Premier Health

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System Departmental

Premier Facility: **(select all that apply)**	☒Atrium Medical Center ☐Premier Health Plan ☐Samaritan Behavioral Health	☐Fidelity Home Health Services ☒Miami Valley Hospital ☐Premier Physician Network ☒Upper Valley Medical Center
Title:	Financial Assistance Policy	Effective Date: 07/23/2018 Updated: 11/11/2022; 01/01/2025
Responsible Dept.	Patient Financial Services and Patient Access Services	

OBJECTIVE

To establish guidelines for when Premier Health Hospitals may provide its patients with discounted or free care under its Financial Assistance Program. This policy applies to all Premier Health Hospitals, which include Miami Valley Hospital, Miami Valley Hospital North, Miami Valley Hospital South, Atrium Medical Center, and Upper Valley Medical Center. All hospitals are referred to collectively in this policy as "Premier Health Hospitals."

SCOPE

All hospital facilities providing hospital services.

DEFINITIONS

Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care.

Assets: Liquid assets that can easily be converted into cash in a short amount of time. Examples of assets include cash balances in checking, savings accounts, CDs, stocks, and bonds.

Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

Extraordinary collections actions (ECAs): Actions that require legal or judicial process (liens, foreclosures, garnishments), selling an individual's debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying medically necessary care due to nonpayment for prior care.

Family: A "family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children natural or adoptive under the age of eighteen who live in the home. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home of the minor application.

Federal Poverty Guidelines (FPG): Poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Financial Assistance Policy (FAP): A hospital policy that considers income, assets, and family size to determine a discount for patients.

Financial Assistance Program: The program by which Premier Health Hospitals administer the FAP.

Gross Charges: The full amount charged for items and services before any discounts, contractual allowances, or deductions are applied.

Health Savings Account (HSA): Tax-deductible savings account set up by participants in high deductible health plans. This money should be used to pay current and future medical expenses.

Hospital Care Assurance Program (HCAP): HCAP is the Ohio Department of Job and Family Services' mechanism for meeting the federal requirement to provide additional payments to hospitals that provide a disproportionate share of uncompensated services to those ineligible for Medicaid coverage.

Income: Income is defined as total salaries, wages, retirement monthly withdrawals, and cash receipts before taxes. For self-employed and farm employment individuals, receipts that reflect reasonable business expenses shall be counted. Other sources of income may include, but are not limited to, alimony, child support, veteran's benefits, and unemployment compensation.

Medically Necessary Care: Basic, medically necessary hospital-level services are those defined as all inpatient and outpatient services covered under the Medicaid program in Chapter 5160-2-07.17 of the Administrative Code except for transplantation services and services associated with transplantation. Cosmetic and elective procedures, or complications relating to them are not available for discount under this policy.

Non-compliance: A patient or guarantor's failure to cooperate with requests for information from the Hospital, third party payer/resource, or agents of either the Hospital or third-party payer/resource.

Premier Health Hospitals: For the purpose of this policy, Premier Health is defined as Miami Valley Hospital, Miami Valley Hospital North, Miami Valley Hospital South, Atrium Medical Center, and Upper Valley Medical Center.

Presumptive Eligibility: The process by which Premier Health Hospitals may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for the Financial Assistance Program.

Third-Party Resource: Any person or entity who may be responsible for payment of a patient's medical bills. This includes coverage that may extend to the patient through another person, entity, or policy. Third-party resources may include, but are not limited to the following:

1. Health Insurance
2. Limited Benefit Health Plans
3. High Deductible Health Plans
4. ERISA Plans
5. Workers' Compensation Coverage
6. Medical Saving Accounts and Patient Health Savings Accounts
7. Employee Benefit Plans
8. Automobile Insurance
9. Medical Payments or PIP coverage
10. Underinsured/Uninsured Motorists Coverage
11. Indemnity Insurance Plans
12. Umbrella Coverage
13. Liability Insurance
14. Third-party Liability Coverage
15. Government Benefits or Insurance
16. Any other person or entity that Premier Health Hospital representatives identify
17. Other coverage for all or any part of patient's bill

Uninsured Patient: An Uninsured Patient is a patient who does not have another source of payment or reimbursement for the charges related to their health care.

POLICY

Premier Health Hospitals are committed to providing financial assistance to persons who require emergency or medically necessary care and meet the eligibility requirements for the Financial Assistance Program outlined in this policy. Premier Health Hospitals strive to ensure that peoples' finances do not prevent them from seeking or receiving emergency or medically necessary care.

Premier Health Hospitals provide individuals, without discrimination and regardless of their ability to pay, emergency medical care consistent with the Emergency Medical Treatment and Labor Act (EMTALA) regardless of their eligibility under this policy. Premier Health Hospitals prohibit any action that would discourage individuals from seeking emergency medical care, such as demanding that an emergency department patient pays before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care.

PROVISIONS

PROGRAMS: Premier Health Hospitals provide free or discounted services to eligible patients for Emergency Care or Medically Necessary Care. Premier Health Hospitals' programs include the following:

1. Hospital Care Assurance Program (HCAP). The HCAP program is the Ohio Department of Job and Family Services' (ODJFS) mechanism for meeting the federal requirement to provide additional payments to hospitals which provide a disproportionate share of uncompensated services to those ineligible for Medicaid coverage.
2. Financial Assistance Program. The Financial Assistance Program provides assistance in accordance with Appendix A of this policy for Emergency Care and Medically Necessary Care.
3. 3. Catastrophic Assistance Program. The Catastrophic Assistance Program is for patients who make above 300% of the FPG, whom Premier Health, in its discretion, has determined are unable to pay a portion of their medical bills because their medical bills exceed 15% of their family's annual income and assets, even though they have enough income and/or eligible assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under this policy.
4. Where none of the above programs apply, Premier Health reserves the right to also consider an application on a case-by-case basis for Catastrophic Assistance for patients who otherwise demonstrate that a financial hardship is catastrophic, unusual, or extraordinary. Both the Financial Assistance Program and the Catastrophic Assistance Program are programs of last resort, meaning that if another state or federal program is available to provide assistance, or if other Third-Party Resources are available to pay for a patient's care or reimburse the patient for charges relating to that care, that program or resource must be exhausted before the patient becomes eligible for the Premier Health programs.

Patients who do not qualify for one of the above-mentioned programs, and therefore, do not qualify as eligible under this policy, may be eligible for other discounts for Emergency or Medically Necessary Services that are administered outside of this policy.

ELIGIBILITY REQUIREMENTS:

Premier Health Hospitals' Financial Assistance Program is available to patients who meet the criteria outlined in Appendix A and who do not qualify for Medicaid, HCAP, or other government sponsored programs. Patients seeking assistance under this policy are only eligible under the Financial Assistance Program after all Third-Party Resources are exhausted to the satisfaction of Premier Health Hospitals. Patients are expected to cooperate with requests for information from the Premier Health Hospitals, third party payers/resources, or agents of either the Premier Health Hospitals or third-party payers/resources. Patients

with income within Medicaid guidelines will be screened for Medicaid and must complete the Medicaid application process to be eligible for financial assistance.

Financial assistance is only provided for care that is deemed Emergency Care or Medically Necessary Care and after patients have been found to meet established financial criteria outlined in this policy. Premier Health Hospitals offer both free care and discounted care, depending on individual's family size, income, and assets as a percent of the Federal Poverty Guidelines, as identified in Appendix A of this policy. Additionally, Premier Health Hospitals may use a family's assets to determine whether a patient meets the eligibility criteria for financial assistance. Patients receiving a discount are expected to pay their remaining balance, and may work with Premier Health Hospitals' financial counselors to set up a payment plan based upon their financial situation.

Premier Health Hospitals will not charge patients who are eligible for the Financial Assistance Program more for Emergency Care or Medically Necessary care than the established AGB outlined in this policy. Patients for whom Premier Health determines qualify for Premier Health's Catastrophic Assistance program will not be charged more than the AGB.

DETERMINING DISCOUNT AMOUNT:
To calculate the AGB, Premier Health uses the "look-back" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule.

1. In this method, Premier Health Hospitals use data based on claims allowed by Medicaid in combination with Medicare fee for service and all private health insurers that pay claims to the hospital during the prior 12-month period. Each hospital calculates their AGB separately, however Premier Health Hospitals use the same discount for all Premier Health Hospitals which provides the most generous benefit to the patient.

2. The AGB percentage is then multiplied by gross charges for Emergency Care and Medically Necessary Care to determine the AGB. Premier Health Hospitals re-calculate the percentage each year. See Appendix (A) for current AGB percentages and discounts. The calculated AGB rate must be applied by the 120th day after the 12-month period.

3. The Financial Assistance Program eligible patient is charged only the amount he or she is personally responsible for paying, after all deductions, discounts, and insurance reimbursements have been applied. The minimum discount resulting from the AGB calculations applies to the amount the patient is personally responsible for paying, rather than the total account.

APPLICATION PROCESS:
To apply for financial assistance, patients must submit a complete application including supporting documents upon request, in person, by mail, via email, or through MyChart.

1. Patients can apply for financial assistance through the Financial Assistance Program before, during or after receiving Emergency or Medically Necessary care, up to 240 days after the first post discharge statement.

2. Financial Assistance Program applications, which are used for both HCAP and Premier Health Hospitals' Financial Assistance Program, are available in the registration and financial counseling areas of the hospitals, and on the Premier Health Hospitals' web sites. Individuals may also request the applications by mail by sending a request to Premier Health Hospitals, PO Box 932715, Cleveland, OH 44193. Applications are also available on the reverse side of the patient's billing statement. Applications are available in English and in Spanish.

3. Financial counseling office hours are generally 8 am to 7 pm weekdays and can be reached by calling 937-499-7364. Bi-lingual services are generally available for Spanish speaking individuals.

4. Applications should be signed by the patient or the patient's representative. The information on the application must be completed as to the applicant's name. Completed applications can be provided to any registration clerk, financial counselor, email, MyChart, or may be mailed to Premier Health Hospitals, PO Box 932715, Cleveland, OH 44193.

5. Premier Health Hospitals' financial counselors may assist patients applying for financial assistance from Third-Party Resources. If the patient does not qualify for Third-Party Resources, Premier Health Hospitals will review the patient's application for the Financial Assistance Program under this policy.

6. The information required in the application can be obtained by personal interview, phone conversation, faxed information, email, and/or mail. A spouse, significant other or member of the immediate family may also provide this information through a personal interview.

7. In addition to completing the application, individuals should be prepared to supply the following documentation:
    a. Proof of income for applicant (and spouse if applicable) such as a pay stub, unemployment insurance payment stubs, or sufficient information on how patients are currently financially supporting themselves.
    b. Bank Statement
    c. Social Security Statement
    d. Tax Return – Schedule C for self-employment income
    e. Documentation of the family's assets.

8. Premier Health Hospitals may use, as an exception, a previous determination of Financial Assistance Program eligibility as a basis for determining current eligibility in the event the individual does not provide sufficient documentation to support an eligibility determination. Additionally, an application will not need to be repeated for subsequent hospital services occurring within six (6) months after the date of service the signed application is applied to.

9. Once a completed application is received, it is reviewed and matched to the appropriate discount percentages. The discount percentages are included in Appendix A of this policy. Once eligibility for financial assistance has been established, Premier Health Hospitals will not charge patients who are eligible for financial assistance more than the AGB for Emergency Care or Medically Necessary Care.

10. For patients approved for financial assistance under this policy, Premier Health Hospitals will refund any payments made by the patient in amounts in excess of the amount the patient owes according to the Financial Assistance Program discount percentage.

11. After the financial assistance adjustment has been made, any remaining patient balance will be treated in accordance with the Collection Policy section below. Payment terms will be established based on Premier Health's policy for payment arrangements. If a patient is unable to meet the established payment guidelines, a Patient Financial Services authorized representative may approve an exception allowing for longer payment terms.

12. Once financial assistance eligibility has been granted, all open self-pay balances for dates of service rendered within three (3) months before the date of approved date of service may be determined to be eligible.

13. Catastrophic Assistance Application: After a patient has completed a Financial Assistance Program application and has been determined not to be eligible for HCAP or the Financial Assistance Program, or has not satisfied the other criteria for eligibility, Premier Health reserves the right to consider a Catastrophic Assistance application on a case-by-case basis for patients who Premier Health

determines to be eligible on the basis of an unusual financial situation that creates a demonstrably catastrophic, unusual, or extraordinary situation. To apply for the Catastrophic Assistance program, the patient must send a letter describing the unusual circumstances and requesting consideration along with any supporting documentation to: Premier Health Hospitals, PO Box 932715, Cleveland, OH 44193. Consideration of a Catastrophic Assistance requires that the patient declare all assets, including investments or other property of significant value, stocks, bonds, any settlements that have been received, and all other sources of assets or income.

PRESUMPTIVE ELIGIBILITY:
There are instances when a patient may be eligible for the Financial Assistance Program without a completed application on file. Presumptive eligibility may be determined on the basis of individual life circumstances that include but may not be limited to:

1. Homelessness or receiving care from a homeless clinic.
    a. Incarcerated patients who do not qualify for Medicaid or resource funding.
2. Patient's address is considered low-income or subsidized housing.
3. Patient is deceased with no known estate.
4. Patient is eligible for Medicaid or Medicaid Managed Care Plan at the time of financial assistance application review; or
5. Patient is eligible for other unfunded state or local assistance programs.

Premier Health Hospitals may use additional information from external sources, consistent with applicable legal requirements, to determine estimated household size, income amounts, and assets for the basis of determining patient eligibility for the Financial Assistance Program. Sources include, but are not limited to, credit reports, information from state or federal insurance enrollment forms, and other publicly available information. Premier Health Hospitals may use income and asset based on 3-month forward calculations.

Patients eligible for presumptive eligibility will be discounted in accordance with Appendix A. Patients presumed eligible for less than the most generous assistance under the Financial Assistance Program may submit additional information outlined in this policy for review.

COLLECTION POLICY: ACTIONS IN THE EVENT OF NON-PAYMENT
Premier Health Hospitals will make reasonable efforts to determine whether an individual is eligible for financial assistance under the Financial Assistance Program before it engages in Extraordinary Collections Actions (ECAs). Premier Health Hospitals will not initiate any ECAs for at least one-hundred and twenty (120) days from the date the hospital facility provides the first post-discharge billing statement for the care. Before any ECAs are initiated, Premier Health Hospitals will:

1. Provide written notice to the individual which:
    a. Indicates that financial assistance is available.
    b. Identifies the ECAs that Premier Health Hospitals or other authorized third parties intend to initiate to obtain payment for care.
    c. States a deadline after which Premier Health Hospitals may initiate ECAs that is no earlier than 30 days after the written notice is provided.
2. Provide the individual with a plain language summary of the Financial Assistance Policy with the written notice.
3. Make reasonable efforts to orally notify the individual about Premier Health Hospitals' Financial Assistance Program and about how the individual may obtain assistance with the application process.

If the patient returns the application as a result of the notification, the processing of the application will be expedited.

If an incomplete application is submitted after Premier Health Hospitals have appropriately started ECAs,

Premier Health Hospitals will suspend the ECAs and provide verbal and/or written notice that outlines the information or documentation needed to complete the application. Financial counselors or agency representative contact information will be provided. ECAs may continue if the patient does not submit the requested information within the reasonable period of time provided in the notices.

If a complete application is submitted after the ECA is initiated, the ECA will be suspended while the application is being reviewed for approval. If the patient is approved for financial assistance under this policy, Premier Health Hospitals will:

1. Notify the patient in writing regarding the decision within 30 days from the date of the decision.
2. If the patient is eligible for less than free care, provide a billing statement indicating the amount owed, and how to learn more about the AGB for the care.
3. Refund any amounts paid above amounts required by the Financial Assistance Program.
4. Reverse any ECA that can be reversed.

If the patient is determined to be ineligible for the Financial Assistance Program or does not submit an application within the two-hundred and forty (240) day period, Premier Health Hospitals may initiate ECAs or resume any ECAs that have been appropriately started.

After commencement of the ECAs, external collection agencies shall be authorized to report unpaid accounts to credit agencies, and to file litigation, garnishment, obtain judgment liens. Prior approval of a Premier Health Hospitals' authorized representative is required before ECAs may be initiated.

REGULATORY REQUIREMENTS:
In implementing this policy, Premier Health Hospitals shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

Per request from the Medicare Administrative Contractor, CGS, Premier Health Hospitals shall comply with federal, state, and local laws, rules, and regulations through its reporting of bad debts, charity care and courtesy allowances according to 42 CFR § 413.89 *Bad debts, charity, and courtesy allowances.*

ELIGIBLE PROVIDERS:
This policy only applies to Premier Health Hospitals. Patients at Premier Health Hospitals are commonly seen by private physician groups or other third-party providers. These health care providers are not covered by this policy and do not participate in Premier Health Hospitals' Financial Assistance Program.

However, these providers may have their own financial assistance program. A list of these providers is maintained in an appendix, which is updated quarterly, and is not attached to this policy. Individuals may readily obtain the appendix free of charge on the individual Premier Health Hospital's web site or by contacting customer service department by phone at 937-499-7364.

FINANCIAL ASSISTANCE PROGRAM CHANGES:
Premier Health Hospitals, with the approval of the Premier Health Board of Trustees, reserves the right to amend the criteria by which an individual qualifies for the Financial Assistance Program under this policy.

Patients concerned about their ability to pay for services or who would like to learn more about financial assistance should contact the customer service department at 937-499-7364.

APPENDIX A

% of Poverty Level	Uninsured	*Insured
0% - 100%	100%	100%
100% - 200%	100%	100%
200% - 300%	80%/AGB	80%/AGB

*Insured percentages apply to non-covered charges determined by insurance as patient responsibility. Examples include cost sharing insurance determined copays, deductibles, and co-insurance percentages.

Preliminary Approval: Directors Patient Access
Director Patient Financial Services
VP Revenue Cycle
VP Managed Care & Reimbursement

Final Approval: Chief Financial Officer & Hospital Board