MARION GENERAL HOSPITAL, INC.
BOARD OF DIRECTORS POLICY/PROCEDURE

Subject: **Financial Assistance Policy (FAP)**

Source: Finance Department Page 1 of 10

Approval: Board of Directors Review Date:

Effective Date: April 1, 2016 Revised Date: 10/1/18

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PURPOSE

The purpose of this policy is:

- To ensure transparency, consistency and fairness towards uninsured (self-pay) or underinsured patients who obtain medically-necessary or emergency services from Marion General Hospital (MGH).

- To outline the circumstances under which MGH will provide free or discounted care to patients who are unable to pay for services.

- To address how MGH calculates amounts billed to patients.

- To screen patients for their ability to pay, evaluate eligibility for health coverage programs or third party coverage, and explore all available resources to identify assistance needs in a timely manner. Health coverage programs could include, but are not limited to, Medicaid, Medicare Savings Programs, subsidized insurance plans purchased through the "Marketplace" or the Affordable Care Act (ACA) Exchange, or other state, federal and local programs. To qualify for financial assistance, an individual must apply and comply with the requirements for any other possible payer source.

POLICY:

As a charitable not-for-profit Hospital and pursuant to its mission to provide service, excellence and value, it is the policy of MGH to provide medically necessary health care services to all patients of MGH, without regard to the patient's financial ability to pay. MGH is designated as a charitable (i.e. tax exempt) organization under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, MGH is required to adopt and widely publicize its Financial Assistance Program (FAP). Financial assistance determination will be made without regard to a patient's age, sex, race, creed, disability, sexual orientation, or national origin.

MGH will identify a dollar amount in its annual budget for financial assistance that is to be made available for medically necessary health care services provided to patients who are "financially" and/or "medically" unable to pay. The budgeted dollar amount for financial assistance shall be

considered as part of the annual amount expended by MGH in meeting its Community Services and Charitable Obligations, and shall be approved by the Board of Directors as part of its approval of the MGH's Operating Budget.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with MGH procedures for obtaining assistance or other forms of payment, and to contribute to the cost of their care based on their individual ability to pay.

Regardless of an individual's ability to pay or qualify under this Financial Assistance Policy, MGH will provide, without discrimination, care for any emergency medical condition(s) as designated under the U.S. Federal Governments Emergency Medical Treatment and Labor Act (EMTALA) OF 1986.

No person shall be discouraged from seeking emergency care.

DEFINITIONS:

- **Amount Generally Billed (AGB) -** Following a determination of financial assistance, an individual eligible for financial assistance will not be billed more for emergency or other medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care. MGH will calculate the AGB annually using the "look-back method" based on actual claims paid to MGH from Medicare fee-for service together with all private health insurers paying claims to the hospital (including, in each case, any associated portion of these claims paid by Medicare beneficiaries or insured individuals). MGH will begin applying its AGB percentages by the 45th day after the end of the 12-month period used in calculating the AGB percentage.

- **Cosmetic Services -** Are those services and procedures that may modify or improve the appearance of a physical feature and are typically not covered by any insurance and are categorically excluded from any financial assistance.

- **Emergency Services -** an emergency, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate attention may result in serious medical consequences. Or as defined in Section 1867 of the Social Security Act (42.U.S.C 1395dd).

- **Elective -** Healthcare services and procedures that are needed to support the health and well-being of the patient whether or not they are deemed medically necessary. Such services are eligible for consideration under this policy. A physician order containing the reason for the test or procedure may be required.

- **FAP –** Financial Assistance Program as defined in this policy.

- **Gross Charges -** An established price, listed in the hospital's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any

contractual allowances, discounts or deductions.

- **Household Unit -** Is defined as one or more persons who reside together and are related by birth, marriage, or adoption (i.e. parents and children who are filed as dependents on their tax return) or adult child supporting a parent(s) within a single household; Patients over the age of 18, such as adult children living with their parents, siblings or friends are not considered part of the household unit unless such persons are legally obligated for the debts of the patient.

- **Income -** Income includes salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment compensation income, business income (IRS Schedule C), pensions and annuities, farm income (IRS Schedule F), rentals and royalties, inheritance, strike benefits, and alimony income. Income is also defined as payments received from the state for legal guardianship or custody.

- **Indiana Certified Navigator –** ClaimAid employees who are registered with the Indiana Department of Insurance and meet the requirements of IC 27-19 to help Indiana residents complete health coverage applications on the federally-facilitated Marketplace and/or insurance affordability program applications (such as Medicaid, The children's Health Insurance Program ("CHIP"), or the Healthy Indiana Plan ("HIP") – dfrbenefits.in.gov).

- **Insured Patient -** A patient who has third party coverage or whose injury is a compensated injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by MGH.

- **Medically Necessary -** for the purpose of this policy, is defined as a service that is necessary to treat a condition that in the absence of medical attention could reasonably be expected to result in jeopardizing the health or condition of the individual.

- **Patient Advocate –** An MGH employee, contractor or volunteer designated to assist patients with screening, application for and enrollment in health coverage programs.

- **Plain Language Summary –** A statement written in clear, concise, and easy to understand language notifying individuals that MGH offers financial assistance under its FAP.

- **Self-Insured or Uninsured -** A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of workers' compensation, automobile insurance or other insurance as determined and documented by MGH.

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- **Underinsured -** – A patient and/or responsible party with third party coverage for healthcare services who may have an extraordinary amount due that they cannot pay due to household unit income.

Financial Assistance Policy (FAP)

APPLICATION AND DETERMINATION:

The patient's qualification for financial assistance will be determined through an application process. FAP information and applications are available at registration stations, online at **www.mgh.net**, and included in the hospital Welcome Guide.

When applying online, the patient should receive a letter within 14 days describing the status of their request as either approved, denied or additional financial documentation is required. Paper application are processed manually and as they are received. Every attempt is made to process the paper applications as timely as possible but they could take up to 30-45 days to complete depending on the volumes.

Printed copies of the FAP and Application may also be obtained by:

- Calling Customer Service at (765)660-6100 or (765)660-7600

- Presenting to:
    - Patient Financial Services Office located at: 513 N. River Road, Marion, IN 46952
    - Physician's Billing of MGH located at: 330 N Wabash Avenue, Suite G-20, Marion, Indiana 46952

- Requesting by mail in writing to:

Marion General Hospital
PO Box 1169
Marion, IN 46952

Patients with balances after insurance (e.g. deductibles, non-covered services and co-insurance amounts) may be eligible for financial assistance if the eligibility requirements are met.

Patients who have exhausted their policy limits are eligible for FAP if the eligibility requirements are met.

Patients shall cooperate in supplying all third-party insurance information and third-party liability information.

The patient must cooperate with pursuing enrollment in all affordable health coverage programs that are accessible to them prior to consideration of financial assistance approval. Assistance with the assessment and enrollment is provided as a service of MGH free of charge to the patient by certified Indiana Navigators.

If the account is with a collection agency, the patient may still apply for financial assistance.

The Federal Poverty Income Guidelines in effect at the time of application will be utilized to make a determination regarding qualification based on income. A determination based on assets may be

made as deemed appropriate by MGH.

A signature is required on the application (the patient, guarantor or legal representative). It is the responsibility of the patient/guarantor to complete a FAP application.

The application requires the patient to provide their name, valid contact information and the names, relationship and ages of persons in their household.

The application requires the patient to list all income amounts and their sources.

Documentation of income information provided may be required to complete the assistance application. MGH, or its designee, may also use other sources to verify or validate the information that is provided.

If current income or lack thereof is not sufficient to meet daily living expenses, a written statement from the individual supporting the applicant may be requested.

An application for financial assistance may be applied to a period of time up to one year from the date of the application if there is no change in financial or other circumstances. MGH always reserves the right to request additional documentation or verification of application information at any time.

If the patient is a minor or not an emancipated child, the financial assistance determination would be based upon the income and assets of the parent(s) or legal guardian. If the Patient has a spouse, the financial assistance determination will be based upon the combined income and assets of both the patient and his/her spouse.

Services Eligible for Financial Assistance

Any MGH service that is medically necessary to treat a condition that in the absence of medical attention could reasonably be expected to result in jeopardizing the health or condition of the individual.

Limitation on Amounts Billed

MGH will not bill patients approved for financial assistance under this FAP for emergency or other medically necessary care more than the amounts generally billed to individuals who have insurance.

Household Size and Income

The following factors may be considered in determining the eligibility of the patient for assistance and may be provided by income earning residents in the countable household unit unless they are not dependents based on IRS guidelines for determining whether a household member can be considered a dependent.

Financial Assistance Policy (FAP)

- Eligibility for patient assistance will be based on Gross Income. If self-employed (include schedule C from tax return:) or if taxes are not filed a completed income and expense report.
- Indiana workforce wage report for last 2 quarters (unemployment income)
- Three (3) paystubs or a letter or printout from employer(s) providing verification of gross income if currently employed. This documentation should not be more than 30 days old from date of issue and include year-to-date information.
- Social Security aware or entitlement letter or other proof of gross monthly award.
- Retirement Income
- Investment Income
- Statement from person(s)that are providing direct support
- Number of dependents
- Other financial obligations
- The amount and frequency of MGH medical bills
- Other financial resources that produce income.

Financial Capacity

- Individuals with the financial capacity to purchase health insurance coverage through the Health Insurance Marketplace may be required to purchase and will be provided access to meet with an Indiana Certified Navigator as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.

- Individuals ineligible for Medicaid or other affordable health care coverage may be required to provide proof of denial.

- Food Stamps or Supplemental Nutrition Assistance Programs (SNAP) will not be counted as income.

- Cosmetic services are not eligible for any kind of assistance and cannot be included in the amount of MGH medical bills owed.

ELIGIBILITY CRITERIA:

MGH will attempt to identify those patients who may qualify for financial assistance at time of admission or within a reasonable period of time after healthcare services are rendered and before extraordinary collection efforts are initiated. MGH will consider qualified Indiana Health Center (IHC) patients and Bridges To Health (Bridges) patients approved for financial assistance since the patients have been deemed to meet MGH's policy and IHC and Bridges have agreed to maintain documentation supporting this determination.

Patients visiting from out of the country and requiring emergency services are eligible for consideration of financial assistance. However, patients visiting the United States with the intent of receiving non-emergent care are not generally eligible for financial assistance.

Financial Assistance Policy (FAP)

Catastrophic or Economic Assistance

To determine if a patient is "medically unable to pay," the Hospital will utilize **50%** of the patient's gross income at the time of the completed application and after payment by any third party payors. This determination is subject to evaluation of other financial information regarding the patient's ability to pay. Expenses may be calculated included but not limited to, the total outstanding accounts with MGH. Eligibility for "medically unable to pay" could be approved up to 100% assistance on the balance remaining but will be based on income and asset determination criteria

Presumptive Eligibility

Financial Assistance may also be considered and granted for the following with eligibility based on each encounter, without completion of a Financial Assistance Application:

- The patient files bankruptcy and the court determines there are not any assets or insufficient assets to pay the patient's MGH bill;

- The patient expires and there is insufficient money in the estate or no estate to pay the patient's MGH bill;

- MGH and/or patient has attempted to obtain coverage through governmental Medical Assistance programs, including Medicaid, and such coverage is not available or approved or only partial coverage is available.

- The patient is presently enrolled in a government assistance program that validates income and/or resource levels.

- For the purpose of assisting patients, information from a third-party may be utilized to conduct a review of patient information in order to assess financial need. These reviews utilize health care industry-recognized standards to place the patient into a Federal Poverty Level (FPL) for purpose of financial assistance. These standards enable MGH to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

Patients who are deemed presumptively eligible for Financial Assistance may receive an adjustment to their account. Attested information may be accepted for purposes of determination; however, MGH reserves the right to request additional information to verify income and assets at any time.

Other Available Discounts and Payment Plans

The following are additional discounts available or payment plans:

- A 40% Self-Pay discount will be posted on the patient account when the account final bills. Self-Pay accounts are those where the patient and/or other responsible party is the total source of payment for services.
- Discounts as may be deemed by MGH, in its sole discretion, to be appropriate in certain circumstances.
- Payment plans are available with no interest from twelve (12) to thirty-six (36)months depending on the remaining balance.

BILLING & COLLECTION:

MGH has a separate Billing & Collection Policy outlining its policies and procedures used to collect account balances from patients and/or other responsible parties. MGH will not impose extraordinary collection actions without first making reasonable efforts to determine whether a patient is eligible for financial assistance. Reasonable efforts shall include:

- Validating that all sources of third-party payments have been identified and billed by MGH.
- Documentation MGH has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the hospital's application requirements.
- Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

COMMUNICATION:

- MGH maintains signs to inform and notify patients and visitors in prominent places throughout MGH, including emergency room and registration area waiting rooms.
- FAP brochures with contact information are located throughout MGH.
- FAP application and brochure is included in the MGH admission packet that provides the patient with admission information.
- FAP policy and application are available on the MGH website at **www.mgh.net**.
- FAP paper applications are available at all MGH registration locations and upon request.
- FAP information is included on all MGH statements and letters sent out for billing purposes.
- Referrals are accepted from any staff member, medical staff, nurse, financial counselor, social worker, case manager, or chaplain.
- Requests can be made by patient, family member, close friend or associate.

Regulatory Requirements:

In implementing this FAP, MGH shall comply with all other federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this FAP.

Failure to Provide Appropriate Information:

Failure to provide information necessary to complete a financial assessment may result in a negative determination, but the account may be reconsidered upon receipt of the required information. The account may also be submitted for approval if MGH has been able to verify information from a reliable third party, i.e. Social Security, Medicaid, credit reporting bureau, etc. A determination of eligibility for financial or catastrophic assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances as determined by MGH in its sole discretion.

Patients who fail to provide required documentation or information will be provided notification.

No patient may be denied assistance due to their failure to provide information or documentation not specified in the FAP or application.

Failure of a patient/guarantor to apply for assistance or pay the balance on the account could cause the account to be placed with a collection agency. The account could be subject to further collection action.

Unfavorable Determination:

An unfavorable determination will be provided in writing and will include an explanation or reason such as:

- Services are categorically excluded from consideration. (i.e. workers compensation, cosmetic or non-covered or services performed at MGHExpress.)
- The individual is fully covered or receives services fully covered by a third party insurer or government program
- The eligibility standards under FPL were not met.

PERCENTAGE OF FEDERAL POVERTY LEVEL

300% of FPL = 100% as financial assistance on patient balance

Reviewed:	Revised: 3/29/05;4/28/08;11/29/10; 3/1/12; 5/28/13/ 5/28/14

EXHIBIT A

Hospital based Physicians that may deliver emergency or other medically necessary care at Marion General Hospital

- Emergency Medicine of Indiana — Does NOT accept MGH Financial Assistance Policy
- Marion General Radiology, Inc. — Does Accept MGH Financial Assistance Policy
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- Associated Anesthesiologists of
    - Fort Wayne, P.C. — Does NOT accept MGH Financial Assistance Policy
- Pathologist Dr. Ricks — Does accept MGH Financial Assistance Policy
- Pathologist Dr. Ren — Does accept MGH Financial Assistance Policy
- MGH Express — Does NOT accept MGH Financial Assistance Policy

Reviewed:	Revised: