HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: COMMUNITY SERVICES AND COLLECTION PRACTICES FOR HARDIN COUNTY GENERAL HOSPITAL AND CLINIC
FINANCIAL ASSISTANCE PROGRAM (FAP) AND PRESUMPTIVE ELIGIBILITY POLICY

Effective Date: 2/28/2006

Revised: June 5, 2025

Policy Number: HW139

Med Staff:

Regulation: Hospital Uninsured Patient Discount Act(Public Act 95-0965) IRS 501® No Surprises Act Jan 2022, Fair Patient Billing Act
Department of Health and Human Services
Federal Register Volume 69No.30 and 42CFR 413.89

Admin:

I. POLICY

Hardin County General Hospital and Clinic will assist patients who cannot pay for part or all of the care they receive in a respectful, compassionate manner in accordance with the hospital's mission, vision and strategic plan. **YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE** based on the information provided to the hospital. Balances due on accounts that have been billed to any insurance available or any uninsured individual will be pursued based on the collection procedures provided in this policy. All assistance will be made without discrimination based upon race, color, creed, national origin, gender, sexual orientation or other grounds unrelated to the individual's need for these services. The Financial Assistance Program application, Plain Language summary and policy is currently available in English, if you need assistance with interpretation in another language, please contact the hospital using the methods listed above.

II. DEFINITIONS

AGB: Defined as Amounts Generally Billed. Hardin County General Hospital uses the "Look-Back" Method to determine AGB. The "Look-Back" Method is based on actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Back Method to determine AGB to individuals based upon the Medicare fee-for-service together with all private health insurance paying claims to the hospital facility. This percentage will be determined after each audit completion in October/November and will be adjusted as such in the FAP.

Civil Union: A legal relationship between two (2) persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Covered Services: Defined as emergent or medically necessary.

DOS: Defined as Date of Service

Fair Billing Act: Section 501RC of the Internal Revenue Code establishing a financial assistance policy (FAP).

Family Size: All people who reside in the household, regardless of relation.

Financially Indigent: An uninsured or underinsured person who does not have the ability to pay for services rendered.

FPL: Federal Poverty Level

FAP ADD-ON Acct: Refers to account(s) that are identified while a FAP application is in the review process or the original application has been final approved. These accounts are not on the original FAP Worksheet.

Financial Assistance Program (FAP): Financial Assistance provided to Hardin County General Hospital patients who meet Financially Indigent, Medically Indigent Hospital Uninsured Discount Act criteria.

HCGHC: Hardin County General Hospital and Clinic

Hospital Uninsured Patient Discount Act: Rural and critical access hospitals are required to provide discounts for uninsured Illinois residents with family income less than or equal to 300% FPL. Discount is 100% minus 135% of cost utilizing the ration of cost to charges from worksheet C Part 1 from the most recent filed Medicare Cost report. Maximum that can be collected is 20% of annual household income.

Medically Indigent: Refers to a patient whose hospital bill(s), after application of Financially Indigent criteria, exceeds a specified percentage of the patient's annual household income and who is unable to pay the remaining balance of their bills(s).

Party to a Civil Union: A person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act. Party to a civil union means, and is included in any definition or use of the terms spouse, family, immediate family, dependent, next of kin, and other terms that denote the spousal relationship.

Poverty Guidelines: The federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services.

Presumptive Eligibility: The criteria used to deem a patient eligible for financial assistance, and the criteria is defined as the categories identified as demonstrating financial need.

Provider: A physician or mid-level (Nurse Practitioner or Physician Assistant) who treats patients medically.

Total Annual Household Income: The sum of the yearly gross income for the entire household (patient and dependents).

Visit: A billable event where a patient is seen by a HCGHC provider in the hospital or clinic.

Uninsured Patient: A patient of HCHGHC who is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, worker's compensation, accident liability insurance, or other third-party liability.
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III. RESPONSIBILITY

Credit and Collections staff, Credit Manager, Director of Fiscal Services, Administration and Board of Directors.
The FAP Plain language summary, application and policy can be located, downloaded and returned in the following ways:

1) On the hospital website located at: **www.ilhcgh.org.** Under Financial assistance tab.
2) The FAP application is also available at the front lobby desk of the hospital and clinic.
3) Upon request by phone at (618) 285-6634 ext.301 or 302.
4) By mail at: 6 Ferrell Road, Rosiclare, IL 62982.
5) Email request to Kathy.jackson@ilhcgh.org.
6) Fax request or completed application at: (618)285-3564.
7) You may visit the Credit Manager for financial assistance during office hours of: 7:00AM until 4:30PM Monday through Friday. In the absence of the Credit manager your request will be referred to the Patient Account Manager or the Director of Fiscal Services.

IV. EQUIPMENT

Hospital Information System: Computer related software used to register or scan information received or printed on behalf of a patient.

V. PROCEDURES

INFECTION CONTROL: N/A

Financial Assistance Program (FAP), Presumptive Eligibility Criteria, Collection practices and Bad Debt referral procedures:

Community Service in the form of financial assistance and/or charity will be available to persons who are uninsured. Financial Assistance may be given in the form of free care, discounts on bills and/or payment plans. The financial assistance program includes all bills from the hospital, provider based rural health clinic and hospital employed providers who have reassigned their benefits to the hospital (hospital bills for physicians). This currently includes physician fees for Dr. Sunga, Dr. Hastie, Dr. Chatto and Dr. Bose. You may receive separate bills for professional fees by other health care professionals. The hospital FAP **does not cover** outside bills for independent physician bills including radiology and pathology which currently includes Specialist Medical Imaging (SMI)/ Saline Valley of Radiology Partners and Laboratory of America Holdings (LabCorp) and Quest Diagnostics, as well as Cardio/Pulmonary services provided by: iRhythm Technologies, INC, Phillips Biotel Heart and Black Stone Medical.

No one eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed **(AGB)** to individuals who have insurance coverage. The **AGB** billed by Hardin County General Hospital is a

combination of the "Look-back method and a percent of the Medicare fee schedule. This includes a comparison and review of the hospital's Medicare Cost Report submitted annually, as well as the past year's private health insurance claims paid to the facility and the Medicare fee schedule times 2.5.

A) Upon admission and registration, the patient's pay status is determined and recorded (i.e., insured or uninsured). Information regarding the availability of financial assistance is distributed and posted to all patients in the waiting areas or on the hospital website at www.ilhcgh.org. This includes access to the FAP plain language summary and application.

   If an individual is deemed to be uninsured, a bill with the hospital telephone number, address, brief explanation of services, total bill and information about the availability of an itemized bill and financial assistance is provided within 10 days of the date of service. **If you are uninsured, a Social Security Number is not required to qualify for free or discounted care.**

B) Based on the No Surprises Act, (refer to No Surprises Act Policy) effective January 1, 2022, a good faith estimate (provided on form CMS-10780) will be provided to all uninsured and/or self-pay patients with a test or procedure scheduled 3 days prior to said test or procedure. The bill will automatically reflect a 10% discount off of billed charges for all uninsured customers with an additional 10% discount if paid promptly. The customer will be directed to the Collection Manager if the bill is unpaid after 30 days.

C) In the event the patient is deemed insured, Co-payments and deductibles will be expected at time of service. If the customer is unable to pay or has prior bad debts, they will be referred to the collection manager. Patients with prior balances may be requested to make either payment in full or partial payment on balances before additional non-emergency services are rendered. 50% of the bill will be requested and/or a payment plan established based on the following guidelines: 6-month interest-free loan for amounts less than $600. 12-month interest free loan for amounts over $600. If the customer misses the established payment or goes over the allotted time for repayment, the account is automatically sent to the outside collection agency. Exceptions will only be made through proof of hardship. This would include loss of job, income, etc. The customer will be asked to provide proof of hardship, by producing termination letter, bank statements and any other proof requested.

D) Charges are posted and bills are submitted to all available insurances. Upon receipt of Explanation of Benefits or remittance advice from insurance company, any balance remaining on account is placed in private pay class and sent an initial bill in the same manner as Step B for uninsured. Non-covered or denied services will be treated as uninsured services.

E) When outstanding bills are 60 days old, a second statement is mailed with financial assistance information included.

F) A third statement is mailed at the end of an additional 30 days with information concerning financial assistance, discounts and payment plans available. After 30 more days a final demand notice is mailed (120 days total). At this point the credit manager or

assigned agent of the hospital attempts to contact customer by telephone, cell phone, email, mail, text message or any other acceptable manner of contact and determines whether the bill is collectible. Hospital will consider this a refusal to pay.

G) If at any time during the time of registration or through the entire collection process, the customer notifies the hospital about the need for financial assistance, the credit manager will promptly respond with the proper application (in 2 days if contacted by telephone and 10 days in writing). The applicant has up to 120 days from the date of service to complete the application and submit it to the hospital. The application will be reviewed for the following:

1. Eligibility requires proof of need which includes: State and Federal tax returns, proof of income and a minimum of two most recent bank statements. Proof of disability or letter from family or responsible party indicating need. Self-Employment tax returns. Proof of social security, retirement income and any other form of income. If a patient meets presumptive eligibility criteria, the patient shall not be required to complete the application's section on monthly expenses.

2. Applicants may be asked to apply for assistance from other appropriate sources if it is determined they could qualify for another program. Once the information is compiled and reviewed by the Credit Manager and a determination is made that the Financial Assistance Application meets the criteria, it will be forwarded to Administration for review. Prompt determination of eligibility will be based on income level set by the current Department of Health and Human Services Poverty guidelines. The patient will receive notice as to the approval or denial of Financial Assistance/Charity Care. The patient will also be notified about any discounts or payment plans that might be available. The approved application is valid for the year applied in and must be renewed annually.

3. Presumptive Eligibility: As soon as possible after receipt of hospital services by an uninsured patient, the hospital will attempt to determine if the patient automatically qualifies for free care based on presumptive eligibility criteria as follows:
    a) Expired patients with no estate.
    b) Homeless
    c) Resident of shelter facilities.
    d) Rape victim or victim of violent crimes.
    e) Unemployed with no benefits.
    f) Inability to contact as a result of bad address and telephone number after 1 year of attempts.
    g) Non-covered, denied services or non-billable services.
    h) Mental incapacitation with no one to act on patient's behalf
    i) Medicaid eligibility, but not on date of service or for non-covered service.
    j) Recent personal bankruptcy
    k) Incarceration in a penal institution
    l) Insured patients who have Medicaid secondary coverage or become Medicaid eligible after filing date passes, with a deductible/coinsurance, not paid or covered by Medicaid.
    m) Enrollment in the following assistance programs for low-income individuals: 1) Temporary assistance for Needy Families (TANF), 2)

Illinois Housing Development Authority's Rental Housing Support Program. 3) Women, Infants and Children Nutrition Program (WIC). 4) Supplemental Nutrition Assistance Program (SNAP).

Patients will be expected to make a good faith effort to provide information assist the hospital in determining if the patient meets presumptive eligibility.

4. HCGHC has made determination that patients receiving the following services will automatically qualify for 100% assistance without application.
    a) Medicaid patients determined to be Medicaid qualified after the 6-month timely filing period, verified through HFS.
    b) Medicaid small balances of $10.00 or less (after a statement is mailed if deductible or copay).
    c) Billed Medicaid services that have been denied or rejected for payment by HFS.
    d) Medicaid spend downs.

5. HCGH utilizes the Federal Poverty Guidelines published annually by the US Department of Health and Human Services to determine eligibility for Financial Assistance or Community Benefits. All patients whose income is less than or equal to 125% of the FPL and have been approved for assistance will receive 100% reduction (free care). Partial financial assistance (discounted care) is provided for the following income levels:

    126%-200% X's FPL- 50% reduction in charges.
    201%-300% X's FPL- 30% reduction in charges. Maximum that can be collected is 20% of income.
    Over 301% X's FPL- 10% reduction in charges.

G) After reasonable hospital collection efforts are made, the credit manager will determine if the unpaid balance is sent to the collection agency. The following criteria will normally be used to establish whether an account is sent to collection or ascertained as a bad debt or an allowable Medicare bad debt.

1. Small debit balances for ten dollars ($10.00) or less are automatic write-offs.

2. Cumulative balances lower than fifty dollars ($50.00) per guarantor will receive additional collection efforts but will not be sent to the collection Agency.

3. All accounts subject to be sent to collection agency will first be checked for public aid eligibility.

4. Once an account becomes a bad debt or goes to the collection agency they are compiled monthly and reviewed by the Administrator and the Board of Directors. After approval they are written off of the hospital Accounts Receivable.

5. If a payment is made to an account after AR removal, a credit to bad debt is made and in the case of a Medicare bad debt, a credit to Medicare will be made monthly and to the current years cost report.

6. Once an account is sent to collection agency, all accounts they deem uncollectible or surpasses 120 days after the date of service, whichever comes first, unless there was activity on the account within the last Ninety days will be returned to the hospital and considered uncollectible.

7. If a patient's bill has been sent to collection wishes to pay the hospital in full, said payment will be accepted. Payments set up by the collection agency will need to be paid directly to the collection agency.

H) Medicare allowable bad debts are established after Medicare bills are sent and remittance advices are received, including secondary insurance, supplements and public aid. Criteria for an allowable bad debt include:

1. The debt must be related to covered service and derived from deductible and coinsurance amounts only applicable to payment systems based on costs (billed on a UB); not a fee schedule payment deductible or coinsurance. Non-covered or denied services cannot be recovered as a Medicare bad debt.

2. Once a person is proven to be indigent (a Public Assistance voucher received for proof of billing) the bad debt can be immediately written off. Otherwise, reasonable collection efforts the same as all other pay classes must be made. In some cases, a Medicare bad debt may be taken if the patient can be determined to be self-pay indigent, that is not qualified for Public Assistance but indigent based on US Health and Human services Federal poverty guidelines. In the event of a death, a copy of the death certificate is required and proof of no estate established (courthouse verification). Normal collection efforts will be made for a minimum of 120 days.

3. Collections efforts will be made for a minimum of 120 days from the date of the initial bill and sent to collection agency based on private pay collection efforts. Only after they have been returned from collection agency and deemed uncollectible will they be claimed as a Medicare bad debt. Documentation of the provider's collection efforts should be kept in the patient's file in the form of bill(s), follow-up letters, and telephone and personal contacts.

4. The debt should be considered uncollectible when claimed as worthless and sound business judgment established that there is no likelihood of recovery at any time in the future.

5. Once an account is verified as an allowable bad debt it is submitted monthly to the Administrator and the Board of Directors for approval and listed in the following manner: beneficiary's name, beneficiary's account number, date of the first bill sent to the patient, date of write-off of the bad debt, amount written off as bad debt, deductible and coinsurance amounts charged to the beneficiary and date of service.

VI. DOCUMENTATION

Financial Assistance Plain Language Summary
Financial Assistance Application
Public aid application
Proof of income
Department of Health and Human Services Poverty guidelines (updated annually).
Death Certificate
Letter from family/friend indicating support of patient if no income is indicated on application.