PURPOSE:

To provide guidelines for Financial Assistance to uninsured and underinsured individuals who need 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 applies to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity, and 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.

Margaret Mary Health [MMH] is further committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services, MMH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. MMH will provide, without discrimination, emergent medical care in accordance with applicable regulations to individuals regardless of their eligibility for financial assistance or for government assistance.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with MMH's procedures for obtaining financial assistance or other forms of payment, and 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 assuring access to health care services, for their overall personal health, and for the protection of their individual assets. In implementing this Policy, MMH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this 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: Any 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].

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.

Financial Assistance: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Financial assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

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.

Household/Family Income**:** Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. 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.

- Noncash benefits (such as food stamps and housing subsidies) are not included in income
- Income is determined on a pre-tax basis (gross)
- Income calculation excludes capital gains or losses
- Includes the income of all family members living together or participating in shared costs and expenses (non-relatives, such as roommates are not included)

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: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial ability.

PROCEDURE:

1. Eligibility Criteria

- Included Services (further defined in the Definitions section above) 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.
  - Non-elective services provided in response to urgent circumstances in a non-urgent setting;
  - Medically necessary services, evaluated on a case-by-case basis at MMH's discretion.
- Excluded Services:
  - Elective services, services deemed not medically necessary, are not eligible for financial assistance.
- Income Criteria:
  - 100% Discount: Patients who are part of a household where annual income is at or below 200% of the Federal Poverty Guidelines may receive free care.
  - Partial 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 on a sliding scale.
  - Catastrophic Financial Discount: 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 additional or diminished financial assistance. Additional criteria that are used to determine eligibility status includes employment status, future earnings capacity, and other financial resources. The Financial Assistance calculation could be subject to reduction in situations where additional criteria indicate that the individual's household income is greater on an annualized basis than a limited review of recent months may indicate.
- In the event of a patient's failure to apply for outside assistance or to provide information which would lead to the discovery of the availability of outside assistance, financial assistance may not be available.

2. Discrimination

- Patient financial assistance eligibility does not consider race, gender, age, sexual orientation, religious affiliation, or social or immigrant status.

3. Patient Liability Calculation

- 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 as calculated by MMH 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 gross 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). For 2024, the applied AGB calculation results in a minimum discount rate of 59%.

4. 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 up to 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.
- Financial need will be determined in accordance with procedures that involve an individual assessment of financial need including:

- An application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial, and other information and documentation relevant to making a determination of financial need.
- Reasonable efforts by MMH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of nonemergent medically necessary services. However, 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 a year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

- MMH's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for financial assistance shall be processed promptly and MMH shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

5. 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 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.)
  - Two most recent pay stubs (applicable when current year income changes from previous year) for each employed household member or written verification of wages from employer(s)
  - Award letter from Social Security or 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.)
  - Other supporting documents required, if applicable: copies of any weekly or monthly child support or alimony income, copies of any monthly rental income
  - Pension Benefit Confirmation Letter

6. Collection Efforts

- All patients have the right to apply for financial assistance prior to MMH engaging in any extraordinary collection activities (ECA's). The Hospital will not engage in ECA's against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for financial assistance.
- The Billing Office is responsible 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.
- Following at least 3 attempts to contact the patient by written correspondence including paper statements or electronic text or email communication and at least 120 days from the first statement correspondence or electronic communication patients who do not qualify for financial assistance due to income levels or failure to complete the application process may be transitioned to bad det and would be subject to ECA's. Patients who are able, but unwilling, to pay are considered uncollectible bad debts and will be referred to outside agencies for collection.

7. Notification of Financial Assistance Approval/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 Office at 321 Mitchell Ave. Batesville, IN 47006. Additional information can be presented at that time to support the appeal request.

8. 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:
  a. Signage posted within hospital, including Emergency Department
  b. Notification on all patient statements
  c. 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
  d. Margaret Mary Health website: https://www.mmhealth.org/for-patients/bill-payment/
  e. Patient Financial Counselors are available to assist patients with counseling regarding any available options to assist with the financial obligations
  f. Copies will be provided to local community advocate organizations
  g. Copies of all financial assistance documentation available through the collection agency utilized by MMH
  h. MMH will translate and make available for each language group consisting of the lesser of 5% or 1,000 individuals of the community served.

9. Provider Eligibility

- Emergency and medically necessary care delivered by the following provider groups would be included:
  - Hospitalists
  - Emergency
  - Family practice/Minor Care (Batesville, Brookville, Milan & Osgood)
  - Internal medicine
  - Specialty practices of:
    - Cardiology
    - Gastroenterology
    - Obstetrics/Gynecology
    - Occupational Health
    - Otolaryngology (ENT)
    - Orthopedics
    - Physical Medicine & Rehab
    - Podiatry
    - Pulmonology
    - Radiation Oncology
    - Sleep Medicine
    - Surgery
    - Urology
    - Wound Care

- 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
    - Hill Hear Better Clinic (audiology)
    - Additional non-MMH healthcare facilities participating in the patients care

10. **Eligibility Criteria and Amounts Charged to Patients**. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by MMH to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts MMH will charge patients qualifying for financial assistance is listed in *Appendix 'A.'*

AUTHOR(S): Aaron Waldie, Director of Revenue Cycle
DATE: 05/7/2024

REVIEWED BY: Craig Gilliland, Chief Financial Officer
DATE: 05/7/2024

EFFECTIVE DATE: 05/21/2024

APPROVED BY: CFO (Margaret Mary Health Board of Directors reviewed 5/20/24)

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CFO

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Date:

Appendix 'A'

Family Size*	Federal Poverty Level - 2024	100% Assistance	80% Assistance	60% Assistance
		< 200%	< 250%	< 300%
1	**$15,060**	$30,120	$37,650	$45,180
2	**$20,440**	$40,880	$51,100	$61,320
3	**$25,820**	$51,640	$64,550	$77,460
4	**$31,200**	$62,400	$78,000	$93,600
5	**$36,580**	$73,160	$91,450	$109,740
6	**$41,960**	$83,920	$104,900	$125,880
7	**$47,340**	$94,680	$118,350	$142,020
8	**$52,720**	$105,440	$131,800	$158,160
9	**$58,100**	$116,200	$145,250	$174,300
10	**$63,480**	$126,960	$158,700	$190,440
11	**$68,860**	$137,720	$172,150	$206,580
12	**$74,240**	$148,480	$185,600	$222,720

*For families/households with more than 12 persons, add $5,380.00 for each additional person