Financial Assistance

PATIENT ACCOUNTS

Review responsibility: Patient Accounts Manager

I. **PURPOSE:** Mille Lacs Health System ("the health system") is committed to providing excellent health care to the community. We recognize that not all persons have adequate financial resources to pay for necessary health care. Consequently, we will provide financial assistance services to patients who qualify.

II. **APPLICABLE REGULATORY STANDARDS:**

III. **DEFINITIONS:**

IV. **POLICY:**

V. **PROCEDURE:**

A. Financial Assistance Determination

1. Requests for financial assistance discounts may originate from the patient, a family member, or an associate of the family, a member of the health system medical staff, the hospital Social Service Department, members of the health system's managerial staff, nursing personnel or patient accounts personnel. All other alternate programs and services within the community intended to assist individuals in need must be aggressively researched.

   Requests for charitable services may be at the following times:

   - During pre-admission screening procedures
   - At registration for patient services
   - When and if it is determined that the patient's insurance coverage is not effective or adequate
   - An individual who has questions about financial assistance or who would like assistance with the application process can contact the health system's Patient Accounts Self-Pay Representative by calling (320) 532-2640.
   - You can also visit the Patient Accounts Office at 200 North Elm Street in Onamia.

2. Financial Assistance Applications
   An application for financial assistance will be considered if it is received within 365 days of sending the billing statement to the patient. The financial assistance discount is in effect for any open accounts with dates of service 365 days prior to and one year from the date of MLHS's determination of eligibility.

An individual will be considered for financial assistance when they submit a complete financial assistance application. MLHS may require submission of the following documents before an application is considered complete:

- A copy of the most recently filed tax return is required;
- 3 most recent pay stubs
- Social security or other benefit monthly payment vouchers

Completed financial assistance applications should be submitted to the Patient Accounts Supervisor. Acceptable methods of submission are:

- In-person delivery:
Patient Accounts Supervisor,
200 N. Elm St., Onamia

- Mail: Patient Accounts Supervisor,
200 N. Elm St., Onamia, MN 56359

- Fax: Patient Accounts Office, (320) 532-2658

The CFO and or the Patient Accounts Supervisor will review and approve all financial assistance discounts according to the health system's financial assistance guidelines.

If the health system has reason to believe that the information in the financial assistance application is unreliable or incorrect or that the information was obtained under duress or through coercive practices, the health system will consider the application incomplete. We will not consider incomplete applications, but will notify applicants by phone or mail of an incomplete application and provide you an opportunity to send in the missing documentation or information within 30 days from the date of notification. During the 30-day waiting period, for the patient to submit a completed FAP Application; MLHS will suspend any extraordinary collection activity (ECA) against the individual.

The health system will consider the application complete once the health system's concerns are resolved.

A response to a request for financial assistance discount service will be provided within 20 days of a complete application filing.

If an individual does not qualify for financial assistance, a letter will be sent indicating that they have not qualified and explaining the basis for the denial.

If an individual qualifies for financial assistance, an approval letter will be sent. The letter will indicate their approved discount, their original total balance, their discounted amount, their updated remaining balance, and the contact information an individual can use to obtain their AGB Limit.

3. Eligible Services

   Only emergency medical care and other medically necessary services offered at Mille Lacs Hospital and Clinic are eligible for financial assistance. Services offered at Lake Song Assisted Living, Mille Lacs Health System Long Term Care Room & Board are not eligible.

   All procedures offered at Mille Lacs Hospital are considered medically necessary, except for the following: massage, sports physicals, Department of Transportation physicals, home care, and respite care.

   Emergency Medical Care is defined in section 1867(e)(1) of the Social Security Act as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

   - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
   - Serious impairment to bodily functions, or
   - Serious dysfunction of any bodily organ or part;

   Or, with respect to a pregnant woman who is having contractions:

   - That there is inadequate time to effect a safe transfer to another hospital before delivery, or
   - That transfer may pose a threat to the health or safety of the woman or the unborn child."

4. Evaluation Process

   The Federal Poverty Guidelines ("FPG") published by the U.S. government l framework to determine the individual's ability to pay. The FPG are based on income and family size. See Attachment A for the currently applicable FPG. Attachment A will be updated annually when new FPG are published.

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If annual income and assets are:	Then financial assistance is:	And the patient's remaining responsibility is:
Less than 100% of FPG	100%	0%
Between 100% and 110% of FPG	90%	10%
Between 110% and 120% of FPG	80%	20%
Between 120% and 130% of FPG	70%	30%
Between 130% and 140% of FPG	60%	40%
Between 140% and 150% of FPG	50%	50%
Between 150% and 160% of FPG	44%	56%
Between 160% and 170% of FPG	44%	56%
Between 170% and 180% of FPG	44%	56%
Between 180% and 190% of FPG	44%	56%
Between 190% and 200% of FPG	44%	56%
Greater than 200% of FPG	0%	100%

Individuals must be evaluated to see if they qualify for assistance from any federal, state, or county programs, such as Medical Assistance or Medicare.

Before granting financial assistance, the health system will refer an individual to alternative programs or services within a community. The health system will make every effort to locate alternative payment sources for the patient. This allows the health system to provide the maximum level of services to the under-served within the limit resources. Exceptional circumstances will be handled on a case-by-case basis.

If a patient qualifies for partial financial assistance, their remaining liability after financial assistance will be determined by multiplying their remaining responsibility percentage (from the table above) by the individual's responsibility after any insurance payments.

See Attachment B for further information about those providers who are eligible for financial assistance under this policy. Attachment B will be updated at least quarterly to maintain accuracy.

After determining financial assistance, any remaining liability may be paid on a reasonable payment schedule over a one- or two-year period based on the individual's available resources.

Insured individuals may qualify for financial assistance, primarily because the patient deductible and non-covered services may be large enough that the individual is incapable of paying the amount.

5. Amounts Generally Billed

Amounts Generally Billed ("AGB") is the average amount billed to individuals who have insurance covering their emergency medical care and other medically necessary care.

An individual who qualifies for financial assistance will not be required to pay more for emergency medical conditions and other medically necessary care than the amounts generally billed to have insurance covering such care (the "AGB Limit"). The health system will calculate this AGB Limit for a patient using the Look-Back Method and including individuals covered by Medicare and all commercial payers. The AGB Limit will be calculated annually using the 12-month period October 1 – September 30 and will be implemented no later than January 31. See Attachment C for the AGB Limit currently in effect.

The health system may require a copayment for a non-emergency medical procedure prior to receiving the care. However, in no instance will this pre-payment be greater than the AGB Limit for that care.

6. Patients are not eligible for financial assistance discounts when:
    - The patient or family refuses available alternative care sources.
    - The patient or family refuses to provide information needed by the health system to make an income determination.
    - An application is not filed within pre-specified time frames defined in the health system's operating procedures.

7. Confidentiality of Information
   Confidentiality of information and individual dignity shall be maintained for anyone seeking a financial assistance discount.

8. Non- discrimination
   Financial assistance will be based solely on an individual's inability to pay and will not be abridged on the basis of age, sex, race, religion or national origin.

9. A summary of the patient's situation and a copy of the completed financial statement are referred to the Patient Accounts Manager. After approval, a percentage or the balance is written off to Financial Assistance. A letter then is sent to the patient stating amount being adjusted. The account is adjusted when the patient signs and returns the letter for the health system's file.

10. Documentation
    All offerings of Financial Assistance and/or any other alternative programs will be documented in the patient's account notes.

B. Communication of Financial Assistance

The health system will inform the public about the availability of financial assistance through the following methods.

1. The health system will post conspicuous public displays that inform patients about the financial assistance program. Such displays will be located in the emergency room and all admissions areas that include the following information.

    - Financial assistance is available under the health system's Financial Assistance Policy.
    - Information about how or where to obtain information about the Financial Assistance Policy and application process.
    - Information about how or where to obtain copies of this Financial Assistance Policy, a plain language summary of this Financial Assistance Policy, and the financial assistance application.

2. The health system will offer a paper copy of the plain language summary of this Financial Assistance Policy to all patients as part of the intake and/or discharge process.

3. The health system will include the following information on all billing statements. The information will be conspicuously placed and of sufficient size to be clearly readable.

    - Financial assistance is available under the health system's Financial Assistance Policy.
    - The telephone number of a health system office or department that can provide information about the Financial Assistance Policy and process.
    - The direct website address (URL) on which the Financial Assistance Policy, a plain language summary of this Financial Assistance Policy, and the financial assistance application are available.

4. The Financial Assistance Policy, a plain language summary of the Financial Assistance Policy, and the financial assistance application will be available at all times on the health system's website.

5. Paper copies of the Financial Assistance Policy, a plain language summary of the Financial Assistance Policy, and the financial assistance application will be made available upon request and without charge by mail, in the health system's emergency room, and in all admissions areas.

6. The health system will take reasonable efforts to notify and inform community members about this Financial Assistance Policy in a manner that is reasonably calculated to reach those individuals who are most likely to need financial assistance.

7. If any population with limited English proficiency comprises more than 5% of the population in the health system's community or more than 1,000 individuals, then all communication methods described in this policy will also be followed in the primary language of that population.

C. Billing and Collections

The health system has a separate Billing and Collections Policy. The Billing and Collections Policy includes the actions the health system may take in the event of nonpayment of the remaining liability owed by an individual who has qualified for financial assistance. Copies of the Billing and Collections Policy are available to the public upon request.

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Attachment A

Federal Poverty Guidelines

Federal Poverty Guidelines ("FPG") are published annually in the Federal Register by the U.S. Department of Health and Human Services. This information is available online at https://aspe.hhs.gov/poverty-guidelines.

This table is applicable for calendar year 2024.

BASED ON 2024 POVERTY LEVEL GUIDELINES											
MILLE LACS HEALTH SYSTEM****Per DHHS Guidelines 2024											
Percent to Pay Based on Family Size & Gross Monthly Income											
Monthly SLIDING FEE SCHEDULE											
FAMILY SIZE	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%
1	1,255	1,381	1,506	1,632	1,757	1,883	2,008	2,134	2,259	2,385	2,510
2	1,703	1,874	2,044	2,214	2,385	2,555	2,725	2,896	3,066	3,236	3,407
3	2,152	2,367	2,582	2,797	3,012	3,228	3,443	3,658	3,873	4,088	4,303
4	2,600	2,860	3,120	3,380	3,640	3,900	4,160	4,420	4,680	4,940	5,200
5	3,048	3,353	3,658	3,963	4,268	4,573	4,877	5,182	5,487	5,792	6,097
6	3,497	3,846	4,196	4,546	4,895	5,245	5,595	5,944	6,294	6,644	6,993
7	3,945	4,340	4,734	5,129	5,523	5,918	6,312	6,707	7,101	7,496	7,890
8	4,393	4,833	5,272	5,711	6,151	6,590	7,029	7,469	7,908	8,347	8,787
Add $448 for each add'l family unit over 8	448	493	538	582	627	672	717	762	806	851	896
Annual income above is already based on 2 times the Federal Poverty Income Guidelines											

Last updated: 01/15/2024

Updated by: Beverly Insley, Patient Account Supervisor

Approved by: Andrew Knutson, CFO

Attachment B

Medical service expenses for a patient can generally be categorized as either hospital fees or provider fees. All hospital fees for emergency medical care and other medically necessary care are eligible for financial assistance under this policy. However, not all provider fees are eligible for financial assistance under this policy.

The following information is provided to assist the public in understanding which provider fees are eligible for financial assistance under this policy. If this information is unclear, you may contact the Patient Accounts Supervisor at the health system by calling (320) 532-3154.

The health system defines a "provider" as a physician or similarly credentialed individual whom Mille Lacs Health System bills the professional fee on behalf of. Providers do not include nurses or technicians.

Last updated: 01.19.2024

Updated by: Beverly Insley, Patient Accounts Supervisor

Approved by: Andrew Knutson, CFO

Attachment C
Amounts Generally Billed Calculation

An individual who qualifies for financial assistance will not be required to pay more for emergency medical conditions and other medically necessary care than the amounts generally billed to individuals who have insurance covering such care (the "AGB Limit").

Mille Lacs Health System ("MLHS") uses the Look-back Method as defined in Reg. 1.501(r)-5(b)(3) to calculate the amount generally billed ("AGB Limit") to individuals who have insurance covering medically necessary care. An individual who is determined to be eligible for financial assistance under this policy shall not be required to pay more than the amounts generally billed to individuals who have insurance covering such care.

MLHS calculates a single AGB Limit to apply to all individuals who qualify for financial assistance. The AGB limit currently in effect is 56%, based on an average discount of 44%.

The AGB limit was calculated using the following formula:

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Total Allowed Claims and Other Payments

Gross Charges

In the AGB calculation, "Total Allowed Claims" are those claims that have been submitted by MLHS and were paid under Medicare Parts A and B and all private health insurers over the 12-month period, October 1 – September 30. MLHS uses all claims for medical care in this calculation, rather than just those allowed for emergency and other appropriate hospital-based medical services (including Clinics).

"Other payments" are co-payments, co-insurance, deductibles, and any other payments made in relation to a claim included in Total Allowed Claims.

"Gross Charges" are the total charges of the services for those claims included in Total Allowed Claims.

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Updated by: Beverly Insley, Patient Accounts Supervisor

Approved by: Andrew Knutson, CFO