PURPOSE:

To provide guidelines for Financial Assistance to uninsured and underinsured individuals who are in need of emergency or medically necessary care and do not have adequate financial resources to pay for these services. Margaret Mary Health is committed to providing emergency and medically necessary care to individuals regardless of their ability to pay.

POLICY:

The Margaret Mary Health (MMH) Financial Assistance Policy offers both free and discounted services to patients based upon eligibility criteria set forth in this policy. After a determination that the patient or account guarantor meet the eligibility criteria contained within this policy, financial assistance will be provided for any emergency or medically necessary care. Information related to the MMH Financial Assistance Program will be made available to patients and/or the account guarantor through multiple methods described within the policy.

DEFINITIONS:

Amount Generally Billed (AGB): The amount generally billed to a patient for emergency or medically necessary care, regardless of whether the patient has insurance coverage for such services. AGB is based on the look back method that considers discounts allowed by Medicare and commercial insurances that pay claims to MMH.

Emergency Care: Condition manifesting itself by acute symptoms for sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ. Full definition can be found within Section 1867 of the Social Security Act [42 U.S.C. 1395dd].

Gross Charge: The established MMH price for a service or item that is charged consistently and uniformly to all patients before any contractual allowances, discounts, or deductions are applied.

Household/Family: According to the United States Census Bureau, a family is defined as a group of two or more people who reside together and who are related by birth, marriage, or adoption. If the responsible party claims an individual as a dependent on their Federal Income Tax return, the individual may be considered a dependent on the Financial Assistance Application.

Federal Poverty Guidelines: A measure of income issued every year by the Department of Health and Human Services. These guidelines provide income thresholds, based upon the number of individuals in a family, to calculate eligibility for the MMH Financial Assistance Policy.

Income: Income includes: gross wages, self-employment income, social security, disability, unemployment, pension, alimony/child support, etc. This list is not all inclusive - any income reported on the individual's annual income tax return or any income received by an individual who is not required to file an annual tax return should be provided.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Plain Language Summary: A written statement that notifies an individual that MMH offers financial assistance under a Financial Assistance Policy and provides the information in a clear, concise, and easy to understand description.

Self-Pay or Uninsured: Patient who does not have health insurance coverage through a third party health insurance plan, Medicare, state funded Medicaid, or whose injury is covered by workers' compensation, automobile insurance, or other insurance as determined and documented by MMH.

Underinsured: Patient who has limited health insurance coverage, or coverage that leaves the patient with an out of pocket liability that requires financial assistance.

PROCEDURE:

1. Eligibility Criteria

- Services eligible for financial assistance include emergency and medically necessary care. These are further defined in the Definitions section above.
- Elective services, or those services deemed non-emergent or not medically necessary, are not eligible for financial assistance.
- Other procedures may be considered non-covered depending on the medical necessity of the procedure.
- Patients who are part of a household where annual income is at or below 200% of the Federal Poverty Guidelines may receive free care (100% discount).
- Patients who are part of a household where annual income is between 200% and 300% of the Federal Poverty Guidelines may receive discounted care as illustrated in Appendix A.
- Patient is a permanent resident within the MMH service area.

Additional Criteria

- If the balance due from a patient or account guarantor exceeds 10% of the household's annual gross income and the annual household gross income is greater than 300% of the Federal Poverty Guidelines, the patient may be granted partial assistance for the amount due above 10% of the household's annual gross income.
- Circumstances requiring individual consideration may occur and exceptions may be made to grant more or less financial assistance based on these circumstances. Additional criteria that are used to determine eligibility status includes employment status, future earnings capacity, and other financial resources. Financial assistance would be subject to reduction only in situations where the additional criteria indicate that the individual's household income is greater on an annualized basis.
- In the event of a patient's failure to apply for outside assistance or failure to provide information which would lead to the discovery of the availability of outside assistance, financial assistance would not be available.
- MMH will also take into consideration the value of any Assets listed within the Financial Assistance Application when determining financial assistance eligibility.
- Patient financial assistance eligibility does not take into account race, gender, age, sexual orientation, religious affiliation, or social or immigrant status.

2. Basis of Calculation – Amounts due from Patients

- MMH limits the amounts charged for emergency and medically necessary services provided to individuals eligible for assistance under the Financial Assistance Policy to not more than the amounts generally billed (AGB) to individuals who have insurance coverage for such care. The AGB is derived by dividing (1) the sum of all claims for emergency and medically necessary services provided at MMH and paid during the relevant period by Medicare fee-for-service and all private health insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-pays, co-insurance or deductibles, by (2) the charges set forth in the MMH charge master at the time the services are rendered. The Hospital-Specific AGB Percentage shall be calculated annually for a 12 month period from January 1 to December 31. The recalculated AGB will be calculated and effective no later than

120 days after the previous year-end. The calculation of the Hospital-Specific AGB Percentage shall comply with the "look-back method" described in the IRS Regulation 501(r)-5(b) (1) (B).

3. Application Process

- The patient's eligibility for financial assistance will be determined through an application process. The MMH Financial Assistance Application is the authorized and approved form for this process.
- Determination of financial assistance eligibility will require the patient or account guarantor to submit the completed financial assistance application, along with all supporting documentation, to the MMH Patient Resource Advocate. The application can be submitted by an individual listed as the Power of Attorney.
- If financial circumstances have not changed, the financial assistance application on file with MMH will remain valid for a period of 12 months.
    - It is the patient or guarantor's responsibility to request consideration on future services within the 12 month period that were not reviewed as part of the initial request.
- Patients may apply for financial assistance by completing the Financial Assistance Application prior to, at the time of, or after services are rendered.
- Financial Assistance Applications will be accepted by MMH up to 240 days from the date the first statement is made available.

4. Income

- The income amount reported on the Financial Assistance Application should include all sources of earnings for all individuals listed as household members.
- Copies of all income supporting documentation must be submitted in order for application to be considered. Examples of acceptable documentation are defined below:
    - Prior year tax return (all schedules), including copies of documentation of all income (W-2s, 1099s, Social Security letters, etc.) – **PREFERRED**
    - Two most recent pay stubs (applicable when current year income changes from previous year)
    - Written verification of wages from employer(s)
    - Award letter from Social Security
    - Award letter for Unemployment
    - Legal decree documenting tax dependent eligibility and court ordered income
    - Two most recent Bank Statements (checking, savings, investments, retirement, etc.)
    - Two most recent Investment Statements (retirement, annuity, CD, etc.)

5. Collection Efforts

- All patients have the opportunity to apply for financial assistance prior to MMH engaging in any extraordinary collection activities (ECA). The Hospital will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for financial assistance.
- The Business Operations Manager has the responsibility for monitoring and ensuring that a reasonable effort is made to determine eligibility and for determining whether and when extraordinary collection actions may be taken in accordance with this policy and the Billings and Collections Policy.
- Patients who are able, but unwilling, to pay are considered uncollectible bad debts and will be referred to outside agencies for collection. The unpaid discounted balances of patients who qualify for the Financial

Assistance Policy are considered uncollectible bad debts and such patients will be referred to outside agencies for collection.

6. Notification of Financial Assistance Approval or Denial

- The Patient Financial Services department will notify the patient in writing within 30 business days of the receipt of the financial assistance application as to whether the application was approved or denied. If approved, the letter will indicate the amount of assistance provided. If the application is denied, the denial reason will be provided within this letter. For incomplete applications, patients will be provided with a listing of the information and/or documents necessary to complete the review of the financial assistance application and where to submit the missing information.
- Any patient who receives less than a 100% discount on billed charges will be given 30 days to submit an appeal to the Business Operations Manager at 321 Mitchell Ave. Batesville, IN 47006. Additional information can be presented at that time to support the appeal request.

7. Publication of Financial Assistance and related information

- MMH communicates the availability of the Financial Assistance Policy, Financial Assistance Policy Summary, and the Financial Assistance Application form through the following:
  - Signage posted within hospital, including Emergency Department.
  - Notification on all patient statements.
  - Brochure format of the Financial Assistance Policy Summary made available during patient registration process. Copies of brochure will be located within all MMH registration/waiting areas.
  - Margaret Mary Health website: https://www.mmhealth.org/for-patients/bill-payment/
  - Patient Resource Advocates are available to assist patients with counseling regarding any available options to assist with the financial obligation.
  - Copies will be provided to local community advocate organization.
  - Copies of all financial assistance documentation available through the collection agency utilized by MMH.

8. Provider Eligibility

- Emergency and medically necessary care delivered by the following provider groups would **not** be considered under the MMH Financial Assistance Policy:
  - Greater Cincinnati Pathology
  - Insight Diagnostics
  - Premier Anesthesia

AUTHOR(S): George Loudenslager
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REVIEWED BY: Brian Daeger
DATE: 11/8/2017

EFFECTIVE DATE: 12/1/2017

APPROVED BY: Margaret Mary Health Board of Directors

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President

APPENDIX A

Margaret Mary Health
Financial Assistance Sliding Scale

		100% Discount	75% Discount	50% Discount	25% Discount
Persons in Household	2018 Federal Poverty Guidelines (FPG)	200% of FPG and Below	250% of FPG and Below	275% of FPG and Below	300% of FPG and Below
1	$12,140	$24,280	$30,350	$33,385	$36,420
2	$16,460	$32,920	$41,150	$45,265	$49,380
3	$20,780	$41,560	$51,950	$57,145	$62,340
4	$25,100	$50,200	$62,750	$69,025	$75,300
5	$29,420	$58,840	$73,550	$80,905	$88,260
6	$33,740	$67,480	$84,350	$92,785	$101,220
7	$38,060	$76,120	$95,150	$104,665	$114,180
8	$42,380	$84,760	$105,950	$116,545	$127,140