Policy Statement

Anderson Regional Medical Center (ARMC) is committed to providing high quality, compassionate health care to you and your family. In order to maintain our high standards of health care delivery in the most cost-effective manner, a co-pay is required. As a part of ARMC's mission to serve the health care needs of our community, financial assistance is available to patients who are without financial means to pay for emergency and medically necessary care. This policy sets the requirements for the ARMC Financial Assistance (FA) program.

Purpose

This policy serves to establish and ensure a fair and consistent method for the review and completion of requests for financial assistance to our patients in need. This policy is issued in compliance with section 501(r) of the Internal Revenue code.

Scope

This policy applies to all emergency and other medically necessary care provided by the following (collectively referred to as "ARMC"): 

• Anderson Regional Medical Center
• Anderson Regional Medical Center South Campus and its subsidiary
• Rural Health Clinics – Airpark, Enterprise, and Children’s Clinic
• For a complete list of providers who adhere to this policy please see appendix B
• For example statements of covered providers please see appendix B-1
• For a complete list of providers who do not adhere to this policy please see appendix D

Definitions
Refer to Appendix A - Glossary of Policy

Article 1 Provisions
ARMC provides a FA program to mitigate financial barriers to receiving emergency and medically necessary care for eligible patients regardless of a patient's age, disability, gender, race, religious affiliation, social or immigrant status, sexual orientation, national origin, or membership status.

Section 1.1 Services Eligible Under the Financial Assistance Policy
FA may be applied to all emergency and medically necessary health care services provided by the facility including care provided by a substantially related entity as well as:

• Medical Center Inpatient - "Facility" inpatient services performed at ARMC and ARMC South, including Inpatient Rehab and Geriatric Psychiatry.
• Medical Center Outpatient - "Facility" outpatient services performed at ARMC and ARMC South including Anderson Pain and Wound Centers.
• Rural Health Clinics - Airpark, Enterprise, and Children's Clinic
• Please see Appendix B for a full list of providers who adhere to this policy.
Section 1.2 Financial Assistance Does Not Apply to the Following:

- Outlying affiliated clinics- please refer to provider list in Appendix B for affiliated providers who do not adhere to this policy.
- Any elective services considered cosmetic in nature
- Non-covered treatment or procedures
- Retail Pharmacy

Article 2  How to Apply for Financial Assistance

Section 2.1

- As part of the pre-admission, registration and/or discharge process, ARMC representatives will ask how the patient intends to pay for the Medical Center's services. All applicable EMTALA regulations will be followed. If the patient alleges inability to pay, ARMC staff may assist the patient in completing the FA application. Patients who are not qualified through presumptive measures must complete and submit an FA application to apply for the FA program.

- The FA program application describes the personal, financial and other information and documentation a patient must submit to support eligibility determination for public and private health coverage programs as well as the FA program. ARMC has the patients consent to verify all information given by the patient.

- Documentation may not be required in the event that ARMC financial counselors, or their 3rd party providers can utilize external data sources or electronic eligibility tools to verify the patient's or patient's guarantor's financial status, to support eligibility determination.
• For assistance with the FA policy application please contact:
  Patient Financial Services at 601-553-6850

Section 2.2

Patients who wish to apply for FA must submit a FA application within 240 days after
the date that the first post-discharge billing statement for the episode of care was
provided.

Section 2.3

• Completed applications including all required information and
documentation should be submitted to ARMC for eligibility determination.
  Completed applications can be:
• Submitted by mail to Patient Financial Services, 2124 14th Street,
  Meridian, MS 39301, or
• Delivered in person to the address

above Section 2.4

ARMC reviews submitted applications within thirty working days of receipt and
will determine whether the patient is eligible according to the ARMC FA Policy

Section 2.5

Incomplete applications are not considered. Patients are notified by mail or by phone when
their application is incomplete and provided an opportunity to send in the missing
documentation or information within two weeks from patient notification (i.e., date of patient
mailing or phone conversation).
Section 2.6

- ARMC has the right to, and may, revoke, rescind or amend awards at our discretion when:
- A case of fraud, misrepresentation, theft, changes in a patient's financial situation or other circumstances that undermine the integrity of the FA program.
- If health coverage information or other payment sources are identified after a patient is awarded FA, retroactive billing adjustments may occur

Section 2.7

In the event that a patient believes their application was not properly considered, they may submit a written request for reconsideration. The request should include information that was not submitted with the original application to help support their reason for appealing the decision. The patient application denial letter provides information about the appeal process.

Section 2.8

If a determination was made that a patient has the ability to pay all or a portion of the self-pay bill and the patient's financial situation adversely changes at a later date, the patient may apply for re-consideration of the remaining balance of the patient's bill.

Article 3 Program Eligibility

Section 3.1

Patients are evaluated for eligibility for the FA at the earliest possible opportunity. ARMC may not deny FA under its FA policy based on an applicant's failure to
provide information or documentation unless that information or documentation is described in the FA application.

Section 3.2
Evaluation of a patient's eligibility for FA includes the following steps: 3.2.1
Patients receive financial counseling, referral and assistance to identify potential public or private health coverage programs to assist with long term needs.

- The patient must cooperate with Anderson Regional Medical Center or its agents in finding any available coverage, either through governmental agencies, or private insurance coverage.

3.2.2
Presumptive Financial Assistance Eligibility Requirements –

Eligibility is determined using a number of factors. Patients are evaluated to determine if they qualify under presumptive eligibility. ARHS understands that certain patients may be unable to complete a Financial Assistance Application. As a result, the patient's eligibility for financial assistance will be established using externally available third-party data sources. The criteria from this source would include using the Federal
Poverty Guidelines and/or Income Scoring. An affordability calculation is used to determine eligibility. In addition, Presumptive Financial Assistance will be granted to the following.

- Illegal aliens whose identity cannot be established.
- Decedents with no estate or known family. Criteria for this include must obtain letter from family stating no probate established at Chancery Clerk. All probates in Chancery Court will be validated by the Patient Account Manager.
- Transient, homeless persons.
- Persons whose identity cannot be established – The Patient Account Manager or Revenue Cycle Director must approve these accounts for Charity Care.
- If a patient was previously determined to be financial assistance eligible within the past 6 months, presumptive eligibility exists.
- Patient who have declared Bankruptcy.
- Patient with exhausted Medicaid Benefits.

**Section 3.3**

Patients who meet presumptive eligibility may be required to complete basic financial information and attest to its validity.

**Section 3.4**

Any patient who meets presumptive eligibility criteria is eligible for financial assistance.
Section 3.5

Patients who do not meet presumptive eligibility criteria are evaluated to determine if they meet FA eligibility criteria by completing a Financial Assistance Application.

- Number of dependents (based on IRS guidelines) residing in a household and their combined gross annual Household Income, plus other factors.
- Financially Indigent: Determining Financial Indigence is based upon an affordability calculation that considers the interaction between household income, household size, affordability guidelines and balance of the self-pay bill.
- Affordability Guidelines - Affordability Guidelines are developed from the Federal Poverty Guidelines and/or Income Scoring.

Article 4   Financial Assistance Program Award Structure

Section 4.1

ARMC provides financial assistance to eligible patients in any of the following manners:

- For a particular course of treatment and/or episode of care.
- Patients may be eligible for FA up to 6 months after the initial eligibility determination based on a discussion with financial counselors.
Section 4.2

ARMC uses the Look Back method to calculate amounts generally billed (AGB) to individuals insured for emergency and other medically necessary care. For details relating to the AGB calculation and current applicable percentage, see Appendix C. Following a determination of FA eligibility, the FA eligible individual will not be charged more than AGB for emergency and other medically necessary care.

Section 4.3
Basis for calculating amounts charged for FA

4.3.1 Eligible uninsured patients receive a financial assistance discount (subject to the co-pay described in section 4.4) on all eligible services and medical supplies.

4.3.2 Eligible insured patients receive financial assistance discount (subject to the co-pay described in section 4.4) for the portion of the bill that is not covered by insurance.

4.3.3 Eligible insured patients may be asked to provide documentation (e.g. Explanation of Benefits or EOB) to determine the portion of the bill not covered by insurance.

4.3.4 Eligible insured patients are required to provide ARMC with the payments received from their insurer.

4.3.5 Eligible uninsured patients will receive Financial Assistance equal to the AGB percentage.

4.3.6 Insured patients may receive Financial Assistance equal to the AGB percentage.

4.3.7 Some patients may qualify for additional Financial Assistance.
Section 4.4

All eligible patients will be responsible for a co-pay as detailed below. The co-pay will be the lesser of the amounts specified below or an amount which shall not exceed the amounts generally billed to insured individuals who receive the equivalent care. The co-pay will not be collected in advance for any patient receiving emergency medical services.

- Patients will not be denied service for emergency and other medically necessary care because of an outstanding balance with ARMC.
- EMTALA regulations (Emergency Medical Treatment and Active Labor Act), require that a medical screening exam be performed to determine if a patient is experiencing an emergent condition or a woman is in active labor, prior to any financial arrangements being requested. After a medical screening to determine if an emergency medical condition exists, and there is no emergent condition, payment may be requested prior to continuing with treatment.
- Where no emergent condition exists, all uninsured Emergency Department all eligible patients are required to pay a co-pay of $150 for every Emergency Department visit. This co-pay amount is not eligible for financial assistance and only applies to the "Facility" charges
- All eligible Inpatients are required to pay a co-pay of $200 per day, up to a maximum of $800. This co-pay amount is not eligible for financial assistance and only applies to the "Facility" charges
- All eligible Medical Center Outpatients are required to pay a co-pay of $150 per visit. This co-pay amount is not eligible for financial assistance and only applies to the "Facility" charges.
• All eligible Medical Center Observation patients are required to pay a co-pay of $200 per day. This co-pay amount is not eligible for financial assistance and only applies to the "Facility" charges.

Section 4.5

In the event the individual overpaid for an episode of care the organization will either refund the excess payment or apply it to an outstanding balance for services provided by the ARMC.

All credits resulting from payments made by patients, that do not qualify for a refund, will be applied to another open account as the first option to reduce unpaid balances, particularly those that are aged and or in bad debt.

Article 5 Action in the Event of Non-payment

Section 5.1

The organization's Financial Assistance Counselor had the final authority for making determinations of eligibility. ARMC does not conduct, or permit collection agencies to conduct on their behalf, collection actions against individuals before 120 days following the initial billing. After the initial billing ARMC will make reasonable efforts to notify the patient of the financial assistance offered. The following collection efforts will be pursued in compelling circumstances after the 120 notification period and after approval from ARMC personnel who can be reached at 601-553-6850

5.1.1 Permitted collection actions include, but are not limited to:

• Wage garnishment
• Legal action
• Credit reporting
5.1.2
ARMC will notify patients at least 30 days prior to engaging in any of the above collection actions.

Section 5.2
Before engaging in any collection action(s) or reporting to a credit or collection agency, patients/guarantors are informed of the financial assistance program.

Section 5.3
ARMC or outside collection agencies cancel and return on a retrospective basis, any accounts that qualify for charity care according to the eligibility criteria outlined in the financial assistance program.

Section 5.4
Before taking legal action for non-payment of medical bills, financial counseling is offered to determine whether the patient/guarantor is eligible for applicable public assistance programs or the financial assistance program.

Section 5.5
When reasonable collection efforts have occurred and the patient/guarantor debt is deemed uncollectible within a minimum of 120 days after the initial billing statement, qualified receivables will be placed with a collection agency.

Section 5.6
ARMC may contract with outside collection services to pursue collection of delinquent accounts. All unpaid accounts without prior exception or payment arrangements are placed in outside collection after a minimum of 120 days from the initial billing statement and the delivery of all scheduled patient account statements to the patient/guarantor has occurred. The collection agency may not report to the credit bureau until 120 days after the initial billing statement.
Article 6 Measures to Publicize the Financial Assistance Program

Section 5.7
Collection agencies may report adverse information to a consumer credit reporting agency or commence civil action against the patient/guarantor for nonpayment only after completing appropriate collections per contract and laws. ARMC reserves the right to request deletions of accounts reported to a credit bureau only due to errors.

Section 6.1
- Information about the financial assistance program and the availability of financial counseling is communicated broadly. Financial assistance program communications include, but are not limited to the following:
- Counseling for financial assistance from ARMC is available to all patients.

Section 6.2
Information about the financial assistance program including copies of the financial assistance policy, how to apply for financial assistance (e.g. application form) and program brochures are available to the general public without charge. This information is available in any of the following ways:

- Electronic copies can be accessed on the ARMC website at: www.andersonregional.org
- Paper copies are available free of charge by mail at: Patient Financial Services, 2124 14th Street, Meridian, MS 39301

- Paper copies are available free of charge upon request from the Patient Financial Services office at 2124 14th Street, Meridian, MS 39301.
• Paper copies are also made available free of charge in the admissions office and in the emergency department on billing statements/invoices. From ARMC personnel upon request.

Section 6.3
ARMC informs local public agencies and community organizations that address the health needs of the community's low-income population