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Regional Medical Center

Financial Assistance Policy

PURPOSE

Consistent with its mission to provide high quality compassionate care to our community, Regional Medical Center (RMC) recognizes there will be instances where emergency or medically necessary treatment is provided to individuals that do not have healthcare insurance, government coverage or the ability to pay for the cost of the care received. Charity is available to residents of Orangeburg and Calhoun counties for eligible services. This policy does not apply to RMC Physician Practices or Edisto Regional Health (ERHS) Physician Practices or private/independent physician practices that are not employed by RMC.

POLICY

Regional Medical Center is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Regional Medical Center strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. Regional Medical Center will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Regional Medical Center's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

The determination of a patient's financial responsibility will be made according to the patient's ability to pay as determined by the eligibility criteria established within the procedural guidelines of this policy. These guidelines include Federal Poverty Guidelines established and updated annually by the Department of Health and Human Services, and/or completion of the RMC income based financial assistance application. This policy covers emergency or medically necessary treatment provided by the Regional Medical Center for Orangeburg and Calhoun County residents. This policy does not apply to RMC owned or affiliated physician practices.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash

inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis
- Excludes capital gains or losses
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of- pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Amounts Generally Billed (AGB): Amounts no greater than the amounts generally billed to (received by the hospital) for commercially insured or Medicare patients.

Early Out Agency: An agency that partners with the hospital and works in the name of the hospital to ensure outstanding bills are collected before formal collection activity is pursued.

PROCEDURES

Services Eligible Under This Policy:

For the purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by RMC without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting.
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health

status of an individual

3. Non-elective services provided in response to life-threatening circumstances in a nonemergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis at Regional Medical Center's discretion.

Charity care is available to all patients meeting income and eligibility guidelines. Charity care is always secondary to all other financial resources available to pay for the patient's care and treatment at the hospital. If a patient is eligible for coverage through third party insurance, Medicaid, Crime Victims, Health Insurance Marketplace, or other available source of payment for services, and does not cooperate, comply, or follow-through with the application for the available coverage; the patient will not be eligible to receive a charity care adjustment.

The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Following a determination of Financial Assistance Program eligibility, a Financial Assistance eligible individual will not be charged for emergency or other medically necessary care more than the Amounts Generally Billed to individuals who have commercial insurance or Medicare coverage. This will be calculated annually utilizing the Look-Back Method.

■ AGB = Payments divided by Gross charges for Accounts Paid in Full.

PROCESS FOR ELIGIBILITY DETERMINATION

The screening is established by completing the Financial Assistance Form. The form is furnished to patients when charity care is requested, or when the initial Patient Profile financial screening indicates a possible eligibility for Charity Care. All completed application should be accompanied by documentation to verify income. Required information includes a proof of income and most recent copy of 1040 form, showing year to date total income for you and your spouse (if married). Also proof of residency is required (Driver's License, Mortgage/rent or utility bill or similar document).

FINAL DETERMINATION

Upon approval, eligible accounts will be adjusted by the indicated percentage found in the Charity Poverty Guideline Matrix. Charity write offs are approved at the following levels:

• Financial Counselor (Eligibility Vendor)	<=	$10,000
• PFS Director	$10,000	$50,000
• Revenue Cycle AVP	$50,000	$100,000
• CFO	>	$100,000

The hospital will notify the applicant of its final determination of charity eligibility within 30 days of receipt of all application and documentation materials. If the information provided by the patient is incomplete the patient will be notified and given 30 days to submit the missing information. The Charity Application will be considered invalid if not completed within 60 days of initiation.

When a patient's application for charity care is denied, the patient will receive a written notice of denial which

includes the reason for the denial and instructions for appeal or reconsideration. All appeals will be reviewed by the Revenue Cycle AVP and CFO. The Compliance Committee will evaluate whether the facility has made reasonable efforts to determine Financial Assistance Eligibility on an annual basis.

Any exceptions to this policy must be submitted with documentation to the CFO for consideration and approval.

ELIGIBILITY CRITERIA AND AMOUNTS CHARGED TO PATIENTS

Services eligible under this policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination.

Federal Poverty Level - Information from a Financial Assistance Application will be used to determine eligibility for charity care. Household size and income level will be used to determine amount of charity care based on the Federal Poverty Level. (See Exhibit B).

The full amount of charges will be determined to be charity care for a patient whose gross family income is at or below 200% of the current federal poverty level.

Patients whose family income is between 200% and 280% of Federal Poverty Level are eligible to receive services at amounts no greater than the amount general billed to (received by the hospital for) commercially insured or Medicare Patients based on a sliding scale. (See Exhibit B)

Patients whose family income exceeds 280% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Regional Medical Center; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital for) commercially insured or Medicare patients.

Presumptive Financial Assistance Eligibility - There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, Regional Medical Center could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless
- Free Clinic Referral
- Eligibility for other state or local assistance programs that are unfunded (Medicaid spend down)
- Patient is deceased with no known estate as identified by the patient's attorney or executor.

Accounts with a date of service one-year prior to the date the application is approved will receive charity adjustments subject to the visit meeting the emergent/medically necessary guidelines. Applications must be updated every 6 months. Patients are required to notify RMC during the charity care eligibility period if their financial situation changes such that their income status improves, and/or they become eligible for employer provided insurance coverage, Medicaid, or other source of third-party payment.

COMMUNICATION OF THE CHARITY PROGRAM TO PATIENTS AND WITHIN THE COMMUNITY

A notice advising patients that the hospital provides charity care is posted in key areas of the hospital, including Admitting and Registration Departments, and the Emergency Department

Regional Medical Center also shall publish and widely publicize a summary of this charity care policy. Information shall also be included on facility websites, in brochures available in-patient access sites and at other places within the community served by the hospital as Regional Medical Center may elect, and in the Conditions of Admission form.

Patient statements also have a notation stating that if a patient is unable to pay their bill due to a financial hardship, to contact the hospital to discuss financial assistance programs. If for some reason the patient is not notified of the existence of charity care before receiving treatment, he/she is notified as soon as possible thereafter.

Both the written information and the verbal explanation are available in any language spoken by more than five percent of the population in the hospital's service area, and interpreter for other non-English speaking or limited-English speaking patients and for other patients who cannot understand the writing and/or explanation.

Referral of patients for charity may be made by any member of the Regional Medical Center staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, Chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws. Registration staff will direct inquiries about Medicaid or our Charity Care program to the hospital's Financial Counselors.

A summary of the Financial Assistance Policy will be given to every uninsured patient upon admission or at discharge.

Written information about the RMC Charity Care Policy is available to any person, who requests the information, either by mail, by telephone, or in person.

RELATIONSHIP TO COLLECTION POLICIES

Regional Medical Center outsources the collection of self-pay balances. A copy of RMC's Early Out Collections Policy is available upon request. Accounts are worked for 120 days from date of first statement as early out accounts. Patients will continue to receive notification of the availability of financial assistance during this period. Patients will have 240 days from date of first statement to submit application for financial assistance. Once a financial assistance application is received the agency is notified and all collection activity will be put on hold until a determination is made. If a patient does

not provide insurance information, attorney information, setup a formal payment arrangement, or apply for financial assistance, the account will be placed into Bad Debt after the notification period (120 days) has ended. Any account receiving a payment within 65 days of the monthly bad debt placement will not be placed in Bad Debt. A copy of RMC's policy "Transferring Accounts to Bad Debt" will be provided upon request.

Extraordinary collections action will not be imposed by The Early Out Agency or RMC during the first year of collection attempts. Examples of extraordinary collections include wage garnishments; or liens on primary residence, or other legal actions, and will cease all collection efforts for any patient without first making

reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

- Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital;
- Documentation that Regional Medical Center has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements;
- Documentation that the patient does not qualify for financial assistance on a presumptive basis;
- Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

RMC Departments Applicable to Financial Assistance Guidelines

Exhibit A

Regional Medical Center of Orangeburg and Calhoun Counties

Bamberg-Barnwell Emergency Medical Center

Financial Assistance Guidelines

Exhibit B

Federal Poverty Guidelines are published annually in January.

	Gross Annual Income Less Than 200% Federal Poverty Level	**Gross Annual Income Between 200-250% of Federal Poverty Level**	**Gross Annual Income Between 250-280% Federal Poverty Level**
Family Size	**Patient responsible for 0% of Charges (100% Charity Write off for eligible services)**	**Patient responsible for 16% of Charges (84% Charity Write-off for eligible services)**	**Patient Responsible for 26% of Charge (74% Charity Write-off for eligible services**
1	$25,520	$31,900	$35,728
2	$34,480	$43,100	$48,272
3	$43,440	$54,300	$60,816

4	$52,400	$65,500	$73,360
5	$61,360	$76,700	$85,904
6	$70,320	$87,900	$98,448
7	$79,280	$99,100	$110,992
8	$88,240	$110,300	$123,536
Each Additional Family Member, Add this amount	$8,960	$11,200	$12,544