Lima Memorial HEALTH SYSTEM

Affiliate of ProMedica

***Effective: 12/14/00***
***Policy # 205***
***Revised: 2/15/22***
***Effective: 1/1/22***

# SUBJECT: Hospital Financial Assistance, Billing, and Collections Policy

## PURPOSE

The purpose of this Policy is to define eligibility and the circumstances under which Lima Memorial Health System (LMHS) will provide free or discounted care to patients who are unable to pay for services and to also address how LMHS will calculate the amounts charged to patients. This policy applies to all emergency and other medically necessary care. In addition, this document memorializes the provision of delivering emergency medical services without discrimination and without regards to the ability to pay.

This Policy also memorializes the billing and collection practices, both internal and external, that will be applied consistently for all such patients to assure that no extraordinary collection actions are taken until reasonable efforts have been made to determine whether a patient is eligible for financial assistance.

## SCOPE

This policy is applicable to patients receiving Medically Necessary Care services at Lima Memorial Health System (LMHS). For a complete list of providers covered and **not covered** by the LMHS Financial Assistance Policy, see appendix A.

Any patient seeking urgent or emergent care [within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)] shall be treated without discrimination and without regard to a patient's ability to pay for care. LMHS shall operate in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). LMHS will be guided by our emergency services policy, EMTALA regulations and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an urgent or emergent condition and the processes to be followed with respect to each.

LMHS will not engage in any actions that discourage individuals from seeking emergency medical care nor will we demand that emergency department patients pay before receiving treatment for emergency medical conditions, or will otherwise engage in debt collection activities in other areas of the hospital where such activities could interfere with the provision, without discrimination, of emergency medical care.

## FINANCIAL ASSISTANCE

LMHS may provide free or discounted care to patients who qualify for financial assistance under this Policy. The Ohio Hospital Care Assurance (HCAP) program applies to eligible Ohio residents and the General Financial Assistance (HFA) policy applies to those who are uninsured or underinsured and do not qualify under HCAP but reside in the hospital service area. Eligibility will be determined by using gross individual or family income, as defined by Ohio Administrative Code 5160-2-07.17.

All available financial resources shall be evaluated (excluding Medicaid) before determining financial assistance eligibility. LMHS shall consider financial resources not only of the Hospital patient, but also of other persons having legal responsibility to provide for the patient (e.g. the parent of a minor child or a patient's spouse). Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and copays.

- **Ohio Hospital Care Assurance Program (HCAP)**
  As a participant in the HCAP Program, LMHS offers emergency and other medically necessary hospital-level services free of charge if the patient is a resident of Ohio and the patient's income is at or below 100% of the Federal Poverty Guidelines (the FPG).
  https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

- **General Financial Assistance Policy**

  In addition to HCAP, under LMHS's Financial Assistance Policy, LMHS provides financial assistance for emergency and other medically necessary care as a discount from our gross hospital charges if the patient is a resident in the Hospital Service Area and meets one of the following criteria as determined by the patient's insurance status: Insured vs. Uninsured.

  - **Insured**
    - For those patients who have insurance and do not qualify for HCAP but fall within 100-300% of the FPG, they will be eligible for a 100% discount on any co-pay, co-insurance, and deductible after insurance. Patients whose family income falls between 301-400% of the FPG, they will be eligible for a 76% discount and patients whose family income fall between 401-500% of the FPG will be eligible for a 61% discount on any co-pay, co-insurance, and deductible after insurance. Those patients whose family income is 501+% of the FPG will not be eligible for a discount.
  - **Uninsured**
    - For patients without insurance, a discount of up to 100% will be extended to those whose family income is at or below 300% of the FPG. Patients whose family income falls between 301% and 400% of the FPG will receive a discount of 76%, and patients whose family income is at or above 401% of the FPG will receive a discount per AGB calculations (61%). All uninsured applicants will be screened for Medicaid coverage and must cooperate with the Medicaid representatives to be eligible for assistance under our financial assistance policy
  - **Income**
    - Eligibility will be determined by using gross individual or family income, for the 12 months before the date of service, or by multiplying by 4 the individual or family gross income for the 3 months before the date of service.
  - **Assets**
    - Some situations an individual may not report income but may have significant assets to pay healthcare services LMHS will require documentation as proof of those assets that could be converted to cash. Those assets would not be necessary for daily living expenses.

- **Medical Catastrophic Indigence**

  Patients may also be extended a discount based upon medical indigence. A determination as to a patient's medical indigence takes into consideration significant and/or catastrophic medical bills not covered by insurance, in addition to the patient's income level. Such a patient may be

extended discounted or free care, based upon the facts and circumstances. The patient will never be responsible for out-of-pocket responsibilities that incurred at Lima Memorial Health System exceeding 25% of the gross annual family income within twelve (12) month period prior to the date of service. Extension of medical indigence financial assistance will be based upon a review of application and additional documents that may include, but are not limited to:

- **Income:** Pay stubs, Unemployment information, Social Security award letters, Self-employment records, Disability or Workers Compensation, Alimony, child Support, Pensions, or Income Tax returns
- **Expense:** Rent/Mortgage, Electric, Gas, Phone, Other Medical, Auto or Other Loans, Non-Employer Health Insurance premium(s), Life/Auto insurance

- **Other**
  In addition to the Financial Assistance opportunities outlined above, lump sum settlements or payment plans may be offered to Uninsured Patients on an exception basis for cases with unusually high dollar account balances or other special circumstances demonstrating an inability to pay.

## Applying for Financial Assistance

Upon registration, and after all EMTALA requirements are met, hospital patients without any health insurance or other local health care financial assistance, and adequate health insurance shall receive either (1) a packet of information that addresses the Financial Assistance policy and procedures or (2) immediate financial counseling assistance from staff, including aid with the completion of financial assistance application if requested.

A completed and signed application is required for consideration of all financial assistance. An application can be obtained as follows:

- Any Hospital Registration Point
- From a Hospital Patient Accounts Representative
- Hospital Emergency Room
- At http://www.limamemorial.org/financial-assistance
- By calling the Patient Accounts Department at (567) 242-0460
- By writing to:

  Lima Memorial Health System
  Attn: Financial Services (HCAP)
  1001 Bellefontaine Ave
  Lima, OH 45804

According to LMHS's Application Period, an application for Financial Assistance will be accepted for services until 1 year from the date of the first statement to the patient that informs the patient of the Financial Assistance policy as described above.

Oral Applications may be filled out over the telephone yet will still require a physical signature upon its completion before the application can be approved.

Patients that are eligible for the Hospital Care Assurance Program (HCAP) need to complete an application for:

- Inpatient admission unless readmitted within 45 days of discharge of the same condition
- Approved outpatient applications are good for 90 days from the original date of service
- Inpatient approved application can also cover an outpatient visit if it is within 90 days from the first day of inpatient admission.
- Applications are accepted up to 3 years from when the first notification of the balance was sent to the patient regardless of the bad debt status. Applications that are completed for visits greater than 3 years will be denied.

## Denied Financial Assistance or Incomplete Application

- LMHS patients/guarantors shall be informed in writing if Financial Assistance is denied or an application is incomplete. The incomplete application will be returned with a written notice that specifies the additional information required. The notice will also advise the patient that failure to respond or make payment may result in the following actions:
  - Referral to a collection agency which may report the debt to a credit reporting agency.
  - Filing a civil lawsuit to obtain a civil judgment; if a civil judgment is granted, the judgment may be collected by garnishing your wages or attaching your bank account or other personal property, to the extent permitted by law.

The hospital will wait at least 30 days from receiving the incomplete application prior to continuing any further collection activity. All denials must be credible and determined with the highest integrity with the denial reason listed in comments in the billing notes.

## Post-Service Collection Activity

- Three (3) billing statements or letters, with each generally sent 30 to 45 days apart.
- Phone calls may also be placed for outstanding balances. Frequency and number of calls follow an established protocol based on the dollar amount of the outstanding balance.
- During the Notification Period, the patient will receive a billing statement and notice that informs the patient of the collection activities that the Hospital may take if the individual does not submit a Financial Assistance application or pay the amount owed by a deadline specified in the notice. Deadline date will be no sooner than 120 days from the date of the first billing statement, and 30 days from the date of the Final notice.
- It is the responsibility of the individual to provide a correct mailing address at the time of service or if they have moved. If the account has an invalid address, the determination for "Reasonable Effort" will have been made.

## Actions that May be Taken in the Event of Non-Payment

After the Financial Services Department has determined that all required notices specified above have been provided within the required time frame, the Financial Assistance application has been properly evaluated and notice of the determination has been given, accounts with unpaid balances (gross charges minus approved discounts) may be referred to an external collection agency ("Agency"). External collection agencies are required by contract to operate in accordance with all state and federal law, and under the following protocols:

1. The Agency will send a disclosure notice to the patient stating the unpaid balance owed and providing 30 days' notice to dispute the claim. The disclosure notice to Uninsured Patients will include notification of the availability of Financial Assistance, the eligibility criteria, and the method to apply.
2. The Agency must make at least one attempt to reach the patient by telephone if a number is obtainable.
3. Ninety days after the date of the written disclosure letter, the unpaid balance may be reported to one or more credit reporting agencies unless the patient has made contact with the Agency and has either: a) paid in full; b) submitted an application for HCAP or Financial Assistance; c) provided evidence that the liability was covered by insurance or another third party; d) entered into an acceptable payment agreement.
4. If a patient misses two payments during their payment arrangement the unpaid balance may be reported to a credit reporting agency.
5. If a debt is reported to a credit reporting agency, but the debtor later establishes eligibility for HCAP or 100% write-off under this policy, the Agency will advise the credit reporting agency that the debt is not owed and should be removed from the report. If the debtor establishes eligibility for a Financial Assistance adjustment, the adjusted balance will be reported to the credit reporting agency.

6. Patients/Guarantors with aggregate accounts in excess of $25, who fail to make appropriate payment agreements, or fail to comply with payment agreements, may be referred to legal counsel for suit or probate claim. This will occur if the Agency has reason to believe that:
    a. Debtor has substantial employment, and
    b. Debtor's income exceeds 200% of FPL for family size; and
    c. Debtor's employment appears stable or secure (i.e. for low income employment, employment in the same job for one year); or
    d. Debtor has intangible assets (e.g. bank account, certificate of deposit, stocks) sufficient to satisfy the debt; or
    e. In the event of an estate, the estate appears to have sufficient assets to satisfy the claim
7. Legal counsel will send a disclosure notice under the Fair Debt Collection Practices Act. The disclosure notice to Uninsured Patients will include notification of the availability of Financial Assistance, the eligibility criteria, and the method to apply. Any Uninsured Patient who at any point in the collection process expresses an interest in applying for Financial Assistance will be referred to Financial Services to determine eligibility.
8. Financial Services may authorize suit, if after review of the file, it is satisfied that all internal procedures specified above were followed. Once approved for suit, the Agency retains counsel to file suit to obtain a judgment for the unpaid standard charges, court costs and post judgment interest, as permitted by law.
9. If judgment is obtained, wages may be garnished to satisfy the judgment as permitted by law.
10. No judgment liens will be filed on personal residences of the patient or guarantor except in connection with a claim against an estate.
11. Upon satisfaction of a judgment, the attorney will file a notice of satisfaction of judgment and release any existing liens.

## STATEMENTS OF CHARGES

LMHS maintains a Procedure Dictionary with gross standard charges ("gross charges") for all services and procedures. The schedule of gross charges is reviewed and updated annually. Charges for all patients services, regardless of whether the patient is insured or uninsured, and regardless of third party payer, are initially calculated in accordance with the hospital's schedule of gross charges, and an initial statement calculated on the basis of gross charges may be issued to all payers, including Uninsured Patients who have not yet submitted a completed Financial Assistance application as of the time the statement of charges is issued.

If an Uninsured Patient has submitted a completed Financial Assistance application before billing, the billing statement will be held for a reasonable period of time until eligibility is determined. Following a determination of eligibility, a patient will not be charged more than the amounts generally billed ("AGB") for emergency or other medically necessary services. When eligibility is confirmed, a billing statement will be submitted to the patient that informs the patient of the reduced amount (if any) that the patient is expected to pay.

Any billing statements issued to Uninsured Patients for gross charges will inform them of the availability of Financial Assistance that may provide free or discounted care and the opportunity and process to apply for Financial Assistance. The statement for gross charges will expressly state that individuals with income at or below the federal poverty guidelines are eligible for medically necessary services without charge and will specify the federal poverty guidelines for individuals and families of various sizes at the time the bill is sent.

No patient who establishes eligibility for Financial Assistance under this policy will be required to pay gross charges.

**Amounts Generally Billed (AGB)**

See Appendix B

## PUBLICIZING THE AVAILABILITY OF FINANCIAL ASSISTANCE

**Signage:** All admitting locations, emergency room, and related waiting rooms frequented by patients will have signage compliant with HCAP requirements and informing Patients of the opportunity to apply for Financial Assistance. Literature describing the Financial Assistance policy, the eligibility criteria and the method to apply, together with application forms, will be available.

**Communication:** During the pre-registration and registration process patients are provided the plain language summary. All patients will be asked to provide insurance information. However, emergency medical services are provided without regard to the existence of insurance and without regard to eligibility for Financial Assistance under these policies. In no event will any person seeking emergency medical services be asked to make any payment before receiving treatment. Registration staff in all locations of the facility will inform the Uninsured Patient of the available Financial Assistance programs, the method of applying and will provide the Uninsured Patient with the Financial Assistance Application Form.

**Website:** LMHS will publish this Policy to its Hospital website along with a link to the Financial Assistance Application Form.

## DEFINITIONS

**Amounts Generally Billed (AGB):** The amount generally billed to a Lima Memorial Health System (LMHS) patient who has insurance coverage as defined in IRS Section 501(r)(5).

**Application Period:** The period during which LMHS must accept and process FAP applications. This period shall be from the date of service until _12__ months after LMHS provides the patient with the first billing statement for the care delivered. HCAP application period would be 36 months from after the date of service.

**Application Process:** A process by which a patient or their appropriate representative completes a paper that provides LMHS with information on the patient's income and family size. All applications will be evaluated on a case-by-case basis by appropriate LMHS representatives taking into consideration family size and income three (3) or twelve (12) months prior to the date of service.

**Extraordinary Collections Actions (ECAs):** Actions which require a legal or judicial process or reporting adverse information to credit agencies or bureaus. LMHS will determine charity eligibility prior to taking any extraordinary collection action. Written notice must be provided at least 30 days in advance of initiating specific ECAs and meet informational requirements.

**Family:** The patient, the patient's spouse (regardless of whether s/he lives in the home) and all of the patient's children (natural or adoptive) under the age of eighteen (18) who live at home. If the patient is under the age of 18, "Family" includes the patient, his or her natural or adoptive parents (regardless of whether they live in the home), and the parent's other children (natural or adoptive) under the age of 18.

**Federal Poverty Guidelines (FPG):** Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services and in effect at the date(s) of service for which financial assistance may be available.

**Financial Assistance or Financial Assistance Discounts:** Discounts or elimination of payment for health care services provided to eligible patients with financial need.

**Hospital Service Areas**: LMHS hospital service areas for the purpose of financial assistance are defined as the following counties: Allen, Auglaize, Hancock, Hardin, Mercer, Logan, Putnam, Paulding, Shelby, and Van Wert.

**Look-Back Method:** The methodology specified by IRS Codes Section 501(r) and selected by LMHS to determine AGB which uses past payments from Medicaid or a combination of Medicaid and commercial insurer payments.

**Medically Indigent Patients:** Those patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses, in relationship to their income, and would make them indigent if they were forced to pay fully for their medical care.

**Medical Necessary Care** – For the purpose of this policy, "medically necessary services" are those that qualify as "basic, medically necessary hospital level services" under HCAP, (O.A.C. 5101:3-2-07.17), which include all inpatient and outpatient services covered under the Medicaid program in Chapter 5101:3-2 of the Ohio Administrative Code. Medically Necessary Services **Excludes**:

- Services where Advanced Beneficiary Notice (ABN) is provided
- Cosmetic services or elective services that are not medically necessary
- Experimental
- Out of Network insurance plans
- Patients whom have medical insurance but choose to not have their charges submitted to their medical insurance.

**Notification Period:** The period of time during which LMHS will make every reasonable effort to inform the patient of the availability of financial assistance under this policy. This period shall be from the date of service until 120 days after LMHS provides the patient with the first billing statement for the care delivered.

**Private Pay:** Patient identified as having no insurance coverage or opting out of their insurance coverage for specific services/events.

**Underinsured:** Insured patients who receive Medically Necessary Care that are determined to be non-covered services or have limited benefit coverage by the insurance provider.

**EMTALA:** Federal Emergency Medical Treatment and Active Labor Act.

**Approvals:** **Chief Financial Officer** _____

**Chief Executive Officer** _____

# Appendix A

Physicians and Providers Covered under Lima Memorial Health System Financial Assistance Policy:

None

Physicians and Providers Not Covered under Lima Memorial Health System Financial Assistance Policy:

The Lima Memorial Health System Financial Assistance Policy does not cover services provided by physician or non-physicians (e.g. Nurse Practitioners, Physician Assistants). Therefore, any professional services provided are not covered under the Lima Memorial Health System Financial Assistance Policy.

# Appendix B

**Amounts Generally Billed (AGB)**
The AGB will be determined based on all claims paid in full to the hospital by Medicaid and Private Insurers and the individuals they insure, over a specified 12-month period, divided by the gross charges for those claims.

The AGB for LMHS for the 12 month period ending December 31, 2020 is __39%__ of gross charges. Therefore, the largest amount charged to persons eligible for financial assistance will be determined by multiplying the gross charges for the medically necessary services provided by __39%.