

Hennepin Healthcare System	
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PURPOSE

Hennepin Healthcare System, Inc.'s (HHS's) mission includes providing the best possible care to every patient we serve, including those who are not able to pay for that care. HHS has developed this policy for the provision of free or discounted services consistent with that mission and its obligation of stewardship to Hennepin County. Hennepin Healthcare System, Inc. does business as Hennepin County Medical Center (HCMC), Minnesota Visiting Nurses Association (MVNA) and Hospice of the Twin Cities (HOTC).

POLICY

HHS is committed to providing emergency and medically necessary care to all persons including those who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Consistent with its mission, HHS strives to ensure that people are not prevented from seeking or receiving care because of a real or perceived inability to pay for it. Free or discounted care will be made available to those who cannot otherwise afford it to the fullest extent possible within the financial resources available to HHS. Free or discounted care, however, is not to be considered a substitute for personal responsibility. Patients are expected to contribute to the cost of their care based on their individual ability to pay and to cooperate with HHS's procedures for obtaining all other forms of medical assistance (e.g., private health insurance, or any applicable federal, state, county or HHS programs). Consistent with Hennepin County's support of HHS, this policy grants Hennepin County residents greater access to free or discounted care than HHS is able to provide to the residents of other non-contributory counties.

DEFINITIONS

Amounts Generally Billed (AGB): Amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. Refer to Section III (D) of the Financial Assistance Policy (FAP) for the method of AGB calculation.

Application Period (Financial Assistance): The period from date of care in which an application for financial assistance would be available to the patient.

Charity Care: Healthcare services that have or will be provided by HHS but are not expected to result in cash inflows of an amount equal to the cost of care. Charity care results when an individual needing care meets the eligibility established and is provided emergency or medically necessary care in accordance with HHS's Financial Assistance Policy.

ECA (Extraordinary Collection Actions): Actions taken by a hospital against an individual related to obtaining payment of a bill for care as described in the IRS Rule 501(r).

Emergency Medical Care Policy: A written emergency care policy that provides care for emergency medical conditions without discrimination and regardless of the individual's eligibility under the hospital FAP.

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 starting with 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;

1. Noncash benefits (such as food stamps and housing subsidies) do not count;
2. Determined on a before-tax basis;
3. Excludes capital gains or losses; and
4. If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Hennepin Care: HHS's financial assistance program for Hennepin County residents.

Liquid Assets: Liquid Assets are defined as the sum of any assets held either in cash, marketable securities, or other funds easily converted to cash.

Medically Necessary Care: For the purposes of determining whether a healthcare service is medically necessary care for the purposes of this policy, the following reference and procedure shall be used:

1. Emergency medical services provided in an emergency room setting shall be medically necessary care;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual shall be medically necessary care;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting shall be medically necessary care; and
4. Other services, as determined to be medically necessary through a process established by the Office of the Medical Staff. That process shall consider any relevant community standards and shall be administered to affect both the mission of the institution and its stewardship responsibilities.
5. Services not provided by HHS will not be considered as part of this policy.

Most Favored Insurer: nongovernmental third party Payor that provides the most revenue to HHS during the previous calendar year.

Presumptive Eligibility: exists when HHS provides a patient who is uninsured with an uninsured discount without the completion of a financial assistance application.

Reasonable Effort: Include notification by HHS of financial assistance policy upon admission, and in written and oral communication with the patient/guarantor regarding the patient's bill, including statements and telephone calls, before collection action is initiated.

Sliding Fee Discount: Discounts provided to HHS patients based upon income and family size.

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 has insurance/assistance coverage that does not cover medically necessary care as defined by this policy.

PROCEDURE

I. Eligibility for Financial Assistance

A. Services Eligible under this Policy

Financial assistance is provided to Financial Assistance Policy eligible patients for emergency and medically necessary healthcare services provided by HHS. The granting of free or discounted care shall be based on an individualized determination of financial need, and the eligibility status for other insurance/coverage programs, and shall not take into account age, gender, race, color, national origin, disability, social or immigrant status, sexual orientation or religious affiliation.

1. Financial assistance may not be applied to any of the following:
 - a) Non-HHS facilities, providers, or services.

- b) Services that are not considered emergency or medically necessary as determined by a HHS physician or physician practice.
 - c) Third Party Liability, and/or Workers Compensation services.
 - d) Optical, hearing aids, durable medical equipment, and retail medical supplies.
 - e) Pharmacy services including over-the-counter drugs or supplies, and prescriptions not prescribed by an HHS employed practitioner. Retail prescriptions discounts/coverage is limited.
 - f) Transplants.
 - g) Dentistry services are limited to services outlined in the FAP HHS Plain Language Document.
 - h) Laboratory services that are not related to emergency and medically necessary care.
2. Financial assistance may be considered on a case-by-case basis under special circumstances for services provided by HHS not covered under this policy.
- B. Financial Assistance Programs Available**
1. Hennepin Care – Hennepin County Residents
- a) All residents of Hennepin County whose Family Income is at or below 300% of the Federal Poverty Level (FPL) will be provided access to Hennepin Care consistent with this policy through an application process.
 - b) Eligibility for Hennepin Care will be considered for those individuals, who are uninsured, underinsured, or ineligible for any government healthcare benefit program, or who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy.
 - c) Patients whose Family Income is at or below 300% of the FPL, but who are eligible for State or Federal health care coverage, are eligible for Hennepin Care up to the date of eligibility for the healthcare coverage.
 - d) Non-Hennepin residents are not eligible for Hennepin Care for clinic or other outpatient services, unless it is:
 - (1) Follow up care provided post-hospitalization, or
 - (2) A medically necessary service not reasonably available in a Minnesota resident’s locale.
2. Sliding Fee Discount – Non Hennepin County Residents
- a) All non-Hennepin County residents who reside in the United States whose Family Income is at or below 300% of the FPL will be provided access to HHS sliding fee discounts through an application process.
 - b) Eligibility for HHS sliding fee discounts will be considered for those individuals, who are uninsured, underinsured, or ineligible for any government healthcare benefit program, or who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy.
 - c) Patients whose Family Income is at or below 300% of the FPL, but who are eligible for State or Federal health care coverage, are eligible for a sliding fee discount up to the date of eligibility for the healthcare coverage.
3. AGB Discount – Insured Patients
- a) Patients with insurance whose Family Income is at or below 300% of the FPL may apply for a discount established by the Amount Generally Billed calculation of the FAP.
 - b) Under this policy a FAP-eligible individual will not be personally responsible for more than the AGB after reimbursements from the health insurer have been applied.
 - c) Insured patients are not eligible for Hennepin Care or Sliding Fee discounts unless the service provided meets the definition of under-insured.
- C. Determination of Financial Need**
1. Financial need will be determined in accordance with procedures that involve an individual assessment and may include:

- a) An application process to HHS, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial, and other information and documentation relevant to making a determination of financial need;
 - b) The use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c) Reasonable efforts by HHS to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
 - d) Taking into account all other financial resources available to the patient.
 - e) A review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
2. The need for payment assistance shall be re-evaluated at least annually.

D. Determination of Residency

1. Unless there is reason to believe that a person is not giving his or her correct address, the address provided will be considered accurate. If there is reason to believe otherwise, HHS shall have the right to pursue all lawful means of verifying the address, including reasonable requests for information and documentation from the patient.

II. Application Process for Financial Assistance

- A. Application Period for Financial Assistance:** A patient must apply for financial assistance within (6) six months of the date of service for which the financial assistance is requested. The application period begins on the date the care is provided and ends on the latest of the 240th day after the date that the first post-discharge billing statement for the care.
- B. Applications**
1. An application for financial assistance may be obtained from any of the following sources:
 - a) HHS CSC Building-Financial Counseling, 715 South 8th Street, Minneapolis, MN
 - b) HHS Neighborhood Clinics – Financial Counseling Offices
 - c) By calling: 612-873-2767
 - d) Apply online by visiting HHS website at hennepinhealthcare.org
 2. It is preferred, but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. However, a request shall be considered within the financial assistance Application Period of this policy.
 3. The patient must complete and submit a FAP application to apply for financial assistance. The FAP application will contain the information and documentation required for financial assistance application, the phone number and physical locations of the HHS department that can provide additional information and the phone number and physical location of the HHS department that can assist with the application process.
 4. Completed applications including all required information and documentation should be submitted to HHS for eligibility determination. Completed application can be:
 - a) Submitted by mail to: HCMC, 701 Park Avenue (G9), Minneapolis, MN 55415-9399.
 - b) Delivered in person at the following locations:
 - (1) HHS CSC Building-Financial Counseling, 715 South 8th Street, Minneapolis
 - (2) HHS Blue Building-Financial Counseling, 900 South 8th Street, Minneapolis
 - (3) HHS Neighborhood Clinics – Financial Counseling Offices.
 5. Requests for eligibility for financial assistance shall be processed promptly and HHS shall notify the patient or applicant of eligibility determination in writing within 30 days of receipt of a completed application.
- C. Incomplete Applications:** HHS reviews submitted applications only once they are complete, and will determine whether a patient is eligible according to the HHS FAP. Incomplete applications are not considered. Patients are notified by mail or by phone when their application is incomplete and

provided an opportunity to send in the missing documentation or information within 30 days from patient notification (i.e., date of patient mailing or phone conversation).

- D. Revoking Application/Eligibility For Financial Assistance: HHS has the right to, and may revoke, rescind or amend awards when:
1. A case of fraud, misrepresentation, theft, changes in a patient's financial situation or other circumstances that undermine the integrity of the FAP.
 2. A patient has been screened for a public or private health coverage program and is presumed eligible, but is not cooperating with the process to apply for the public or private health coverage program.

III. Financial Assistance Program Discounts

- A. Hennepin Care – Hennepin County Residents
Refer to the FAP HHS Plain Language Document.
- B. Sliding Fee Discount – Non-Hennepin County Residents
Refer to the FAP HHS Plain Language Document.
- C. Amount Generally Billed Discount – Insured Patients
Refer to the FAP HHS Plain Language Document.
- D. Amount Generally Billed Discount Calculation
1. For patients with insurance who are approved for AGB Discount for emergency and medically necessary care the patient responsibility will not exceed the amount established by the Amount Generally Billed calculation of the FAP.
 2. Amount Generally Billed Discount Calculation: FAP eligible patient will not be charged more than the amounts generally billed (AGB) for emergency or other medically necessary care. The AGB discount is based upon a look-back method with the following calculation.
 - a) Review of actual past claims paid by Medicare fee-for-service during a prior 12 month period and determine the average percent of Medicare fee-for-service payments to gross charges for claims paid: (all claims allowed for Medicare fee-for-service) divided by (total claim charges for Medicare fee-for-service for those claims allowed) X 100 = AGB discount percentage.
 - b) Allowed claims include payments owed by the individual, including co-pays, co-insurance and deductibles, regardless of whether they have been paid.
 - c) Free Standing Clinics, Hospice, and Home Health AGB will each be calculated separate from Hospital based facilities following the AGB formula provided.
 - d) The discount amount will be applicable by the 120th day after the 12-month period used for calculating the AGB percentage. AGB will be calculated at least annually.
- E. Presumptive Eligibility: Non – FAP Uninsured Self-pay Discounts
1. For patients who are Minnesota residents and are not eligible, or do not submit an application for discounts provided by HHS FAP – HHS will establish discounts to assist patients who do not have insurance and whose annual household income is less than \$125,000.
 2. The patient will receive the same discount as HHS provides its “most favored insurer” as defined by HHS Hospital Agreement with the Minnesota Office of the Attorney General.
 3. The Self-pay Discount will not be applied to patient balances after insurance payment including co-pays, deductibles, and co-insurance.
 4. Patients who are provided a Self-pay discount based upon presumptive eligibility and may be eligible for a more favorable discount through an application process will be notified on the patient statement of other programs available to them.

IV. HHS Providers Covered Under Financial Assistance Policy

- A. HHS providers are covered under HHS FAP free and discounted care program for emergency or other medically necessary care provided.
- B. A list of HHS providers can be obtained by visiting HHS website at www.hennepinhealthcare.org .

V. Billing and Collections Policy

- A. HHS's management shall maintain policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for free or discounted care from HHS, and a patient's good faith effort to comply with his or her payment agreements.
- B. HHS does not conduct, or permit collection agencies to conduct on their behalf, Extraordinary Collection Actions (ECA) against individuals before reasonable efforts have been made to determine whether the patient is eligible for HHS financial assistance. ECAs include, but are not limited to:
 - 1. Wage garnishment
 - 2. Lawsuit
 - 3. Property liens
 - 4. Property foreclosure
 - 5. Arrest
 - 6. Reporting patient debt to credit reporting agencies
- C. Before engaging in any collection action(s) or referring patient debt to a collection agency, patients/guarantors are informed of HHS financial assistance program. HHS or outside collection agencies will return any accounts that qualify for financial assistance according to the eligibility criteria outlined in HHS FAP.
- D. When reasonable collection efforts have occurred and the patient/guarantor debt is deemed uncollectible within a minimum of 120 days after the initial billing statement, qualified receivables may be considered for placement with a collection agency. Placement prior to 120 days is permitted in the following situations:
 - 1. The patient/guarantor bill/statement is returned due to an invalid mailing address.
 - 2. The patient/guarantor has communicated that he/she does not intend to pay the charges.
 - 3. The patient/guarantor defaulted on a payment plan and does not meet the FAP eligibility criteria.
- E. HHS may contract with outside collection services to pursue collection of delinquent accounts. All unpaid accounts without prior exception or payment arrangement are placed in outside collection after a minimum of 120 days from the initial billing statement and the delivery of all scheduled patient account statements to the patient/guarantor has occurred.
- F. HHS will not give any outside collection agency or attorney any blanket authorization to take legal action against its patients for the collection of medical debt.
- G. HHS will not give any outside collection agency or attorney any blanket authorization to pursue the garnishment of patients' wages or bank accounts.
- H. HHS patients/guarantors will be provided written notice at least 30 days prior to an ECA of financial assistance available to them. Notice will include a copy of the FAP Plain Language document.

VI. Emergency Medical Treatment and Active Labor Act (EMTALA) Policy

- A. HHS shall provide emergency medical services in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and applicable regulations.
- B. HHS shall not engage in actions that discourage individuals from seeking emergency medical services, and it shall provide emergency medical services without discrimination and regardless of health coverage or financial status. HHS maintains a separate emergency medical care policy separate from FAP.

VII. Communication of Hennepin Healthcare Systems, Inc. Financial Assistance Programs

- A. Notification about HHS financial assistance programs shall include contact information and shall be disseminated by HHS by various means, which may include, but are not limited to, the publication of notices in patient billing statements and by posting notices in emergency rooms, admission areas, urgent care centers, clinics, admitting and registration departments, hospital business offices, patient financial services offices located on and off facility campuses, and at other public places as HHS may elect. Such information shall be provided in the primary languages spoken by the population serviced by HHS.

- B. Information about HHS Financial Assistance Programs (FAP) including copies of the HHS FAP and application forms are available to the general public without charge. This information is available in any of the following ways:
1. Electronic copies can be accessed on the HHS, Hennepin County Medical Center website at <http://hennepinhealthcare.org>
 2. Paper copies are available:
 - a) By mail at: Hennepin Healthcare, 701 Park Avenue (G9), Minneapolis, MN 55415-9939,
 - b) By calling: 612-873-2767,
 - c) Upon request at the following locations:
 - (1) HHS CSC Building-Financial Counseling, 715 South 8th Street, Minneapolis, MN
 - (2) HHS Neighborhood Clinics – Financial Counseling
 - d) Provided to patients upon admission to, and discharge from, an HHS inpatient facility.

VIII. Interpretation of Policy

For matters requiring interpretation of this policy, the Chief Medical Officer and the Chief Financial Officer shall be consulted. In the absence of one or both of these Officers, a designee(s) will be appointed by the Chief Executive Officer.

SUPPORTING DOCUMENTS

FAP HHS Plain Language Document
 Financial Assistance Policy Discounts

SUPPORTIVE INFORMATION

Regulatory Statute/ Standard Reference: IRS Rule 501(r)
Related Policies: Admission and Treatment; Emergency Medical Treatment and Active Labor Act (EMTALA)
References:
Communication/ Staff Education:
Patient Education: