CAPE FEAR VALLEY HEALTH SYSTEM
Policy – Procedure

Title: Debt Mitigation and Presumptive Financial Assistance	**Effective Date:** 1/1/2025

Purpose: The purpose of this policy is to inform and guide decision making in regard to the reduction of medical debt and the application of presumptive financial assistance.

Scope: Cape Fear Valley will provide approved patients with a discount on hospital debt, according to the process set forth in this policy.

Departments: All departments

Keywords: charity

Definitions:

Policy: Debt Mitigation/Financial Assistance

Eligibility

All North Carolina Residents that have a non-cosmetic balance due for hospital services are eligible for this program under the following conditions:

Eligible deemed through Presumptive Measures

I. Non-income driven presumptive eligibility may be granted to patients based on their eligibility for or enrollment in other means-tested public assistance programs or life circumstances such as:

- Homelessness or receipt of care from a homeless clinic or shelter.
- Mental incapacitation with no one to act on the patient's behalf.
- Enrollment in Medicaid of patient or a child in their household.
- Women, Infants and Children (WIC) program.
- SNAP benefits (Supplemental Nutritional Assistance Program, (formerly known as Food Stamps) as proof of need and are therefore presumptively eligible).
- Minors 17 years of age or younger who are deemed financially responsible for a minor child who has received services at a Cape Fear Valley Hospital.
- Minors 17 years of age or younger who Cape Fear was unable to obtain a parent or legal guardian to be financially responsible for services rendered to the minor.
- Eligibility in other state or local assistance programs, such as Victims of Violent Crimes.

II. Income Driven presumptive eligibility may be granted based on the level in which the patient falls within the Federal Poverty Guidelines. Cape Fear Valley may use a third party to conduct a review of publicly available information about the patient or guarantor to assess financial need. In no event will Cape Fear Valley or the third party access the patient's or guarantor's credit file.

a. The data returned from the presumptive eligibility review will constitute adequate documentation of financial need under this Policy.
b. If a patient will be screened under the presumptive eligibility model, the following will occur:
    - Non-Income driven screening for non-emergency department services for insured and uninsured patients shall be completed prior to or at the time of check-in. The patient will be notified of their eligibility prior to discharge.
    - Non-Income driven screening for emergency department services for insured and uninsured patients shall be completed as soon as possible but prior to discharge, if feasible. The patient will be notified of their eligibility prior to receiving a bill.
    - Income driven screening for uninsured patients shall be completed prior to bad debt assignment or after all other eligibility and payment sources have been exhausted to ensure the patient is screened for presumptive charity/financial assistance prior to pursuing any extraordinary collection actions.
c. If the information obtained through the presumptive eligibility screening does not support a finding that the patient qualifies for financial assistances, the patient may still apply through, provide the requisite information for, and be considered under the traditional financial assistance process.

Procedural Guidelines:

Criteria

III. The Health System Acute hospitals discount patient balances according to the following criteria:

a. Determine if Procedure is Cosmetic
    i. If NO
    ii. Determine appropriate balance due patient.

b. Insured Patient
    i. Final remittance from third party insurance defining the patient specific contribution to hospital allowed reimbursement for medically necessary services.
    ii. Occurs post final appeal in the case of a disputed payment case.

c. Uninsured Patient
    i. Balance due on account after Automatic Self Pay Discount is applied.

Procedure to Determine Patient Responsibility

IV. Prior to Patient Billing process, determine patient financial status as a percentage of the Federal Poverty Level

This can be done through electronic measures (ie third party software processing) or by patient supplying final Tax Assessment

a. Apply Patient FPL level to Table 1 to assess level of discount to be applied to patient defined balance as indicated in final remittance to the account using medical debt mitigation adjustment code.
b. These adjustments may be modified in the case of retrospective review of account that results in new information that would alter the FPL score.
c. These adjustments may be requested by the patient or appropriate guardian or representative of patient.
d. Reduce adjusted balance by any prepayments made by patient.
e. For Emergency Department services, Cape Fear Valley will collect a fee from insured and uninsured patients that is the greater of (1) the amount the patient would owe based on the percentage discounts specified in IV. a. above. or 2) $35.00, not to exceed cost-sharing under the patients health plan (for insured paitents)
f. In no case will there be a full adjustment for Emergency Room services
g. Proceed to Billing Procedure

Table 1.

Income Range Benchmarked against Federal Poverty Level (FPL)	***Discount off Balance***
0-200%	***100%***
201-300%	***75%***
301-400%	***50%***
401-500%	***25%***

V. Billing and Collection Process

a. Patients receive four statements: The initial statement is generated on the day that patient's responsibility is established, followed by a second notice 30 days after the initial statement is issued, a third notice 60 days after the initial statement is issued and the final notice 90 days after the initial statement is issued.

b. Patient balances are considered qualified for bad debt collection processes if the following statements apply:

i. The patient balance is not paid in full.
ii. The patient balance is outstanding 120 days from the date of patient notification of responsibility.
iii. The patient balance exceeds $3.99; and
iv. The patient has failed to make payments according to the plan they agreed to or otherwise meet commitments made to RC staff engaged in collection activities.

c. Cape Fear Valley will NOT take any of the following actions to collect the debt or as the result of not collecting the debt.

i. Causing an individual's arrest
ii. Causing an individual to be held in civil contempt or imprisoned.
iii. Foreclosing on an individual's real property
iv. Garnishing wages or State income tax refunds

d. In the case of an uninsured patient presenting valid insurance, the billing process will stop, and the claim will be resubmitted to insurance, thus restarting the process of determination of appropriate patient responsibility.

VI. Payment Plan Enrollment Process

a. Patients may request to be (and shall be) enrolled in a payment plan at any time during this collection process.
i. Patients will be offered the opportunity to enroll in a payment plan that meets the following criteria:
ii. Monthly payment must not be greater than 5% of patient household monthly income.
iii. Payment plans must not exceed 36 months in length.
iv. IF agreed to by Cape Fear Valley and Patient, the plan MAY exist greater than the 36 months as long as the total owed is NO greater than what the original 36-month plan would've required.

b. All third-party vendors must adhere to the request as well.

Related Documents/Policies: Financial Assistance, Bad Debt and Collections

References: NC DHHS, NC General Assembly