Garnet Health	**POLICY LEVEL** ☑ Garnet Health ☐ Garnet Health Medical Center ☐ Garnet Health Medical Center - Catskills ☐ Garnet Health Doctors ☐ Garnet Health Urgent Care	**Page 1 of 5**
APPLIES TO: ☑ System ☑ Organization ☐ Department (specify)	**CATEGORY:** Financial Assistance Program	**DOCUMENT CONTROL NUMBER:**

Title:
FINANCIAL ASSISTANCE POLICY

Attachments: **A. Financial Assistance Policy**	**B. Financial Aid Application** **C. Summary Letter** **D. Determination Notice**	**E. Appeal Form** **F. Sliding Scale**

Purpose:
Garnet Health understands that there are times when patients in need of care will have difficulty paying for medical services provided. The purpose of this Financial Assistance Policy (FAP) is to provide a reduction in the amount of a patient or responsible party's financial liability for eligible uninsured or underinsured patients. Charges on all uninsured patients will be adjusted to approximate cost plus a slight markup. Eligible uninsured or underinsured patient/responsible party may receive further charity care reductions based on financial need. All determinations will be made in a non-discriminatory manner, following an individualized review of all documentation and the submitted application. Eligibility for Financial Assistance will be based on the current income guidelines established by the Federal Department of Health and Human Services and published in the Federal Register, encompassing sliding scale reductions up to 400% of the Federal Poverty Guidelines (FPG). Monthly, a batch file review will be completed to establish presumptive eligibility. This will be conducted by our third-party vendor using proprietary software to estimate income

Definitions:
AGB means "Amounts Generally Billed" for emergency or other medically necessary care to individuals who have insurance coverage.
Application Period means the period during which Garnet Health must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins at any point, starting from the date of service and throughout the collections process.
Elective Services means a treatment or procedure that is chosen (elected) by the patient or physician that is advantageous to the patient but is not medically necessary or urgent for a condition that is not life threatening (e.g., cosmetic surgery, MCR HINN) and/or discretionary charges, such as private rooms, private nursing are not covered by this policy.

EMTALA means the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd.

FAP means Financial Assistance Policy.

FPG means Federal Poverty Guidelines.

Medically Necessary Services means a treatment that is a covered health service or a treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.

Service Area includes ZIP codes in Orange, Sullivan, and Ulster Counties. Garnet Health has defined its community and service areas as its broader service area with a primary focus on Orange County and Sullivan County, allowing the hospital to more effectively direct resources toward addressing significant health needs, particularly in areas with the greatest disparities.

Policy:

Any patient who is a resident of the State of New York is eligible for financial assistance through Garnet's program for emergency services for residents of the State of New York. For all other services, it is the policy of Garnet Health to provide the level of financial assistance to emergent, urgent, and medically necessary treatment to patients who reside in Garnet Health's primary service areas, as well as patients that work, reside or visit the primary service areas. Garnet Health reserves the right to refuse to provide financial assistance for elective services.

Patients cannot be denied admission or denied medically necessary treatment or services because of unpaid medical bills.

The Financial Assistance Summary summarizes this FAP, and physical copies will be made available to all patients at all facilities at the time of service and discharge. Patients also may request a copy to be mailed free of charge upon request by phone or writing to the address below.

Commitment to Provide Emergency Medical Care: Garnet Health provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. Garnet Health will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions, requiring a credit card be on file, or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, are provided to all Garnet Health patients in a non-discriminatory manner, pursuant to Garnet Health EMTALA policy.

Measures to Widely Publicize the Availability of Financial Assistance: Garnet Health implements various measures to widely publicize the availability of financial assistance in the communities served. Among other things, Garnet Health will publicize the existence of its financial assistance program to the community served by posting a copy of the FAP, FAP application, and a plain language summary of the FAP on its internet website. Furthermore, patient billing statements will advise patients of the existence of the financial assistance program and notice of availability of the financial assistance program will be posted in the Patient Registration, Credit & Collection, Billing, Emergency Department sections of Garnet Health's website, along with physical copies being made available in patient waiting areas.

Uninsured/Underinsured Patient Discounts: Garnet Health Centers provides a discount to all uninsured patients for all services resulting in a reduction in charges down to an approximate cost, plus a slight markup. Garnet Health

Doctors/Urgent Care provides a discount to all services (excluding cosmetics and HINNs) using the current Medicare RBRVS Loc03 Fee Schedule.

In addition, Garnet Health provides additional discounts for the uninsured and underinsured patients eligible for financial assistance. Procedures under this discount are to be deemed medically necessary to qualify. Elective services do not qualify for this additional discount:

- Uninsured and underinsured patients at or under 200% of the Federal Poverty Guidelines will receive a 100% discount on patient liability.
- Uninsured and underinsured patients at 201-300% of the Federal Poverty Level may qualify for a 10% reduction of Medicaid rates or up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
- For patients whose eligibility is between 301% and 400% of the Federal Poverty Level may qualify for a 20% reduction of Medicaid rates, or up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
- For patients whose eligibility is above 400% resources will not be considered.

Authority to Approve and Update Discount: On an ongoing basis, and at minimum annually, the Chief Financial Officer (CFO) and/or Vice President, Revenue Strategy & Managed Care, have been granted the authority to approve and update the charge discounts based on updated costs.

Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance: Following a determination of eligibility under this policy, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than AGB. Garnet Health uses the Look-Back Method to determine AGB for each of its hospital facilities. Under this method, AGB is calculated by dividing the sum of all of its claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service that pay claims to the respective hospital facility during a prior 12-month period by the sum of the associated gross charges for those claims. Garnet Health will begin applying the AGB percentage by the 120th day after the end of the 12-month period used in the calculation. Members of the public may obtain the current AGB percentage for any Garnet Health location free of charge by submitting a written request to the Credit & Collections Department, as indicated at the end of this policy, or online at www.garnethealth.org.

Garnet Health does not bill or expect payment of gross charges from a patient/responsible party who qualifies for financial assistance under this policy. Patients will not be charged more than the AGB.

"Underinsured" is defined as patients whose paid medical expenses have exceeded 10% of their income in the last 12 months.

- Income is assessed as the gross monthly income of the household, before expenses.
- Paid medical expenses refer to any out-of-pocket costs for emergency or medically necessary care (i.e. deductibles, copays, coinsurance, deposits, etc.), but do not include the cost of health insurance premiums.
    - If care totaling more than 10% of a patient's income was received at the hospital at which the patient is applying for financial assistance, hospitals may use a patient's account to determine eligibility. Otherwise, patients must provide proof of paid bills or other documentation to indicate that medical expenses werepaid.

How to Apply for Financial Assistance: An evaluation of the patient's financial situation will be completed with the use of a Financial Assistance Application (with supporting documentation from the patient/responsible party).

- It is prohibited for any hospital, health care provider, or employee/agent of a hospital or health care provider to complete any portion of an application for medical financial products for the patient, or otherwise arrange for or establish an application that is not completely filled out by the patient. Providers may answer patient's questions and provide assistance if requested, so long as the application is completed wholly by the patient.
- All applications must be signed and dated by the person making the request.
- Applications will not be deemed completed until all income documentation required is provided.
- All applications will indicate the date, name and title of the Garnet Health employee reviewing the said application.
- As part of financial assistance counseling, the patient will be screened for Medicaid eligibility, if still within the timeframe (90 days) from the date of service.

Financial Assistance Eligibility Determinations: Determination of eligibility will be made, in writing, to each applicant within 30 days of receipt of complete application and documentation. Immigration status is not considered when determining eligibility. Determinations will be based on the application and information submitted. A Patient's Assets (such as residence, car, etc.) may not be considered. Eligibility for financial assistance is determined solely based on household income.

A copy of all determinations will be kept on file.

Appealing a Financial Assistance Eligibility Determination: Once a denial determination is made, the patient will have 30 days from receipt of written notification to submit an appeal with supporting documentation. The denial determination shall include the following information on how to appeal:

- If it is determined that the patient does not qualify for the Financial Assistance program, the patient will be informed in writing within thirty (30) business days of the denial. All reasons for denial will be provided in the correspondence, including information on how to appeal the denial.
- The appeal and supporting documentation will be reviewed by the Director of Revenue Cycle Shared Services within twenty (20) days of the decision.
- The Revenue Cycle leadership shall have fifteen (15) business days to review the appeal and respond to the patient in writing.
- If the patient remains dissatisfied with the Revenue Cycle Leaders decision, the patient may appeal the leader's decision in writing, including reasons therefor, and any supporting documentation to the Hospital's Chief Financial Officer (CFO).
- The Chief Financial Officer shall decide to write within fifteen (15) days of receipt of the appeal; and their decision shall be final.
- No collection activity shall be pursued during the pendency of any appeal.

Installment Payments: The patient/responsible party may arrange to pay on an installment plan. The monthly payment of the installment plan is capped at 5% of the eligible patients' gross monthly income. Any deposit amount will be included as part of financial assistance settlement.

Financial Assistance Eligibility and Discounts: The Federal Poverty Guidelines as published in the Federal Register (and updated annually) will be used to determine additional discounts for uninsured and the underinsured eligible patients.

Actions Taken in the Event of Nonpayment: Information regarding the actions that Garnet Health may take in the event of nonpayment are described in a separate Billing and Collection Policy. Members of the public may obtain a free copy of this separate policy from Garnet Health via the contact information listed below or on website garnethealth.org. Among other things, the policy provides as follows:

- During the financial assistance determination process, collection efforts will be placed on hold and account will be assigned to a Charity financial status.
- In the event of non-payment, Garnet Health will not refer accounts to collection agencies 180 days following the issuance of the first medical bill, regardless of a patient's eligibility for financial assistance.
- Garnet Health will provide written notification to patients not less than 30 days prior to referral to a collection agency.
- Garnet Health is prohibited from selling any patient debt to a third party, unless the third party intends to forgive all debt and does not intend to pursue any collections.
- Forced sale or foreclosure of patient's primary residence is prohibited. Outside collection agencies will make the assistance application available to patients.
- Accounts pending payment from Medicaid for eligible patients will not be referred to collections.
- Garnet Health is prohibited from initiating lawsuits against patients with incomes below 400% APL.

Financial Assistance Approval: The approval of financial assistance will be good for 180 days from the approval date. The individual will be required to submit a new application after the initial expiration date.

Presumptive Financial Assistance Eligibility: In circumstances where documentation is unobtainable or patients do not complete an application for financial assistance, Garnet Health may grant financial assistance without a formal request, based on presumptive circumstances. In cases where an application is in process with documents and a presumptive eligibility write-off has occurred the documentation will be used as the basis to determine the eligibility percentage.

- Presumptive eligibility will be based on a proprietary credit-scoring program. This will not negatively impact the patient's FICO score.
- For patients with established eligibility at or below 200% of the FPG, by credit scoring, said accounts will be deemed eligible for 100% write off of account balances, with no other requirements.
- Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for charity upon verification of Medicaid coverage for the service date(s). No other documents will be required in order to approve the charity application. The hospital may submit the application and verification of coverage as proof of qualification.

Eligible Providers: This policy applies to emergency and other medically necessary care provided by the following facilities within Garnet Health:

- Garnet Health Medical Center

- Garnet Health Medical Center- Catskills
- Garnet Health Doctors (Orange and Catskill)
- Garnet Health Urgent Care (Orange and Catskill)
- In addition to care delivered by Garnet Health, emergency and medically necessary care delivered by the providers listed below is also covered under this Financial Assistance Policy:

  Emergency Department Services |SCP Health (Schumacher Group)
  200 Corporate Blvd
  Lafayette, LA 70508
  Phone: 800.893.9698
- See https://www.garnethealth.org for a complete list of all providers, in addition to Garnet Health itself, delivering emergency or other medically necessary care at Garnet Health hospital facilities that specifies which providers are eligible and covered by this policy and which are not covered.

Contact Information.

Garnet Health Medical Center/ Garnet Health Doctors/ Garnet Health Urgent Care
Financial Advocate Office
707 East Main Street
Middletown, NY 10940
Telephone-845-333-1888
Website-www.garnethealth.org

Garnet Health Medical Center-Catskills/ Garnet Health Doctors/ Garnet Health Urgent Care
Credit & Collections
P.O. Box 800
Harris, NY 12742
Telephone-845-333-8989
Website-www.garnethealth.org

Standard(s):

Reference(s): Hospital Financial Assistance Law (HFAL)-subdivision 9-a, to Section 2807-k of the NYS Public Health Law; Section 501(r) of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations issued thereunder.
Public Health Law 2807-k-(9-a)- financial aid

Financial Assistance Policy

Author/Title: Director of Revenue Cycle Shared Services

Approver/Title:
James Grigg/CFO

Concurrences

Credit & Collection Department	Garnet Health Administrator
VP, Revenue Strategy/Managed Care	Compliance Office

Document Control

Status Key:		**A** = New	**B** = Reviewed **+ #**	**C** = Revised **+ #**	**D** = Archived
Status	**#**	**Description of Change**		**Date**	**Author/Title**
C	0	Updated to NYS Guidelines		3/2025	
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