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Owner	Karla Marshburn: CORP DIRECTOR OF REVENUE CYCLE
Area	Finance
Applicability	Cape Fear Valley Medical Center

Debt Mitigation and Presumptive Financial Assistance

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. Patients 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.

III. Beginning July 1, 2025 and thereafter, the Institution shall evaluate all patients who are North Carolina residents and enrolled in Medicaid for past medical debt within 60 days of the patient's inpatient discharge or outpatient encounter from the hospital and must reclassify any past debt as presumptive

charity care.

- The Institution shall not advertise about the policy but must inform the Medicaid-enrolled patient about the policy during the patient's encounter at the hospital.
- The Institution must reclassify as charity care any past debt of Medicaid-enrolled patients that proactively contact the hospital to inquire about medical debt relief.
- The Institution may confirm the patient's Medicaid enrollment prior to reclassifying past debt as charity care.
- Patients will be notified within 30 days of the reclassification of their debt as charity.

Procedural Guidelines:

Criteria

IV. 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

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

This will 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. Re-evaluations may be modified in the case of retrospective review of account that results in new information that would alter the FPL score.
c. Re-evaluations may be requested by the patient or appropriate guardian or representative of patient.
d. Review is completed on each qualifying patient individually and separately from other household members.
e. Balances will be reduced by any prepayments made by patient.

f. 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 patients)

g. In no case will there be a full adjustment for Emergency Room services

h. 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%*

VI. **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. Patients 18 years of age or older are and will their own guarantor holding no one else liable for any unpaid debt.

c. 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 debt collectors engaged in collection activities.

d. Cape Fear Valley, to include third party contracted vendors, 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

    v. Sale any patient debt when the patients FPL falls under 300% prior to 120 days of the first statement

vi. Initiate legal action against a patient for any claims where an insurance appeal or review is pending within the previous 60 days.

vii. Refer debts to an external debt collector if an insurance appeal or review was pending witihn the previous 60 days.

e. 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.

VII. **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, medical creditors to include medical credit card vendors marketed by CFVHS, must adhere to CFVHS's Debt Mitigation and Financial Assistance policies.

c. Cape Fear Health System nor it's vendor's will charge interest or penalties on unpaid balances. If at any time debt is sold, interest will be capped at 1% plus the secure overnight financing rate.

Related Documents/Policies:

Financial Assistance, Bad Debt and Collections

References:

NC DHHS, NC General Assembly

All Revision Dates

Sep 17, 2025, Sep 15, 2025, Aug 04, 2025

Approval Signatures

Step Description	Approver	Date
Final Approver	Karla Marshburn: CORP DIRECTOR OF REVENUE CYCLE	Sep 17, 2025
Document Owner	Karla Marshburn: CORP DIRECTOR OF REVENUE CYCLE	Sep 17, 2025

Applicability

Cape Fear Valley Medical Center