

MEADVILLE MEDICAL CENTER HEALTH SYSTEM POLICY AND PROCEDURE MANUAL

Administrative Policy A-401

SUBJECT: Patient Financial Assistance

PURPOSE:—This policy and the Financial Assistance Program (FAP) outlined herein are intended to address the interests of providing access to care to those without the ability to pay and to offer a discount from billed gross charges for those who are able to pay a portion of the costs of their care. This policy sets forth the process for determining patient eligibility for financial assistance (a/k/a charity care, free care or discounted care) for the population of our community and to ensure that Meadville Medical Center (MMC) will not discriminate in the determination of eligibility on the basis of race, color, creed, sex, sexual orientation, religion, age, or handicap. Applications will be processed and approval will be determined based on specified criteria. If approved, patient's obligation to MMC may be reduced or eliminated for a period of time as specified.

POLICY:—It is the policy of Meadville Medical Center to follow federal poverty household guidelines in making reasonable efforts to determine eligibility for patient financial assistance before pursuing collection actions. For services provided by a professional not employed by MMC (pathologist, radiologist, and/or anesthesiologist), these services will be billed to you separately from the hospital and are excluded from MMC's Financial Assistance Program. A list of providers covered under MMCHS FAP is attached.

Eligibility is provided to patients where the following applies:

- You must be uninsured, underinsured, ineligible for any government healthcare insurance programs, or under financial hardship.
- For Pennsylvania residents whose household income is lower than 133% of the Federal Poverty Level, the patient must apply for Pennsylvania Medicaid.
- The services provided to you must be medically necessary.
- Examples of non-medical necessary exclusions in our financial assistance program includes: cosmetic surgery, retail products, vision enhancing intraocular lenses, life line, hearing aids and associated products, investigational services or where an Advanced Beneficiary Notice (ABN) was signed. All insurances to include workers compensation and auto insurances must have been billed and benefits paid to Meadville Medical Center as well as all insurance guidelines/plan provisions must have been followed such as obtaining a preauthorization.
- Proof of household gross income and family size is required along with a completed application. Your eligibility must meet the financial assistance criteria based on gross household income and asset calculations as compared to the Federal Poverty Level.

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- ~~Examples of required documentation include Income Pay Stubs, Social Security or Disability benefit statement, Unemployment or Pension/Annuity benefits, ANFC, SSI, Federal Income Taxes, Business Taxes Returns, bank statements showing liquid assets and any other extenuating information to show special circumstances.~~
- ~~Individuals included in household size need to be a dependent on the federal tax return provided.~~
- ~~Examples of liquid assets include cash, savings, checking, and CD's.~~
- ~~Assets such as primary residence, rental property, and personal property such as vehicles, furniture, or livestock are not considered in determining eligibility.~~

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~~The income guidelines will be reviewed on an annual basis based on the changes in the Federal Poverty Guidelines.~~

~~This policy and the FAP set forth herein constitute the official financial assistance policy within the meaning of section 501(r) of the Internal Revenue Code for Meadville Medical Center as approved by Meadville Medical Center Health System's Finance Committee and Board of Directors.~~

~~Meadville Medical Center FAP may include: Uninsured Financial Assistance/Charity Care, Presumptive Charity, Self-Pay Discount and Catastrophic Discount.~~

~~Meadville Medical Center offers: Estimates of Financial Responsibility, Medical Line of Credit and Recurring Credit Card options.~~

~~No FAP eligible individual will be charged more for emergency or other medically necessary care than the amounts generally billed. MMCHS is required to provide individuals who come to MMC's Emergency Departments care for any treatment for emergency medical conditions without discrimination as may be required to stabilize the medical condition pursuant to MMCHS's EMTALA Medical Screening and Stabilizing Treatment Policy. Care must be provided regardless of the individual's ability to pay or FAP eligibility.~~

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~~DEFINITIONS:~~

- ~~Advanced Beneficiary Notice (ABN): also called a "waiver of liability" is a notice that Medicare providers and suppliers are obligated to give to an Original Medicare enrollee when they find that Medicare does not cover the services the enrollee requests.~~
- ~~Alcohol and Drug Abuse Program (ADAP): A program administered by the PA Dept. of Health to help Pennsylvanians prevent and eliminate the problems caused by alcohol and other drug use.~~
- ~~Amounts Generally Billed (AGB): Meadville Medical Center (uses the "look back method" as defined in section 501 (r) (5) (b) (1) of the Internal Revenue Code. MMC will limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under this policy to not more than AGB. MMC will update the AGB annually. The AGB's will be updated annually within 120 days of MMCHS's fiscal year end.~~
- ~~Annual Out of Pocket Maximum: The maximum amount a patient is responsible to pay for services received at MMC each year. If patient is FAP eligible, this amount will not exceed (25%) of the household income which is consistent with the definition of catastrophic encounters.~~

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- ~~Application Period:~~ the period during which the hospital accepts and processes FAP applications. This period begins with the date of the first post-discharge billing statement and ends 240 days after MMC provides the individual with their first post-discharge billing statement.
- ~~Authorized Representative:~~ you can give a trusted person permission to talk about the Pennsylvania Health Connect application, your information, and act for you on matters related to the Pennsylvania Health Connect application.
- ~~Bad debt~~ means a debt that is not collected and is worthless to the creditor.
- ~~Charged:~~ only the amount the FAP-eligible individual is personally responsible for paying, after all deductions, discounts (including discounts available under the FAP), and insurance reimbursements have been applied.
- ~~Co-insurance~~ means the percentage of total charges that a person is required by their insurance to pay out-of-pocket.
- ~~Commercial Payer:~~ any insurance payer other than a State or Federal Insurer such as Medicare or Medicaid. Examples: BCBS or MVP.
- ~~Contractual Adjustment~~ means a discount as a result of the contractual arrangement with an insurance carrier. MMC will bill most insurances and does not have a contract with all insurances.
- ~~Copay~~ means a set fee for services that a person must pay at each visit. The amount of the copayment is determined by the person's health insurance carrier.
- ~~Creditor:~~ Is a person or organization to which money is owed by a debtor (Meadville Medical Center is a creditor.)
- ~~Debtor:~~ Is a person who owes a creditor; someone who has the obligation of paying a debt. (Meadville Medical Center's customers are debtors.)
- ~~Extraordinary collection actions (ECA):~~ ECAs are actions taken against the patient related to obtaining payment of a bill for care covered under MMC's FAP that require a legal or judicial process or involve selling an individual's debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
- ~~Financial Assistance Program (FAP):~~ A charity care program providing access to those without the ability to pay and to offer a discount from billed gross charges for those who are able to pay a portion of the costs of their care.
- ~~Federal Poverty Guidelines (FPG):~~ a simplified calculation of the official poverty population statistics used for administrative purposes, such as, determining financial eligibility for programs.
- ~~Guarantor~~ means an adult receiving medical services, or the parent of a minor child (under age 18) receiving services who signs the consent for medical treatment on their behalf (not the subscriber of insurance).
- ~~Household:~~ all family members or cohabitants residing in the same home. Individuals included in household size need to be a dependent on the federal tax return provided.
- ~~Income:~~ Gross earnings, unemployment compensation, workers compensation, social security benefits, supplemental security income, public assistance, veteran's benefits, survivor benefits, pension or retirement, interest, dividends, rents, royalties, estate income, trusts, educational assistance, alimony, annuities, and child support for a

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household.

- Income-eligible means a person who meets the financial criteria according to Federal Poverty Guidelines and who qualifies for particular Medicaid programs (as outlined below).
- Indigent means poor or destitute.
- Insurance Deductible means an amount a person must pay for healthcare expenses before insurance covers the cost; often based on a yearly amount.
- Liquid Assets: any asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, and CD's.
- Medically Indigent: Health insurance coverage does not provide full coverage for all of the medical expenses and the self-pay unreimbursed medical expenses, in relationship to family income, would make the patient indigent if the patient were required to pay full charges for the medical expenses.
- Medically Necessary: health services and supplies that under the applicable standard of care are appropriate: (a) to improve or preserve health, life, or function; or (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."
- Medicare Low Income Beneficiaries Limitation: recipients with liquid assets limited to \$7,160 for a single person and \$10,750 for married couples.
- Notification Period: the period during which Meadville Medical Center must notify an individual about the FAP. The period begins with the date of the first post-discharge billing statement and ends 120 days later.
- Outside Collection Agency (OCA): a company hired by MMC to collect a debt that is owed.
- Reasonable Collection Efforts: Notification to an individual about our FAP; in the case of an individual who submits an incomplete FAP application, we will provide the individual with information relevant to completing the FAP application; and in the case of an individual who submits a complete FAP application, we will make and document the determination as to whether the individual is FAP eligible.
- Underinsured patient: a patient that is exposed to significant financial losses due to inadequate health insurance coverage.
- Uninsured patient: a patient who is not covered under a medical insurance plan.

PROCEDURE: Meadville Medical Center Health System will:

1. Post information on Meadville Medical Center Health System's website, MMCHS.org regarding Government Assistance Programs and the MMCHS FAP, including copies of the FAP, FAP plain language summary, guidelines for qualification, contact information and application forms;
2. Notify patients of the FAP at the time of registration, check-in or prior to discharge. A FAP plain language summary will be provided.
3. Post "Need Help Paying Your Bill" signs in all public areas which include Financial Counselors contact information;

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4. Include FAP plain language summary, guidelines for qualification, and contact information on the back of all patient billing statements.
5. Mention FAP to the individual when discussing the bill over the phone or in e-mail. FAP plain language summary brochure and application will be mailed when:

- a. MMCHS Business Associate, Avadyne, will be calling the patient to ask them to develop a payment plan;
- b. The patient calls to request it.

The Financial Counselor contact information is (814-333-5737) to access help with FAP applications for uninsured or underinsured patients. To pay your bill on line, please visit Meadville Medical Center Health System's website MMCHS.org.

6. Make the FAP plain language summary brochure available without charge;
7. Publicize the FAP plain language summary brochure at Community Health Centers of the Meadville region and at social service agencies;
8. Include FAP information in Meadville Medical Center Health System's newsletter to staff and physicians, as well as, in annual Meadville Medical Center Health Center's mandatory training;
9. Include FAP information in appropriate reports filed with state governments;
10. Publicize the FAP through local news media and/or social service agencies.
11. The FAP application will be used to determine if patient is eligible for ADAP, e.g., Stepping Stones. Patients that qualify for ADAP must have a household income of 250% FPL or less.

Meadville Medical Center Registration and all MMCHS clinics and providers will:

1. Offer all patients a plain language summary brochure of the Meadville Medical Center Health System's FAP.
2. Refer patient to a Financial Counselor for assistance in completing applications for Government Assistance Programs and the MMCHS FAP.
3. Note on the patient's registration that this information was provided. Meadville Medical Center Health System Financial Counselors will:
 1. Attempt to contact all inpatients who are uninsured, underinsured, or have no health insurance secondary to Medicare to provide information regarding Government Assistance Programs and the MMCHS FAP while still receiving inpatient care.
 2. Verify insurance coverage and benefits for all patients scheduled for services, and contact those who are uninsured, underinsured, or have no health insurance secondary to Medicare, to provide information regarding Government Assistance Programs and the MMCHS FAP.
3. Make appointments with patients to review guidelines for qualification and/or help complete Government Assistance Programs and the MMCHS FAP applications.
4. Document in MMC's Health Information Systems anything pertinent to the financial assistance process.
5. To access interpreter services for patients who have Limited English

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- Proficiency and/or have indicated their preference to discuss health care issues in a language other than English, staff will identify which language the patient speaks and contact telephonic interpreting services to access an appropriate interpreter. Staff will contact Facilities Engineering to borrow the dual handset that allows both Meadville Medical Center staff and the patient to communicate with the interpreter.
6. Attempt to contact by phone all uninsured and underinsured patients to discuss the MMCHS FAP.
7. The Meditech Insurance Plan codes for FAP will be used in the Revenue Cycle system to identify FAP potential patients. These are the action codes to be used: applying for FAP, FAP application received, FAP Follow-up done, FAP denied and Medicaid Application Assistance done.
8. FAP Application Hold must be applied to the encounter while application is being reviewed.
9. Provide each uninsured and underinsured patient an application offering financial assistance through the Meadville Medical Center Health System FAP and respond to any and all requests for information and assistance while applying for financial assistance.
11. When mail is returned due to an incorrect address, demonstrate that due diligence was exercised in attempting to obtain correct contact information for the patient before referring the account to an outside agency for collection due to a bad address.
12. Review financial assistance application to include:
- a. A completed FAP application showing required full names, demographic information, household income, and signatures.
 - b. Review proof of income based on the application. This could include:
 - Copy of current Federal Income Tax Return (FTR) with all corresponding schedules January through June
 - Copy of current paystubs for prior 30 days.
 - Copy Social Security statement of income
 - Copy of unemployment document
 - Copy of State Aid income statement (cash assistance)
 - Copies of business ledgers, if self-employed
 - For Medicare (all)
 - patients, copies of bank statements both checking and savings for the prior month
 - Proof of incarceration
13. Screen for Medicaid eligibility.
- a. If Medicaid was active for the patient (during the period of time the date of service was provided), the Financial Counselor will update the insurance information so that billing can be done within the Medicaid 6-month timely filing period.
 - b. If Medicaid was not active for the patient during this period of time and;
 - i. if patients household income are within the required FPL
 - ii.

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- iii. the date of service is within 3 months of the retroactive Medicaid activation period
- iv. the date of service is within the Medicaid timely filing period of 6 months

The Financial Counselor will attempt to complete the retroactive Medicaid form with the patient. If approved, PFS staff will change insurance and bill Medicaid.

- c. Lastly, if the date of eligibility is
 - i. past the 3 month retroactive period;
 - ii. past the 6 months timely filing period;
 - iii. within 240 days (from 1st billing statement) of services;
 - iv. and out of pocket expenses are due

The patient will automatically qualify for financial assistance and therefore adjustments can be done without completing a FAP application. A copy of the Medicaid website showing this proof will be used in lieu of the actual FAP application.

Note: An authorized representative form can be completed if patient isn't able to help with retroactive eligibility. An example of this would be a deceased patient.

14. The patient must apply for Pennsylvania Medicaid when:

- a. Patient is a self-pay Pennsylvania resident whose household income is lower than 130% of the Federal Poverty Level.
- b. Patient is a Medicare Pennsylvania resident whose household income is lower than 100% of the Federal Poverty Level
- c. Any exceptions to this must be approved by the Supervisor, Patient Financial Services.

15. For any Medicare Pennsylvania residents whose household income is lower than 90% of the Federal Poverty Level, Financial Counselor should coordinate an appointment for patient to meet with the Social Security Department to apply for Supplemental Security Income (SSI).

16. Determine eligibility based on household gross income (less insurance benefits paid out) for non-Medicare patients and on household gross income (less insurance benefits paid out) and liquid assets for Medicare patients per the Medicare Low Income Beneficiaries Limitation.

17. In the case of self-employed applicants or S-Corporations the following will be considered:

- Cost of goods sold
- Employee wages
- Officer income
- Employee benefits
- Pension and profit sharing plans
- Contract labor

18. In the case of a farming applicant, the following will be considered:

- Custom hire
- Feed
- Seeds/plants
- Hired labor
- Pension or profit sharing plans

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19. Any patient that is deceased and has no estate (as verified in writing by Probate Court) will have their balances adjusted off in full.

20. Any self-pay patient of the Stepping Stones Alcohol and Drug Unit can apply for ADAP and/or FAP assistance. If patients household income is less Than 250% of FPL, amounts owed can be written off to ADAP. Otherwise, 251%-500% would fall under the Meadville Medical Center Health System FAP.

21. Patients will not be eligible for financial assistance when:

- There is an insurance carrier or other party responsible for payment.
- The insurance carrier determined services provided were not medically necessary.
- Any portion of the service was denied by the insurance carrier due to non-compliance of the plan provisions or was deemed not medically necessary.
- The Medicare patient does not provide bank statements, when applicable.
- The Medicare patient has liquid assets equal to or greater than \$7,160 for a single person and \$10,750 for married couples per Medicare Low Income Beneficiaries Limitation.

- The amount owed is for a service of medical benefit, but not medically necessary. Examples include: durable medical equipment (DME), DME service such as hearing aids, retail products or for elective services such as cosmetic surgery or intraocular lens.

22. The Financial Counselor will complete the Financial Assistance checklist and submit to the Manager of Patient Access Services for final review and approval.

- Approval/Denial of financial assistance will be at the discretion of the Manager of Patient Access Services following the guidelines outlined.

- Unique situations may arise and financial assistance may be approved by the Manager of Patient Access Services or the Supervisor, Patient Financial Services based on circumstances relative to the patient's or guarantor's ability to make payments.

23. In the event the application is not returned, Meadville Medical Center must provide each patient at least three billing statements showing balance owed for services received, as well as, on final billing statement and notification (120 days after discharge) before transferring an encounter to an outside collection agency.

24. If the individual submits an incomplete application, the Financial Counselor will send the patient a written notification indicating what is still required within 30 days and include a plain language summary of the FAP. If ECA's began, they will be suspended until determination of FAP eligibility is completed.

- If notification of required documentation is mailed to patient at the end of the application period (prior to 240 days from first post-discharge billing statement sent to patient), Meadville Medical Center will not begin ECA's until day 270

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days from first billing statement.

- If FAP application is ~~denied~~ because patient does not meet the eligibility guidelines or the patient did not send Meadville Medical Center the required additional documentation to complete the application within the 30-day notification, a letter will be sent to the patient notifying the patient that they were denied and ECA's will resume if payment is not made.
- If complete FAP application is received and approved, all ECA's will be suspended and any ECA actions taken will be reversed.
 - Financial Counselor will document determination in the health information system and make adjustments to any open accounts prior to the date of FAP approval for services provided 240 days (from 1st post-discharge billing statement) and for services 1 year after the approval date, at which time new proof of income will be required.
 - The remaining balance after AGB discount has been applied to uninsured accounts or any balances for underinsured accounts will be adjusted as appropriate using the Federal Poverty Levels.
 - If a patient's income falls at 300% of Federal Poverty Guidelines or below, they will not be responsible for any portion of their hospital bill, and Financial Assistance will be provided at 100%;
- 25. Any FAP eligible encounter payments made by the patient within the application period (prior to the application approval date) will be refunded.
- 26. A written notification will be sent to the patient notifying them of FAP eligibility decision, FAP eligibility timeframe, and their financial responsibility.
- 27. Monthly billing statements will be sent to the patient if there are remaining balances owed along with contacts to obtain information on AGB and how the amount owed was determined.

~~2019~~ Federal Poverty Guidelines

Persons in Family or Household	100% FPL	Medicaid 133% FPL	ADAP 250% FPL	Up to 300% FPL
1	\$12,490	\$16,612	\$31,225	\$37,470
2	\$16,910	\$22,490	\$42,275	\$50,730
3	\$21,330	\$28,369	\$53,325	\$63,990
4	\$25,750	\$34,248	\$64,375	\$77,250
5	\$30,170	\$40,216	\$75,245	\$90,510
6	\$34,590	\$46,005	\$86,475	\$103,770
7	\$39,010	\$51,883	\$97,525	\$117,030
8	\$43,430	\$57,762	\$108,575	\$130,290

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POLICY

Allowed Discount		100%	100%	100%	100%
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Meadville Medical Center (MMC) is committed to providing financial assistance to individuals who have health care needs and are uninsured, underinsured, ineligible for government assistance, or otherwise unable to pay for emergent and/or medically necessary care. MMC strives to make certain that the financial circumstances of individual who require health care services; does not prevent them from seeking or receiving care.

PURPOSE

This Financial Assistance Policy (FAP) establishes the guidelines as to how MMC will fairly, respectfully and consistently ensure that it follows the same billing and collection procedures for all individuals without regard to age, gender, race, social or immigration status, sexual orientation, gender identity or religious affiliation. This policy will address the various types and levels financial assistance.

With implementation of this policy, MMC will comply with all federal, state, and local laws, rules and regulation that may apply to activities conducted pursuant to this policy, including but not limited to any proposed, temporary or final regulation issued under Section 501(r) of the Internal Revenue Code of 1986, as amended.

SCOPE

This policy applies to Meadville Medical Center and providers employed by Meadville Medical Center listed on Addendum A.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

- AGB Amounts Generally Billed – The amounts generally billed for emergency or other medical necessary services to individuals who have insurance covering such services.
- Catastrophic Charity - Available to uninsured and underinsured patients. This program limits your out-of-pocket costs when medical debts exceed 25% of your family adjusted gross income.
- Charity Care – Available to uninsured patients. If Medicaid application is denied as over income, MMC offers financial assistance based on your family size, adjusted gross income and resources according to the eligibility criteria.
- Eligible Services – Inpatient and/or outpatient treatment of an illness or injury which are emergent or medically necessary; provided by MMC or a MMC employed provider for the treatment of an illness or injury.

- Eligibility Period – The period during which MMC will recognize an approved application submitted by an individual for assistance under MMCs FAP.
- Emergency Medical Care – Care or treatment for emergency medical conditions as defined by EMTALA (Emergency Medical Treatment and Active Labor Act).
- Emergent Medical Conditions – Emergency medical conditions as defined in Section 1867 of the Social Security Act (42 U.S.C. 1295dd).
- ECA Extraordinary Collection Action – An action described in Section 1.50(r)-6(b) of the Internal Revenue Code.
- Family – As defined by the U.S. Census Bureau, a group of two or more individual who reside together and may be related by birth, adoption, marriage, same-sex marriage, unmarried or domestic partnership.
- Federal Poverty Guidelines – Updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code; current Federal Poverty Guidelines can be reference at <http://aspe.hhs.gov/poverty-guidelines> and are available for review in Addendum B.
- Financial Assistance – Free or discounted healthcare services to individuals who meet the established criteria.
- Gross Charges – MMC's full, established price for medical care in which the facility consistently and uniformly charges all patients before applying any contractual allowances, discounts or deductions.
- Household Income – Consists of and/or includes adjusted gross earnings, unemployment compensations, worker's compensation, Social Security, Supplemental Security Income, public assistance, VA income 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; determined on a before-tax basis; includes income of the individual, spouse and/or all parents of minor children.
- Presumptive Charity - Available to uninsured patients. While you may appear eligible for financial assistance, your application and supporting documentation may not be on file. If no evidence exists to support your eligibility, MMC may ask outside agencies, that rely on household information and/or credit scores, to help determine eligibility.
- Sliding Fee Scale – Available in Rural Health Clinics. A sliding fee scale is a price for services, based on a customer's ability to pay. Such fees are reduced for those who have lower incomes. Alternative for uninsured medical and dental patients using the Rural Health Clinics; complete a Financial Application, if qualified based on validated annual income – a Sliding Fee Scale discount may apply instead of the 40% Uninsured Patient Discount on total charges.

- Uninsured – Individual has no level of insurance (private or government) or other potential assistance options, such as Victims of Violent Crimes, auto insurance, third-party liability, etc. to assist with meeting her/her payment obligations for health care services received from MMC.
- Uninsured Discount - Available to uninsured or insured patients with non-covered charges. This program offers a 40% discount on total charges.
- Underinsured – Individual has some level of insurance (private or government) or other potential assistance options, such as Victims of Violent Crimes, auto insurance, third-party liability, etc. but still has out-of-pocket expenses that exceed his/her financial ability to pay for health care services at MMC.

PROCEDURE

Emergency Medical Care

Any individual seeking urgent or emergent care within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd) at MMC will be treated without discrimination and without regard to an individual's ability to pay for care. MMC will operate in accordance with all federal, state and local requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). MMC will consult and be guided by the facilities established emergency department policies and procedures, EMTALA regulation and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an urgent or emergent condition and the processes to be followed with respect to each.

Eligible Services

For the purposes of this policy, *financial assistance* refers to inpatient or outpatient services provided by MMC and MMC employed providers without charge or at a discount to qualifying individuals.

The following health care services are eligible for financial assistance:

- Emergency medical services provided in an emergency room setting;
- Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

- Services provided in response to life-threatening circumstance in a non-emergency room setting; and
- Medically necessary services.

Financial assistance does NOT cover the following:

- Retail products; (Hearing Aids reference policy AUD-4.1 Hearing Aid Dispensing Program)
- Ineligible services which are deemed as not medically necessary and/or emergent;
- Elective services such as cosmetic services.
- Vaccines
- Pre-Pay Maternity Contracts (Refer to A-401.3 Pre-Pay Maternity Contact)

Financial assistance is limited to services rendered at MMC and/or rendered by a MMC employed provider and charges for eligible services (as set forth below) and does not cover any services that may be charged to an individual by any independent provider not employed by MMC, including but not limited to those physicians/practitioners and physician groups with exclusive and/or non-exclusive agreements with MMC.

It should be noted that some of the providers listed may have their own financial assistance policy and individuals seeking financial assistance should inquire directly with that provider rendering the service.

Eligibility

Generally eligibility for the financial assistance program will be taken into account for those individuals who are uninsured, underinsured, and 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 FAP. Underinsured individuals are eligible to obtain financial assistance; if qualified, for deductible, co-pay and/or co-insurance responsibility within the Catastrophic Charity. Uninsured individuals are eligible to obtain financial assistance; if qualified, for Charity Care, Presumptive Charity or Uninsured Discount. The approval of financial assistance will be based on an individualized determination of financial need, and shall not take into account gender, race, age, social or immigrant status, sexual orientation or religious affiliation.

Specific eligibility this policy does not apply to includes but is not limited to the following:

- Individuals who opt out of available insurance coverage;

- Individuals who fail to reasonably comply with insurance requirements; such as obtaining authorization for referrals;
- Nonresident and/or illegal alien individuals who come into the community to seek non-emergent treatment from MMC or a MMC employed provider;
- Individuals who are uninsured and do not qualify for financial assistance based on national poverty income guidelines may be eligible for a 40% discount of billed charges in accordance to MMC's Uninsured Discount Policy. The Uninsured Discount Policy (refer to A-401.1) may be reviewed under Addendum C.

Presumptive Eligibility

In situations where an uninsured individual may seem to be eligible for financial assistance, but there is no financial assistance application on file due to a lack of supporting documentation, financial assistance may still be available in certain circumstances based upon presumptive conditions. MMC contracts with outside agencies that rely on household information and/or credit scores to assist determine eligibility. Presumptive Charity covers 100% of total charges.

How Individuals Can Apply for MMC Financial Assistance

Requesting financial assistance can be done by individual requesting in person, over the phone, through mail or through accessing our website at www.mmchs.org. Contact information for the Financial Counselors that can provide assistance regarding MMC's financial assistance program along with a copy of the FAP application are included in Addendum D.

Every reasonable attempt is made by MMC's Financial Counselor's to meet with uninsured patients who are admitted to the hospital in order to recommend appropriate assistance such as federal, state or local programs, or eligibility for assistance under the FAP. When appropriate, the Financial Counselors may provide assistance to the individuals in qualifying for financial assistance under the policy or to various government programs, such as Medicaid.

MMC's Financial Counselors can also initiate a financial assistance application on behalf of the patient; however, it is the individual's responsibility to provide the necessary information to qualify for financial assistance. There is no guarantee that the individual will qualify for financial assistance. Referral of patients for financial assistance may be made by any member of MMC's staff or medical staff; including physicians, nurses, social workers, case managers, chaplains and religious sponsors. A request for financial assistance may be made by the individual or a family member, close friend or associates of the individual, subject to applicable HIPAA laws. MMC recognizes that an individual's ability to pay over an extended period of time may be significantly hampered due to illness or financial hardship.

Determination and Notification

In circumstances where presumptive eligibility for the financial assistance program does not apply, individuals must apply for state Medicaid prior to any MMC Financial Assistance. Individuals must apply for financial assistance and cooperate with MMC in determining if they are eligible for assistance. This application process will involve the following:

- The individual or guarantor must apply for state Medicaid and have a Denial;
- The Individual or guarantor is required to complete a MMC financial assistance application form and supply all personal, financial and other information requested on the application in order for MMC to make the appropriate determination for financial need. Sources of adjusted gross household income that is required to be included, but are not limited to: wages, salaries, farm income, self-employed income, interest/dividends, rental income, Social Security payments, public assistance, unemployment and worker's compensation, veterans benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property and one-time insurance or compensation payments;
- A review of the individual's liquid assets and all other financial resources available to the individual; including retirement funds such as pensions/annuities and IRA's/401K's as required by Medicare for Medicare beneficiaries apply for financial assistance. The primary personal residence, auto and/or boat are excluded from this review;
- A review of household income for the individual, spouse, significant other and/or all parents of minor child will be completed;
- If the application for financial assistance is not complete when submitted, a financial counselor will call or follow up in writing to the individual, requesting the additional information and/or try to get the information from third party sources if applicable.

Request for financial assistance shall be processed promptly and MMC will notify the individual or applicant in writing of approval/denial within 15 business days of receipt of a completed application. If MMC denies the request for financial assistance, the reason for denial will be provided in the letter. Individuals will be notified in the denial letter that they may appeal this decision and will be provided with contact information for an appeal. Financial assistance will not be denied based on the omission of information or documentation is such information or documentation is not specifically required by the FAP or application form. Examples of the FAP Approval Letter and FAP Application Denial Letter can be referenced in Addendum E.

Length of Eligibility

Once financial assistance has been approved, the eligibility period for the Financial Assistance Program is three (3) months retroactive and one (1) year going forward from the application approval date; with the exception of accounts which have been placed with a collection agency and exceed 240 days from the first post discharge bill. Each patient must re-apply at the end of the one (1) year period, and be determined to be eligible for financial assistance to continue to receive free or discounted care. In addition, if there is a material change in the patient's financial situation during any period that a patient is participating in the FAP, such as household income or family status, the patient is obligated to advise MMC of such change, which subsequently requires a reevaluation of financial assistance eligibility.

Disqualification

Disqualification after financial assistance has been granted, may be for reasons that include, but are not limited to the following:

- Information Falsification – Financial assistance will be denied to the individual if they or their guarantor provides false information;
- Third Party Settlement – Financial assistance will be denied if the individual received a third party financial settlement associated with the care received at MMC or by one of MMC's employed physicians. The individual is expected to use the settlement amount to satisfy any patient account balance.
- Change in financial situation where the individual may have access to health insurance and/or no longer meets eligibility criteria based upon the Federal Poverty Guidelines.

Basis for Calculation Amounts Charged to Patients

Amounts charged for any emergency or other medically necessary care MMC provided to an individual eligible under this FAP will be limited to no more than the amounts generally billed (AGB) to individuals with insurance covering that care. Financial assistance may also apply to co-pays, deductibles and/or co-insurance. The discounts available to individuals under the policy will be at least equal to the average discount given to individuals with certain insurance plans. This minimum discount is calculated by determining what is called the amounts generally billed (AGB). The AGB establishes the limit as to what can be charged to an individual that qualifies for financial assistance. MMC has chosen to use the look back method which utilizes 12 months of allowed claim payments made to MMC by Medicare and all commercial payers divided by the gross charges. The result provides the maximum percentage of gross

charges that an FAP-eligible individual may be asked to pay; with inverse representing the minimum financial assistance discount that will be offered. This AGB and if necessary the related discounts given to individual will be updated at least annually. For the AGB refer to Addendum F.

Individuals whose household income and assets are at or below 300% of the FPL are eligible to receive free care with qualified FAP.

Widely Publicize

Notification about financial assistance availability from MMC will be communicated by various means, which may include, but are not limited to the following:

- The current policy, application form and a plain language summary of the policy will available on MMC's web site at www.mmchs.org;
- The FAP Plain Language Summary will be available upon request and without charge, both in public locations in the facility and by mail. MMC's Plain Language Summary can be referenced in Addendum G;
- MMC will offer brochures regarding the policy to all patients in the emergency department, registration areas and business office;
- The policy, application forms and plain language summary of the FAP will available in English which constitutes more than 95% of the residents in the community. For those individual speaking and/or reading languages other than those for which the financial assistance guidelines are printed, interpreters will be made available to clearly communicate the policy and provide assistance in completing the necessary forms;
- MMC will distribute information sheets on the FAP to appropriate local public agencies and nonprofit organization that address the health needs of the community's low-income populations;
- Financial Counselors will make every reasonable attempt to visit, as necessary, with individuals to answer questions and assist patients in application regarding the policy before discharge from the facility;
- All hospital billing statements will include a notice regarding how to request information about the FAP, including a phone number for inquiries about the policy.

Education

All Patient Access Services Financial Counselors and the Oncology Financial Navigator are required to read and sign that they have read and understand the policy.

Monitoring

These accounts will be monitored on a monthly basis to adjust off approved balances as indicated for the period of time Financial Assistance is applicable.

Cross Reference

A-401.1 Uninsured Patient Discount Guidelines Policy

A-420 Debt Collection Policy

Addendums

~~28. All insured accounts that were approved for financial assistance will be adjusted as appropriate using the Federal Poverty Guidelines matrix shown above.~~

~~EDUCATION:~~

~~All Patient Access Services Financial Counselors are required to read and sign that they have read and understand the policy.~~

~~MONITORING:~~

~~These accounts will be monitored on a monthly basis to adjust off approved balances as indicated for the period of time financial assistance is applicable.~~

~~CROSS REFERENCE:~~

~~A-401.1 Self Pay Payment Policy~~

~~A-420 Debt Collection Policy~~

~~REFERENCES:~~

~~1. 42 CFR 413.89 Bad Debts, Charity and Courtesy Allowances, Medicare~~

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- Provider Reimbursement Manual, CMS Pub 15 Part 1, Ch 14, 304-326
2. Patient Protection & Affordable Care Act, Internal Revenue Code Section 9007(a) Pub. L No. 111-148
 3. Healthcare Education Affordability Reconciliation Act, 2010, (H.R. — 4872) Pub. L No. 111-152, Amendment to Pub. L No. 111-148, — Section 501(r) (5)
 4. Federal Poverty Guidelines
 5. Federal Register, Vol. 77 No. 123
 6. Internal Revenue Code Section 501 (r) and Treasury Regulation 1.501(r) — et seq.
 7. Translating Service website: <http://www.refugees.org/about-us/where-we-work/vrrp/our-services/interpretation-services.html>

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