HRMC
Huron Regional Medical Center

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Patient Payment, Discounting & Financial Assistance

STATEMENT OF PURPOSE:

To establish guidelines for financial assistance and patient payments including upfront collections at the time of service.

TEXT:

1. HRMC will not discriminate in providing medically necessary services to those in need regardless of their ability to pay.
2. HRMC Business Office staff will use best efforts to assess payment options for uninsured patients and underinsured patients (patients who have some insurance coverage, but who may be unable to pay remaining self-pay amounts), including but not limited to the following:
    - State Medicaid programs
    - Other public programs
    - HRMC Financial Assistance Program
3. At the time of registration or prior to discharge, all patients will be given a Summarized Billing, Payment and Financial Assistance Policy, which includes notice of availability and application information for financial assistance. This policy can be accessed on HRMC's website at www.huronregional.org.
4. Prior to the date of service, or if applicable during scheduling, HRMC will use best efforts to identify and communicate the patient deductible and co-insurance owed. At the time of scheduling and/or registration insured patients will be asked to pay 50% of their deductible and co-insurance. Self-pay patients are expected to pay a minimum of $350.00 or the lesser of the charge. Payment arrangements for the remaining balance will be made per policy (see 9B).
5. HRMC Physicians Clinic is a department of the hospital therefore, office visit co-pays may not

apply and charges may be subject to the patient's outpatient deductible and co- insurance. Office visit co-pays will be collected at the time of service. Self-pay patients pay a minimum of $50.00 for an office visit or $100.00 for a procedure. Payment arrangements for the remaining balance will be made per policy (see 9B).

6. HRMC will file all insurance claims once the patient has provided the necessary information. HRMC has signed preferred provider contracts and therefore considered in network with the following carriers:
    - America's PPO
    - Avera Health (Not including Avera Select)
    - Coventry Health Care/First Health
    - Dakotacare
    - First Choice of the Midwest
    - GEHA (Government Employees Hospital Association)
    - HealthPartners
    - Humana Choice Care Network
    - Integrated Health Plan, Inc.
    - Medica
    - Everence
    - Midlands Choice
    - Sanford Health (Not including Sanford Elite)
    - SelectCare
    - TLC Advantage
    - United Healthcare
    - Wellmark (Blue Cross/Blue Shield)
7. HRMC will make every effort to resolve settlement with the payor once the insurance claim has been filed on behalf of the patient. The balance is ultimately the responsibility of the patient/guarantor if not paid by insurance if:
    - HRMC is out of network with the payor.
    - Policyholder fails to provide requested information to the payor within the timely filing limits established by the payor.
8. Once payment or denial has been received from a third-party payor, statements will be sent, and reminder calls made over the next 120 days. If the account is not paid as agreed a final notice will be mailed and Extraordinary Collection Actions (ECA) will be pursued.
9. Outstanding balances to be paid based on the following options:
    A. Payment in full by cash, check, or credit/debit card within 30 days of third-party payment or denial notification. Payments can be made online at www.huronregional.org.

B. Monthly payment options based on the following schedule:

Balance Due	Minimum Monthly Payment
$0 to $499.99	$50.00
$500 to $749.99	$75.00
$750 to $999.99	$100
$1000 to $1499.99	$150
$1500 to $1999.99	$200
$2000 to $4999.99	$300
$5000.00 to $10,000.00	$400
Greater than $10,000.00	$500

A $35 return check charge will be imposed on checks returned from the bank for insufficient funds.

Accounts in which monthly payments have been established (see 9B) will be monitored for consistent and timely payments. If two monthly payments are missed or not paid per the schedule, patient will be notified, and the account may be placed with a third party collection agency. Receipt of payments below the minimum monthly payment amount described above will not discontinue collection efforts for the full outstanding balance.

C. Financial Assistance - HRMC will grant financial assistance for medically necessary services to individuals who supply a completed financial assistance application and meet the required criteria. This assistance is the last resort in satisfying a patient's account and cannot be applied in lieu of governmental assistance programs.

1. Financial Assistance is available up to 240 days from the first billing statement sent to the guarantor. Applications are available in both English and Spanish at the HRMC Business Office (605) 353-6223, or 1-800-529-0115 (in state only), ext. 223 or www.huronregional.org
2. Financial Assistance applications need to be signed, completed and returned within 30 days from the time the request is received, along with the required documentation requested in the application cover letter.
    a. If an incomplete Financial Assistance Program (FAP) application is received HRMC will suspend any ECA in process and notify patient in writing that additional information or documentation is required within 60 days to make determination.
    b. HRMC will provide the applicant with one written notice within 30 days from the application completion deadline or last day of the application period (240 days) that ECA will proceed if application is not completed or balance is not paid.
3. Required supporting documentation (as applicable)
    a. Most recent Federal Income Tax Return including all schedules

b. 60 days of pay stubs for each income listed on the application
c. 2 consecutive months bank statements
d. Social Security Income verification
e. Unemployment verification
f. Social Services denial
g. Most recent county property tax assessment.

4. Once a completed application is supplied HRMC will grant financial assistance to qualified individuals based on the following criteria.
    a. The poverty income guidelines as published by the Federal Department of Health and Human Services (HHS) will determine eligibility and extent of financial assistance adjustments.

The 2022 guidelines are: ***(updated 1/01/2022)***	Size of Family Unit	Poverty Guideline
	1	$13,590
	2	$17,310
	3	$23,030
	4	$27,750
	5	$32,470
	6	$37,190
	7	$41,910
	8	$46,630

The threshold increases for each additional family member by: $4,720.

    b. The definition of family and residency will be applied consistently as defined in local, state and federal programs and guidelines.
    c. Application for State of residence (State) and/or County of residence (County) assistance must be made, if eligibility for such assistance exists in the judgment of Business Office staff.

5. A final review and determination is made by the Vice President of Finance and financial Assistance Adjustments will be made as follows:

Income Level	Adjustment
0-125% of Poverty Guidelines	100% Discount
126-174% of Poverty Guidelines	75% Discount
175-200% of Poverty Guidelines	50% Discount

The applicant will be notified in writing by the President/CEO if financial assistance is granted. Financial assistance adjustments will be applied to the original balance after insurance payments. Patient payments made prior to the approval of financial assistance that exceed remaining balance after applicable financial assistance adjustment will be refunded or applied to any other existing unpaid accounts. Once a completed application is received and approval or denial is confirmed, a facility representative sends the patient a letter informing them of the decision. A decision will be made within 30 days of receipt of a complete application.

6. Financial assistance dollar amounts will be reported to the Finance Committee of the Board of Directors monthly.
7. Individuals qualifying for financial assistance will be charged no more than the Amounts Generally Billed (AGB) other payers. This amount is reviewed and updated periodically and implemented within 45 days of board approval.
8. Financial assistance may be denied for patients who:
    - Are "indigent by design" as defined by SDCL 28-13-27, an individual who meets any one of the following criteria:
        - Is able to work but has chosen not to work.
        - Has failed to purchase major medical health insurance made available through any employer-based health benefit plan although the person was financially able to purchase or elect the insurance or health benefit.
        - Has failed to purchase available major medical health insurance, although the individual including a student at a postsecondary institution was insurable and was financially able to purchase the insurance including coverage through the Affordable Care Act.
        - Has transferred resources for purposes of establishing eligibility for medical assistance.
    - Fail to pre-authorize care with the County after being advised they must do so
    - Have adjusted resources/assets in excess of the hospital bill amount as determined by SDCL 28-13-32.8
    - Fail to return financial assistance application or supply all required documentation within 30 days of request.
    - Have an account balance or a combined account balance of $100 or less.
10. Upon request, prompt pay discounts are available for services if there is no insurance coverage/benefit. Deductible, co-insurance and co-pay amounts do not qualify for a discount. Prompt pay discounts for payment in full of 40% if paid within 30 days, 30% if paid within 60 days or 20% if paid within 90 days.

11. If the patient qualifies for county assistance the patient will be allowed monthly payments based on the ability to pay calculation over 5 years.
12. Accounts of Medicare beneficiaries deemed indigent based on hospital policy and CMS Provider Reimbursement Manual, Part I, chapter 3 will be treated as Medicare bad debt for cost reporting purposes.
13. Third Party (Insurance Companies not already contracted with), settlement requests will be directed to the Vice President-Finance or Patient Financial Services Director and discounts given as follows:

    5% discount if payment released within 5 business days, or 3% discount if payment is released within 10 business days.
14. Managed Care Contracts requesting discounts will be reviewed by the Finance Committee and acted upon by the Board of Directors.