

McLeod Health
The Choice for Medical Excellence

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Owner Dudley Harrington: VP OF BUSINESS OPERATIONS
Area Administration - Administrative Manual
Applicability McLeod Health System Documents

Financial Assistance Policy

I. Purpose Statement

To provide a program overview of Financial Assistance offered to patients throughout McLeod Health.

II. Policy

McLeod Health is committed to providing financial assistance to persons who need hospital services and are uninsured, under-insured, ineligible for government assistance programs, or are otherwise unable to pay for medically necessary care based on their individual financial situation.

Consistent with its mission to improve the overall health and well being of people living in our service areas, McLeod Health strives to ensure that individuals who require health care services are not prevented from seeking or receiving care because of an inability to pay or whose limited means makes it difficult to pay for services.

This policy includes the

- A. eligibility criteria for Financial Assistance
- B. calculations for expected payments from patients
- C. application process

Definitions

Eligible services: Health care services that have been or will be provided, but are not expected to result in cash inflows. Financial assistance results from a provider's policy to provide health care services free or

at a discount to individuals who meet the established criteria.

Family: Using the United States Census Bureau definition, a group of two (2) 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 Inclusions: Family Income is determined using the United States Census Bureau definition, which uses the following income sources when computing Federal Poverty Guidelines:

Pre-tax Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rent, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. If a person lives with a family, the income of all the family members. For self-employed, adjusted or net income will be used as reported on the Profit and Loss statement (Schedule C).

Family Income Exclusions:

- Non-cash benefits (such as food stamps, housing subsidies)
- Capital gains or losses
- If a person lives with a family, but is not related, the income from Non-Family persons

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. A patient whose treatment could be considered a non-covered service by their health insurance plan or who has exhausted benefits under their health insurance plan may be deemed to be an Uninsured Patient. A patient who is fully responsible for the entire allowable amount, based off a co-payment or deductible outstanding, is not deemed to be an Uninsured Patient. A patient who has insurance that does not have a contractual relationship with a McLeod entity (also referred to as Out-Of-Network) may not be deemed an Uninsured Patient. A patient who is covered by and/or has a claim against any Responsible Party for the hospital services provided will not be deemed to be an Uninsured Patient

Under-insured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency Medical Condition: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: Shall in general mean not-elective inpatient and outpatient acute hospital services that are normally reimbursable under Medicare and/or Medicaid programs.

III. Procedure

A. McLeod Health expects patients to contribute to the cost of their care based on their individual

ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of (1) assuring access to health care services, (2) improving their overall personal health, and (3) protecting of their individual assets. Information is an essential part of the application/approval process and patients and/or families are needed to assist McLeod Health with obtaining Financial Assistance or other forms of payment or charity.

B. Discounts Available Under the Financial Assistance Program

1. Full Financial Assistance: Patient whose gross family income is at or below 200% FPL will receive 100% on Uninsured or Balance After Insurance
2. Partial Financial Assistance: Patient whose gross family income is more than 200% and at or below 300% will be expected a partial discount on uninsured balances and balance after insurance.
3. Hardship Discount: Any patient whose uninsured balance or balance after insurance exceed 20% of the patient's annual gross family income will be provided a 100% charity care discount for the balance in excess of 20% of the patient's gross family income.

C. Services Eligible under This Policy.

1. Emergency Medical Services provided in an emergency room setting
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the patient
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting
4. Medically Necessary services, as determined by a McLeod Health Physician.

D. Eligibility for Financial Assistance

Eligibility for the program will be considered for those individuals who are uninsured, under-insured, or ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. Participation in the program will be based on an individual's financial need, and does not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

- E. Patients will first be screened for a public health coverage program, including Medicaid. It is a McLeod Health policy to not offer Financial Assistance in situations where the applicant fails to cooperate with insurance company's application process or for health-sharing plans where the Applicant is paid benefits directly.

F. Disqualification for Financial Assistance

1. The following patients shall be disqualified from Financial Assistance:
 - a. Patients who have not cooperated with insurance or other payment source, which results in non-payment.
 - b. Patients who had liability coverage or where the patient's insurance company paid directly to the patient;
 - c. Patients eligible for workers compensation

- d. Services provided where a patient has a claim against a responsible party
- e. Patients with income \geq 300% of FPL, unless using the Hardship Discount
- f. If the applicant was eligible for group health insurance that would have covered services provided but elected not to have coverage through the employer, the account will not be eligible for Financial Assistance; or
- g. Patients who have not met other enrollment criteria as determined by McLeod Health.
- h. Services outside of McLeod Health hospital departments, including MPA Physician Offices, Home Health and Hospice.

G. Presumptive Eligibility for Financial Assistance

1. McLeod Health may use outside agencies in determining final presumptive qualification. As such, presumptive eligibility may also be determined on the basis of individual life circumstances that may include, but is not limited to, the following:
 - a. Eligibility for Medically Indigent Assistance Program(MIAP)
 - b. State-funded prescription programs;
 - c. Homeless or received care from a homeless clinic;
 - d. Participation in Women, Infants and Children programs (WIC);
 - e. Food stamp eligibility;
 - f. Subsidized school lunch program eligibility;
 - g. Eligibility for other state or local assistance programs that are unfunded (e g., Medicaid spend-down);
 - h. Low income/subsidized housing is provided as a valid address; and
 - i. Patient is deceased with no known estate.
 - j. Eligibility for SC Medicaid Family Planning, NC Medicaid Family Planning, SC Medicaid Emergency Only on the date of service, but not filed to Medicaid
 - k. Eligibility for McLeod's Cancer Clinic but not adjusted to Cancer Clinic.
 - l. Eligibility for Best Chance Network and not filed to Best Chance
 - m. Eligible for Medicaid out of state and unable to file to Medicaid
 - n. Personal bankruptcy within the past 7 years
2. Independent Eligibility Assessments are administered via a third party and identifying patients that can determine eligibility without the typical application. The assessment is proprietary and relies primary on a soft inquiry to the guarantors credit report. For patients with no or minimal credits history, there is a scoring process based on credit statistics and patient demographic to provide a propensity to pay. This model is enhanced by sending information about past bad debt balances, current balance, etc. For Emergency encounters on qualifying patients, the financial assistance adjustment is performed automatically. For scheduled services, an indicator will flag the patient as qualifying for presumptive charity. Staff will

confirm the information with the patient or with historical information in the record and manually approve the presumptive charity discount.

H. Application of Sliding Fee Schedule

- a. Should a patient not qualify for Financial Assistance through the above presumptive qualification screening processes, eligible services as outlined under this Policy for a Sliding Fee Schedule through a written application process, in accordance with financial need, as determined according to the Federal Poverty Level (FPL) in effect at the time of the determination.

The Sliding Fee Schedule applicable shall be as follows:

- Family Income < 200% of FPL; eligible to receive free care;
- Family Income \geq 200% and < 225% of FPL; 10% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
- Family Income \geq 225% and < 250% of FPL; 30% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
- Family Income \geq 250% and < 275% of FPL; 50% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
- Family Income \geq 275% and < 300% of FPL; 70% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
- Family Income > 300% of FPL; may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as a catastrophic event or medical indigence, at the discretion of McLeod Health; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital as expected payment from) patients with insurance coverage.

Once McLeod Health determines that a patient or responsible party is eligible to receive financial assistance under this Financial Assistance Policy, he or she will not be charged more than the Amounts Generally Billed (AGB). The AGB is determined through the "Look-back Method" as defined in the Federal Income Tax Regulations. This method accumulates the total amount that patients and their insurance carriers paid for certain medical services during the 12-month look-back period and then divides by the total gross charges for those services. The resulting percentage becomes the AGB discount that patients receive. In following this method, McLeod Health used medical claims from 06/01/2024 - 05/31/2025 to determine what portion of gross charges were typically paid (by the payer and the covered individual) for claims for Emergency Care and Medically Necessary Care by Medicare Fee-For-Service or a private commercial insurer as the primary payors. Using this methodology, the AGB is 28% for services provided and discharges on or after 07/02/2025.

- b. A Financial Assistance Application Form shall be provided to any person requesting financial assistance. Referral of patients for financial assistance may be made by any member of the McLeod Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
- c. The Financial Assistance Application form must be completed and returned within 240 days of the first postdischarge billing statement. Financial assistance may only be granted if sufficient information is available to allow for a determination to be made that establishes that the patient satisfies all applicable criteria. The qualifying period can be for a specific episode of care or for a 1 year term, extending 6 months prior to determination date and forward 6 months forward from determination date.

Qualification for the Sliding Fee Schedule shall be determined in accordance with procedures that involve an individual assessment of financial need; and may:

- Include personal, financial and other information and documentation relevant to making a determination of financial need;
- Include the use of external publicly available data sources that provide information on a patient's or a patient guarantor's ability to pay (such as credit scoring);
- Include reasonable efforts by McLeod Health to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients in applying for such programs;
- Take into account the patient's available assets and all other financial resources available to the patient. Collectively, checking and savings account balances are not to exceed two (2) months gross income/ expenses. Reverse Mortgages issued on a residence shall also be evaluated as income. Based on the terms of the Reverse Mortgage, financial assistance may be denied; and
- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

The determination may be done at any point in the collection cycle. The need for Financial Assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than 90 days prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

Because McLeod Health values human dignity and the value of the person, financial stewardship shall be reflected in the processing of Financial Assistance applications. Such applications shall be processed promptly. McLeod Health shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

I. Application Review & Account Management

All Financial Assistance Applications received shall be reviewed and evaluated as follows

1. Upon receipt of an application submitted and signed by the patient or guarantor, the eligibility vendor (hereinafter referred to as the "Eligibility Vendor") shall review the application using all guidelines outlined in this policy to determine eligibility

If the application is deemed incomplete, it shall be returned to the patient or guarantor along with specific directions for re-submission in a complete and accurate manner not more than 30 days from receipt. In such cases, the patient or guarantor may provide the required missing or incomplete information and request the application be reconsidered if sure consideration is requested within a period of 120 days from the first post-discharge billing statement.

If the application is deemed complete, it shall continue through this procedure.

2. Review of Family Income shall take place through recent pay stubs, W-2's, prior year tax returns, or written statements from employers. Review of other supporting documentation, as available and necessary, shall also take place.
3. If criteria are met, the Eligibility Vendor shall forward the application, including written recommendation for approval to the appropriate individual(s) for management approval:
 - \leq \$ 50,000.00 per Account - Director of Registration;
 - $>$ \$50,000.00 per Account - Vice President, Business Operations or Chief Financial Officer
4. If the application is approved by management, the Eligibility Vendor shall notify the applicant of the approval in writing within 30 days of initial receipt of the completed application and it shall continue through this procedure directly to item "(7)" below.
5. If an application is denied, due to failure to meet criteria, disapproval by management or for any other valid reason, the Eligibility vendor shall notify the applicant of the denial, and the specific reason(s) for that determination in writing within 30 days of initial receipt of the application.

In such cases, related account(s) shall be re-altered to reflect the appropriate (original) financial class and payor code in the active accounts receivable file. If the patient or guarantor fails to pay the account(s) in a timely manner, the account(s) may be reported to the appropriate credit bureau and the account(s) will be referred to a bad debt vendor and collection procedures will begin.

If patient or guarantor provides supplemental information and requests that the denied application be reconsidered, reconsideration shall be granted if the reconsideration request is made within 240 days from the date of the first post-discharge billing statement.

6. The responsible Patient Account Representative shall be notified to manually demand a bill to drop for submission to the South Carolina Budget and Control Board, State Office of Research and Statistics.

7. If an applicant is determined to be eligible for financial assistance under this policy after collection activity has been initiated, McLeod Health will refund any excess funds it collected from the applicant over the amount the applicant actually owes.

Copies of all written notifications and related correspondence, inclusive of the original application and associated information, shall be retained by McLeod Health as part of the patient's account records.

J. Communication of the Financial Assistance Program to Patients and Within the Community.

Any person seeking health care services at McLeod Health should be provided written information about the McLeod Health Financial Assistance Program as part of the admission process. Such information shall include a contact telephone number and shall be disseminated by various means, which may include but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the appropriate admission- related consent form, in admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as McLeod Health may elect. McLeod Health shall also publish and widely publicize a summary of this financial assistance policy on facility websites, in brochures available in patient access sites and at other places within the community served as determined by McLeod Health. Such notices and summary information shall be provided in the primary languages spoken by the populations' served by McLeod Health, but at a minimum shall be provided in English and Spanish.

K. Relationship to Collection Policies.

McLeod Health management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) 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 financial assistance from McLeod Health, and a patient's good faith effort to comply with his or her payment agreements with McLeod Health. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, McLeod Health may offer extended payment plans. McLeod Health will not impose extraordinary collections actions for non-payment such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for the Financial Assistance Program under this Policy.

Reasonable collection efforts shall include:

- Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by McLeod Health;
- Documentation that McLeod Health has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this Policy and that the patient has not complied with McLeod Health application requirements;
- Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

L. Regulatory Requirements.

In implementing this Policy, McLeod Health and its management shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

This policy applies to all McLeod Health hospital services, ambulatory surgery center services, home health services, and hospice services.

Additionally, services provided and/or billed by private or independent entities, practice groups or other providers are not covered by this policy. Patients should address any payment questions or concerns directly with the private physician/provider practice. These groups include, but are not limited to the following:

- Emcare
- Pee Dee Pathology
- Carolina Radiological Associates
- Florence Radiological Associates
- Pediatrix Medical Group
- American Anesthesiology
- Mednax Services
- TeamHealth
- All private or independent physicians not employed by McLeod Health or physician practices not owned by McLeod Health.

IV. Equipment Needed

Not Applicable

V. Addendums

Not Applicable

VI. Attachments

Not Applicable

VII. Related Links

Not Applicable

VIII. References

Not Applicable

All Revision Dates

12/2024, 11/2024, 06/2023, 12/2021, 08/2021, 10/2018, 02/2018, 09/2014, 12/2013

Approval Signatures

Step Description	Approver	Date
	Madge Hamer: AVP OF ACCREDITATION/ CERTIFICATION [LS]	12/2024
	Dudley Harrington: VP OF BUSINESS OPERATIONS	12/2024

Applicability

MPA / Provider Based Clinics, McLeod Darlington, McLeod Dillon, McLeod Family Medicine, McLeod Health, McLeod Health Clarendon, McLeod Hospice | Home Health, McLeod Loris Seacoast, McLeod Regional Medical Center, McLeod Cheraw

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