ST. MARYS & CLEARWATER VALLEY HOSPITAL AND CLINICS

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| Title: NHSC Discount Program  | Approval Date: 4/1/2020 |
| Type: Organizational  | Effective Date: 04/01/2020 |
| Category: Administrative | \*\*\*Revision Date: 12/21/2020 |
| Section: Business Office |  |
| Primary Author: Director of Revenue Cycle |  |
| Approval Body: Leadership Team  | Page 1 of 5 |

**Scope: Clearwater Valley and St. Mary’s Hospitals and clinics**

# Purpose:

# Scope: National Health Service Corp clinic locations.

# To outline how St. Mary’s & Clearwater Valley Hospital/Clincs will meet the requirements of the National Health Services Corps when providing healthcare services for free or on a sliding fee scale for low-income patients seeking services at a NHSC approved location.

**Definitions:**

1. **Federal Poverty Guidelines (FPG):** Income guidelines published annually by the U.S. Department of Health and Human Service that are used for determining financial eligibility for certain programs. Guidelines vary by family size.
2. **Household Income**: Includes earnings, unemployment compensation, worker’s 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
3. **National Health Service Corp (NHSC):** A network of primary health care professionals that provide medical, dental and mental and behavioral health services in communities, known as Health Professional Shortage Areas (HPSA’s) across the country that have limited access to health care.
4. **NHSC Approved sites:** Health care facilities that provide comprehensive outpatient, ambulatory, primary care services to populations residing in HPSA’s. Each site that would like to use the NHSC to recruit and retain health professionals must submit a Site Application and be approved as an NHSC site. NHSC sites are required to provide services for free or on a sliding fee scale for low-income individuals.
5. **Underinsured Patient:** An individual, with private or other insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by SMH/CVH. This would also include benefit exclusions in the insurance policy such as pre-existing conditions or mental health benefits.
6. **Uninsured Patient:** An individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program such as Medicare, Medicaid, TriCare and CHAMPUS, Worker’s Compensation, third-party liability (e.g. auto), Medical Savings Accounts or other third-party assistance to assist with meeting their payment obligations.

**Policy:**

1. Patients seeking emergent or medically necessary care at CVH/SMH, NHSC sites, shall be treated without regard to their ability to pay for such care. Financial Assistance will be based on financial need and shall not take into account race, color, ethnicity, national origin, religion, creed, gender, age, social or immigration status, residency, disability, sexual orientation or insurance status.
2. NHSC sites are required to provide services on a sliding scale discount program to low-income patients. Discounts will be offered based on patient’s household income and family size. (Attachment A)
3. A sliding fee schedule will be used to calculate the basic discount and is updated each year using the FPGs.
4. Patient will be required to complete an application to the NHSC Discount/Sliding Fee Scale

Program. (Attachment B)

1. The front desk/Registration staff will be responsible to offer patients information about the

 NHSC Discount/Sliding Fee Scale Program and screen them for eligibility, when applicable.

1. Patients who qualify for the NHSC Discount/Sliding Fee Scale Program will also be eligible for any and all other applicable CVH/SMH discounts. Patients may also apply for CVH/SMH Financial assistance programs.

**Procedure:**

1. To be eligible for the NHSC Discount/Sliding Fee Scale Program the patient must receive services at one of the NHSC approved locations, Clearwater Valley Clinics and St. Mary’s Clinics and qualify as low-income (can be uninsured or underinsured patients).
2. Discount Application process
	1. Applications will be available at the registration desk and given to the patient by staff at each NHSC location.

i. The Registrar will inform the presenting patient of this Program and provide the patient with the application package which includes the return envelope, contact information for a patient account representative, income guidelines, and instructions for the patient on how to submit the application and a return envelope at the time of service.

ii. The patient must provide verification of their home address: i.e. copy of driver's license or other I.D. This information will need to be scanned into the billing system by the Registrar.

iii. The patient must complete the application and provide verification of income. Verification should include two (2) of the most recent pay stubs for each adult household member, SSI or any other source of income for each adult member of the household.

iv. The patient must return the completed application along with the required documentation to the address listed below:

 Clearwater Valley Hospital & Clinics St. Mary’s Hospital and Clinics

 301 Cedar Ave PO Box 137

 Orofino ID 83544 Cottonwood ID 83522

 Phone: 208-476-4555 Phone: 208-962-3251

 Fax: 208-476-5385 Fax: 208-962-2478

1. If approved, the application will be approved for one year. Income and address verification must be updated annually along with the application.
2. If denied, the patient may re-apply at any time their financial situation changes.
3. Patient will be given 30 days to complete and return the application. If completed application is not returned, reasonable collection efforts will commence/continue according to the Collection Policy.
4. Discount Calculation
	1. The FPGs will be used when calculating the discount.
	2. Income guidelines will be adjusted at the beginning of the fiscal year (July) using the prevailing FPGs.
	3. All other applicable CVH/SMH financial assistance/discounts will be applied prior to the NHSC discount.
	4. When applying the NHSC Discount/Sliding Fee Scale Program the adjustment code A CV SLIDE for Clearwater Valley and A SM SLIDE for St. Mary’s will be used. This will ensure separate tracking for reporting purposes.
5. Discount Limitations
	1. This discount only applies to clinic services received at the NHSC designated sites.
	2. The discount does not apply to those services purchased outside of the clinic such as reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist and such other services.

**Financial Assistance Authorization Matrix**

|  |  |
| --- | --- |
| **Self-Pay Balance** | **Locations** |
|  | **Cottonwood, Clearwater and Associated Clinics** |
| $0.01 - $9,999 | Financial Counselor Manager |
| $10,000 - $24,999 | Financial Counselor Manager |
| $25,000 - $49,999 | Director of Revenue Cycle |
| $50,000 - $99,999 | Director of Revenue Cycle & CFO |
| $100,001 + | Director of Revenue Cycle & CFO |

1. Processing the application
	1. Designated Business Office Representatives will be responsible to:

i. Process application, ensuring that required documentation has been received.

ii. Patient Accounts Supervisor will approve and apply the appropriate discount based on household income and family size.

iii. Assist patient in completing the application when necessary.

* 1. When patient is eligible for the discount, the Representative will:

i. Complete the section: “Office Use Only” that is found on the application.

ii. Provide the patient with a letter informing them of the approval. (Attachment D)

* 1. When patient is not eligible for the discount, the Representative will:

i. Complete the section: “Office Use Only” that is found on the application.

ii. Complete the discount box with a note: “not eligible due to excess income” or other reason.

iii. Provide the patient with a letter stating the application was denied. (Attachment E).

* 1. Applications will be scanned into folder. Copies of letters will be saved in the folder.
1. Communication
	1. All approved sites will have a notice posted in a clearly visible location. (Attachment G). At the minimum, the notice should be posted in the front office or waiting area at each site.
	2. The notice explicitly must state that no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available.
	3. Postings and notices will be in English, and in any other language that is a prominent language of the communities in each NHSC site service area (defined as greater than 10% limited English proficiency in the area).Interpreter services will be available upon request as needed to discuss the Program further with patients or their guarantors.
2. Staff Training
	1. Registration staff will be aware of the program and the Patient Financial Counselors will be trained upon the availability of the NHSC Discount Program.

i. New employees will receive information during their standard new hire training.

ii. Annual training will occur for registration staff working at an NHSC approved site.

**Attachments:**

Attachment A – Discount/Sliding Fee Schedule

Attachment B – Discount/Sliding Fee Application

Attachment D – Discount/Sliding Fee Approval Letter

Attachment E – Discount/Sliding Fee Denial Letter

Attachment F – Discount/Sliding Fee Needs Info Letter

Attachment G – Notice of NHSC Program

**Replaces Policy #:**

**\*\*\*Previous Revision Dates:** 3/9/2016; 6/23/2016

**Approval Dates:**

 04/01/2020

Attachment A

**Discounted/Sliding Fee Schedule**

**4/1/2020 – 3/31/2021**

|  |
| --- |
| **Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty** |
| **Poverty Level\*** | **At or Below 100%** | **125%** | **150%** | **175%** | **200%** | **Above 200%** |
| **Family Size** | **Charge** |
| **Nominal Fee ($0)** | **20% pay** | **40% pay** | **60% pay** | **80% pay** | **100% pay** |
| **1** | 0-$12,760 | $15,950 | $19,140 | $22,330 | $25,520 | $25,521+ |
| **2** | 0-$17,240 | $21,550 | $25,860 | $30,170 | $34,480 | $34,481+ |
| **3** | 0-$21,720 | $27,150 | $32,580 | $38,010 | $43,440 | $43,441+ |
| **4** | 0-$26,200 | $32,750 | $39,300 | $45,850 | $52,400 | $52,401+ |
| **5** | 0-$30,680 | $38,350 | $46,020 | $53,690 | $61,360 | $61,361+ |
| **6** | 0-$35,160 | $43,950 | $52,740 | $61,530 | $70,320 | $70,321+ |
| **7** | 0-$39,640 | $49,550 | $59,460 | $69,370 | $79,280 | $79,281+ |
| **8** | 0-$44,120 | $55,150 | $66,180 | $77,210 | $88,240 | $88,241+ |
| **For each additional person, add** | $4,480 | $5,600 | $6,270 | $7,840 | $8,960 |  |

\* Based on [2002](http://aspe.hhs.gov/poverty-guidelines) Federal Poverty Guidelines (FPG)

**Does your income fall anywhere on this table? If so you could qualify for this discount program.**

**ST. MARY’S & CLEARWATER VALLEY HOSPITAL & CLINICS**

 **Discounted/Sliding Fee Program**

**ATTACHMENT B**

|  |  |
| --- | --- |
| Name of Head of Household | Place of Employment |
| Street | City | State | Zip | Phone |
| Health Insurance Plan | Social Security Number (Optional) | Medical Record Number |

**Please list spouse and dependents under age 18**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Name** | **Date of Birth** |
| Self |  | Dependent |  |
| Spouse |  | Dependent |  |
| Dependent |  | Dependent |  |
| Dependent |  | Dependent |  |

**Annual Household Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips etc. |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| 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 |  |  |  |  |
| **Total Income** |  |  |  |  |

Attachment B (continued):

**I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved**.

|  |  |
| --- | --- |
| Name (Print) | Date |
| Signature |
|  |

**Office Use Only**

|  |  |
| --- | --- |
| Patient Name | Discount |
| Date of Service | Approved by |

|  |  |  |
| --- | --- | --- |
| **Verification Checklist (attach copies)** | **Yes** | **No** |
| Identification/Address: Driver’s license, utility bill, employment ID or other |  |  |
| Income: Prior tax year return, three most recent pay stubs or other  |  |  |
| Insurance: Insurance card(s) |  |  |
|   |  |  |

**If you have any questions regarding this application, please call our Business Office at**

**Clearwater Valley Hospital & Clinics 208-476-4555**

05/2020

**St. Mary’s Hospital & Clinics 208-962-3251**

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |

**Attachment D**

 **ST. MARY’S & CLEARWATER VALLEY HOSPITAL & CLINICS**

Date

Gur Name

Gur Address

City State Zip

Guarantor Number

Dear Guarantor,

Thank you for applying to our Discount/Sliding Fee Program. We are happy to tell you that you have been approved for a \*\*\*% discount. In addition this discount will be effective until \*\*\*. (1 yr from date of application)

Location Account Balance Discount Balance Due

\*\*\* \*\*\* \*\*\* \*\*\*

Please note: The “Balance Due” column tells how much you still owe. If you have a “Balance Due”, please call to make payment arrangements.

If you have questions regarding your application please call our Business Office at the phone number listed below.

If you feel that your concerns have not been addressed, please contact our Business Office at one of the phone numbers at the bottom of this letter first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the Idaho Attorney General's Office at 208-334-2400.

Sincerely,

Discount/Sliding Fee Program

208-476-5777

**Attachment E**

**ST. MARY’S & CLEARWATER VALLEY HOSPITAL & CLINICS**

Date

Gur Name

Address

City State Zip

Gur #

Dear Gur,

Thank you for taking the time to apply to our Discount/Sliding Fee Program.

We have reviewed your application and find that we must deny your requests. The reason for this decision is:

Your income is over the Discount/Sliding Fee Program guidelines for your household size.

We have not received the following information, which we need in order to process your application: \*\*\* Drop Down (**Identification**-driver’s license, utility bill, employment ID, or other, **income verification** – prior tax year return, 3 most recent pay stubs, and verification of other income reported on your application, **Insurance card**, **Medicaid** -application made or denial)

If your financial circumstances change, you can apply again for financial help, just call our office and ask for a new application.

You will receive monthly bills from each CVH/SMH clinic if there is a balance due. Please call the phone number on your bill to make payment arrangements

If you have questions regarding your application, please call our Business Office at 208-476-5777

Sincerely,

Discount/Sliding Fee Program

**Attachment F**

**ST. MARY’S & CLEARWATER VALLEY HOSPITAL & CLINICS**

Date

Gur Name

Address

City State Zip

Gur #

Dear Gur,

Thank you for taking the time to apply to our Discount/Sliding Fee Program.

We know that tracking down information can feel overwhelming, but spending some time collecting this information could ultimately reduce or eliminate your medical bill.

Please help us by providing the following information listed below:

We have not received the following information, which we need in order to process your application: \*\*\* Drop Down (**Identification**-driver’s license, birth certificate, employment ID, Social Security card or other, **income verification** –prior tax year return, 2 most recent pay stubs, and verification of other income reported on your application, **Insurance card**, **Medicaid** -application made or denial)

We look forward to receiving this information within 14 days from the date of this letter. If we do not receive this information from you we will continue to bill you for these services.

If you have questions regarding your application please call our Business Office at 208-476-5777.

If you feel that your concerns have not been addressed, please contact our Business Office first and allow us the opportunity to try & address your concerns. If you continue to have concerns that have not been addressed, you may contact the Idaho Attorney General's Office at 208-334-2400.

Sincerely,

Discount/Sliding Fee Program

**Attachment G**

