Mon Health℠
Preston Memorial Hospital

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FINANCIAL ASSISTANCE POLICY

POLICY:

Preston Memorial Hospital CORP (PMH) is a not-for-profit hospital committed to providing quality health care services. To provide necessary medical services to our community, PMH must maintain a strong financial foundation that includes the collection of Accounts Receivable where possible. This policy establishes PMH's financial requirements for payment of services based on consistent compliance criteria incorporating individual patient financial conditions and circumstances. This policy will ensure the appropriate resolution of patient financial obligations to PMH and attempts to resolve patient financial obligations with customer satisfaction in mind. As part of the mission of Preston Memorial Hospital to provide medically necessary services to members of the community, as well as those who do not possess the ability to pay in full for healthcare services, those individuals will be provided financial assistance (also referred to as "charity care") as established by this policy. Preston Memorial Hospital provides "medically necessary and appropriate" care to all who seek it without discrimination due to age, sex, race, religion, national origin, or ability to pay. Cosmetic and/or purely elective procedures (including but not limited to cosmetic or restorative surgeries) or procedures that may otherwise not be covered by Medicare, Medicaid, as well as third party payers, may not be eligible for Financial Assistance if they are determined to be elective, cosmetic, and/or not medically necessary. Physician services that are not billed by Preston Memorial Hospital are also excluded from this policy. Any procedure that is questionable will be reviewed to determine its eligibility based on the sole discretion of Preston Memorial Hospital. Payment for excluded procedures may be required prior to the performance of those specific procedures or services. The Affordable Care Act ("Healthcare Reform") has impacted payment opportunities for our patients. Effective January 1, 2014, WV has expanded its Medicaid coverage (up to 138% of the Federal Poverty level) and has established its Health Insurance Marketplace Exchange and the related government subsidies. If a financial assistance applicant has enrolled in the Health Insurance Marketplace Exchange, he or she will need to provide documentation of such enrollment including eligibility for government subsidies. Those that have enrolled in a Health Insurance Marketplace Exchange product or who have purchased insurance thru an employer, or on their own, may be eligible for PMH financial assistance up to 200% of the Federal Poverty Guidelines (FPL). If a financial assistance applicant has not enrolled in a Health Insurance Marketplace Exchange product or does not have private insurance, he or she will only be eligible for PMH financial assistance if he or she has been denied Medicaid coverage and available income is under 200% of FPL. The Medicaid denial must result from a completed full application. The IRS under section 501(r)(5) requires a hospital organization to limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's Financial Assistance Policy (FAP=eligible individuals) to not more than the amounts generally billed to individuals who have insurance covering such care. Section501(r)(6) also prohibits the use of gross charges. To meet this requirement, the hospital has decided to set the minimum

Financial Assistance for qualified individuals to 40% of gross charges to be comparable to Medicare Critical Access Hospital reimbursement.

Definitions:

Household Income - income for the patient or any related guarantor as listed on the most recent Federal Tax Return regardless of filing status.

Federal Poverty Guidelines - Published annually by the Community Services Administrations in the Federal Register. (Federal Poverty Guidelines 2014 link)

PROCEDURE:

A. Financial Assistance will be considered according to the following:

1. Identification of Financial Assistance is provided through Financial Counseling, Patient Access, Registration, as well as employees within the Patient Financial Services Department.
2. A complete Patient Guarantor Financial Statement (Application, Financial Application) must be submitted within 120 days of the initial statement date, or 120 days from the hospital being notified by the guarantor of the intent to file an application.
3. All applicants must notify the hospital by calling the number on the statement or the Financial Counseling office at 304-329-4719 to advise PMH of their intent to complete an application to place the accounts on a hold status to prevent additional collection efforts while their application is processing.
4. All applicants must complete a full application for Medicaid assistance and be denied coverage.
5. All financial assistance is only granted where there are not substantial cash convertible assets as determined by the completion of the Financial Assistance Application.
6. Bankrupt patients may be considered for financial Assistance upon receipt of bankruptcy notice. A Proof of Claim must be filed, except when the bankruptcy notice indicates that there are no assets from which any dividend can be paid.
7. Financial assistance may be provided when patient is deceased and without an estate.
8. An individual's failure to comply with our documentation and/or soliciting Medicaid eligibility shall be excluded from consideration.
9. An individual's failure to comply with their insurance company requirements resulting in penalty or unpaid claims are not eligible for financial assistance. Patients will be required to assign or pay, to the Hospital, all insurance payments or liability settlements designated as remuneration for medical expenses.
10. Payment received on an account with a Charity Care Adjustment will be applied to the account and the adjustment reversed up to the amount of the Charity Care Adjustment.

B. Assistance:

1. Financial Assistance will be provided at 100% only to those patients where the household income regardless of filing status is at 138% or below federal poverty guidelines.
2. Financial Assistance will be provided at 60% only to those patients where the household income is at or below 175% but above 138% of the Federal Poverty Guidelines and enrolled with insurance.

3. Applicants will be encouraged (and assisted by PMH) to enroll in the Health Insurance Marketplace Exchange.
4. Financial Assistance will be provided at 40% only to those patients where the household income is at or below 200% but above 175% of the Federal Poverty Guidelines and enrolled with insurance.
5. Medical expenses higher than 7.5% of the adjusted gross income could be considered to determine if a one-time percentage financial assistance should occur.

C. Completion of the Patient/Guarantor Financial Statement:

1. Any patient/guarantor requesting financial assistance must complete the Patient/Guarantor Financial Statement Application including demographic information, sources of income, monthly earnings from employer, total household income, self-employed income must be verified by appropriate supporting documents, child support, rental income, monthly expenses including prescription drug expenses, immediate assets (same as is used for Medicaid program e.g. cash, checking and savings accounts), mortgage or rent as well as current tax returns, current pay stubs, and current bank statement. If the patient is a dependent on a Federal Tax Return, that Tax return must also accompany the application.
2. Any item not documented must be explained thru a notarized letter accompanying the application.
3. The Medicaid eligibility denial letter must also be attached to the application. If the denial is three months old, a new denial is needed. If the denial was due to spend down not being met, a new denial will be needed each month to verify.
4. If the appropriate documentation is not submitted the application will be returned with a letter indicating what is needed. The needed documentation must be returned within 15 days of the date the hospital mailed the letter. If the needed documentation is not received within 15 days the application will be denied.
5. A determination letter will be mailed to the patient/guarantor upon the evaluation of the completed application. If the determination is unfavorable a letter will be provided explaining the reason for the determination. The letter the patient/guarantor receives outlining the financial assistance award must be presented each time the patient/guarantor receives future services. The award is valid for 180 days from the date of the determination letter unless a significant change in either insurance, Medicaid or financial status has occurred.

D. Applying:

1. Information regarding Financial Assistance will be posted in all patient access and registration areas including clinics.
2. Patient Access and registration personnel will provide information on Preston Memorial Hospital's Financial Policy while registering the patient/guarantor. Schedulers and Financial Counselors will also inform patients of the availability of Financial Assistance.
3. A summary of the Finance Policy will be placed on the back of the patient statements.
4. A summary of the Financial Policy will be posted on the Preston Memorial Hospital Website.
5. Applications will be available at every access point within the organization along with business cards for contacting the financial counselor. The application will also be available for downloading from the Preston Memorial Hospital Website.
6. Preston Memorial Hospital will provide assistance with the Medicaid Application process, the Health Insurance Marketplace and completion of the Financial Statement Application.

7. All applications will be sent to the Financial Counselor to review the documentation for completeness and initial determination. If there are any questions or missing documentation a letter explaining what is needed will be sent to the patient/guarantor. The applicant will have 15 days to provide the needed information or the application will be deemed incomplete and will be denied.
8. All applications will be placed on the Financial Application log which will also indicate the status and ultimate determination. The Financial Application log will be shared with the hospital's private pay processing company who will assist in the application process and will monitor required billing cycles by account.
9. Applications with initial determination and documentation will be sent to the CFO for final determination.
10. A determination letter will be mailed to the patient/guarantor either denying the application, or awarding 40%, 60% or 100% assistance.
11. A patient/guarantor has up to 120 days from the date of the initial statement to request an application for assistance. Once the patient/guarantor has notified PMH of the intent to file an application, the patient/guarantor has 120 days to provide the application before extraordinary collection efforts may begin.
12. The Financial Coordinator will place any award on a transmittal and post the financial assistance on the account with adjustment code 99016. The financial counselor will work on a payment plan with the patient/guarantor on any remaining balance. Accounts that are already in bad debt or already paid are not eligible for financial assistance.
13. The letter the patient/guarantor receives outlining the financial assistance award must be presented each time the patient/guarantor receives future services. The award is valid for a period of six months (180 days) unless a significant change in either insurance, Medicaid or financial status has occurred.
14. Applicants that are not approved for financial assistance may reapply for financial assistance by completing a new application six months after the denial letter is mailed unless a significant change in patient's financial status or family can be substantiated.
15. All applications and related documentation will be scanned into Paperstore. Award letters will also be scanned into the shared U drive for Patient Access/Registration review should the Patient/Guarantor fail to bring their award letter.
16. All claimable Medicare charity accounts will be listed on the Medicare Charity log. Medicare accounts will be processed and kept until requested for audit. All Medicare accounts are to include demand bill, Medicare EOMB, account history and current financial application and determination.

E. Collection Practices for Financial Assistance Patients

1. Internal and external collection practices and procedures will take into account the extent to which a patient is qualified for financial assistance or discounts. In addition, patients who qualify for partial discounts are required to make a good faith effort to honor payment arrangements, including payment plans and discounted hospital bills. PMH is committed to working with patients to resolve their accounts, and at its discretion, may provide extended payment plans to patients making a good faith effort. Preston Memorial will not pursue legal action for non-payment of bills against financial assistance patients who have cooperated with the hospital to resolve their accounts and have demonstrated their income and/or assets are insufficient to pay medical bills.
2. The hospital will not impose a lien nor will it force the sale or foreclosure of a financial assistance patient's primary residence for outstanding medical bills. Reporting to credit agencies and legal actions, such as the garnishing of wages, may be taken to enforce the terms of a payment plan if clear evidence

exists that the patient has sufficient income and/or assets to honor the agreements with the approval of the VP, Financial Services. For financial assistance patients meeting all requirements, PMH will cease all collection efforts on their account and will not send unresolved balances or bills to outside collection agencies.

F. Communication of Financial Assistance Program

1. PMH communicates the availability and terms of its financial assistance program to all patients, through means which include, but are not limited to:
    a. Posted signs within waiting rooms, registration areas or desks, as well as emergency department, urgent care center, hospital based physician offices, and financial services departments.
    b. Notification on patient bills or statements
    c. Posted policies on the organization's website (under development)
    d. Designated staff knowledgeable on the financial assistance policy to answer patient questions or who may refer patients to the program.
2. Requests can be made by a patient, their family members, friend or associate, but will be subject to applicable privacy laws.
3. Patients concerned about their ability to pay for services or would like to know more about financial assistance should be directed to the Financial Counselor at 304-329-4719.

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