Purpose Statement

Huron Medical Center (HMC) will treat all patients with respect, dignity and compassion regardless of their ability to pay. Huron Medical Center's expectation for payment is based on the patient's ability to meet payment obligations.

Policy

Huron Medical Center is pleased to offer patients financial assistance in the form of discounts up to 100% of the amount owed. Eligibility is based on income as well as other criteria set forth in this policy. This policy describes the eligibility and application process to determine discounts patients may qualify for. This policy gives consideration to and complies with IRS regulations pertaining to charitable hospitals as defined under section 130266-11. This policy also complies with the process for determining discounts under Public Act 107 of the Healthy Michigan law, section 105d, which indicates that hospitals cannot charge uninsured individuals at 250% of poverty level and/or below more than 115% of the Medicare reimbursement rate. Throughout this procedure this law will be referred to as the Uninsured Mandated Cap. It is the hospital's responsibility to communicate its financial assistance policies to patients and it is the patient's responsibility to provide information necessary to determine eligibility in a timely and complete fashion.

This policy applies to the insured and the uninsured. All patient balances including coinsurance, deductible or other non-covered services may be considered for discounts as explained in the procedure below.

Providers Covered/Not Covered by FAP Policy

This policy covers all inpatient and outpatient services provided at the main hospital campus, the Port Austin Clinic, the Ubly Clinic, and the Elkton Clinic.

Procedure

Communication of FAP/Obtaining an Application

The hospital communicates its FAP to patients in the following ways:

- About Your Hospital Bill pamphlet which is available in all waiting rooms and includes a plain language summary of the hospital's assistance program.
- Signs in all registration areas and the Emergency Department alerting patients to our FAP and how to apply.
- Messages on all statements alerting patients to our FAP and how to apply.
- Information on the hospital website concerning our FAP and how to apply.
- Financial Counselor personnel discuss FAP and payment options with patients when they call to discuss their bill. For patients with charges of $5,000 or more, an attempt to contact the patient is initiated by Financial Counselor prior to placement with a collection agency.

- Registration staff and Financial Counselors provide applications and plain language summary to patients who ask or who express financial hardship and when applicable, arrange for Financial Counselor to talk with a patient during their visit.
- Hospital Case Manager/Discharge Planner provide plain language summary to patients as part of the intake or discharge process.
- An application for assistance and a copy of this policy can be obtained by calling Financial Counselor (989-269-8933) to request a mailing, downloading a copy from the hospital website, or in person at the Financial Counselor's office in the main hospital or any area that registers patients.

Eligibility Determination and Timeframe to Apply for Assistance

Eligibility for FAP is primarily based on annualized household income. The determination of eligibility is based on the patient's financial situation at or near the time service is rendered.

Patients on a fixed income need to apply once a year. All other patients must apply every six months or more frequently if their income changes significantly. The hospital will accept FAP applications up to 240 days from the date of the first billing statement. However, accounts may be referred to collections after 120 days from the date of the first billing statement and if it has been more than 30 days since an application was requested by and sent to the patient. It is in the patient's best interest to apply for financial assistance as early as possible.

If an account has been placed with a collection agency and the patient requests financial assistance, collection efforts will cease for at least 30 days to allow the patient time to complete the application. If it is determined that the patient is eligible for financial assistance, the account will be withdrawn from collections and the agency will reverse any credit reporting that may have occurred. If there is a balance remaining after the discount is applied, the agency may resume collections if that balance is not paid within 30 days or acceptable payment arrangements are not made with the agency. Accounts that are 240 days past the date of the first billing statement are no longer eligible for assistance.

With a few exceptions, the Affordable Care Act requires all individuals to have insurance coverage; therefore, the only discount available to the uninsured is the uninsured mandated cap and if applicable the Huron Medical Center 50/50 (explained below). The law does provide an exception for those that cannot afford coverage; however, in Michigan these patients are eligible for Healthy Michigan (Medicaid) so this exemption is not a valid reason for having no insurance coverage. If the patient is exempt by law and if they are also not eligible for Healthy Michigan, consideration for additional discounts can be considered on a case-by-case basis.

Method of Applying for Financial Assistance

The following information is required in order to be considered for an FAP discount.
1. Application for Assistance (Attachment I)
2. Copy of a current payroll check stub showing year to date earnings. If check stub does not show YTD earnings or does not have sufficient information to estimate annual income, additional documentation may be requested.

3. Support for all other income including but not limited to:
    -Unemployment benefits
    -Pension, disability, social security or retirement income
    -Child support or alimony
    -Rental income
    -Dividends from stocks or bonds
    -Housing or rental allowances
    -Income for caring for foster children
    -Any other income received
4. Latest federal income tax return, if any of the following apply:
    -Patient/guarantor is self-employed. For patient's self-employed with self-employed income exceeding $5,000, the tax return must be prepared or reviewed by a reputable tax firm.
    -Clergy (because of housing allowance)
    -A tax return can be requested on any application if it would be helpful in making a determination or it is needed to confirm information.
5. Denial of Medicaid may be required and considered on a case-by-case basis. A denial from a Medicaid eligibility company (currently L&S Associates) is sufficient as a Medicaid denial as long as the denial reason supports that the patient cooperated in providing information to L&S. As explained previously, most uninsured patients are not eligible for discounts beyond the uninsured mandated cap so requiring a Medicaid application may not be applicable. (Note: Healthy Michigan does not provide retroactive coverage.)
6. Bank Account statements representing at least 30 days activity. (Not required if only applying for the mandated cap or 50/50 program.)
7. IRA Statements unless the patient is 55 or over. (Not required if only applying for the mandated cap or 50/50.)

The completed Application for Assistance and supporting documentation can be submitted in one of the following ways:

-Mailed to Huron Medical Center Hospital Attn: Financial Counselor, 1100 S. Van Dyke, Bad Axe, MI 48413
-Dropped off at the Financial Counselor's office at the main hospital campus

<u>Exclusions</u>

The following are exceptions and exclusions, and these persons are not eligible for assistance other than the mandated cap or 50/50 program.
1. Persons incarcerated
2. Services provided related to felony activity
3. Persons who should have legally filed an income tax return but did not
4. Illegal aliens
5. Persons living outside of Huron Medical Center Hospital's service area and do not regularly utilize Huron Medical Center Hospital (these patients should be seeking financial assistance

from their local community hospital).
6. Frequent visits to the Emergency Department when these visits are non-emergent or non-urgent in nature (to discourage inappropriate use of the Emergency Department).
7. Injuries resulting from driving under the influence of drugs or alcohol.
8. Failure of insurance to pay because pre-certification rules, COB questionnaires or other requirements were not followed by the patient.
9. Persons who do not cooperate in providing the requested information in the required timeframe.
10. Anyone who is required by law to have insurance but does not have insurance.

Actions taken in the Event of Non-Payment

The actions that are taken by the hospital in the event of non-payment of any balance due from the responsible party are described in the hospital's Collection Policy. Collection action taken could include placement with third party collection agency, a blemish on the responsible party credit report, garnishment of wages or other litigation. A copy of the Collection Policy is available to the public and can be obtained by calling Financial Counselor (989-269-8933), viewed on or downloaded from the hospital's web-site (www.huronmedicalcenterhospital.org), or in person at the Financial Counselor office in the main hospital lobby.

Cash

The actions that are taken by the hospital in the event of non-payment of any balance due from the responsible party are described in the hospital's Collection Policy. Collection action taken could include placement with third party collection agency, a blemish on the responsible party credit report, garnishment of wages or other litigation. A copy of the Collection Policy is available to the public and can be obtained by calling Financial Counselor 989-269-8933, viewed on or download from the hospital's web-site (www.huronmedicalcenterhospital.org), or in person at the Financial Counselor office in the main hospital lobby.

Balances in IRA

Income drawn from a retirement account is included as income for determining eligibility.

Balances in IRA are considered cash for determining eligibility unless the patient is on permanent disability or age 55 or older. All other patients who have balances exceeding $2,000 in a retirement account and who would otherwise qualify for assistance will be limited to a 75% discount. If the balance in their retirement together with their income is at or below the income guidelines patients will be eligible for assistance based on adding these together. If the amount owed exceeds the IRA balance, the amount of the bill in excess of their retirement balance should be considered for the discount the patient would otherwise qualify for.

Expenses

Expenses are typically not considered in determining eligibility for assistance. In unusual circumstances when the patient or their family has experienced a catastrophic event, expenses may be considered and can be documented on the back of the Financial Assistance Application.

Family Size Definition

The family size will be the same as filed on the person's latest income tax return plus any other person's whose income is considered in determining eligibility and adjusted for any applicable changes since the income tax return was filed. Parental income for adult children is considered in determining eligibility if the adult child is claimed by their parent(s) on their parent's income tax return. In the case of divorce, children who are supported by child support can be included even if they are unable to be claimed on the family's income tax return.

In the case of cohabitation without marriage both party's income is considered when determining income and both parties' dependents are considered in the family size. (Patients can, however, be eligible for the mandated cap without providing their significant other income).

Presumptive Assistance

For patients that are enrolled in an out-of-state Medicaid program, presumptive assistance can be granted if the patient was unable to get the service in their home state (i.e., emergency) and the patient can provide proof of active coverage. Otherwise, these patients are only eligible for the mandated cap.

AGB

The AGB (Amounts Generally Billed) is calculated annually by the Finance Department and represents an overall average that the hospital is reimbursed by all payers, excluding Medicaid. The hospital calculates two AGB percentage rates: inpatient and outpatient. The AGB is updated in April of each year following the hospital's fiscal year end. The current AGB is shown on Attachment II. This amount is used to ensure that patients that are FAP eligible are not charged more than the AGB per IRS regulations. The hospital uses the look back method to calculate the AGB.

Huron Medical Center 50/50 Plan

The Huron Medical Center 50/50 Plan is an assistance/discount plan that helps people pay large balances. The plan provides a discount on large balances, matching patient payments up to 50% of the bill. Depending on the amount owed, any patient regardless of income may potentially

qualify. This discount is in addition to any discounts the patient may qualify for as described previously.

To qualify for the 50/50 program, patients must meet the account balance and income criteria described in Attachment II.

For every dollar the patient pays, the hospital provides a matching discount up to 50% of the bill.

Balances apply to single accounts only with the exception of mom and newborns. These can be combined for the purpose of 50/50. Exceptions for catastrophic or episodes of care that result in multiple account balances may be considered on a case-by-case basis if approved by the Director of Patient Financial Services. Balances can be self-pay, copay/deductible, or even balance after a partial assistance discount.

Patient must enroll in the program and provide proof of income. Enrollment is done as part of the Application for Assistance process, however, if patients do not want to be considered for other discounts they only need to provide proof of income and family size.

Once the patient enrolls, any payments they make within 60 days will be matched up to 50% of the bill. Any payments the patient made prior to the enrollment date are also matched. Payments after the expiration date are not matched. Only self-pay payments are matched. Insurance payments are not matched.

The 60-day time frame can be extended if authorized by the Director of Patient Financial Services. This may be appropriate at times to allow patients more time to secure funds if they are applying for a loan or disposing of assets. The write-off is unconditional and applies regardless of what happens with any balance remaining. Patients can still make payment arrangements for any balances remaining at the end of 60 days.

Incomplete Applications

When the financial application is incomplete or missing information, Financial Counselor staff will send the patient a notification in the mail advising the patient what information is needed to complete the application. Patients have 30 days to provide this information. If the information is not provided within 30 days, normal collections will proceed.

Patients can reapply or submit missing information at any time as long as it has not been more than 240 days since the first statement was sent and it has not been more than 30 days since the request for missing information was sent.

Notification of Determination

Every effort is made to process all applications within 30 days of receipt. While patients remain in the statement cycle while their application is being processed, once an application is received all collection activity (referral to collection agency) will cease until a determination of eligibility

has been made. Patients are notified in writing of the determination. If patients do not qualify, they are given the reason that they did not qualify and can reapply if additional information or correction is applicable. When a partial discount is taken, the patient will have at least 30 days to pay the balance or make payment arrangements prior to any collection activity being taken or resumed.

The Financial Counselor Director will review all applications and authorize assistance up to $10,000 per individual account. For assistance exceeding $10,000 but less than $25,000, the authorization of the Controller or Reimbursement Director is also required. For assistance exceeding $25,000, the authorization of the Chief Financial Officer is required.

If a patient is determined to be FAP eligible and has made payments in excess of the discount, they will be refunded the overpayment amount.

Emergency Medical Care Policy

The hospital does not allow actions that discourage individuals from seeking medical care and has insured that its FAP policy is in compliance with EMTALA. A copy of the hospital's EMTALA policy can be obtained by calling Financial Counselor at 989-269-8933.

Help is Available

IRS regulation 501(r)-4(5)(ii) indicate that the FAP documents should be translated to other languages if the population of the community served constitutes the lesser of 1,000 individuals or 5%. Huron Medical Center does not meet this threshold but is happy to assist any individuals that may need help with interpretation or help of any kind completing the application.

If patients have questions regarding this policy, need help submitting a financial application, or for any other inquires related to the financial assistance program or the patient's outstanding accounts, contact the Financial Counselor at 989-269-8933.