Approved 1/23/19

Howard County Medical Center

Financial Assistance Policy

Introduction

Howard County Medical Center (HCMC) recognizes the individual's right to quality healthcare regardless of age, sex, race, religion, national origin, or ability to pay. HCMC will provide necessary medical services to patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. This Financial Assistance Policy (Policy) is intended to comply with Section 501(r) of the Internal Revenue Code and shall be interpreted and applied in accordance with such regulations. This policy has been adopted by the HCMC Board of Directors in accordance with the regulations under Section 501(r).

The financial assistance policy provides guidelines for financial assistance to individual patients receiving emergency and other non-elective medically necessary services based on financial need.

This policy applies to all HCMC billings (hospital & clinic). All billing office staff, management and administration shall follow the steps for financial assistance considerations as outlined herein.

Resources

- Emergency Medical Care Policy
- Financial Assistance Policy
- Schedule A – Patient Financial Assistance Application
- Schedule B – Charity Care Guidelines
- Schedule C – Authorization for Financial Assistance

Emergency Medical Care Policy

Consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), HCMC will provide an appropriate medical screening to any individual, regardless of ability to pay, requesting treatment for a potential emergency medical condition. If, following an appropriate medical screening, HCMC personnel determine that the individual has an emergency medical condition, HCMC will provide services, within the capability of the facility, necessary to stabilize the individual's emergency medical condition, or will effect an appropriate transfer as defined by EMTALA. The evaluation of payment alternatives will not take place until the required medical care is provided.

Financial Assistance Policy

A. Services Eligible under this Financial Assistance Policy

For purposes of this policy, "financial assistance" or "charity" refers to inpatient, outpatient, and clinic health care services provided by HCMC without charge or at a discount to qualifying patients. The following health care services are eligible for financial assistance:

1. Emergency medical services provided in an emergency room setting;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at HCMC's discretion.

B. Eligibility for Financial Assistance

1. General Eligibility - Eligibility for financial assistance will be considered for those patients who are uninsured, underinsured, ineligible for any government health care benefit program 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 immigrant status, sexual orientation or religious affiliation. When a patient's circumstances do not satisfy the particular requirements for financial assistance under this Policy, a patient may still be able to obtain financial assistance. These situations will be evaluated on a case by case basis based on the patient' specific circumstances, such as catastrophic illness or medical indigence, at the discretion of HCMC.

2. Financial assistance is generally determined by a sliding scale of total household income based on federal poverty guidelines. When total household income is less than 150% of the federal poverty guideline, a 100% discount from gross charges applies. When total household income is between 150% and 300% of the federal poverty guideline, a partial discount applies. See Schedule B for the Financial Assistance Guidelines. Please note that the amounts within Schedule B are updated annually based upon federal poverty guidelines published in the Federal Register.

C. Covered Providers

1. HCMC and HCMC-employed physicians, billable providers and practitioners providing care are covered by this policy.

2. Independent physicians and other independent service providers are not covered by this policy. Patients should contact these providers to discuss their financial assistance program(s).

3. A list of covered providers can be found at www.hcmc.us.com, requested, free of charge, at HCMC, or by calling 308-754-4421.

D. Determination of Financial Assistance and Basis for Calculating Amounts Charged to Patients

1. Following a determination of eligibility (as set forth herin), individuals who qualify for financial assistance shall not be charged more than Amounts Generally Billed (AGB) for any emergency or medically necessary care provided.

2. Discounts based upon the FPL provided to individuals who qualify for financial assistance shall be taken from HCMC's AGB.

3. No individual who is eligible for assistance under this Policy will be charged Gross Charges for any health care service provided by HCMC.

4. HCMC determines an AGB percentage on an annual basis utilizing the look-back method as described in §1.501(r)-5(b).

5. If the individual is determined to be medically indigent, they will be extended at least a 50% discount off AGB. If the individual's medical debt owed to HCMC is 75% of Household Income, they will be extended a discount of 75% off AGB. If medical debt to HCMC is 100% of Household Income, all charges will be considered charity care.

E. Application Process for Financial Assistance

Applying for financial assistance can be initiated by a patient requesting assistance in person, over the phone, through the mail or via the web site at www.hcmc.us.com. Copies of this policy, a plain language summary of this policy, and an application are available free of charge.

In order to apply for financial assistance, the individual will complete the HCMC Financial Assistance Application Form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income.

A completed HCMC Financial Assistance Application Form will be submitted to the Billing Office for processing. Proof of income and available assets will be required from the individual. A review is completed to determine individual eligibility based on the individual's total resources.

The "Application Period" for purposes of this policy begins on the date the care is provided to the individual and ends on the later of (1) 240th day after HCMC provides the individual with the first billing statement for the care OR (2) not less than (30) days after the date of the written notice for extraordinary collection actions (ECAs) to begin.

1. If an individual submits a **complete** Financial Assistance Application Form during the application period , HCMC must take the following actions:

    i. Suspend any extraordinary collection actions;

    ii. Make and document the determination as to an individual's eligibility for financial assistance;

    iii. Notify the individual in writing generally within 60 days after receiving a completed Financial Assistance Application Form of the eligibility determination and the basis for the determination;

    iv. Provide the individual with a letter that indicates the amount owed as a financial assistance-eligible individual and describes how the individual can get information regarding the AGB for care and how HCMC determined the amount the individual owes; and

    v. Refund any excess payments to the individual

2. If an individual submits an **incomplete** Financial Assistance Application Form during the application period, HCMC must take the following actions:

    i. Suspend any extraordinary collection actions;

    ii. Provide the individual with a written notice that describes the additional information and/or documentation required under the Policy that the individual must submit to complete the application; and

    iii. Provide the individual at least one written notice that informs the individual about the extraordinary collection actions the hospital may take or reinstate if the individual does not complete the application or pay the amount due by a date that is not earlier than the last day of the application period and thirty (30) days after the date of the written notice.

F. Authorizations for Financial Assistance

All financial assistance applications must be approved according to the balances listed on Schedule C.

G. Presumptive Financial Assistance Eligibility

Presumptive eligibility may be determined in certain situations based on the approval of HCMC's management and on the basis of individual life circumstances. Individuals who are uninsured and are represented by one or more of the following may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application Form:

- Individual is homeless;
- Individual is deceased and has no known estate able to pay hospital debts; and
- Individual is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application Form.

H. Length of Eligibility

Once financial assistance has been approved, it is effective for all outstanding patient accounts and for all services provided within six months after approval.

I. Financial Assistance Disqualification

Disqualification before or after financial assistance has been granted may be for reasons that include, but not limited to one of the following:

1. Information Falsification. Financial assistance will be denied to the patient if the patient or responsible party provides false information, and

2. Third Party Settlement. Financial assistance will be denied if the patient received a third party financial settlement associated with the care received at HCMC. The patient is expected to use the settlement amount to satisfy any patient account balance.

3. Medicaid Eligible. Financial assistance will be denied if the patient may be eligible for Medicaid and fails to apply within thirty (30) days of HCMC's request.

J. Record-Keeping

1. A record, paper or electronic, will be maintained reflecting authorization of financial assistance along with copies of all application and worksheet forms.

2. Summary information regarding applications processed and financial assistance provided will be maintained for a period of seven years. Summary information includes the number of patients who applied for financial assistance at HCMC, how many patients received financial assistance, the amount of financial assistance provided to each patient, and the total bill for each patient.

3. The cost of financial assistance will be reported annually in the Community Benefit Report. Financial Assistance (Charity Care) will be reported as the cost of care provided (not charges) using the most recently available operating costs and the associated cost to charge ratio.

K. Actions against Non-Payment (Collections)

HCMC may forward outstanding debts to a collection agency (120) days from the date the first billing statement was provided to the patient. HCMC will not take ECAs against a patient until HCMC has made "reasonable effort" to determine the need of financial assistance and provided the patient with written or oral communication about the financial assistance policy.

1. Registration and pre-registration processes notify patients of the FAP and promote identification of individuals in need of financial assistance.

2. Each billing statement that is sent to the individual during the 120-day period after the first billing statement will contain language notifying the individual of available financial assistance.

3. HCMC will make every reasonable effort to notify individual patients about the HCMC FAP in oral communications.

4. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to forward the account to a collection agency if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual.

The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

L. Subordinate to Law

The provision of financial assistance may now or in the future be subject to federal, state or local law. Such law governs to the extent it imposes more stringent requirements than this policy.

DEFINITIONS

Amounts generally billed (AGB) - The amounts generally billed by HCMC for emergency or other medically necessary care to individuals who have health insurance calculated using the AGB Percentage multiplied by Gross Charges.

AGB percentage - HCMC must calculate its AGB Percentage on an annual basis. Individuals may obtain information on the calculation of the AGB Percentage free of charge from HCMC, by contacting the Chief Financial Officer at 308-754-4421.

Application period - The period during which HCMC must accept and process an application for assistance under its financial assistance policy (FAP) submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by HCMC to an individual, the application period begins on the date the care is provided to the individual and ends on the 240th day after HCMC provides the individual with the first billing statement for the care.

Charity Care - Health care services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

Emergency medical care - Care provided by HCMC for emergency medical conditions.

Extraordinary collection action (ECA) – Actions taken by HCMC against a patient or any other individual who has accepted or is required to accept responsibility for the patient's bills that involve (i) a legal or judicial process; (ii) selling an individual's debt to a third party; or (iii) reporting adverse information about the individual to a credit bureau.

Financial assistance policy (FAP) - Written policy that meets the requirements described in §1.501(r)-4(b).

Financial assistance application form - Application form (and any accompanying instructions) that HCMC requires an individual to submit as part of his or her FAP application.

Gross charges – HCMC's full, established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts or deductions.

Household Income – Total income of patient, spouse and/or all parents of a minor child.

Medically Indigent – Persons whom HCMC has determined are unable to pay some or all of their medical bills because their HCMC accounts exceed twelve percent (12%) of their Household Income even though they have income that otherwise exceeds the Federal poverty guidelines adopted by HCMC for free or discounted care under this Policy.

Notification Period – Begins on the first date care is provided and ends on the 120th day after HCMC provides the individual with the first bill for care.

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

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.

Schedule A

Howard County MEDICAL CENTER

PATIENT FINANCIAL ASSISTANCE INSTRUCTION LETTER

Dear Patient:

You may qualify for Partial or Full Financial Assistance, a program provided by Howard County Medical Center. If you are unable to pay for health care services and do not qualify for Federal or State Medical assistance programs, please complete the enclosed Financial Assistance application and return with **all** the required proof of income.

Please be advised that a determination for discount cannot be made until we are in receipt of all the following required information (check the items you have enclosed). **Please return the application by _____, or contact our office by that date if you are still in the process of gathering the needed documentation.** The necessary documents we require are:

- ☐ **Federal Tax Return including W-2 forms for tax year _____.**
  If you did not keep a copy, you can contact the IRS at 1-800-829-0922 or www.irs.gov to request a free transcript of the Federal Tax Return. If you did not file taxes, you must explain in writing why you did not file.
- ☐ **Proof of income for the 3 most recent months for guarantor and spouse**
  Proof of income can be copies of pay stubs, a copy of an unemployment check, a copy of a disability check, a copy of the Social Security Award Letter and/or copy of a pension letter.
- ☐ **Copies of bank statements for the 3 most recent months for all accounts (checking, savings, etc)**
- ☐ **Letter of Denial from the Department of Health & Human Services**
  To apply for benefits, you can contact the Customer Service Center at 1-855-632-7633 or visit www.dhhs.ne.gov
- ☐ **A letter of explanation for any documentation you are unable to obtain.**
- ☐ **Each box must be filled in on the enclosed application.**
  For any item that does not apply, please write "N/A"

If you are unable to include one or more of the items above, provide an explanation. This application should be received in our office with all required documentation attached by the date listed above.

If you have any questions, please call the number listed below.

Sincerely,

Patient Accounts
Jamie Oeltjen
308.754.4421 ext 436

Howard County MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

GUARANTOR	SPOUSE
Name Date of Birth	Name Date of Birth
Social Security Number Home Phone Business Phone	Social Security Number Home Phone Business Phone
Street	Street
City State Zip Code	City State Zip Code
Household Size	Household Size
Name and Address of Employer:	Name and Address of Employer:
Position/Title: Length of Employment:	Position/Title: Length of Employment:

MONTHLY INCOME

	Guarantor	Co – Applicant	Total
Gross Earnings			
Farm/Self Employed			
Disability/SSI			
Child Support/Alimony			
Food Stamps/Gov Assistance			
Military/Pensions			
Dividends			
Other			
Other			

ASSETS

Under "Details" column, please list institution name for all banking information. For autos, please list year, make, model, and mileage

	Details	Value
Cash on Hand		
Checking Balance		
Savings Balance		
Real Estate		
Vehicles		
Vehicles		
Other (CD, etc)		
Other		

LIABILITIES

	Balance	Institution
Howard County Medical Center		**Howard County Medical Center**
Real Estate Mortgage		
Rent		
Vehicle Lien		
Vehicle Lien		
Credit Card		
Credit Card		
Credit Card		
Other Loan		
Other Debts		
Other Debts		
Other Debts		
Total Liabilities		
Net Worth		

PATIENT ACKNOWLEDGMENT

I hereby submit this application for financial assistance to Howard County Medical Center. I acknowledge the above information given to be true and correct and authorize Howard County Medical Center to verify any information given on this form. It is understood and agreed that any misrepresentation by me in this application will be sufficient cause for automatic denial of financial assistance.

Date _____ Signature _____

Schedule B

Howard County Medical Center
2019 Financial Assistance Guidelines

Percent of Federal Poverty Guideline			150.0%	187.5%	225.0%	262.5%	300.0%
Percent of Discount (off of AGB)			100%	80%	60%	40%	20%
Size of Household	1	$12,490	$18,735	$23,419	$28,103	$32,786	$37,470
	2	$16,910	$25,365	$31,706	$38,048	$44,389	$50,730
	3	$21,330	$31,995	$39,994	$47,993	$55,991	$63,990
	4	$25,750	$38,625	$48,281	$57,938	$67,594	$77,250
	5	$30,170	$45,255	$56,569	$67,883	$79,196	$90,510
	6	$34,590	$51,885	$64,856	$77,828	$90,799	$103,770
	7	$39,010	$58,515	$73,144	$87,773	$102,401	$117,030
	8	$43,430	$65,145	$81,431	$97,718	$114,004	$130,290

Source: Federal Register, Updated 1/23/19

Schedule C

Authorization for Financial Assistance

All financial assistance applications must be approved according to the following matrix:

All Balances	Patient Accounts Representative, Howard County Medical Center
All Balances	Billing & Admissions Supervisor, Howard County Medical Center
All Balances	Chief Financial Officer, Howard County Medical Center