Subject: Financial Assistance Policy		Last Revision Date: April 14, 2021
Scope	☐Departmental ☒Organizational	Review Dates: 6/2019;8/2019;4/2021
Approved by: Director Patient Financial Services, CFO, Director Compliance		Effective Date: 3/15/2017
		Supersedes:
Owner: Director Patient Financial Services		

PURPOSE

As a tax e-exempt nonprofit organization. Montrose Memorial Hospital serves the healthcare needs of its community and is committed to providing charity care to persons who have healthcare needs. Consistent with its mission to deliver compassionate high-quality, affordable healthcare services, and to advocate for those who are poor and underserved. Montrose Memorial Hospital strives to ensure that the ability to pay for healthcare is not a barrier for needed healthcare services and does not prevent them from seeking or receiving care. Montrose Memorial Hospital will provide care, without discrimination for emergency medical condition regardless of people's ability to pay. This policy will be made readily available to prospective and current patients and to the community at large.

SCOPE

Patients who are eligible for financial assistance- free or discounted (partial charity) care-under this program or any MMH patients with services on an inpatient or outpatient basis, who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Financial assistance under this policy is available to residents of the hospital's service area. There are no geographic restrictions on services to Medicaid beneficiaries. This policy does apply to the hospital's owned and operated clinics.

POLICY

This policy serves the purposes as outlined under IRS Section 501(r) as enacted in 2016

DEFINITIONS (IF APPLICABLE)

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

Family: A group of two or more people who reside together and who are related by birth, marriage, or adoption. Patient has claimed someone as a dependent on their income tax return; they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Determined through computing federal poverty guidelines. It includes 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, educational assistance, alimony, child

support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as food stamps and housing subsidies) are excluded.

Uninsured: The patient has no insurance, third-party assistance, or funding mechanism to fund their payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities. This is defined as out-of-pocket costs, excluding premiums, over the prior 12 months that are equal to 10% or more of household income> or out-of-pocket costs, excluding premiums, that are equal to 5% or more of household income if income is under 200% of the federal poverty level; or an unmet deductible that is 5% or more of the household income.

Gross/billed charges: The total charges at the organization's full established rates for the provision of patient care services, exclusion of any net deductions in revenue or discounting.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

ABBREVIATIONS (IF APPLICABLE)

EMTALA- Emergency Medical Treatment Active Labor Act

AGB- Amounts generally billed (AGB): This is the calculation performed by the hospital annually. This calculation identifies a percentage that an eligible patient may be billed for services. MMH uses the look back method for calculating AGB.

Excluded Services

1. Cosmetic procedures and all associated costs related to provision of these services.
2. Audiology supplies, including hearing aids, hearing aid accessories and battery packs.
3. Lab kit draw fees, venipuncture fees and outpatient TB skin test are excluded if not performed in conjunction with other MMH laboratory services.
4. Procedures that are already discounted to prevailing market rates (UCR) , including but not limited to self-pay fee schedules for imaging and lab services, self-referred screening studies, and any other procedures deemed at MMH's discretion to be determined as "discounted".
5. Physician services provided by MMH.
6. All pediatric, adult physical is directly admitted through the emergency room or is a direct EMTALA transfer.
7. High-cost implantable devices and chemotherapy drugs: MMH will make every attempt to have high-cost devices and chemotherapy drugs provided at no cost by the vendors for patients eligible for charity discounting. In the event the high-cost implantable or pharmaceutical cannot be donated. MMH will discount these items down to the purchase price (hospital cost), and the patient will be financially responsible for this component of their care.

8. Services not covered or deemed medically necessary by the Medicare/Medicaid programs.
9. Non covered services.

Application

Patients may apply or reapply for financial assistance before, during or after care, or after collection agency assignment if their situation changes by contacting a financial counselor at 970-252-2666 to make an appointment. Their office is on 800 South Third Street Montrose, CO 81401. Additional financial assistance information can be obtained through our website at www.montrosehospital.com.

Insured patients with Medicare and/or commercial insurance may apply for financial assistance as a mechanism for secondary funding. Eligibility and discounting will be applicable under the provisions of this policy. Prompt-pay discounts are also available according to the guidelines within this policy. Payment plans may also be requested and may be granted according to this policy on a case-by-case basis.

It is preferred but, not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance may be reevaluated at each subsequent time of service if the last financial evaluation was completed more than one year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.
Required items for application include:

CICP/MISS

- All household members social security numbers, dates of birth, and full legal names (i.e. Driver's Licenses, Birth Certificates, Passports)
- Cards or copies of cards for any current health insurance
- Proof of gross income for all household members for the past 30 days
- PAID medical expenses in the past 12 months
- PAID pharmacy expenses incurred in the past 12 months
- Current bank account statements for all accounts
- Copy of Medicaid Denial Letter
- (Self-employed patients → profit and loss statement for one month)

Medicaid

- All household members birth certificate or passport
- State issued ID with current address
- 8 weeks of proof of income for all household members
- All household members social security numbers
- Any current health insurance cards
- If the patient has applied for Medicaid before, a case number for the previous application is required.

PROCEDURE

All patients will be expected to pay for hospital services on or prior to the day they receive services. Patients with health insurance coverage will be expected to pay deductible balance, estimated coinsurance, and/or any copays due on or prior to the day they receive services. Deductible and copays are required in accordance with laws and regulations governing the programs and/or benefit plan. Patients without insurance will be expected to pay a discounted rate within their ability to pay and apply for financial assistance as required.

Exceptions for pre-payment:

- Emergency or obstetric services, as defined by EMTALA
- Approved payment plan contract in effect with hospital
- Medically urgent or emergent services as determined by a physician
- Participants in clinical trials or grant programs

In processing charity applications and determining eligibility, reasonable efforts by MMH will review all the patient's outstanding account receivables for prior services rendered and the patient's payment history, and consider the patient's available assets, and all other financial resources available to the patient. MMH will explore appropriate alternative sources of payment and coverage from public and private payment programs and agrees to assist patients to apply for such programs. MMH may use external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit or community 'non-credit scoring).

Financial assistance and charity is not a replacement for financial responsibility. Patients are expected to fully cooperate with MMH's financial assistance application process and procedures for obtaining charity or other forms of payment or financial assistance, 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 to ensure access to healthcare services, personal health and for the insulation of their individual assets.

Presumptive Eligibility

In the event MMH lacks evidence to support a patient's eligibility for charity care. MMH will use outside agencies and/or data sources in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts. Patients without health insurance or other verified funding sources, who meet any of the following criteria, can be granted eligibility presumptively by MMH:

- Verified resident address of a shelter/homeless, without signed financial assistance application on file
- Presence of a financial assistance application on file
- Verified "homeless" or "transient" status, without a signed financial assistance application on file

- For medically urgent or emergent services, that are verified with current eligibility in a Medicaid or other public assistance program in a state other the Colorado, of which MMH is not an enrolled provider
- Account is identified in official bankruptcy and there are no estate assets
- Undocumented patient as applicable under Section 1011, Federal Reimbursement of Emergency Health Services furnished to undocumented aliens

Procedural Guidelines for Discounted Services

Services eligible under this policy will be discounted on a sliding scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. This discount will be applied to individual's eligibility for financial assistance who have completed a MMH financial assistance application and provided all necessary documentation for qualifications required for the financial assistance program. The basis for the amounts MMH will charge patients qualifying for financial assistance area as follows:

- Patient's whose family income is at or below 40% of the FPL area presumptively eligible to receive services at amount no greater than the amounts generally billed
- Patient's whose family income is not more that 40.9% of the FPL are eligible to receive a 100% discount off billed charges.
- Patient's whose family income exceeds 40.9% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of MMH: However, the discounted rates shall not be greater that amounts generally billed to (received by the hospital for) commercially insured or Medicare patients.

Any patient eligible for discounting will be required to pay their copay or percentage due upon determination of their eligible, or they must sign an approved payment plan contract. Discounts will be applied to any and all outstanding hospital bills of a patient determined to be currently eligible for any charity or public assistance program that MMH participates in including Medicaid.

Discounted charges will not exceed the lowest average commercial and/or Medicare payer reimbursement rate, whichever is lower. MMH will limit the amounts that the hospital will collect for emergency or other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed the hospital for commercially insured and Medicare patients. This amount generally billed (AGB) will be calculated within three (3) months of the fiscal year.
AGB=Amounts Generally Billed – 2021 =49.5% of gross charges
Calculation:
Medicare Average Reimbursement = 22%
Commercial Average reimbursement = 77%

Prompt-pay Discounting

Patients without health insurance or those who choose not to elect insurance billing, who do not qualify for charity discounting, will be eligible for a 25% self-pay discount. For medically urgent or emergency admissions where it is not practical to collect payment in advance of receiving services, the 25% prompt payment discount will be accepted following discharge. If actual billed charges exceed the estimated amount paid at the time of service, a 25% self-pay discount will be applied to the charge amount. When actual charges exceed the amount originally estimated by the hospital, an effort will be made on a case-by-case basis to adjust the charges if requested by the patient. Charity discount and a prompt pay discount cannot be combined, nor combined with any other discount offered by the hospital or its affiliates. Discounting is not available for the "Excluded Services" list under this policy.

Collection Practices

MMH's debt collection policies area available upon request. MMH reserves the right to take certain actions in the event of nonpayment or non-participation in the financial assistance application process, including, but not limited to, collections action and reporting to credit agencies. For patients who have submitted a financial assistance application, provided all requested documentation, and cooperating in good faith to resolve their hospital bills, MMH will cease extraordinary collection practices for a period of 180 days from discharge. MMH will ensure extraordinary collections actions such as wage garnishments, liens or other legal actions do not occur without documented reasonable efforts to provide notice and to determine whether that patient is eligible for charity care under this financial assistance policy.

DOCUMENTATION (IF APPLICABLE)

SPECIAL CONSIDERATIONS (IF APPLICABLE)

ATTACHMENTS AND FORMS

REFERENCES
IRS Section 501(r)

REVISION HISTORY		
Revision Date	**Revision Description**	**Revised By**
8/27/2019		Christina Ingram
9/6/2019	Incorporated AGB calculation and other recommended minor changes	Christina Ingram
4/14/2021	Removed 25% discount language that pertained to "must be paid prior to services" to receive discount and 30-day limit for self-pay. Updated AGB for 2021.	Christina Ingram