Sidney Regional Medical Center

ORIGINATING DEPARTMENT: Patient Financial Services	**POLICY DESCRIPTION:** Financial Assistance Policy /Protocol
PAGE(s): 1 of 3	**REPLACES POLICY and/or DOCUMENT DATED:**
APPROVED DATE: 8-27-10	**RETIRED DOCUMENT:**
EFFECTIVE DATE: 8-27-10	**REFERENCE NUMBER:** PFS.001
REVIEW DATE: 6/11,12/12, 10/13, 9/15 **REVISION DATE:** 5/13, 12/16, 11/17,1/19	**DEPARTMENT(S) DISTRIBUTION:** Patient Access & Patient Financial Services

SCOPE:

Patient Access and Patient Financial Services for all departments at Sidney Regional Medical Center (SRMC).

PURPOSE:

1.10 Sidney Regional Medical Center is a not-for-profit community hospital, committed to providing medically necessary health care services to all persons in need of medical attention regardless of ability to pay or eligibility under the Financial Assistance Policy (FAP). SRMC, and shall not discriminate to those in need regardless of their ability to pay. Patients deemed unable to pay will be eligible to receive available Financial Assistance. The patient is ultimately responsible to fulfill their financial obligation to SRMC. This policy is applicable to both uninsured and under insured patients.

1.11 Sidney Regional Medical Center to treat all patients/guarantors equally, fairly, and consistently.

PROCEDURE/PROTOCOL:

2.10 Financial Assistance is generally secondary to all other financial resources available to the patient. These include: Group or individual medical plans; workers' compensation; Medicare, Medicaid or medical assistance programs; other state, federal, or military programs; third party liability situations (e.g. auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services. During the initial request period, Sidney Regional Medical Center staff may assist the patient &/or guarantor with other sources for funding, including Medicaid.

2.11 Patients may be considered for FAP for medically necessary service, on accounts with current patient due balances and accounts with service dates within 6 months

following the application approval date. When in question, Medically necessary services shall be determined by the examining physician.

2.12 The following services have been determined as not medically necessary hospital services: Home Health, Hospice, Extended Care and Assisted Living

2.13 Patients must be residents of Cheyenne or Deuel County and/or a 20 mile radius of Sidney. If the patient is emergently admitted to inpatient or observation through the emergency room, the residency requirement may be waived by the CFO or Revenue Cycle Director on a case by case basis.

2.14 Percent of assistance will be based on household income and size, real estate, personal property and investment equity, debt to income ratio, with credit to be given for already existing medical loans, in comparison to the current year Federal Poverty Guidelines. The HHS poverty guidelines are published each year in the Federal Register. Free care will be given to households that are at 100% of the poverty level and have a debt to income ratio of less than 10%. Discounted care will be given to households that are up to 200% of the poverty level and with a debt to income ratio less than 40%.

2.15 Household size & income shall include: the patient, spouse, and all legal dependents as allowed by the U.S. Census Bureau. If patient is a minor, the family unit will include parent(s)/legal guardian(s) and all household dependents as allowed by the U.S. Census Bureau.

2.16 Roommates or other cohabitants residing in the same dwelling who each pay a portion of the household expenses will not be considered as part of this definition of Household size & income.

2.17 Roommates shall be defined as a person sharing living space and rent but are not affiliated by guardianship, affinity (kinship) or co-habituating.

2.18 Patients that are “roommates” or otherwise co-habitants in the same dwelling who DO NOT contribute to a portion of the household expenses and DO NOT have any income to report, and are not disabled will be required to claim income in the amount of $600 per month ($7200 annually) for living expense that are being contributed to them, by another, in a non-monetary manner.

2.19 Methods for applying shall be provided by completing application over the phone, in person, online or via mailed application or eligibility may be presumed based on apparent need. Any person wishing to be considered shall have 30 business days to complete and return the application, and any requested supporting documentation, when applicable.

2.20 Assistance in completing the FAP application is provided by contacting Patient

Financial Services at 308-254-8778 or physically at SRMC's Patient Financial Services department at 1000 Pole Creek Crossing in Sidney Nebraska

2.21 Application should be submitted with the following supporting documentation include current year W-2's, tax return, unemployment statement and may include a Medicaid denial letter, if applicable. If W-2's are not applicable or taxes were not filed, submit the last three months most current pay stubs.

2.22 If there is knowledge, evidence or questionable information within the application process, additional supporting documentation may be required before eligibility is determined.

2.23 All applications shall be processed and approved by Patient Financial Services Representative.

2.24 The hospital shall notify patients in writing of their eligibility determination.

2.25 Patients have 240 days from the date of the first post-discharge billing statement to apply for FAP. If they qualify, they can't be charged more than Amounts General Billed (AGB) Calculation. For FAP eligible patients, this includes accounts that have previously been sent to collection.

2.26 Patients that apply and qualify for more than $5000 in FAP shall be required to submit supporting documentation unless the CFO or Director of Revenue Cycle deems it unnecessary based on the circumstances.

2.27 Specifically identified cases may be presumed eligible for charitable assistance and classified without a completed application or assessment. Examples of these cases are: patient is deceased with no known estate or spouse; patients with current eligibility under county or state medical indigent services administered by county or state facilities; patient is homeless or has been identified as being without resources based on previous account action and contact with SRMC staff.

2.28 Patients can reapply for FAP, on accounts that originally did not meet eligibility, in the case of a major life event, such as, divorce, death, or birth of a child. The re-application shall not retro back to include any type of reimbursement on payments already made on account.

2.29 In the event that property has been transferred without a fair market value sale to another family member or affiliated person in the previous 5 years by the applicant, this property shall still be included as real estate owned by the applicant.

2.30 Patients who qualify for FAP after payments have been posted to qualifying

accounts will be eligible for refunds on those payments.

2.31 Collection efforts shall be suspended once a FAP application has been submitted and will remain so until eligibility is determined. An additional 30 days shall be given if an application is incomplete or missing requested documentation, in order to provide time to cure rectify missing information, and/or until eligibility can be determined.

2.32 When Accounts that are at collections have been deemed partially eligible for financial assistance. Only the percent eligible for financial assistance shall be returned to SRMC. The percent that is not eligible for financial assistance shall remain with the collection agency

2.33 Accounts that have gone to collections and have later been deemed uncollectable by the collection agency and have been at collections for less than 24 months shall be eligible for financial assistanceat 100% with exception to Medicare accounts.

2.34 Accounts that enter into bankruptcy are eligible for financial assistanceat 100% within one year of bankruptcy.

2.35 Medicare patients who owe non-covered, self-administered drug charges after an outpatient service may be eligible for FAP without regard to residential real estate asset ownership based on a review of their income sources. These income sources will include Social Security Retirement benefits whether or not the benefits are taxable.

2.36 Medicaid patients shall not be eligible for financial assistancefor any share of cost amount without the patient contacting Medicaid to update any applicable information with them that may lower their share of cost. As Medicaid initially gathers sufficient documentation to support the patient or guarantor's ability to pay the Share of Cost set per patient.

2.37 FAP shall be widely publicized and made available to the community through multiple sources, including online. It will be available in public areas of the hospital in conspicuous displays to be freely accessed, and at Admissions.

2.38 The FAP will be available in any language spoken by at least 5% of the community served by SRMC. The need for translation to additional languages will be determined from the U.S Census Bureau report of percent of population speaking a language other than English in Cheyenne County.

2.39 The FAP Percentage Discount is applied to the portion of the total amount charged for care that is not covered by insurance. In the case of a patient without health insurance, it is applied to the total invoiced amount. In the case of an

insured patient, the percentage is applied to the amount of the charges remaining after the insurer has paid its portion of the charges. For example, the amount to which the percentage is applied may include co-payments, co-insurance and deductibles. The amount of financial assistanceper patient shall be determined as identified in the Amounts Generally Billed AGB Calculations document.

2.40 The Amounts General Billed (AGB) Calculation , represents what the hospital collects in payment from Insurance companies and Medicare. SRMC will collect no more from qualifying FAP patients than from those patients that have health insurance coverage and do not qualify for FAP. FAP eligible individuals may not be charged more than AGB for emergency or medically necessary care.

2.41 The AGB amount is determined by SRMC and is periodically updated and shall be implemented with 45 days of calculation. SRMC is allowed to take up to 120 days after the end of the 12-month period used in calculating the AGB percentage(s) to begin applying the new AGB percentage(s).

2.42 AGB shall be calculated based on reimbursed claims from all payer sources, to include Medicare, Medicaid and all commercial payers or from Medicare and Commercial payers only, excluding Medicaid, whichever is higher.

2.43 SRMC shall use the look-back method for a 12-month period when calculating AGB based on the higher reimbursement rate of the two comparable payer mixes in 2.42.

2.44 The AGB calculation is found by the following calculation: Total payer allowable / Total billed charges = Reimbursement rate. Reimbursement Rate - 100% = the minimum discount rate for the period. This can be found in Amounts Generally Billed Calculation document.

2.45 SRMC does not engage in extraordinary collection actions (ECAs) against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for financial assistance under this policy. Reasonable efforts by SRMC include availability of written notification at admissions. Patients shall be advised of financial assistance options at time of admission and/or prior to collection efforts. In addition, written and/or verbal communication during financial advisement and pre-collection process, shall include financial assistance as a payment option, to include written notification on billing statement, and Pre-collection notices. When a patient is identified on a pre-collect report, reasonable attempts shall be made to contact the patient to advise them of financial assistancebefore the account is turned for collection.

2.46 The actions Sidney Regional Medical Center may take in the event of nonpayment are described in the SRMC Billing and Collections Policy. A free copy of this policy may be obtained by visiting www.Sidneyrmc.com or by calling 308-254-

8778 Monday – Thursday 8:00a.m. -5:00 p.m. MST, or at SRMC's PFS department at 1000 Pole Creek Crossing Sidney Nebraska.

2.47 This policy was initially approved by the board of director's on 11/28/17. It was reviewed and approved by the board of director's most recently on 1/25/19.

REFERENCES:

Collaboration with the Finance Committee of the Board of Directors, 2009
IRS Code Section 501; Medicare Fairbilling & Collections Act
Affordable Care Act Provisions, 501(r) of the Internal Revenue Code, 2015
Billing and Collections Policy
Seim Johnson, 2018 501r Review