| White Plains Hospital | **POLICY NUMBER:** |
|---|---|
| | **ORIGINAL DATE: 10/2015**<br>**REVIEWED DATE: No Review Date** |
| **SUBJECT: Financial Assistance & Collections Policy** | **REVIEWERS:**<br>**Asst. VP Revenue Cycle** |
| **INITIATOR: JENNIFER INDIVIGLIO (SR DIRECTOR, REVENUE CYCLE)**<br><br>**APPROVED: JOSEPH GUARRACINO (SR VP & CFO)** | **PAGE: 1 OF: 15** |

**Subject:**

Financial Assistance and Collections Policy (FAP)

**Purpose:**

White Plains Hospital Center is guided by a mission to provide high quality care for all of its patients. We are committed to serving all patients, including those in our service area who lack health insurance coverage and who cannot pay for all or part of the essential care they receive at White Plains Hospital Center. We are committed to treating all patients with compassion, from the bedside to the billing office, including our payment collection efforts. Furthermore, we are committed to advocating for expanded access to health care coverage for all New Yorkers.

White Plains Hospital Center is committed to maintaining this Financial Assistance Policy (FAP) that is consistent with its mission and values and that takes into account an individual's ability to pay for medically necessary health care services. This policy will constitute the official Financial Assistance Policy (within the meaning of Section 501(r) of the Internal Revenue Code of 1986, as amended, Section 1.501(r) of the Internal Revenue Service's regulations promulgated thereunder and New York Public Health Law) for the Hospital.

**Definitions:**

1. Amounts Generally Billed (AGB) means the amounts generally billed for Covered Services provided to individuals who have insurance covering such care. The Hospital uses a percentage of gross charges (the AGB percentage) and has elected to use the "look-back" method to determine AGB. Generally, in calculating the AGB percentage under the look-back method, the Hospital must include the claims allowed during a prior 12–month period by: (a) Medicare fee-for service; (b) Medicare fee-for-service and all private health insurers that pay claims to the hospital facility; or (c) Medicaid, either alone or in combination with Medicare fee-for-service or Medicare fee-for-service and all private health insurers that pay claims to the hospital. Please refer to the charts in Attachment A to this Policy for more information or contact a Financial Counselor at (914) 681-1004.

2. Application Period means the period during which the Hospital must accept and process an application for financial assistance under the FAP. The Application Period begins on the date the care is provided and ends on the 240th day after the Hospital provides the first post-discharge billing statement.

3. Billing Deadline means the date after which the Hospital may initiate an ECA (as defined) against a Responsible Individual (as defined) who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual provided at least 30 days prior to such deadline.

4. Covered Services means Emergency Medical Care or other Medically Necessary services provided to the Hospital's inpatient and outpatients. Patients who reside in New York State who need emergency services can receive care and qualify for a discount if they meet certain income levels as described below. Patients who reside in Bronx, Orange, Putnam, Rockland and Westchester Counties can qualify for a discount on non-emergency, Medically Necessary services if they meet certain income levels described below.

5. Emergent Condition means a medical condition that has resulted from the sudden onset of a health condition with acute symptoms of sufficient severity (including severe pain) which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions or result in serious dysfunction of any bodily organ or part.

6. Emergency Medical Care means medical care required to be provided for Emergent Conditions pursuant to the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act (42 U.S.C. 1395dd) to individuals, regardless of their eligibility for Financial Assistance under this policy. More specifically, Emergency Medical Care refers to services required to be provided under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations and Treas. Reg. § 1.501(r)-4(c) (or any successor regulations), to the extent such regulations are applicable to the Hospital.

7. Extraordinary Collection Action (ECA) means actions taken by the Hospital against an individual relating to obtaining payment of a bill for care covered under this FAP.

8. FAP-Eligible Individual means an individual eligible for financial assistance under this Policy without regard to whether the individual has applied for financial assistance.

9. Hospital means White Plains Hospital Center and its substantially related entities (not including the following captive professional corporations: Cancer & Blood Medical Services of NY, PC; Scarsdale Medical Group, PC and White Plains Medical Diagnostics, PC ).

10. Medically Necessary means those services necessary to prevent, diagnose, correct or cure conditions in a person that cause acute suffering; endanger life; result in illness or infirmity; interfere with his/her capacity for normal activity; or threaten some significant handicap.

11. Nominal Payment Rate means the nominal rates for major service categories that were specified by NYSDOH in an attachment to the May 2009 Dear Hospital CEO Letter.

12. Patient Accounts Department means the operating unit of the Hospital responsible for billing and collecting self-pay accounts for hospital services.

13. Plain Language Summary of the FAP (PLS) means a written statement that notifies an individual that the Hospital facility offers financial assistance under a FAP and provides necessary information in language that is clear, concise, and easy to understand. The PLS must be offered at intake or discharge and in any bill notifying a Responsible Individual about a possible ECA.

14. Responsible Individual means the patient and any other individual having financial responsibility for a the patient's account. There may be more than one Responsible Individual.

**Policy Guidelines:**

This policy is intended to apply to Covered Services and provides guidelines for administering financial assistance services to patients requiring "medically necessary" treatment after exhausting all sources of insurance payment. Financial assistance is provided to patients with a demonstrated inability to pay, as contrasted to an unwillingness to pay, which is considered bad debt. As of January 1st 2018 Medicaid HMO noncovered denials will also be considered for charity care.

1. Financial assistance shall be available to:

   - Uninsured patients residing in the Hospital's primary service area receiving medically necessary services or emergency care (See Attachment A for Financial Aid Chart and Levels); and

   - Patients residing in the Hospital's primary service area who exhaust their medical benefits.

   Except for emergency services, patients must reside within the Hospital's primary service area for a particular service to be categorically eligible for financial assistance. The Hospital's primary service area is Bronx, Orange, Putnam, Rockland, and Westchester counties. Eligibility for financial assistance for non-residents of New York State will be determined on a case-by-case basis.

   Elective procedures and services that are not deemed medically necessary (e.g. cosmetic surgery) are not eligible for financial assistance.

   A listing of providers (other than the Hospital itself) delivering Emergency or Medically Necessary care in the Hospital that are covered and NOT covered under this policy is available on the Hospital's website (https://www.wphospital.org [click on the "Patients and Families" tab, then click on "Financial and Insurance Information."]) and from the Patient Accounts Department. The list is updated quarterly.

2. The Hospital does not place a limit on services based on a patient's medical condition.

3. Determination of eligibility for financial assistance will be made as early in the care planning and scheduling process as possible. Patient Accounts counselors will assist any Responsible Individuals who require assistance with completing financial assistance applications. Emergency services will never be delayed pending financial determinations. Responsible Individuals can apply for financial assistance prior to services or after receipt of a bill.

Responsible Individuals can also apply for financial assistance after a bill has been sent to a collection agency.

4. Applications for financial assistance will be reviewed and decided upon promptly and within 30 business days for non-emergency services. Responsible Individuals are advised to disregard any bill received while an application is in process. Accounts for patients who have completed financial assistance applications shall not be sent to collections while applications are in process.

5. Responsible Individuals will be given two hundred and forty (240) days from the date of the first post-discharge bill to complete a financial assistance application. The Hospital may waive the 240 day period if the Responsible Individual can show good cause for the late filing. All late filings will require the approval of the Business Office Manager.

6. Incomplete applications (i.e., all required information/documents has/have not been provided) will be returned to the Responsible Individual with an explanation as to what information/documents is/are missing and notifying the Responsible Individual that they may have a reasonable time (i.e., no less than 30 days) to resubmit the application with the missing information/documents. A copy of the PLS, a notice of potential ECAs and contact information for the Patient Accounts Department will also be provided. Reasonable time depends on the particular facts and circumstances e.g., the amount of additional information/documentation that is being requested.

7. Financial assistance approvals will be valid for one year, subject to subsequent reviews based on changes in Responsible Individuals' circumstances.

8. Responsible Individuals are expected to cooperate with the Hospital in applying for available public insurance coverage (e.g. Medicaid, Child Health Plus, and Family Health Plus) if deemed potentially eligible before final financial assistance determinations are made.

9. Eligibility Criteria. Gross income tied to published FPL income guidelines adjusted for family size shall be used to determine eligibility for financial assistance. Decisions are based on annual income.

   a) For uninsured individuals at or below 100% of FPL who are approved for financial assistance, patient financial responsibility will be limited to the Nominal Payment rates listed below for the following services (See Attachment A):

      - Inpatient – $150/discharge
      - Ambulatory Surgery – $150/procedure
      - MRI Testing – $150 per session
      - Adult Emergency Room and Clinic Services – $15/visit
      - Prenatal and Pediatric Emergency Room and Clinic Services – no charge

   b) For uninsured individuals at or below 300% of FPL who are approved for financial assistance, patient financial responsibility will be based on a sliding fee scale capped at the amounts that would have been paid using the look-back method.

c) The Hospital's financial assistance policy also extends to uninsured individuals between 300% and 500% of FPL who are approved for financial assistance (See Attachment A).

d) Uninsured individuals above 500% of FPL residing in the Hospital's primary service area who receive medically necessary or emergency care are eligible for a courtesy discount (See Attachment A).

e) A FAP-Eligible Individual may not be charged more than AGB for Covered Services.

f) Any exceptions to the limits above shall be made on a case-by-case basis and require the approval of the Associate Vice President, Health Service Receivables; Vice President, Professional Services; or Vice President, Finance.

10. Immigration status is not a criterion used to determine eligibility.

11. The Medical Center shall verify current income. Acceptable proof of income is as follows:

a) Unemployment statement

b) Social Security/pension award letter

c) Pay stubs/employment verification letter

d) Letter of support

e) Attestation letter explaining income, support, and/or current financial situation if other proof of income is not available

12. The Hospital uses predictive analysis to assist in charity care determinations in the absence of completed financial assistance applications. Such findings will not deem patients ineligible for financial assistance. If a patient completes a financial assistance application with documentation demonstrating that his/her income is lower than the category determined using predictive analysis, the patient's financial responsibility will be further reduced to the lower amount. Experian is utilized. Experian Healthcare Financial Assistance Screening/Presumptive Charity uses financial information that is contained in a patient's credit report and other patient specific attributes to estimate their income level and where they are in relation to the Federal Poverty Level to qualify for a hospital's charity care program. Inquiries through Experian Healthcare's Financial Assistance Screening are soft inquires that can only be seen by the consumer and do not affect credit score. If consumer has any questions or concerns regarding the inquiry, they can contact Experian Healthcare Customer Care at (763) 416-1030.

13. Presumptive eligibility may also be based on prior FAP Eligibility or the Hospital may use enrollment in certain specified means-tested public programs to presumptively determine that individuals are FAP–eligible, including:

- State-funded prescription programs;
- Homeless or received care from a homeless clinic;
- 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
- Patient is deceased with no known estate.

If the patient is presumptively eligible for less than the most generous assistance available, the Hospital will notify the patient regarding the basis for the presumptive FAP eligibility determination and the way to apply for more generous assistance available under the FAP. The Hospital will also give the patient a reasonable period of time to apply for more generous assistance before initiating ECAs (as discussed below) to obtain the discounted amount owed for the Covered Services.

14. Full financial assistance will be granted to patients with outstanding self-pay bills and current Medicaid coverage.

15. Responsible Individuals will receive financial assistance decisions via mail, with notification on the bottom of the approval/denial letter explaining how to appeal the decision. The Hospital's billing statements will advise Responsible Individuals if they have received a financial assistance or self-pay discount and will show the adjustment.

16. Responsible Individuals may appeal the Hospital's financial assistance decisions if they are denied financial assistance or deem a decision to be unfavorable. Responsible Individuals appealing financial assistance decisions must provide supporting documentation (i.e., proof of current income). Responsible Individuals have 30 days to submit their appeals to the attention of the Director of Revenue Cycle, Patient Accounts Department and will be notified of decisions via mail within 30 days of the submission of appeals applications. Based upon the information provided, Responsible Individuals may be evaluated for further reductions or extended payment plans.

17. Responsible Individuals are offered payment plans if they are not able to make reduced payments in full. Extended payment plans are also offered through the appeals process. If a Responsible Individual makes a deposit, it is included as part of a payment towards his/her financial assistance balance. White Plains Hospital Medical Center does not charge interest on balances.

18. At least three (3) separate account statements will be mailed to the last known address of each Responsible Individual. At least 120 days must elapse between the first post-discharge bill and initiation of Extraordinary Collection Actions (as discussed below).

19. At least one of the statements sent during this time will include written notice that informs the Responsible Individual about the ECAs that may be taken if the Responsible Individual does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline. Such statement must be provided to the Responsible Individual at least 30 days before the deadline specified in the statement, if commencing ECAs.

20. Extraordinary Collection Actions (ECA). ECA refers to any action against an individual related to obtaining payment such as selling an individual's debt to another party; reporting

adverse information about the Responsible Individual to consumer credit reporting agencies or credit bureaus; deferring or denying or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previous care covered under the Hospital's FAP; or other actions that require a legal or judicial process including:

- Placing a lien on an individual's property (other than a lien that the Hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Hospital provided care);
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest;
- Causing an individual to be subject to a writ of body attachment; and
- Garnishing an individual's wages.

21. All collection agencies affiliated with the Hospital have a copy of and must follow the Hospital financial assistance policy and will refer any Responsible Individual needing assistance back to the Hospital for evaluation and reduction of a bill based on annual income and family size.

22. Responsible Individuals will receive a written notice 30 days prior to any account being forwarded to a collection agency or the initiation of any ECA. A reasonable effort to orally notify the Responsible Individual by telephone at the last known telephone number must also be made. During all conversations, the Responsible Individual will be informed about the financial assistance that may be available under the FAP.

23. The Hospital prohibits collections against any patient who is eligible for Medicaid at the time services are rendered.

24. The Hospital will not send an account to collection if a Financial Assistance application is pending.

25. After the commencement of ECAs is permitted, external collection agencies shall be authorized to file litigation, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior written approval from the Patient Accounts Department shall be required before any legal action may be initiated and prior approval of the Patient Accounts Department shall be required before collection agencies may use any means of collection that involves physical detention or arrest of any Responsible Individual.

26. Collection agencies are prohibited from forcing the sale of or foreclosure on a Responsible Individual's primary residence.

27. If the Hospital refers or sells patient debts to another party during the Application Period, the written agreement with such party must obligate such party to:

a) Refrain from engaging in ECAs until the Billing Deadline;

b) Suspend any ECAs if the individual submits a FAP application during the Application Period;

c) If the Responsible Individual is determined to be FAP-eligible, ensure that the individual does not pay and is not obligated to pay more than required, and to reverse any ECA previously taken; and

d) Obtain similar provisions in a written agreement if such party refers or sells the debt to yet another party.

28. The PLS must be offered at intake or discharge and in any bill notifying a Responsible Individual about a possible ECA.

29. Notice of the Hospital's financial assistance policies shall be communicated in writing to patients and local community service agencies. Written information describing the Medical Center's financial assistance policies shall be available in both English and Spanish to any party seeking such information at the following locations:

a) Emergency Room.

b) Admitting offices.

c) www.wphospital.org – (click on the "Patients and Families" tab, then click on "Financial and Insurance Information.") There is no charge to download these materials, and patients are not required to create an account or provide personally identifiable information.

d) By mail upon request to Patient Accounts Department, 41 East Post Road, White Plains, NY 10601.

e) In person from the Business Office located at 101 East Post Rd (3rd Floor).

f) The Call Center at 914-681-1004.

Financial assistance availability and office phone numbers are printed on the bottom of all hospital bills.

30. The Hospital will ensure that translations of the FAP, PLS and Application will be made into the primary language spoken by individuals that use the hospital that constitute the lesser of 1,000 people or 5% of the community serviced.

31. Notification about the availability of financial assistance is also widely publicized to members of the community served by the Hospital by various means, which may include, but are not limited to:

- Making referring staff physicians aware of the FAP through periodic communication; and

- including a prominently-displayed advertisement in the Hospital's newsletter mailed to the individuals in the Hospital's customer database informing readers that the Hospital offers financial assistance and providing appropriate contact information.

32. All intake, registration, and collection agency staff are trained on the Hospital's financial assistance policy on a periodic basis.

33. Responsible Individuals with any complaints about the Hospital's financial assistance policy or process may call the New York State Department of Health Complaint Hotline at 1-800-804-5447. This information is also included on denial letters.

In implementing this policy, the Hospital's management and facilities shall comply with all other Federal, State, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

# ATTACHMENT A

## Financial Aid Chart and Levels

| 2018 FEDERAL POVERTY LEVEL | | GROSS INCOME CATEGORIES (Upper Limits) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | | 6 | 7 | 8 |
| **Family Size** | **FPL** | **150%** | **200%** | **250%** | **300%** | **350%** | **400%** | **500%** | **>500%** |
| 1 | $ 12,140 | $ 18,210 | $ 24,280 | $ 30,350 | $ 36,420 | $ 42,490 | $ 48,560 | $ 60,700 | |
| 2 | $ 16,460 | $ 24,690 | $ 32,920 | $ 41,150 | $ 49,380 | $ 57,610 | $ 65,840 | $ 82,300 | |
| 3 | $ 20,780 | $ 31,170 | $ 41,560 | $ 51,950 | $ 62,340 | $ 72,730 | $ 83,120 | $103,900 | |
| 4 | $ 25,100 | $ 37,650 | $ 50,200 | $ 62,750 | $ 75,300 | $ 87,850 | $100,400 | $125,500 | |
| 5 | $ 29,420 | $ 44,130 | $ 58,840 | $ 73,550 | $ 88,260 | $ 102,970 | $117,680 | $147,100 | |
| 6 | $ 33,740 | $ 50,610 | $ 67,480 | $ 84,350 | $ 101,220 | $ 118,090 | $134,960 | $168,700 | |
| 7 | $ 38,060 | $ 57,090 | $ 76,120 | $ 95,150 | $ 114,180 | $ 133,210 | $152,240 | $190,300 | |
| 8 | $ 42,380 | $ 63,570 | $ 84,760 | $ 105,950 | $ 127,140 | $ 148,330 | $169,520 | $211,900 | |
| For each additional person add. | $4,320 | $6,480 | $8,640 | $10,800 | $12,960 | $15,120 | $17,280 | $21,600 | |

* Based on the 2018 Federal Poverty Guidelines

## Consolidated Professional and Hospital Financial Assistance Policy

Key Highlights of White Plains Hospital Financial Assistance Policy:

- The fees are designated by FPL% level and service. The schedule shows fees for Professional (PB), Hospital (HB) and Combined (PB + HB).
- Level 8 or greater than 500% is considered to be a 'Courtesy Discount.' For PB, the fee will be 61% of billed amount instead of a flat rate. As a result, a patient may receive an additional bill.
- Depending on the service a fee may not be charged and is earmarked with "$ – ".

| | | New Patient Visit (NPV) Family Health Clinic | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB NPV** | ***HB NPV** | **(PB Only Sites) Combined NPV** |
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $ – | $30 | $30 |
| 3 | 200% | $25 | $105 | $130 |
| 4 | 250% | $25 | $120 | $145 |
| 5 | 300% | $25 | $150 | $175 |
| 6 | 400% | $45 | $155 | $200 |
| 7 | 500% | $50 | $200 | $250 |
| 8 | >500% | 61% of Billed | $350 | = PB rate + HB rate |

*$15 for Adults and $0 for Prenatal and Pediatrics

| | | Established Patient Visit (EPV) Family Health Clinic | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB EPV** | ***HB EPV** | **(PB Only Sites) Combined EPV** |
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $ – | $30 | $30 |
| 3 | 200% | $15 | $105 | $120 |
| 4 | 250% | $15 | $120 | $135 |
| 5 | 300% | $15 | $150 | $165 |
| 6 | 400% | $15 | $155 | $170 |
| 7 | 500% | $25 | $200 | $225 |
| 8 | >500% | 61% of Billed | $350 | = PB rate + HB rate |

*$15 for Adults and $0 for Prenatal and Pediatrics

| | | Emergency Department (ED) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB ED** | ***HB ED** | **Combined ED** |
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $20 | $45 | $65 |

| | | | | |
|---|---|---|---|---|
| 3 | 200% | $50 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $70 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $100 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $130 | 26% billed charges | = PB rate + HB rate |
| 7 | 500% | $150 | 34% of billed charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

*$15 for Adults and $0 for Prenatal and Pediatrics

| | | **Ambulatory Surgery (Amb)** | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Amb** | ****HB Amb** | **Combined Amb** |
| 1 | 100% | $50 | $150 | $200 |
| 2 | 150% | $100 | $400 | $500 |
| 3 | 200% | $350 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $400 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $500 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $750 | 24% of charges | = PB rate + HB rate |
| 7 | 500% | $900 | 26% of charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

**Per procedure rate

| | | **Gastrointestinal (GI) Procedures** | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB GI** | ***HB GI** | **Combined GI** |
| 1 | 100% | $50 | $100 | $150 |
| 2 | 150% | $100 | $200 | $300 |
| 3 | 200% | $250 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $300 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $350 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $375 | 26% of charges | = PB rate + HB rate |
| 7 | 500% | $400 | 33% of charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

*Per procedure rate

| | | **Inpatient (Inpt)** | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Inpt** | **HB Inpt** | **Combined Inpt** |
| 1 | 100% | $75 | $150 | $225 |
| 2 | 150% | $250 | $500 | $750 |
| 3 | 200% | 12% of Billed | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | 14% of Billed | 75% of Medicare | = PB rate + HB rate |

| | | | | |
|---|---|---|---|---|
| 5 | 300% | 17% of Billed | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | 20% of Billed | 35% of charges | = PB rate + HB rate |
| 7 | 500% | 51% of Billed | 42% of charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| | | Medical Oncology Infusions (Inf) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Inf** | **HB Inf** | **Combined Inf** |
| 1 | 100% | $ – | $50 | $50 |
| 2 | 150% | $ – | $75 | $75 |
| 3 | 200% | $ – | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $ – | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $ – | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $ – | 24% of charges | = PB rate + HB rate |
| 7 | 500% | $ – | 24% of charges | = PB rate + HB rate |
| 8 | >500% | SP Rate | SP Rate | = PB rate + HB rate |

| | | Radiation Oncology (Rad Onc) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Rad Onc** | **HB Rad Onc** | **Combined Rad Onc** |
| 1 | 100% | $ – | $50 | $50 |
| 2 | 150% | $ – | $75 | $75 |
| 3 | 200% | $ – | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $ – | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $ – | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $ – | 31% of charges | = PB rate + HB rate |
| 7 | 500% | $ – | 39% of charges | = PB rate + HB rate |
| 8 | >500% | SP Rate | SP Rate | = PB rate + HB rate |

| | | Radiology Xray (Rad Xray) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Rad Xray** | **HB Rad Xray** | **Combined Rad Xray** |
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $10 | $15 | $25 |
| 3 | 200% | $10 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $10 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $10 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $10 | 24% of Charges | = PB rate + HB rate |
| 7 | 500% | $40 | 35% of Charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| | | Radiology Ultrasound (Rad US) |
|---|---|---|

| Pricing Levels | % FPL | PB Rad US | HB Rad US | Combined Rad US |
|---|---|---|---|---|
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $20 | $25 | $45 |
| 3 | 200% | $35 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $40 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $45 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $45 | 31% of Charges | = PB rate + HB rate |
| 7 | 500% | $50 | 39% of Charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| | | Radiology Mammography (Rad Mam) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Rad Mam** | **HB Rad Mam** | **Combined Rad Mam** |
| 1 | 100% | $ - | $25 | $25 |
| 2 | 150% | $25 | $35 | $60 |
| 3 | 200% | $40 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $50 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $60 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $65 | 35% of Charges | = PB rate + HB rate |
| 7 | 500% | $70 | 43% of Charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| | | Radiology Computed Tomography (Rad CT) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Rad CT** | **HB Rad CT** | **Combined Rad CT** |
| 1 | 100% | $ – | $40 | $40 |
| 2 | 150% | $30 | $50 | $80 |
| 3 | 200% | $60 | 50% of Medicare | = PB rate + HB rate |
| 4 | 250% | $80 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $100 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $115 | 18% of billed charges | = PB rate + HB rate |
| 7 | 500% | $125 | 32% of billed charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| | | Radiology Magnetic Resonance Imaging (Rad MRI) | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB Rad MRI** | **HB Rad MRI** | **Combined Rad MRI** |
| 1 | 100% | $ - | $150 | $150 |
| 2 | 150% | $35 | $200 | $235 |
| 3 | 200% | $65 | 50% of Medicare | = PB rate + HB rate |

| | | | | |
|---|---|---|---|---|
| 4 | 250% | $80 | 75% of Medicare | = PB rate + HB rate |
| 5 | 300% | $100 | 100% of Medicare | = PB rate + HB rate |
| 6 | 400% | $125 | 27% of billed charges | = PB rate + HB rate |
| 7 | 500% | $150 | 37% of billed charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

| Pricing Levels | % FPL | PET Scan (Global) |
|---|---|---|
| 1 | 100% | $150 |
| 2 | 150% | $600 |
| 3 | 200% | 50% of Medicare |
| 4 | 250% | 75% of Medicare |
| 5 | 300% | 100% of Medicare |
| 6 | 400% | 27% of billed charges |
| 7 | 500% | 36% of billed charges |
| 8 | >500% | SP Rate |

| | | Behavioral Health Services* | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB EPV** | ***HB EPV** | **(PB Only Sites) Combined EPV** |
| 1 | 100% | N/A | $15 | $15 |
| 2 | 150% | N/A | $30 | $30 |
| 3 | 200% | N/A | $50 | $50 |
| 4 | 250% | N/A | 70% of Medicare | 70% of Medicare |
| 5 | 300% | N/A | 100% of Medicare | 100% of Medicare |
| 6 | 400% | N/A | 32% billed charges | 32% billed charges |
| 7 | 500% | N/A | 32% of billed charges | 32% of billed charges |
| 8 | >500% | N/A | SP RATE | SP RATE |

*Locations WME, WCA,WDH,WAPTC

| | | All Other OP | | |
|---|---|---|---|---|
| **Pricing Levels** | **% FPL** | **PB EPV** | ***HB EPV** | **(PB Only Sites) Combined EPV** |
| 1 | 100% | $ – | $15 | $15 |
| 2 | 150% | $ – | $30 | $30 |
| 3 | 200% | $15 | $50 | $65 |
| 4 | 250% | $15 | 50% of Medicare | = PB rate + HB rate |
| 5 | 300% | $15 | 75% of Medicare | = PB rate + HB rate |
| 6 | 400% | $15 | 24% billed charges | = PB rate + HB rate |
| 7 | 500% | $25 | 29% of billed charges | = PB rate + HB rate |
| 8 | >500% | 61% of Billed | SP Rate | = PB rate + HB rate |

All unfavorable decisions or denied applications can be appealed within 30 days of decision.