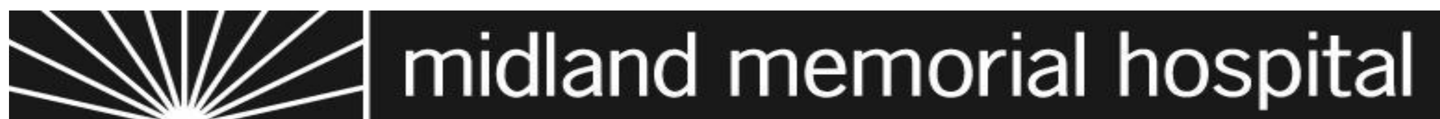

Title:	Financial Eligibility Office-Financial Assistance Policy				
Version:	2	**Approved:**	Committee - Board of Trustees, Russell Meyers (President /Chief Exec Officer), Stephen Bowerman (CFO Senior Vice President)	**Date:**	10/08/2014

Purpose: This policy is intended as a guideline for use in determining an applicant's eligibility to receive financial assistance from Midland Memorial Hospital. It is the responsibility of the Midland Memorial Hospital to provide free or discounted healthcare services to those individuals with a demonstrated inability to pay. Unless otherwise specified, these services will be provided in the facilities of Midland Memorial Hospital and will be consistent with accepted medical standards in the community.

GENERAL

It is the responsibility of Midland Memorial Hospital to determine a patient's and/or legally responsible individual's eligibility for the program. This policy serves as a guideline for use in determining that eligibility. Confidentiality of both medical and financial information can be expected. Midland Memorial will seek to notify patients of the contents of this policy by the following:

- Posted signage throughout the facility,
- Referrals to the financial eligibility office prior to service,
- Communication on patient's statements,
- Information provided on hospital website,
- Summary of the policy as requested.

If at any time, during the application process, it becomes necessary to deviate from the guidelines set forth herein, the Chief Executive Officer or the Chief Financial Officer may waive or make exceptions to the guidelines governing this policy. A quarterly report will be submitted to the hospital Board of Directors listing any exceptions granted in the prior quarter.

It is the responsibility of the applicant to provide proof of eligibility for the program. Midland Memorial's responsibility is to advise the applicant of policies and procedures governing the application process, assist the applicant in completing the application and to provide a written determination of approval or denial of the application.

The financial assistance program shall be the payer of last resort. All commercial and/or private insurance, federal, state, or other governmental programs for hospital care or assistance, will be required to adjudicate claims for covered dates of service prior to financial assistance coverage being applied.

The Financial Eligibility Office, located at 400 Rosalind Redfern Grover Parkway, Midland, Texas is responsible for carrying out the program.

Applicants requesting assistance for payment of hospital bills or prescriptions must present to the Financial Eligibility Office at 400 Rosalind Redfern Grover Parkway, Midland, Texas, and complete the application process. Applications for coverage will be received at any time prior to or after services are rendered. The required documentation supporting the application must be received within 30 days of the submitted application or the application will be denied. If an applicant is legally married or married by common law, both parties will be required to sign the application if the spouse shares the same household.

Applications must be updated every ninety (90) days in order to continue to receive financial assistance. Exceptions are applicants who list zero ($0) income. These applications must be updated every 30 days along with supporting documents showing how their living expenses are being paid. Applicants with zero income must be unemployed or without income for greater than ninety (90) days. If no income received for less than 90 days, the most recent income of the applicant's household will be used to calculate an annual income for the purposes of FPIL classification. If an applicant is over 65 years of age and is not receiving Social Security Benefits, and has zero ($0) income, the applicant will be required to meet the same requirement.

An applicant who is applying for assistance and is receiving Social Security Benefits will not be required to update the financial assistance application every ninety (90) days. These applicants can renew their applications once their Social Security Benefits have changed, which is in January of each year. These applications must be reviewed by March 31st of the renewal year.

Applicants will be required to apply for any/all state or federal programs for which they may be qualified. If an applicant fails to comply with the application process, financial assistance coverage will be denied. The applicant will not be eligible to reapply for a period of 6 months following denial for noncompliance.

Applicants will be required to sign a "Release of Information" form during the application process. The signature will give our Financial Eligibility Office authorization to verify information pertaining to the financial assistance application. Applicants who give false information or misrepresent facts in order to become or remain eligible for assistance through the financial assistance program will be denied. The applicant will not be eligible to reapply for the program for a period of twelve (12) months following denial.

The financial assistance adjustment will be figured using current balance on the eligible patient account.

A. **Application**. In order to qualify for financial assistance, Midland Memorial requires the completion of the hospital Financial Assistance Application. The Application allows for the collection of information in accordance with state law and the income and documentation requirements set forth below. In the case of repeat hospital visits, MMH will attempt to re-verify with the patient or responsible party the Application and income information for each subsequent encounter; however, if possible, a new Application and new supporting documentation should be obtained after 90 days have passed.

1. *Calculation of household Members*. Midland Memorial will request that patients requesting financial assistance verify the number of household members in their household. A household unit consists of all legal dependents of the head of household. In determining the composition of a household the guidelines in Addendum B will be followed.

2. *Income Calculation*. Patients must provide their household's yearly income.

(i) The term "Yearly Income" for purposes of classification as meeting Financial Assistance Discount or a Catastrophic Medical Discount in accordance with this Policy means the sum of the total gross income of the household for the prior 12- month period.

B. **<u>Income Verification</u>**. Patients or the responsible party must verify the income reported on the Financial Assistance Application in accordance with the Documentation Requirements set forth below.

1. *<u>Documentation Requirements</u>*.

(i) *Documentation Available*. The income reported on the Financial Assistance Application may be verified through the following mechanisms:

(a) **Income Indicators**. Income and Resource types/limits are found in Addendum A. Applicants with zero income must be unemployed or without income for greater than ninety (90) days. If no income received for less than 90 days, the most recent income of the applicant's household will be used to calculate an annual income for the purposes of FPIL classification.

(b) **Participation in a Public Benefit Program**. Providing documentation showing current participation in a public benefit program such as Medicaid, AFDC, Food Stamps, WIC or other similar indigence related programs. Proof of participation in any of the above programs indicates that the patient has been deemed Financially Indigent and therefore, is not required to provide his or her income on the Financial Assistance Application.

(ii) *Documentation Unavailable*. In cases where the patient is unable to provide documentation verifying Yearly Income, Hospital may verify the patient's income <u>by providing an explanation of why the patient is unable to provide documentation verifying income</u> **<u>and</u>**:

a) Obtaining the Patient's Written Attestation. By having the patient or responsible party sign the Financial Assistance Application attesting to the accuracy of the income information provided; <u>or</u>

b) Obtaining the Patient's Verbal Attestation. Through the written attestation of hospital personnel completing the Financial Assistance Application that the patient verbally verified Hospital's calculation of the income reported on the Financial Assistance Application.

(iii) *Expired Patients*. Expired patients may be deemed to have no yearly income. Documentation of patient reported income on the Financial Assistance Application is not required for expired patients. MMH must assure there are insufficient assets to settle the estate before automatically qualifying for financial assistance.

2. *<u>Verification Procedure</u>*. In determining a patient's total income, MMH may consider other financial assets and liabilities of the patient as well as the patient's household income and the patient's household's

ability to pay. If a determination is made that a patient has the ability to pay the remainder of the bill, such determination does not preclude a re-assessment of the patient's ability to pay upon presentation of additional documentation.

3. *Classification Pending Application Disposition*. MMH may consider a request for financial assistance at any time before, during or after the dates of service. During the verification process, while MMH is collecting the information necessary to determine a patient's income, the patient may be treated as a private pay patient in accordance with MMH's policies.

4. *Information Falsification*. Falsification of information may result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance, and MMH finds material provision(s) of the Financial Assistance Application to be untrue, financial assistance may be revoked and the financial assistance already awarded may be withdrawn.

C. Classification for Financial Assistance Discount: A Financial Assistance Discount is applicable to a person who is accepted for care with either no obligation or a discounted obligation to pay for the services rendered.

1. *Classification*. Patients may only be granted a Financial Assistance Discount if the household yearly income is less than or equal to 350% of the poverty guidelines updated annually. The attached guidelines (Addendum A) will be updated annually based on the reported poverty guidelines issued in the Federal Register by the United States Department of Health and Human Services. Updates will become effective April 1st of each year and continue through March 31st of the following calendar year. Income & Resource types/limits are found in Addendum A.

2. *Acceptance*. If MMH approves a patient for a Financial Assistance Discount, the patient may be granted financial assistance in accordance with Addendum A.

D. Classification for Catastrophic Medical Discount: A Catastrophic Medical Discount applies to a patient who's medical or hospital bills exceed 25% of the person's yearly income, and who is unable to pay the remaining bill.

1. *Classification.* Patients may only be granted a Catastrophic Medical Discount if their yearly income is greater than 101% but less than or equal to 500% of the poverty guidelines updated annually. The Catastrophic Medical Discount will equal 50% of billed charges. The attached guidelines (Addendum A) will be updated annually based on the reported poverty guidelines issued in the Federal Register by the United States Department of Health and Human Services. Updates will become effective April 1st of each year and continue through March 31st of the following calendar year. Income & Resource types/limits are found in Addendum A.

1. *Initial Assessment*. To be considered for a Catastrophic Medical Discount, the amount owed by the patient must exceed twenty-five percent (25%) of the household's yearly income and the household must be unable to pay the remaining bill. If the household does not meet the initial assessment criteria the patient may not be extended a Catastrophic Medical Discount.

2. *Acceptance*. If MMH accepts a patient as eligible for a Catastrophic Medical Discount, the patient may be granted financial assistance in accordance with Addendum A.

E. **Approval Procedures**. MMH will complete a Financial Assistance Approval Worksheet for each discount granted. The Financial Assistance Approval Worksheet allows for the documentation of the administrative review and approval process utilized by the MMH to grant financial assistance.

F. **Document Retention Procedures**. MMH will maintain documentation in accordance with the hospital retention policies sufficient to identify each Financial Assistance or Catastrophic Medical Discount, the patient's income, the method used to verify the patient's income, the amount owed by the patient, and the person who approved as the application/discount. The hospital's delegation of authority will determine the approval required for the application.

NO EFFECT ON OTHER HOSPITAL POLICIES

This Policy shall not alter or modify other MMH policies regarding efforts to obtain payments from third-party payers, patient transfers, or emergency care.

THIRD PARTY PAYERS

The financial assistance program shall be the payer of last resort. All commercial and/or private insurance, federal, state, or other governmental programs for hospital care or assistance, will be required to adjudicate claims for covered dates of service prior to financial assistance coverage.

SUBROGATION

The filing of an application or receipt of services constitutes an assignment of the applicant's or recipient's right to recovery from:

- Personal Injury insurance
- Another person for personal injury caused by the other person's negligence or wrong-doing
- Other settlement or litigation sources
- MMH reserves the right to be reimbursed any cost of services

REPORTING CHANGES

Applicants must report changes which affect eligibility within thirty (30) days after the date the change actually occurred. Changes may be reported by mail, by telephone, in person or by someone acting for the applicant. Changes reported will be documented by the Financial Eligibility Office staff and reported in the applicable case file.

Applicants, who give false information, misrepresent facts or fail to report changes in order to become or remain eligible for assistance through the financial assistance program will be denied. The applicant will not be eligible to reapply for the program for a period of twelve (12) months following denial

SERVICE PROGRAMS

Hospital
Midland County residents eligible for the financial assistance program will receive appropriate inpatient, outpatient and emergency services performed at MMH. Approved applicants who reside outside of Midland County will be eligible for emergency services only. Several service exclusions apply to this policy which eliminate specific treatments and procedures and can be found in Addendum C.

Pharmacy
Uninsured Midland County applicants eligible for the financial assistance program may receive prescriptions with increasing co-pays based on the policy income and resource guidelines with the following stipulations and limitations:

- Co-pays will begin at $5.00 per prescription up to $30.00 per prescription (reference Addendum A)
- Applicants will be limited to 5 active prescriptions per month-each prescription may not exceed a 30-day supply.
- The financial assistance program will not subsidize other prescription programs, including the Medicare Discount Prescription Program
- In all cases possible generic prescriptions or lowest costing alternative medicines shall be issued
- Authorized prescriptions are restricted to those listed on the approved formulary found in Addendum D
- No over the counter medications will be authorized.
- A medication not found on the financial assistance formulary may temporarily be covered with the Chief Financial Officer's prior approval until the patient can become eligible under the drug manufacturer's indigent care drug coverage program.

Other healthcare providers
This program serves the patients of Midland Memorial Hospital and does not include coverage for other providers.

LIMITATIONS/EXCLUSIONS

Limitations and/ or Exclusions of services provided are set forth in Addendum C.

PRESUMPTIVE CHARITY At the hospital's option, patient accounts may be screened using their credit bureau reporting scores. Patients/guarantors who have a credit bureau reporting score of 500 or less may be automatically processed as charity regardless other program requirements.

BANKRUPTCIES At the hospital's option, upon receipt of any notice received from a bankruptcy court, MMH may approve and process accounts included in the bankruptcy notice as charity.

APPEALS
If an applicant is denied financial assistance due to income exceeding the guidelines, the applicant has the right to appeal with the Financial Eligibility Office. All regular monthly receipts must be provided to the Financial Eligibility Office staff. Expenses incurred, such as credit card receipts (unless it can be proven that the debt was incurred from medical

charges), will not be included. All other instances for appeal will need to be submitted in writing to the financial eligibility office where the applicant applied. All appeals must be received within thirty (30) days of the ineligibility determination date. A response from Financial Eligibility Office must be made within fifteen (15) days of receipt.

References:

Revision number	**Date**	**Description of Document or Document Change**
2	10/08/2014	Archived Financial Eligibility Office-MCHD and Charity policies. Combined policies to form singular policy and included initial IRS Section 501(r) changes into policy.