



**HIGHLAND
DISTRICT HOSPITAL**

Policy/Procedure Title: HOSPITAL CARE ASSURANCE PROGRAM (HCAP) and FINANCIAL ASSISTANCE PROGRAM (FAP)	Current Effective Date: July 1, 2022	Approved by: Business Office Manager
Distribution: Financial Counseling	Origination Date: 2.14 Dates Reviewed: 5.14, 5.15, 9.15, 9.19 Dates Revised: 11.15, 1.16, 1.17, 1.19, 1.20, 6.20, 10.20, 1.21, 1.22, 7.22	
	Category:	Policy #: FC-001

SCOPE: Patient Access (Registration and Central Scheduling) and Business Office Staff

PURPOSE:

Consistent with its mission to provide high quality healthcare services for the community, Highland District Hospital is committed to providing financial assistance to uninsured and underinsured individuals who are in need of emergency or medically necessary treatment and have a household income within 200% of the Federal Poverty Guidelines (FPG).

In accordance with the federal Patient Protection and Affordable Care Act (PPACA), patients eligible for financial assistance under this policy will not be charged more than the amount generally billed (AGB) to insured patients for emergency or medically necessary care.

POLICY STATEMENT:

Financial assistance is provided only when care is deemed medically necessary and after patients have been found to meet all financial criteria. Highland District Hospital offers both free care and discounted care, depending on individuals' family size and income.

Emergency medical care will be provided by Highland District Hospital for emergency medical conditions to individuals regardless of their eligibility under Highland District Hospital's financial assistance policy.

Uninsured patients may be asked or assisted with applying for other external programs (such as Medicaid or insurance through the public marketplace) as appropriate *before* eligibility under this policy is determined.

Uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being.

Free care is provided under the provisions of section 5618.14 of the Revised Code, which states that each hospital that receives payment under the provision shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of Ohio, who is not a recipient of the Medicaid Program and whose income is at or below 100% of the Federal Poverty Guidelines, or are a current recipient of the General Assistance or the Disability Programs as defined in Chapter 5115 of the Revised Code. This free care is referred to as the Hospital Care Assurance Program (HCAP). Signs are posted regarding availability of assistance under HCAP in accordance with rules and regulations.



Uninsured and underinsured patients who do not qualify for free care under HCAP may receive a discount off gross charges for their medically necessary services based on their family income as a percent of the Federal Poverty Guidelines. These patients are expected to pay their remaining balance for care.

When determining patients' eligibility under this policy, Highland District Hospital does not discriminate based upon race, gender, age, sexual orientation, religious affiliation, social, or immigrant status.

DEFINITIONS:

The following terms are meant to be interpreted as follows within this policy:

- **Charity Care:** Medically necessary services rendered without the expectation of full payment to patients meeting the criteria established by this policy.
- **Medically Necessary:** Hospital services or care rendered both inpatient and outpatient to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
- **Emergency Care:** The care or treatment for an Emergency Medical Condition, as defined by EMTALA.
- **EMTALA:** The Emergency Medical Treatment and Active Labor Act.
- **Uninsured:** Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.
- **Insured:** Individuals who have any governmental or private health insurance.
- **Underinsured:** Insured patients whose households' income based upon family size is at or below 200% of the Federal Poverty Guidelines for purposes of this policy.
- **HCAP:** The Hospital Care Assurance Program is Ohio's state-funded, federally required program that compensates hospitals who have a disproportionate share of charity patients that are at or below the Federal Poverty Guidelines as listed by the Department of Health and Human Services.
- **FPG:** Federal Poverty Income Guidelines that are published annually by the U.S. Department of Health and Human Services in effect at the date of service for determination of financial assistance under this policy.
- **Gross Charges:** The full amount charged by Highland District Hospital for items and services before any discounts, contractual allowances, or deductions are applied.
- **Residency:** The patient must be living in Ohio voluntarily. This includes temporary residents, such as students, migrant workers, or illegal aliens, and persons that are temporarily residing with



in-state relatives. Out-of-state patients that are on vacation or any patient who has come to Ohio solely to receive medical care are not considered residents.

- **Family / Household:** Guidelines for a “family” or “household” shall include the patient, the patient’s spouse, and all of the patient’s children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the “family” shall include the patient, the patient’s natural or adoptive parent(s), and the parent(s)’ children, natural or adoptive under the age of eighteen who live in the home. In both of the above instances, children are the only family members who must reside in the home to be counted. Spouses (if still married) are always counted as family members and their income included in the eligibility determination regardless of where they live.
- **Amount Generally Billed (AGB):** The amount generally billed to insured patients for emergent or medically necessary care (determined as described in section (B) of the policy below).

PROCEDURES:

- **Eligibility:**

Highland District Hospital will not charge patients who are eligible for financial assistance more for emergency or medically necessary care than the amounts generally billed to insured patients.

Services eligible for financial assistance include: emergency or urgent care, services deemed medically necessary by Highland District Hospital, and in general, care that is non-elective and needed in order to prevent death or adverse effects to the patient’s health.

Patients who are uninsured or underinsured and have a household income at or below 100% of the Federal Poverty Guidelines (FPG) (Attachment A) may receive free care (a 100% discount) under Hospital Care Assurance Program (HCAP).

Patients with annual household incomes between 101% and 200% of the FPG will be eligible for a 51% discount off of gross charges, as illustrated by the table below.

Financial Assistance Available at Highland District Hospital

Household Income as % of FPG	Discount off of gross charges
≤ 100%	Free Care / HCAP
101% - 200%	51%

Determination for financial assistance eligibility will require patients to submit a completed financial assistance application (including all documentation required by the application) and may require appointments or discussion with the hospital’s Patient Financial Advocate.



- **Determining Discount Amount:**

Once eligibility for financial assistance has been established, Highland District Hospital will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) to insured patients for emergency or medically necessary care.

To calculate the AGB, Highland District Hospital uses the “look-back” method as that term is defined in section 4(b)(2) of the IRS and Treasury’s 501(r) final rule and may be adjusted according to those regulations.

In this method, Highland District Hospital uses data based on claims sent to Medicare and all private commercial insurers for emergency and medically necessary care over a specified previous year period to determine the percentage of gross charges that is typically allowed by these insurers.

Example

If the gross charges for an outpatient colonoscopy procedure is \$1,000, and the AGB percentage is 49%, any patient eligible for financial assistance under this policy will not be personally responsible for paying more than \$490 for an outpatient colonoscopy procedure.

Because the AGB percentage for services is 49%, and because the minimum amount of assistance available under this policy is a 51% discount off gross charges, no patient eligible for financial assistance will be required to pay an amount in excess of AGB.

For patients that have health insurance coverage and are eligible for financial assistance, those patients will not personally be financially responsible for paying in the form of deductibles, co-insurance, and co-payments, more than the AGB for the care after all reimbursements by their health insurance plan have been made.

- **Applying for Financial Assistance**

Highland District Hospital’s billing statements include a written statement that explains the availability of assistance to individuals with income at or below the FPG as eligible for services without charge under HCAP, as well as financial assistance to qualified individuals up to 200% of FPG.

To apply for HCAP or hospital financial assistance, patients must submit a complete application (including supporting documents) either in person or by mail.

Applications can be obtained:

- At any of the hospital’s Patient Registration areas
- From our Patient Financial Advocate in person or by calling (937) 840-6512
- On our website at www.hdh.org ---Services ->Patient Services->Financial Assistance Application

The logo for Highland District Hospital features a stylized orange and yellow arch above the text "HIGHLAND DISTRICT HOSPITAL" in a blue, serif font.

HIGHLAND DISTRICT HOSPITAL

- By calling our Patient Accounts Department at (877) 879-6613
- At the hospital Business Office or by calling (937) 393-6193
- Make a request by mail, sending request to Patient Financial Services, 1275 N. High Street, Hillsboro, OH 45133

Patient or patient representative must complete the application. An application may be taken from the patient or patient representative by the Patient Financial Advocate or Patient Account Associate if the patient is unable to complete an application. All applications should be signed by the patient or by someone who has a legal right to represent. An unsigned application can be deemed acceptable if the patient is physically unable to sign the application or does not live in the vicinity of the hospital and is unable to return a signed application by mail. In these situations, the hospital representative should complete all the questions on the application, sign the application, and document why the patient is unable to sign the application on the form and in the hospital computer system. An electronic signature is acceptable provided there is reasonable assurance it is the patient or the patient's legal representative who signs the application. Applications are accepted up to three-years from date of the first follow-up patient responsibility notice sent to a patient per OAC 5160-2-07.17.

To be considered eligible for financial assistance, patients must cooperate with the hospital to explore alternative means of assistance if necessary, including Medicare and Medicaid. Patients will be required to provide necessary information and documentation when applying for hospital financial assistance or other private or public payment programs.

In addition to completing an application, individuals should be prepared to supply the following documents to verify family income (including spouse and both parents of minors):

- Pay stubs
- Unemployment information
- Social Security statement or award letters
- Disability or Worker's Compensation
- Alimony
- Child support
- Pensions or veteran's benefits
- Letter from employer
- Income tax returns
- Income statement
- Accountant income statement for self-employed for 3 months prior
- If reporting no family income, information on how patients are currently supporting themselves

Income information will be based on all applicable household income for either three (3) months prior to the date of service multiplied by four (4), or twelve (12) months prior to the date of service.

Attestation of income and qualifying information submitted on the application shall be confirmed by signature.

Applications for assistance under HCAP will be accepted for accounts on or after May 22, 1992, and applications for hospital financial assistance will be accepted for accounts for one year from the date-of-service.



Applications will expire in ninety (90) days from date-of-service for outpatient services or forty-five (45) days from date-of-service for inpatient services. Thus a new application is not required for multiple visits that occur during this time period.

Neither HCAP nor financial assistance may be used in conjunction with any other approved prompt pay discount.

HCAP may only be applied to hospital services. Professional services are excluded.

Self-pay payments on HCAP approved accounts will be refunded in full.

Providing false or inaccurate information may serve to disqualify an applicant from receiving financial assistance from the hospital.

Patients covered under Medicaid do not qualify for HCAP or hospital financial assistance. Patients covered under the Disability Assistance or its successor program do qualify for HCAP or hospital financial assistance.

Individuals who do not have any of the documentation listed above, or who have questions about Highland District Hospital's financial assistance application, or who would like assistance with completing the application may contact our Patient Financial Advocate either in person at 1275 N. High Street, Hillsboro, Ohio 45133, or over the phone at (937) 840-6512.

Patient Financial Advocate office hours are Monday through Friday from 8:00 am to 4:30 pm.

- **Actions in the Event of Non-Payment**

The collections actions Highland District Hospital may take if a financial assistance application and/or payment is not received are described in a separate policy.

In brief, Highland District Hospital will make certain efforts to provide patients with information about our financial assistance policy before we or our agency representatives take certain actions to collect you bill (these actions may include reporting negative information to credit bureaus; legal actions including but not limited to: property foreclosure, wage garnishment, lien on property, attaching or seizing a patient's bank account or any other personal property).

For more information on the steps Highland District Hospital will take to inform uninsured patients of our financial assistance policy and collection activities we may pursue, please see Highland District Hospital's Billing and Collections Policy.

You can request a free copy of this full policy in person at Highland District Hospital, by calling us at (937) 840-6512, or by mailing a request to Highland District Hospital at 1275 N. High Street, Hillsboro, Ohio 45133, or online at www.hdh.org.

- **Presumptive Eligibility**



If patients fail to supply sufficient information to support financial assistance eligibility, Highland District Hospital may refer to or rely on external resources and/or other program enrollment resources to determine eligibility when:

- Patient is homeless
- Patient is eligible for other unfunded state or local assistance programs
- Patient is eligible for food stamps or subsidized school lunch programs
- Patient is eligible for state-funded prescription medication program
- Patient receives free care from a community clinic and is referred to hospital for further treatment

Highland District Hospital may also use previous financial assistance eligibility determinations as a basis for determining eligibility in the event that the patient does not provide sufficient documentation to support an eligibility determination. Financial assistance applications on file at Highland District Hospital may be used up to twelve months to screen for potential eligibility for subsequent dates of service.

All patients presumptively determined to be eligible will be informed of the determination and given a reasonable amount of time to submit an application for further assistance if required.

- **Eligible Providers**

In addition to care delivered by Highland District Hospital, emergency and medically necessary care delivered by the providers listed below is covered under this financial assistance policy:

- Dr. Ranga Brahmandam
- Janice Morris, NP
- Dr. Naveed Haq

Care provided by any of the independent providers listed below who provide services at Highland District Hospital will **NOT** be covered under this policy. As such, bills received by Highland District Hospital patients for care provided by any of the following providers will **NOT** be eligible for discounts described in this financial policy.

- Hospitalists
- Anesthesiologist
- Radiologist
- Pathologist

Patients concerned about their ability to pay for services or who would like to learn more about financial assistance should contact the Patient Financial Advocate at (937) 840-6512.



Attachment A

**2022 Federal Poverty Guidelines
1-12-2022**

% of FPG =	100%	200%
Family Unit	HCAP w/o 100%	w/o 51%
1	13,590.00	27,180.00
2	18,310.00	36,620.00
3	23,030.00	46,060.00
4	27,750.00	55,500.00
5	32,470.00	64,940.00
6	37,190.00	74,380.00
7	41,910.00	83,820.00
8	46,630.00	93,260.00
Each add'l	4720.00	9440.00