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Effective	10/2021	Author	T'Kila Moore
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Financial Assistance Program (FAP)

AFFECTED CAMPUSES

- Anderson Regional Medical Center
- Anderson Regional Medical Center – South Campus
- Anderson Family Medical Center – Enterprise
- Anderson Family Medical Center – Airpark
- Anderson Children's Medical Clinic
- Anderson Physician Alliance

AFFECTED DEPARTMENTS

System Wide

PURPOSE

A. Anderson Region Health System (ARHS) dba Anderson Regional Medical Center (ARMC) and/ or Anderson Regional Medical Center - South 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 ARHS'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 set the requirements for the ARHS Financial Assistance (FA) Program.

B. 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.

C. Definitions

1. Refer to Appendix A - Glossary of Policy

POLICY

A. Provisions

1. ARHS 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.

B. Eligible Services Under Financial Assistance

1. 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:
    a. Medical Center Inpatient - "Facility" inpatient services performed at ARMC and ARMC South.
    b. Medical Center Outpatient - "Facility" outpatient services performed at ARMC and ARMC South
    c. Rural Health Clinics - Airpark, Enterprise, and Children's Clinic
    d. Refer to Appendix B for a full list of providers who adhere to this policy.
    e. All EMTALA regulations will be followed.

C. Ineligible Services under Financial Assistance

1. Outlying affiliated Clinics - Refer to provider list in Appendix D for affiliated providers who do not adhere to this policy.
2. Any elective services considered cosmetic in nature.
3. Non-covered treatment or procedures.
4. Retail Pharmacy.

D. How to Apply for Financial Assistance

1. Financial Assistance Applications are available at the Patient Financial Services Department located at 1020 20th Avenue Meridian, MS or at the Hospital Website www.andersonregional.org.
2. For assistance with the Financial Assistance Application, please contact our Patient Financial Services at 601-553-6850,

E. The Financial Assistance Process

1. Patients who wish to apply for Financial Assistance must submit a FA Application within 240 days after the day that the first post-discharging billing statement for the episode of care was provided.
2. Completed application, including all required information and documentation, should be submitted to ARHS for eligibility determination.
3. Completed application can be:

a. Submitted by mail to Patient Financial Services, 2124 14th Street, Meridian, MS 39301, or delivered in person to 1020 20th Avenue, Meridian, MS 39301.

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

c. Incomplete applications will not be 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.

d. Any uninsured account greater than twelve (12) months from Final Bill Date will not be considered within this policy. Any insured account greater than twelve (12) months from Balance after Insurance pays will not be considered within this policy.

F. Financial Assistance Policy Rights

1. ARHS has the right to, and may, revoke, rescind or amend awards at our discretion when:

a. A case of fraud, misrepresentation, theft, changes in a patient's financial situation or other circumstance that undermine the integrity of the FA program.

b. If health coverage information or other payment sources are identified after a patient is awarded FA, retroactive billing adjustments may occur.

G. Financial Assistance Reconsideration Rights

1. 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.

2. 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 reconsideration of the remaining balance of the patient's bill.

H. Financial Assistance Eligibility

1. ARHS uses the Look Back Method to calculate **Amount Generally Billed** (AGB) adjustment. Refer to Appendix A for explanation of AGB. For details relating to the AGB calculation and current applicable percentage, refer to 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.

2. An AGB adjustment from total charges will be given to patients who do not have insurance. Patients of Anderson Physician Alliance Clinics are ineligible for this adjustment.

3. An AGB adjustment may be provided in the following situations:
    a. Eligible uninsured patients receive a self pay discount (Financial Assistance Discount - AGB) on all eligible services and medical supplies.
    b. Eligible insured patients receive financial assistance discount (AGB) for the portion of the bill that is not covered by Insurance.
    c. Eligible insured patients may be asked to provide documentation (e.g. Explanation of Benefits) to determine the portion of bill not covered by Insurance.
    d. Eligible insured patients are required to provide ARHS with payments received from their Insurer.
    e. Eligible insured patients may receive Financial Assistance equal to the AGB percentage.
    f. Some patients may qualify for additional Financial Assistance.
    g. There may be other factors where the insured patients did not qualify for a payment or discount from their Insurance Company. The account will be reviewed as to why the claim was denied and then assigned the appropriate discount adjustment as referred in the Discount Consideration Listing. Refer to Appendix E for details of discount approvals.

I. Presumptive Financial Assistance Eligibility Requirements
    1. 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.
    2. In addition Presumptive Financial Assistance will be granted to the following:
        a. Illegal aliens whose identity cannot be established.
        b. Decedents with no estate or known family. External Third Party Sources are used to check with the Chancery Court Office to verify possible estates to be probated.
        c. Transient, homeless person.
        d. Person whose identity cannot be established.
        e. If a patient was previously determined to be financial assistance eligible within the past 6 months, presumptive eligibility exists.
        f. Person who have declared Bankruptcy. Bankruptcy discharges are searched and noted when found.
        g. Person with exhausted Medical Benefits. Patient who are eligible for Medicaid or other indigent care programs where the charges deemed necessary for diagnosis and treatment of illness or injury have been denied due to non-covered services or length of stay limitations, will be

eligible for financial assistance.

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

J. Financial Assistance Application Eligibility Determination

1. Patients who do not meet presumptive eligibility criteria are evaluated to determine if they meet FA eligibility criteria by completing a Financial Assistance Application.
2. Criteria include:
    a. Number of dependents (based on IRS guidelines) residing in a household and their combined gross annual Household Income, plus other factors.
    b. Financially Indigent - Determining Financial Indigency is based upon an affordability calculation that considers the household income, household size, and other financial information which includes employment and/or social security income verification, bank statements and previous year federal tax return.
    c. Affordability Guideline - Affordability Guidelines are developed from the Federal Poverty Guidelines and/or Income Scoring.

K. Financial Assistance Program Award Structure

1. ARHS provides financial assistance to eligible patients in any of the following manners:
    a. For a particular course of treatment and/or episode of care.
    b. Patients may be eligible for FA up to 6 months after the initial eligibility determination.
    c. All eligible patients will be responsible for a co-pay as detailed below.
        i. Emergency Services - $150.00 per visit.
        ii. Medical Center Outpatient Services - $150.00 per visit.
        iii. Medical Center Observation Services - $200.00 per day up to a maximum of $800.00.
        iv. Medical Center Inpatient Services - $200.00 per day up to a maximum of $800.00.
        v. Rural Health Clinics - $20.00 per visit.

L. Over Payments

1. 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 ARHS.
2. 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.

M. Collection Flow Process

1. The affected campuses and Clinics, through a third-party extended Business Office, communicate with statements, text and makes phone calls requesting patients pay their balance.

N. Action in the Event of Non-payment

1. Administration has the final authority for making determination of eligibility. ARHS 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 ARHS will make efforts to notify the patient for the financial assistance offered. The following collection efforts will be pursued, in compelling circumstance, after the 120 notification period and after approval from ARHS personnel who can be reached at 601-553-6850.
2. Permitted collection actions include, but are not limited to:
    a. Wage garnishment.
    b. Legal action.
    c. Credit Reporting.
    d. ARHS will notify patients at least 30 days prior to engaging in any of the above collection actions.
    e. Before engaging in any collection action(s) or reporting to a credit or collection agency, patient/guarantor is informed of the financial assistance program.
    f. ARHS 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 have occurred. The collection agency may not report to the credit bureaus until 120 days after the initial billing statement.
    g. Agency or commence civil action against the patient/guarantor for nonpayment only after completing appropriate collections per contract and laws. ARHS reserves the right to request deletions of accounts reported to a credit bureau only due to errors.

O. Measures to Publicize the Financial Assistance Program

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:
    a. Counseling for financial assistance from ARHS is available to all patients.
    b. Information about the financial assistance program including copies of financial assistance policy, how to apply for financial assistance and program brochures are available to the general public without charge. This information is available in any of the following ways.
        i. Electronic copies can be accessed on the ARHS website at

www.andersonregional.org.

ii. Paper copies are available, free of charge, by mail, at: Patient Financial Services, 2124 14th Street, Meridian, MS 39301

iii. Paper copies are available for pick up at, Patient Financial Services, 1020 20th Avenue, Meridian, MS 39301

iv. ARHS informs local public agencies and community organizations that ARMC addresses the health needs of the community's low-income population.

P. Retention of Charity Care Application

1. The Patient Financial Services Department maintains approved and denied applications in the patients file in the document imaging system.

Q. Approval/Denial of Financial Assistance

1. After approving financial assistance eligibility, the application and worksheet will be forwarded to the Patient Account Manager, Director of Revenue Cycle and CFO for final approval.
2. Signature approval required:
    a. Billing and Collections Manager - up to $1,500.00.
    b. Director of Revenue Cycle - up to $5,000.00.
    c. Chief Financial Officer - over $5,000.00.
3. Once a final determination has been made, the discount will be posted to the patients account, utilizing the Financial Assistance Adjustment code. Also, an appropriate letter will be sent indicating the decision.

Please Note:

The guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in this document.

Attachments

Appendix A.pdf

Appendix B.pdf

Appendix C.pdf

Appendix D.pdf

Appendix E.pdf

Approval Signatures

Step Description	Approver	Date
	Steven Brown: CFO	09/2022
	Kevin Adams: Director Revenue Cycle	09/2022
	Jessica Boomer: Billing and Collections Manager	09/2022
	Barbara Blackwell: Revenue Cycle Accounting Manager	09/2022
Policy Oversite Team	Katrina Kelly: Accreditation	09/2022