Hurley Medical Center
Standard Practice

FINANCIAL ASSISTANCE & DISCOUNT POLICY

Purpose: The mission of Hurley Medical Center is *Clinical Excellence - Service to People.* As we strive to treat every patient with dignity, respect, and compassion, we serve all patients who have an established need to receive medical services, including those with difficult financial circumstances, and offer financial assistance to those who meet criteria for assistance.

Policy: In recognizing the medical needs of the indigent, Hurley Medical Center (HMC) provides necessary quality medical care regardless of race, creed, color, sex, national origin, sexual orientation, physical abilities, age or ability to pay. Patients requiring medical care will not be denied services based solely on lack of financial means as HMC remains committed to providing treatment to all patients based upon clinical judgment without regard to the financial status of the patient

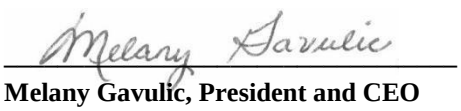
Although reimbursement for services rendered is critical to the operation and financial stability of HMC, it is recognized that not all individuals possess the financial ability to purchase essential medical services. Therefore, in keeping with the commitment to serve all members of its community, a reduced fee agreement will be considered in situations where the need and inability to pay co-exist. The healthcare services provided will be reimbursed at a reduced level based on established income criteria as defined in this policy.

Procedure:

1) Definition of Terms:

- **a. Financial Assistance Discount Program (FADP**): The provision of health care services at a reduced expected payment level for individuals who meet certain financial criteria.
- **b. Federal Poverty Guidelines**: Issued by the U.S. federal government which establishes the Federal Poverty Level (FPL) on an annual basis.
- **c. Self-pay Plan**: Payment arrangement requiring regular periodic payments of a predetermined amount.
- **d. DHS Application:** Application used by the State of Michigan to determine eligibility for Medical Assistance (Medicaid).

Approver: Board of Managers
Reviewer: Legal Services
Owner: Revenue Cycle



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e. **Crime Victim Program**: Assistance for victims of crime.
f. **Uninsured**: Patients / guarantors who lack any form of insurance coverage.
g. **Underinsured**: Patients / guarantors who have some level of insurance coverage but may have out of pocket expenses (deductibles, co-insurance, exhausted or lack of benefits, exceeded LOS or non-contracted insurance plan) that they are personally responsible for.
h. **Exceptions to Policy**: Patients / guarantors who otherwise would not qualify for FADP and have been given case-by-case consideration by the medical center's CFO.
i. **Non-covered**: Services that are not payable by a patient's or guarantor's insurance coverage.
j. **Length of Stay (LOS)**: The number of nights a patient spends occupying a bed at midnight.
k. **Custodial Care**: Non-medical care that can be reasonably and safely provided by non-licensed caregivers or self-administered by the patient.
l. **Advance Beneficiary Notice (ABN)**: A notice given to a patient based on Medicare coverage rules when it is reasonable to believe that Medicare will not cover the service.

2) Eligibility Criteria

a. Total family income is compared to current federal poverty guidelines. (See Exhibit 1 - Federal Poverty Guidelines) If the patient's income falls below 400% of the guidelines, the patient is eligible for some level of discount. The sliding fee scale used to calculate the amount of discount is listed below on Tables 1 & 2 for *Uninsured* persons for *Facility* and *Professional / Clinical* based services, and Table 3 for *Underinsured Facility only* services.

b. Exhibit A will be updated annually by the Patient Financial Services Supervisor using the annual revision of the Federal Poverty Guidelines as published each January in the Federal Register by the Department of Health and Human Services.

c. UNINSURED Persons eligible for assistance will be responsible for a portion of billed charges for facility and / or professional services in accordance with the Federal Poverty Guidelines Sliding Fee Scales in Table 1 and / or Table 2 below.

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d. Patients with charges determined to be non-covered due to exhausted benefits, exceeding length of stay, custodial care or the payer not having a contractual relationship with HMC will be eligible for consideration under this policy's provisions.

e. **UNDERINSURED** Persons eligible for assistance will be responsible for a percentage of their balance for facility services only after insurance payments have been applied in accordance with the Federal Poverty Guidelines Sliding Fee Scales in Table 3 below.

TABLE 1

UNINSURED DISCOUNTS – FACILITY

of Federal Poverty Level (FPL) Minimum	**% of Federal Poverty Level (FPL) Maximum**	**Discount %**	**Patient Pays**
0%	150%	85%	**15%** Of the total balance owed.
151%	250%	70%	**30%** Of the total balance owed
251%	400%	40%	**60%** Of the total balance owed
>401%			**Full Charges**

TABLE 2

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UNINSURED DISCOUNTS - PROFESSIONAL

% of Federal Poverty Level (FPL) Minimum	% of Federal Poverty Level (FPL) Maximum	Discount %	Patient Pays
0%	150%	60%	**40%** Of the total balance owed.
151%	250%	40%	**60%** Of the total balance owed
251%	400%	20%	**80%** Of the total balance owed
>401%			**Full Charges**

TABLE 3

UNDERINSURED DISCOUNTS – FACILITY (ONLY)

% of Federal Poverty Level (FPL) Minimum	% of Federal Poverty Level (FPL) Maximum	Discount %	Patient Pays
0%	150%	60%	**40%** Of the total balance owed.
151%	250%	40%	**60%** Of the total balance owed
251%	400%	20%	**80%** Of the total balance owed
>401%			**Full Charges**

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3) Determining Eligibility

a. As stated in Section 2a (Eligibility Criteria), total estimated family income is first established by HMC through an electronic soft inquiry of National Credit Bureau databases. Once estimated income is established eligible discounts are determined by comparing income to published Federal Poverty Guidelines (see Exhibit A below). Note: HMC uses income levels solely for the purpose of establishing financial assistance and not for purposes of collection activities.

b. Individuals who do not have a Social Security Number (SSN) due to non-United States Citizenship or who are United States Citizens but have an approved 4029 Form (Application for Exemption From Social Security and Medicare Taxes and Waiver of Benefits) on file with the Internal Revenue Service will be eligible based on geographical data by running "soft inquiries" of National Credit Bureau databases.

c. If the discounted amount due from an uninsured or underinsured patient still represents a financial hardship, or if a patient is denied a financial assistance discount under the provisions of this policy, they may request a review of that determination and apply for other additional financial assistance by submitting proof of prior year income and family household size with an application submitted to the Patient Financial Services department.

d. The Vice President of Finance and CFO of Hurley Medical Center has the authority to grant financial assistance on a case-by-case basis to individuals who otherwise would not qualify for financial assistance under this policy.

4) Urgent Care Visits

a. **UNINSURED** patients that receive services at a Hurley Urgent Care center will be offered the option to pay a flat, all-inclusive rate at the time services are rendered and forego further consideration for financial assistance under this policy on a case-by-case basis.

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b. The in-person urgent care flat rate offered to uninsured patients at HMC urgent care centers will be $50.00 and must be collected at the time of service to be considered all-inclusive.

c. The virtual (telehealth) urgent care flat rate offered to uninsured patients at HMC urgent care centers will be $25.00 and must be collected at the time of service to be considered all-inclusive.

5) Reporting

a. All supporting documentation will be scanned and kept on file for one year in the Patient Financial Services Department.

b. All applications will be logged by Patient Financial Services.

c. A monthly report of financial assistance discounts will be generated, reviewed by the Patient Financial Services Supervisor to determine and validate financial discount impacts, and forwarded to the Director of Patient Financial Services for final review.

d. A quarterly report of financial discounts processed will be provided to the Chief Financial Officer. A review of this report will ensure that any deductible or coinsurance amount that is claimed as Medicare bad debt is excluded from the reporting of financial assistance or charity care.

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EXHIBIT A

2024 Poverty Guidelines

Per Year

Household/ Family Size	100%	125%	130%	133%	135%	138%	200%	250%	300%	400%
1	$15,060	$18,825	$19,578	$20,030	$20,331	$20,783	$30,120	$37,650	$45,180	$60,240
2	$20,440	$25,550	$26,572	$27,185	$27,594	$28,207	$40,880	$51,100	$61,320	$81,760
3	$25,820	$32,275	$33,566	$34,341	$34,857	$35,632	$51,640	$64,550	$77,460	$103,280
4	$31,200	$39,000	$40,560	$41,496	$42,120	$43,056	$62,400	$78,000	$93,600	$124,800
5	$36,580	$45,725	$47,554	$48,651	$49,383	$50,480	$73,160	$91,450	$109,740	$146,320
6	$41,960	$52,450	$54,548	$55,807	$56,646	$57,905	$83,920	$104,900	$125,880	$167,840
7	$47,340	$59,175	$61,542	$62,962	$63,909	$65,329	$94,680	$118,350	$142,020	$189,360
8	$52,720	$65,900	$68,536	$70,118	$71,172	$72,754	$105,440	$131,800	$158,160	$210,880

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

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