MEADVILLE MEDICAL CENTER HEALTH SYSTEM
POLICY AND PROCEDURE MANUAL

Administrative Policy A-401

SUBJECT: Patient Financial Assistance

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.

POLICY: 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.

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.
- 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 the individuals 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 the individuals 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.
- Services where the patient has exhausted all insurance benefits
- Services not covered by the patient's insurance plan

  Experimental procedures/services not covered by the patient's insurance plan

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
- Retail Pharmacy

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 and Instruction sheet 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 may 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 may apply for state Medicaid
- 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 six (6) 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. Catastrophic 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.

Debt Collection
See A-420.

Meadville Medical Center will not engage in the following activities:

- Meadville Medical Center will not pursue legal action for nonpayment of hospital bills against any patient who has worked with Meadville Medical Center to demonstrate their inability to pay and who is unemployed or otherwise financially unable to pay.
- Meadville Medical Center will not pursue legal action for nonpayment if the only way to collect payment would be to place a lien on the patient's home.

Meadville Medical Center always has distinguished itself from other hospitals and systems in its treatment of the uninsured:

- Meadville Medical Center will continue to treat patients in their emergency rooms without regard to the patient's ability to pay. All patients will continue to be triaged and treated as appropriate.
- It is not the practice of Meadville Medical Center to place a lien on a patient's home when it is the patient's only asset.
- Meadville Medical Center will continue to work for increased access and coverage for the uninsured through legislative and community activity.

It is the practice of Meadville Medical Center not to pursue legal action for nonpayment unless it has first examined the patient's eligibility for other assistance or charity care.

It is the policy of Meadville Medical Center to appropriately place patient accounts with collection agencies for bad debt collections. Meadville Medical Center will not engage in collection actions before determining if the Patient is eligible for Financial Assistance.

MISSION/VALUES RATIONALE:

The Meadville Medical Center value of integrity requires appropriate follow-up processes in the referral of patients to a bad debt agency. Patients and families are to be treated dignity, respect and compassion during the collection process. The Meadville Medical Center value of stewardship requires accurate collection processes to ensure appropriate and timely reimbursement.

PROCEDURE:

1. Qualifying Accounts for Bad Debt Placement. Accounts are qualified for transfer from Final Billed to Bad Debt during the month. Accounts are reviewed and approved for transfer from Final Billed to Bad Debt and placement with a collection agency throughout the month. In order to qualify for bad debt any one of the following criteria must be met:

- Patient has defaulted on an installment payment agreement and has missed a minimum of two (2) consecutive payments.
- A minimum of four (4) statements over 120 days have been sent to the patient with no payments or agreement to pay. It is Meadville Medical Centers policy to send the guarantor an initial statement within 90 days of the last remittance from the insurance/payer.
- Financial Assistance has been offered to the patient and the patient has failed to cooperate with the process.
- The patient has failed to cooperate with the Medical Assistance Application for Public Aid.
- There has been an inability to locate the patient via phone or mail. (e.g., mail returned with no forwarding address.)
- Account balance is $10.00 or over.

2. Collection Agency Referral. Primary bad debt referrals on accounts $10.00 or over will be done after approval (to transfer account from Final Billed to Bad Debt)

3. Reconciliation of Agency Accounts. On a monthly basis, accounts in bad debt will be reconciled with agencies. Accounts will stay in bad debt (with collection agency) for nine (9) months unless a payment is set up or there is legal activity. Accounts over nine (9) months will be returned from the primary collection agency as uncollectable and and then transferred by MMC to the secondary collection agency. Accounts will remain with the secondary agency for an additional nine (9) months; if after nine (9) months the balance is not resolved the account will be returned to MMC as a bad debt write off. (e.g., Sound business judgment established that there was no likelihood of recovery at any time in the future.)

4. Agency Reporting. Collection agencies will prepare monthly basis reports that include the following:

- Total number of accounts placed in the month.
- Total dollars placed in the month.
- Overall average account age at placement.
- Total accounts collected.
- Total dollars collected.
- Total accounts and dollars returned as uncollectable.

5. Account Cancellation. Accounts may be cancelled out of a collection agency for

various reasons such as:

- Patient Disputes.
- MMC Management request.
- Referred in Error.
- Financial Assistance application approved.

Upon cancellation of an account, credit bureaus will be notified of the cancellation by the collection agency and deleted from the credit bureau.

6. Agency Expectations. Collection Agencies that are working on behalf of Meadville Medical Center must agree to the following:

- No property liens will be placed for sale or foreclosure of a patient's primary residence.
- If patient requests Financial Assistance, the account will be placed on hold with the collection agency and referred back to MMC so that proper follow-up can occur. The collection agency will not pursue the collection process until they are notified by MMC to continue collection activities.
- All collection agency communications with MMC patients and families must be done in a manner reflective of the dignity and respect we have for our patients.
- Collection agencies are able to report to credit bureaus on open unpaid accounts, in accordance with current regulatory guidance. If there is a cancellation of the account, the collection agency will notify the credit reporting agency.

Cross Reference

A-401.1	Uninsured Patient Discount Guidelines Policy
A-420	Debt Collection Policy