e.g., patient is deceased, bankrupt, incarcerated (and not reimbursed by a State Medicaid program), non-responsive, homeless, or unwilling to provide documentation.

(iv) A third party collection agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that Charity Care or the Discount Payment Program be offered.

(v) Subsequent to collection efforts and payor negotiations, any unreimbursed charges from non-cosmetic services, including non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at Prime Healthcare. Charges related to these discounts written off during the fiscal year are reported as uncompensated care.

(vi) The patient is eligible for programs including, but not limited to:

- State-funded prescription programs;
- Participation in Women, Infants and Children programs (WIC);
- Food stamp eligibility;
- Subsidized school lunch program eligibility;
- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
- Low income/subsidized housing is provided as a valid address; and
- Historical significance of non-payment that establishes a justification of future non-payment and lack of ability to pay.

(vii) Other circumstances of Charity Care shall be documented in the patient's record indicated either by transaction type or in the patient's notes.

D. Determination of Income

Using the Ohio Administrative Code definition, the patient, the patient's spouse (regardless of whether they live in the home) and all the patient's children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive, under the age of eighteen who live in the home. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute to income to the family, determination of eligibility shall proceed with the available income information. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home.

Proof of income is requested at the time of application for the 3 and/or 12 months prior to the date of service. Proof of income can include the following: paystubs, unemployment benefits, SSI, SSD, DA, VA benefit letter, pension letter or a letter from employer verifying gross income. A child support letter may be provided if the child is the patient. An income tax return or W-2 may be considered only when the patient cannot produce another form of documentation. Gross income will be considered 12 months of income for both tax returns and W-2s.

If zero income is reported on the application the patient will be requested to produce a statement explaining how living expenses are being met.

If all requested documentation is not received the hospital may consider a completed and signed application as verification of income.

E. Federal Poverty Levels

The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's Family or household. HHS Poverty Guidelines are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code, and available here: <https://aspe.hhs.gov/poverty-guidelines> or per request from the Hospital's patient financial services at 740-623-4244.

2. Charity Care and Discount Payment Program

Financial assistance may be granted in the form of full charity care or discounted care, depending upon the patient's level of eligibility as defined in this Policy.

The patient balances for those patients who qualify for **Charity Care**, as determined by the Hospital, are eligible for Prime Healthcare's Charity Care program shall be reduced to a sum equal to zero dollars (\$0) with the remaining balance eliminated and classified as Charity Care. Please see the addendum "Charity Care Program" for additional information.

The patient balances for those patients who qualify for the **Discount Payment Program** are eligible for Prime Health's Discount Payment Program; any discount will be applied against the gross charges for hospital services provided. Please see the addendum "Financial Assistance Discount Payment Program" for additional information.

The Discount Payment Program shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Hospital and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family Income and essential living expenses.

3. Application Process

Any patient who requests financial assistance will be asked to complete a financial assistance application. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. A patient is expected to submit the financial assistance application promptly following care. Per [Ohio Rule 5160-2-17](#), the Hospital will accept applications for services without charge until three years from the date of the post-discharge follow-up notice.

4. Resolution of Disputes

Any disputes regarding a patient's eligibility for financial assistance shall be directed and resolved by the Hospital's Chief Financial Officer.

5. Publication of Policy

In order to ensure that patients are aware of the existence of this Policy, the Hospital shall take the following measures:

- Notice of the availability of financial assistance shall be clearly and conspicuously posted in locations that are visible to the patients in the following areas: (1) Emergency Department; (2) Billing Office; (3) Admissions Office; and (4) other outpatient settings including observation units; and (5) prominently displayed on the hospital's internet website, with a link to the policy itself.
- Every patient who is seen at the Hospital, whether admitted or not, shall receive the notice in the addendum "Summary of Financial Assistance". The notice shall be provided at the time of service, discharge, or when the patient leaves the facility. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.
- Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include a notice to be included in post-discharge billing statements to patients who have not provided proof of insurance. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

6. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to a patient including private health insurance, coverage offered through the federal health insurance marketplace, Medicare, Medicaid, and/or other government-funded programs designed to provide health coverage.

If a patient does not indicate that he/she has coverage by a third party payor or requests financial assistance, Hospital staff shall provide the patient with a notice that includes the following: (a) a request that the patient inform the Hospital if the patient has private or public health insurance coverage or other coverage, (b) a statement that if the patient does not have health insurance coverage, the patient may be eligible for coverage under the state's Medicaid program or other governmental programs, (c) a statement indicating how the patient may obtain applications for the state's Medicaid program or other governmental programs (and as appropriate, the Hospital will provide such applications to the patient), and (d) information regarding the Hospital's financial assistance program.

7. Collection Activities

The Hospital may use the services of one or more external collection agencies for the collection of patient debt. No debt shall be advanced for collection until the Director of the Hospital Patient Financial Services or his/her designee has reviewed the account and approved the advancement of the debt to collection. If a financial assistance application is received and is incomplete, the Hospital will provide written notice of the outstanding items and wait a reasonable period of time before initiating or resuming Extraordinary Collection Actions.

Any collection agency utilized by the Hospital shall comply with any payment plan entered into between the Hospital and the patient. If a patient applies for financial assistance, any collections actions will be suspended pending the decision on the patient’s financial assistance application. If during collections, it is discovered the patient qualifies in whole, or in part, for Charity Care or a self-pay discount, collection efforts will cease, and the respective balance will be written off to Charity Care or as a self-pay discount. Neither the Hospital nor any collection agency utilized by the Hospital shall (i) use wage garnishments or liens on primary residences to collect unpaid medical bills or (ii) report adverse information to a consumer credit reporting agency or commence civil action against a patient for nonpayment at any time prior to 150 days after the initial billing.

At least thirty (30) days before commencing any Extraordinary Collection Actions (ECA), the Hospital must send a notice to the patient which specifies the following: (i) collection activities the Hospital or contracted collection agency may take, (ii) the date after which such actions may be taken, (iii) that financial assistance is available for eligible patients, (iv) the dates of service of the bill that are being assigned to collections; (v) the name of the entity the bill is being assigned or sold to; (vi) information on how the patient can obtain an itemized bill from the hospital; (vii) the name and plan type of the health coverage for the patient on record with the hospital at the time of services, or a statement that the hospital does not have that information; (viii) an application for the hospital’s Charity Care and financial assistance; and (ix) the date the patient was originally sent a notice of financial assistance application, the date or dates the patient was sent a financial assistance application, and if applicable, the date a decision was made.

If a complete application is received within three years from the date of the post-discharge follow-up notice, any Extraordinary Collection Actions will be suspended while a determination of eligibility is made.

Revision History Table

Document Number and Revision Level	Final Approval by	Date	Brief description of change/revision

Plain Language Summary of Financial Assistance

Eligible patients who have household Family Income equal to or less than 450% of the current Federal Poverty Level and meet certain low- and moderate-income requirements may qualify for free care or partially discounted care and extended payment plan options from Coshocton Regional Medical Center. No patient will be charged more than Amount Generally Billed (AGB) for emergency or other medically necessary care. Emergency Department physicians and other physicians who are not employees of the hospital may also separately offer financial assistance. The Charity Care Program is summarized in the addendum “Charity Care Program”, and the Discount Payment Program is summarized in the addendum “Financial Assistance Discount Payment Program”.

Patients can obtain copies of the Financial Assistance Policy and application forms Coshocton hospital.org on the Hospital website. For further information or a financial assistance application, please contact us:

740-623-4244
Coshocton Regional Medical Center
1460 Orange Street
Coshocton, Ohio 43812

The Financial Assistance Policy documents are available in non-English languages spoken by a substantial number of the patients served by the Hospital.

Completed applications should be delivered to:

Coshocton Regional Medical Center
Attn: Patient Financial Services
1460 Orange Street
Coshocton, Ohio 43812

Charity Care Program

A patient qualifies for **Charity Care** if the following conditions are met:

- (1) The patient (a) is an Ohio resident, (b) is not a Medicaid recipient; **and** (b) has a Family Income that does not exceed 450% of current Federal Poverty Level; **or**
- (2) The patient (a) does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid as determined and documented by the hospital; (b) has an injury that is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital; and (c) has a Family Income that does not exceed 450% of the current Federal Poverty Level.

The Federal Poverty Level is determined by HHS Poverty Guidelines and are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code, and available here: <https://aspe.hhs.gov/poverty-guidelines>.

The patient balances for those patients who qualify for **Charity Care**, as determined by the Hospital, shall be reduced to a sum equal to zero dollars (\$0) with the remaining balance eliminated and classified as Charity Care.

A patient who does not qualify for the Charity Care Program because they have third party coverage or their injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital may qualify for the Discount Payment Program if certain conditions are met, as described in the addendum "Financial Assistance Discount Payment Program."

For further information or a financial assistance application, please contact us:

740-623-4244

**Coshocton Regional Medical Center
1460 Orange Street
Coshocton, Ohio 43812**

Financial Assistance Discount Payment Program

Self-Pay Patients

A self-pay qualifies for the **Financial Assistance Discount Payment Program** if the patient's Family Income is within 351% and 450% of the current Federal Poverty Level. The Federal Poverty Level is determined by HHS Poverty Guidelines and are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code, and available here: <https://aspe.hhs.gov/poverty-guidelines>.

Qualifying self-pay patients do not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid or whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital and whose Family Income does not exceed 450% of the Federal Poverty Level shall be eligible for the Financial Assistance Discount Payment Program.

Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital may qualify for the **Financial Assistance Discount Payment Program** if (i) he or she has a Family Income at or below 450% of the Federal Poverty Level and (ii) has out-of-pocket medical expenses that exceed the lesser of: (a) ten percent (10%) of the patient's Family Income in the prior twelve (12) months (whether incurred or paid in or out of any hospital) or (b) the annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's current Family Income.

The Federal Poverty Level is determined by HHS Poverty Guidelines and are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code, and available here: <https://aspe.hhs.gov/poverty-guidelines>.

Patient Obligation

The patient balances for those patients who qualify for the **Financial Assistance Discount Payment Program** will be reduced; any discount will be applied against the gross charges for hospital services provided. The payment obligation of a patient eligible for the Discount Payment Program will be determined on a case-by-case basis but will not exceed the Amount Generally Billed (AGB); the greater of the amount the Hospital would expect to receive for providing services from Medicare or Medicaid, whichever is greater (the "Discounted Payment Maximum"). An eligible patient with insurance will be obligated to pay an amount equal to the difference between what the Hospital receives from the insurance carrier and the Discounted Payment Maximum. If the amount paid by insurance exceeds the Discounted Payment Maximum, the patient will have no further payment obligation.

The Financial Assistance Discount Payment Program shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Hospital and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family Income and essential living expenses.

For further information or a financial assistance application, please contact us:

740-623-4244

Coshocton Regional Medical Center

1460 Orange Street

Coshocton, Ohio 43812

[Notice to be included in all post-discharge billing statements]

Charity Care & Discount Payment Program

Patients who lack insurance or who have inadequate insurance and meet certain low-and moderate-income requirements may qualify for discounted payments or Charity Care. Patients seeking discounted or free care must obtain and submit an application that will be reviewed by the Hospital. No patient eligible for financial assistance will be charged more for emergency or medically necessary care than amounts generally billed to individuals who have insurance covering such care. For more information, copies of documentation, or assistance with the application process, please contact the Hospital at 740-623-4244 or visit CoshoctonHospital.org to obtain further information. Free copies of financial assistance documentation may also be sent to you by mail and are available in non-English languages spoken by a substantial number of the patients served by the Hospital. The Emergency Department physicians and other physicians who are not employees of the Hospital may also provide Charity Care or Discount Payment Programs. Please contact 740-623-4244 for further information.

**Notice to be included in post-discharge billing statements
to patients who have not provided proof of insurance**

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, state-funded health coverage programs, or other similar programs. If you do have such coverage, please contact our office at 740-623-4244 as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, coverage offered through the federal health insurance marketplace, state- or county-funded health coverage, or Prime Healthcare Charity Care or Discount Payment Program. For more information about how to apply for these programs, please contact our office so we can answer your questions and provide you with applications for these programs.