HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: COMMUNITY SERVICES AND COLLECTION PRACTICES FOR CRITICAL ACCESS HOSPITAL AND RURAL HEALTH CLINIC **Effective Date: 2/28/2006**

Revised: March 31, 2022

Policy Number: HW139 **Med Staff:**

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

I. POLICY

Hardin County General Hospital will assist patients who cannot pay for part or all of the care they receive in a respectful, compassionate manner. We offer community service to uninsured individuals who are financially unable to pay for medical care excluding deductibles, insurance co-payments (including Medicare) and Illinois Department of Healthcare and Family Services spend downs. Balances due on accounts that have been billed to any insurance available will be pursued based on the collection procedures.

II. DEFINITIONS

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, clinic and hospital physicians 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. The hospital FAP **does not cover** outside bills for radiology and pathology which currently includes SMI- Saline Valley of Radiology Partners and Laboratory of America Holdings (LabCorp) and Quest Diagnostics.

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.

Hospital Uninsured Patient Discount Act: Rural and critical assess hospitals are required to provide discounts for uninsured Illinois residents with family income less than 200% of the Federal Poverty Level (FPL). Discount is a minimum of 135% of cost utilizing the ratio of cost to charges from worksheet C Part 1 from the most recent filed Medicare Cost report. A maximum that can be collected is 25% of income.

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

Section 501 ®© of the Internal Revenue Code establishing a financial assistance policy (FAP).

III. RESPONSIBILITY

Credit and Collections staff.
Hours: 7:00AM until 4:30PM Monday through Friday.
In absence of Credit Manager, financial assistance matters are referred to the Patient Account Manager or the Director of Fiscal Services.

IV. EQUIPMENT

N/A

V. PROCEDURES

INFECTION CONTROL: N/A

Collection practices and Bad Debt referral:

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.

B) 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 mailed within 30 days of date of service. 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. 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 deemed as uninsured services.

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

E) 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.

F) 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.

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. HCGH reserves the right to provide Financial Assistance based on reasonable judgment. The circumstances for which assistance may be provided are:

    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.
    g) Non-covered or denied services.

4. HCGH 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.

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:

   2 X's FPL- 50% reduction in charges.
   3 X's FPL- 30% reduction or 135% of cost to charge ratio, whichever is More. Maximum that can be collected is 20% of income.
   4X'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 Application
Public aid application
Proof of income
Department of Health and Human Services Poverty guidelines (updated annually).
Death Certificate