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Last Revised:	*09/2016*
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Owner:	*Amy Ruedisueli*
Policy Area:	*Finance*
References:	

Financial Assistance Program (Charity Care), A-4.5.6

POLICY/PURPOSE:

It is the policy of McKenzie Health System (MHS) to provide Financial Assistance for services which are medically necessary and are not elective procedures/tests in nature for those patients who are uninsured, under insured, ineligible for a government program, or otherwise unable to pay for medically necessary care and meet MHS eligibility criteria. The purpose of this policy is to provide guidelines and consistent criteria for use in determining classification and distinction between a patient's unwillingness to pay (bad debt) and a patient's demonstrated inability to pay (Indigent). Accordingly, this written policy:

- Includes eligibility criteria for financial assistance - free and discounted care.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.
- Describes the method by which patients may apply for financial assistance.
- Describes how the hospital will widely publicize the policy within the community served by the hospital.
- Limits the amounts that the hospital will charge for emergency and medically necessary care provided to individuals eligible for assistance under this financial assistance policy.
- Describes actions that are allowed by the hospital in the event of nonpayment.

DEFINITIONS:

Amount Generally Billed (AGB): means the combined average payment rate from Medicare for reasonable costs as determined under Medicare reimbursement principals together with the majority of the private health insurers (Aetna, Blue Cross, Cofinity, HAP, Health Plus, Priority Health, & United Healthcare). Information regarding the AGB rate and calculation is available free of charge by contacting Patient Financial Services of McKenzie Health System.

Extraordinary Collection Actions (ECA): means actions taken by McKenzie Health System or its agents against a patient or Guarantor related to obtaining payment of a bill for care covered under this Financial Assistance Policy that require a legal or judicial process, involve selling a patient's outstanding patient responsibility to another party, reporting adverse information about the patient to a consumer credit reporting agency or credit bureau or deferring, denying or requiring payment prior to providing medically necessary care

because of an individual's nonpayment of one or more bills for previously provided care under the hospital's Financial Assistance Policy .

Financial Assistance: is defined as a total or partial write-off of patient account balances for individuals determined to be financially eligible for Financial Assistance.

Financial Assistance Application: means the information and accompanying documentation that an individual submits to apply for financial assistance under this Financial Assistance Policy.

Gross Charges: the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Guarantor: means the individual responsible for the financial obligations of a patient and may be used interchangeably with patient.

Household: includes all individuals listed on a patient or Guarantor's federal income tax filing. Guarantor's of a minor dependent who do not claim the dependent on their federal taxes may submit a court decree as proof of the dependent's household status. In the event the patient's (except for minor patients) income does not warrant the filing of a federal tax statement, the patient/Guarantor may submit a notarized affidavit attesting to the foregoing.

Income: means any interest, dividends, wages, compensation for other services, tips, pensions, fees for earned services, price of goods sold, income from rental property, gains on sale of other property, alimony, or royalties. Non-cash deductions (such as depreciation) for self-employed persons will be added back into income.

Plain Language Summary: means a brief description of eligibility requirement and contact information that MHS uses to administer its FAP. The summary will be written in simple, easy to understand language.

Underinsured: the patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Uninsured: the patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligation.

PROCEDURE:

A. **GENERAL GUIDELINES:**

1. No person, regardless of ability to pay, will be refused emergency medical services at McKenzie Health System in accordance to Internal Revenue Section 501(r)(4). Refer to MHS's Compliance with EMTALA Regulations policy, PC-0054.
2. The medical care which the hospital shall provide to all patients shall consist of the same standard of medical care, including food, general nursing care and supervision, semi-private rooms (unless otherwise ordered by a physician due to medical condition), use of operating rooms and facilities, and other usual hospital care and services regardless of ability to pay.
3. The attending physicians shall determine in their medical judgment the extent of medical treatment required for each patient.
4. All patients who are uninsured will be given a "Financial Policy" brochure by staff registering the patient. Patient Access staff will place a copy of the "face sheet" in the Director of Human Services mailbox. During regular business hours, Patient Access staff may contact the Social Worker on duty

(or Financial Counselor if Social Worker is not available) to personally follow up with patients while they are in the building.

5. Any patient may request a Financial Assistance Application F-4997 by contacting the Patient Access Department Monday through Friday, excluding holidays, at 120 Delaware Street, Sandusky, MI 48471, 8:00 a.m. to 5:00 p.m., 810-648-3770 or Patient Accounting Department at 394 Loraine Street, Sandusky, MI 48471, 8:00 a.m. to 5:00 p.m., 810-648-6199. The Financial Assistance Application is also available at www.mckenziehealth.org.
6. Applicants must apply for the Financial Assistance Program within 240 days from the date of receipt of the first statement in accordance with Internal Revenue Section 501(r)(6) or within two weeks of receipt of a Medicaid denial.

B. **ELIGIBILITY:**

1. Eligibility for Financial Assistance will be considered for those individuals who are uninsured, underinsured and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of Financial Assistance shall be based on an individualized determination of financial need and shall not take into account age, gender, race, social or immigration status, sexual orientation or religious affiliation.
2. The patient must have applied for all applicable government assistance programs within 90 days of discharge except when it is apparent that the applicant will not qualify for Medicaid due to Income exceeding the Medicaid income limit of 133% of the Federal Poverty Guidelines, the applicant is not required to apply for Medicaid. On behalf of deceased patients, the family must apply for government assistance.
3. The patient or responsible party must complete an MHS Financial Assistance application (F-4997).
4. Any reasonable method to verify income information necessary to establish eligibility may be used, but should include the last year's Form 1040 (income tax form). The following sources will also be referenced:
    a. Written verification of all income for self and spouse.
        i. Copies of last year's tax return.
        ii. Copies of the last three paycheck stubs.
        iii. Copy of Social Security, SSI, or Disability check/approval letter/bank statement.
        iv. Copy of Unemployment approval letter, bank statement, or written verification from Unemployment Office.
        v. Copy of Pension/retirement check/bank statement.
        vi. Copy of other income sources as requested.
5. A patient is **ineligible** if any of the following apply:
    a. The patient has not applied for applicable government assistance.
    b. The patient has not pursued all options related to insurance, government assistance, third party liability, workers compensation, home-owners insurance, auto insurance, etc.
    c. The patient's Income exceeds 250% of the Federal Poverty Levels.
    d. The patient has family cash assets in excess of $3,000 for the head of household plus $1,500 per each additional person. Applicants will be allowed to "spend down" assets that exceed these

limits through payment of the excess toward the hospital bill. Cash assets do not include retirement savings accounts, college savings accounts or life insurance with a cash value.

6. In the event a patient is deceased, was denied Medicaid or is no longer eligible to apply for Medicaid, and the hospital has determined that there is no estate or moneys available, a family member may supply this facility with a copy of the death certificate. The application process will not need to be completed and the account will then be handled as a Financial Assistance account.
7. A patient/Guarantor determined by MHS to be eligible for Financial Assistance shall not receive any future bills based on Gross Charges for the claims that are covered by the Financial Assistance application and will not be charge more that AGB for emergency or medically necessary care.

C. **FINANCIAL ASSISTANCE DISCOUNT LEVELS:**

1. A patient whose family gross income is at or below 100% of the Federal Poverty Guideline (see Attachment A) may receive 100% discount.
2. A patient whose family gross income is at 101-150% of the Federal Poverty Guideline may receive a 75% discount with 25% patient pay.
3. A patient whose family gross income is at 151-175% of the Federal Poverty Guideline may receive a 50% discount with 50% patient pay.
4. A patient whose family gross income is at 176-250% of the Federal poverty guideline are eligible for a discount which approximates 115% of Medicare Critical Access Hospital reimbursement, in accordance with the Healthy Michigan Law (Public Act 107 - section 105d(2)).

D. **GUIDELINES:**

1. A patient who wishes to have an appointment with hospital personnel for assistance in applying for Financial Assistance will be referred to the Director of Human Services (or Financial Counselor if the Director of Human Services is not available). This can be accomplished either by the patient calling for an appointment or meeting with the patient while they are still in the hospital. If the patient may qualify for Medicaid, the Medicaid application is completed and mailed to the Department of Human Services. If the patient does not meet criteria for Medicaid, the Financial Assistance application will be completed and forwarded to the Financial Counselor for follow up. The final determination is made by the Senior Accountant and/or Vice President of Finance.
    a. The application determination for financial assistance will be valid for outstanding accounts up to 30 days prior to the first billing statement for the account(s) in which Financial Assistance is being applied for.
    b. Discounts will be applied to the account(s) by the Patient Accounting Clerk at the time of the determination. A note will also be placed on the account.
    c. Once determination has been made by the Hospital, the applicant will receive a letter of approval / denial from the Financial Counselor within 30 days.
    d. The burden of proof and production of necessary application documents as well as the cooperation of the applicant is solely the responsibility of the applicant. Applicants who fail to comply with this requirement within 30 days of Financial Assistance application submission will be deemed to have voluntarily withdrawn their application for Financial Assistance.
    e. The hospital will not perform any ECAs for pending applicants until the application process is completed and an eligibility determination has been made.
2. Charges which are eligible for Financial Assistance include:

a. Non-elective Hospital inpatient, outpatient charges and professional charges.

b. Medically necessary outpatient testing.

3. Charges which are not eligible for financial assistance:

a. Private room differences.

b. Elective services generally not covered by insurance (i.e., cosmetic procedures).

c. Non-McKenzie charges (i.e., reference lab, X-ray Associates fees, private physician fees, etc.).

4. Exceptions to this policy can be granted by the Vice President of Finance or the Hospital President/ CEO.

5. This policy and program will be reviewed annually.

6. This Policy may not cover services rendered by some individual providers. A full listing of providers covered and not covered by this Policy are available at www.mckenziehealth.org and updated on a quarterly basis.

E. **PUBLICIZING THE FINANCIAL ASSISTANCE PROGRAM:**

1. Communication of the Financial Assistance Program to patients and within the community shall be disseminated by MHS by various means, which may include, but are not limited to:

a. Include a conspicuous written notice on all patient billing statements that notifies the patient/ Guarantor about the availability of this Policy, the telephone number of its Financial Counselor and Billing Department which can assist patients with any questions they may have regarding this Policy and the direct Website address where copies of the Financial Assistance Policy, Financial Assistance application and Plain Language Summary are available.

b. Make available upon request and free of charge the Financial Assistance notice in the emergency room, admitting and registration departments, hospital business office, and other public areas as MHS may elect.

c. MHS will post the Financial Assistance notice, a plain language summary and application on the hospital's website www.mckenziehealth.org.

d. Such notices will be provided in the primary languages spoken by the population serviced by MHS and shall include appropriate contact information.

e. Make hospital financial representatives available via telephone Monday through Friday, excluding holidays, from 8:00 a.m. to 5:00 p.m. Eastern Time to address questions related to this Policy. Upon request, hospital financial representatives will also mail copies of this Financial Assistance Policy, a Plain Language Summary, and a Financial Assistance Application to patients or their Guarantor free of charge upon request.

f. Broadly communicate this Policy as a part of its general community outreach efforts.

F. **COLLECTION ACTIONS:**

1. For those patients/Guarantors found to be eligible under this Policy, McKenzie Health System and any purchaser of the patient's debt, third-party collection agency, or other party the patient's debt has been referred to will not engage in ECAs against a patient/Guarantor to obtain payment for care before reasonable efforts are made to determine whether the patient/Guarantor is eligible for care under this Financial Assistance Policy.

2. Reasonable determination efforts of a patient/Guarantor's eligibility for Financial Assistance under this Financial Assistance Policy include:
    a. Prior to initiating an ECA, provide written notice within 120 days of the post-discharge statement informing the patient/Guarantor that Financial Assistance is available for those who qualify.
    b. In the case of a patient/Guarantor submitting an incomplete Financial Assistance Application during the application period, notifying the patient/Guarantor of how to complete the Financial Assistance Application and provide the information and time to complete the application as set forth in Section (A)(5)-(6) above.
    c. In the case of a patient/Guarantor submitting a complete Financial Assistance Application, determine whether the patient/Guarantor is eligible for Financial Assistance under this Policy.
3. In addition to the efforts made in Subsection (F)(2)(a)-(c) above, the following actions will be taken at least thirty (30) days before initiating one or more ECA(s) to obtain payment for care:
    a. Provide the patient/Guarantor written notice indicating financial assistance is available to qualifying individuals, identify the ECA(s) that McKenzie Health System or its authorized party intends to initiate for payment of care, the deadline for such ECA(s), which may be initiated no earlier than 30 days after the date that written notice is provided.
    b. Provide the Plain Language Summary and a copy of the Financial Assistance Policy with the written notice required under Subsection 3(a) above.
    c. Attempt to notify the patient/Guarantor verbally about the Financial Assistance Policy and how to obtain assistance through the Financial Assistance Application process.
4. McKenzie Health System and its authorized representative will not initiate an ECA against a patient/Guarantor if he or she has an active Financial Assistance award.
5. McKenzie Health System and its authorized representative may initiate ECA(s) against a patient/Guarantor in accordance with this Policy. ECA(s) may include the following:
    a. Selling a patient/Guarantor's outstanding financial responsibility to a third party;
    b. Reporting adverse information about the patient/Guarantor to consumer credit reporting agencies or credit bureaus;
    c. Deferring or denying, or requiring a payment before providing, non-emergent medically necessary care because of a patient/Guarantor's nonpayment of one or more bills for previously provided care covered under this Policy.
    d. Actions requiring a legal or judicial process, including but not limited to:
        i. Placing a lien on a patient/Guarantor's property;
        ii. Foreclosing on a patient/Guarantor's real property;
        iii. Attaching or seizing a patient/Guarantor's bank account or other personal property;
        iv. Commencing a civil action against a patient/Guarantor;
        v. Causing a patient/Guarantor arrest;
        vi. Causing a patient/Guarantor to be subject to a writ of body attachment ;
        vii. Garnishing the patient/Guarantor's wages.
6. When it is necessary to engage in any collection activity (including ECAs), McKenzie Health System and its authorized representative, will engage in fair, respectful and transparent collections activities.

McKenzie Health System will ensure that all contractual agreements with authorized representatives will conform with the minimum standards required by the Department of Treasury regulations.

7. A patient or Guarantor currently subject to an ECA and who has not previously applied for Financial Assistance may apply for assistance up to two-hundred and forty (240) days from the date of the first post-discharge billing statement.
8. In the event an application is filed within the two hundred-forty (240) day time period, McKenzie Health System and its authorized representative will indefinitely suspend any ECA which may have been initiated against a patient/Guarantor while the Financial Assistance Application is processed and considered.

G. **REFUNDS:**

1. Patient/Guarantor who are determined to be eligible for assistance under this Policy and remitted payment to MHS in excess of their responsibility will be alerted to the overpayment as soon as practicable after discovery of overpayment.
2. Patient/Guarantor with an outstanding account balance on a separate account not eligible for assistance under this Policy will have any refund amount applied to the separate account.
3. Patient/Guarantor with no outstanding account balance will be issued a refund check for their overpayment as soon as reasonably possible.

Attachments:

Indigent Care Income Guildelines

Approval Signatures

Approver	Date
Steve Barnett: President/CEO	09/2016
Steve Barnett: President/CEO	09/2016
Wendy Mcbride	09/2016
Amy Ruedisueli	09/2016