HUTCHINSON REGIONAL MEDICAL CENTER	Manual	Hutchinson Regional Medical Center
	Section (Department)	Patient Accounts
	Title	**Financial Assistance Policy**
	Number	PA1607
	First Approved Date	08/2009
	Most Recent Revision	11/01/2020
	Most Recent Review	11/01/2020

PURPOSE

To assure that financial assistance options are available to all medically indigent patients and guarantors who are unable to pay for medically necessary services provided by Hutchinson Regional Medical Center ("HRMC") while ensuring HRMC's compliance with State and Federal laws and regulatory guidance pertaining to charity care and financial assistance.

POLICY

Hutchinson Regional Medical Center provides financial assistance for medically indigent patients who meet eligibility criteria outlined in this Policy.

Situations where the provision of financial assistance will be considered include but are not limited to:

- Uninsured patients who do not have the ability to pay
- Insured patients who do not have the ability to pay for portions not covered by insurance or Medicaid, including length of stay
- Deceased patient with no estate, and no living trust
- Patients involved in catastrophic illness or injury
- Charges for from an entity that does not have a contractual agreement with the facility

DEFINITION(S)

Amounts Generally Billed - The Amounts Generally Billed (AGB) is the amount generally allowed by Medicare fee for service and private health insurers for emergency and other medically necessary care. SLHS uses the look back method to determine AGB.

Catastrophic Medical Expense - A Catastrophic Medical Expense is defined as patient's financial responsibility exceeding 20% of the annual income and financial resources available to the patient and/or guarantor.

Co Pay - Minimum amount due from patients who qualify for financial assistance. Co pay does not exceed AGB.

Federal Poverty Guidelines - Federal Poverty Guidelines (FPL) means those guidelines issued by the Federal Government that describe poverty levels in the United States based on a person or family's household income. The Federal Poverty Guidelines are adjusted according to inflation and published in the Federal Register. For the purposes of this policy, the most current annual guidelines will be utilized.

Look Back Method - Look Back Method is a prior twelve (12) month period used when calculating Amounts Generally Billed.

Medically Necessary Services - Medically necessary services are services that are reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain , or regarding functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services rendered; and service(s) is (are) furnished in the most appropriate setting. Medically necessary services are not used primarily for convenience and are not considered experimental or excessive form of treatment.

Medically Indigent - A medically indigent patient is defined as a person who has demonstrated that he/she is too impoverished to meet his or her medical expenses. The medically indigent patient may or may not have an income and may or may not be covered by insurance. Each patient's financial position will be evaluated individually using the Federal Poverty Limit as a guideline.

PROCEDURE

Applying for Financial Assistance

Medical indigence must be demonstrated through documentation, financial screening or by presumptive scoring. This determination can be made while the patient is in the hospital, shortly after dismissal, during the normal internal collection efforts and after placement with an outside collection agency. Requests for financial assistance are accepted for up to I year from the date of service.

Patients apply for financial assistance by completing a Financial Assistance application form and providing supporting documents as requested. Patients may obtain a Financial Assistance application by requesting in writing or by contacting the business office by phone or email. The Financial Assistance application is also available on the HRMC website www.hutchregional.com Supporting documentation may be required including items such as Federal Income Tax Return, IRS non filing letter, recent bank statements, recent pay check stubs, and letter from Medicaid eligibility office denying Medicaid coverage. Other documents that support the patient/household income, assets and financial position may be requested but not required. Patients at approved National Health Services Corps (NHSC) sites do not have to provide banking and asset information.

Under special circumstances the requirement to complete the Statement of Financial: position and/or provide additional documents may be waived with supervisor or manager approval. Examples of special circumstances include but are not limited to Medicaid eligible patients receiving non-covered medically necessary or emergent services, patients that potentially qualify based on presumptive scoring, patients unable to provide documents, and homeless patients.

Assistance with the application process is provided by billing office staff or hospital admitting staff. Assistance may be requested by phone or in person by calling or visiting the patient accounting department.

Financial assistance applications are valid for six (6) months after approval date. Financial assistance may be extended for an additional six (6) months with affirmation of the household income or estimated income and household size. All patients must reapply after the initial

twelve (12) month period is over.

Financial Assistance Determination

A patient's eligibility for financial assistance is not determined until activities to identify and secure payment from Medicare, Medicaid, Crime Victims, other government programs, other funded programs, medical insurance, auto insurance personal injury protection (PIP) or med pay, liability liens, estate claims or any other possible appropriate source for payment are exhausted. Reversal of financial assistance adjustments must be made if subsequent third-party payments are received. Financial assistance is to be considered the adjustment of last resort.

Uninsured patients may receive an uninsured patient discount. If the patient qualifies for financial assistance, the uninsured discount is reversed and the financial assistance adjustment is posted.

A patient's eligibility for financial assistance is based on the household income at the time assistance is sought, expressed as a percentage of the Federal Poverty Guideline for family size.

Household Income is defined as:

- Adults: If the patient is an adult, "Yearly Household Income" means the sum of the total yearly gross income or estimated yearly income of the patient and the patient's spouse.
- Minors: If the patient is a minor, "Yearly Household Income" means the sum of the total yearly gross income or estimated yearly income of the patient, and patient' s parent(s) living in the home.

Household size is defined as:

- Adults: In calculating the Household Size, include the patient, the patient's spouse, and any dependents (as defined by the Internal Revenue Code (IRC).
- Minors: In calculating the Household Size, include the patient, the patient' s mother, the patient's father,
- dependents of the patient's mother, and dependents of the patient's father (as defined by IRC).

Financial resources such as checking accounts, savings accounts, IRA's, CD's, retirement savings, and investments may be considered when determining a patient's ability to pay. In all cases the patient's and responsible party's overall financial position and household income are considered when determining financial assistance.

Financial assistance eligibility is based on the Federal Poverty Guideline and other financial resources.
The Federal Poverty Guideline is used as a guideline and applied considering type of service and provider setting differences. The Federal Poverty Guideline as used for the purposes of determining financial assistance is outlined later in this policy.

For unscheduled inpatient or observation admissions, a co pay (minimum patient responsibility) per admission may be due to the hospital. Financial assistance up to I00% of

billed charges less the co pay may be provided for hospital services.

For emergency room visits that do not result in an admission, a co pay per emergency room visit may be due to the hospital. Financial assistance up to 100% of billed charges less the co pay may be provided.

For scheduled hospital services, including all scheduled inpatient and outpatient services, financial assistance is limited to no more than 75% of billed charges.

Basis for Calculating Amounts Generally Billed -Hospital Accounts Only

After the patient's account is reduced by the financial assistance adjustment based on this policy and guidelines, the patient is responsible for no more than amounts generally billed to individuals who have Medicare fee for service and private health insurers for emergency and other medically necessary care. The Look Back Method is used to determine AGB.

The AGB summary document describes the calculation and states the percentage used by the hospital. The Amounts Generally Billed summary is available on the Hutchinson Regional website. www.huctchregional.com
Patients or members of the public may request a copy of this policy available at no charge at the hospital admitting office or by contacting the billing office.

Presumptive Eligibility

HRMC may rely on scoring from a third party for the basis of determining financial assistance when a patient does not complete a financial assistance application. Patients qualifying for presumptive eligibility may receive full or partial assistance. If partial assistance is approved, the patient receives a bill for the reduced amount owed. The patient is notified of partial approval and how they can apply for financial assistance to determine if additional assistance is available. If the patient applies for additional assistance, the application is reviewed and the patient is notified of the decision. Patients that are not approved for full financial assistance receive a statement.

The FPL% guidelines for hospital services are applied as follows:

See Addendum

Patients with religious objections or American Indians with objections to insurance or government programs may owe greater amounts when approved for financial assistance but not exceeding AGB. The ability of the patient to pay along with ability of religious or tribal community to pay the bill is considered.

Collection Action

In the event of non-payment, HRMC will make efforts to obtain payment, which includes sending billing statements or letters; making telephone calls; and/or sending your account to an authorized party, *i.e.*, collection agency. To decide what action to take, HRMC considers a patient's good faith effort to apply for a government benefit program or for Financial

Assistance under this FAP. We also consider a patient's good faith effort to comply with any payment agreement(s) with us.

During all discussions, we make "reasonable efforts" to see if an individual qualifies for Financial Assistance by requiring our staff to tell our patients about our FAP. During the 120-day period post discharge, a written summary of this FAP will be on our billing statements.

For patients who qualify for Financial Assistance and are cooperating in good faith to resolve their discounted hospital bills, HRMC may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all internal collection efforts.

For at least 120 days from the date of the first post-discharge billing statement, HRMC will refrain from using Extraordinary Collection Actions (ECA). In addition, prior to using any ECA, HRMC makes reasonable efforts to determine whether the patient is eligible under this FAP. Reasonable efforts include <u>each</u> of the following:

Validating that the patient owes the unpaid bills and that we have identified and billed all sources of third-party payments.

Documenting that HRMC has offered or has attempted to offer the patient an opportunity to apply for Financial Assistance and that the patient has not complied with HRMC's application requirements.

Sending letters requesting specific information in the event we receive an incomplete application.

If we intend to take any ECA earlier than the 240th day from and after the date HRMC provides its first post-discharge billing statement, HRMC (or its authorized party) will send a written notice to the patient at least 30 days prior to such actions. The notice will inform him/her of the potential ECA if they do not submit an application for Financial Assistance, or pay the amount due by the notice's deadline.

Prior to the expiration of 240-day period (described above), HRMC will process completed application forms. The applicant should return the completed application form and the required documents within thirty (30) days from the date of his/her receipt of the application.

The PFS Director will determine whether HRMC has made "reasonable efforts" before HRMC uses any ECA.

Non-Discrimination

<u>General</u>. HRMC grants Financial Assistance based on an individualized determination of financial need. We do not discriminate based on any legally protected class, *e.g.*, age, gender, race, social or sexual orientation or religious affiliation.

<u>Emergencies</u>. We provide care on a non-discriminatory basis to individuals for Emergency Medical Conditions regardless of their ability to pay.

Referrals or Requests for Financial Assistance

Any employee, chaplain, religious sponsor or our medical staff (*e.g.*, physicians and mid-levels) may refer a patient to the PFS Department to see if he/she is eligible under this FAP.

The patient or Family member, close friend, or associate of the patient, subject to applicable privacy laws, may request Financial Assistance.

Regulatory Requirements

HRMC complies with all other federal, state, and local laws, rules, and regulations that may apply to its activities under this FAP.

Provider List
Created/Last Updated: 06/27/18

Providers affiliated with Hutchinson Regional Medical Center who will provide emergency and Medically Necessary care at HRMC under the terms of HRMC's Financial Assistance Policy:

1. Radiology Professionals of Hutchinson, LLC	
c/o Physician Billing Network (Radiologists)	866-815-9776
2. Clinical Colleagues (Anesthesiologists)	866-902-4406
3. VEP Hutchinson Emergency Medical Group, LLC	
c/o Emergency Group Office (ED Physicians' billing service)	877-346-2455
4. Hutchinson Physicians, PA & South Sound Inpatient Physicians, PLLC	
c/o Hospitalists (Physician billing service)	620-694-2084
5. Reno Pathology Associates, P.A. (Pathologists)	316-612-0556
6. Horizons Mental Health Center	
c/o Trajectory RCS (Behavioral Health)	316-831-1500

Providers affiliated with Hutchinson Regional Medical Center who do not provide emergency and Medically Necessary care at HRMC under the terms of our Financial Assistance Policy:

1. Hutchinson Clinic, PA (all physicians and other providers)

Addendum:

Income% of FPL	CharityPatient Responsibility inpatient and observation admissions outpatient hospital services.
125% FPG =	100% FA
150% FPG =	85% FA
200% FPG	75% FA

Emergency room visits not resulting in admission

Less than 300% FPL	100% less co-pay	$150 per visit co pay