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Subject:	Financial Assistance Policy (Non-Profit Facilities)	Formulated:	10/2016
Manual:	Patient Financial Services	Reviewed:	10/2016, 12/2018
Corporate Board Approval		Date:	Last Revised: 12/2018

I. Policy:

Prime Healthcare nonprofit facilities, including Mission Regional Medical Center (the “Hospital”), offer a financial assistance program for those patients who meet the eligibility tests described below. The intent of this Financial Assistance Policy (the “Policy”) is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and Texas Health & Safety Code sections 311.031 to 311.048 and 324.101; all provisions should be interpreted accordingly.

A significant objective of Prime Healthcare nonprofit facilities is to provide care for patients in times of need. Prime Healthcare nonprofit facilities provide charity care and a discounted payment program as a benefit to the communities we serve as not-for-profit hospitals. To this end, Prime Healthcare nonprofit facilities are committed to assisting low-income and/or uninsured eligible patients with appropriate discount payment and charity care programs. All patients will be treated fairly, with compassion and respect. Notwithstanding anything else in this Policy, no individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care.

Financial assistance policies must balance a patient’s need for financial assistance with the Hospital’s broader fiscal stewardship. Financial assistance through discount payment and charity care programs is not a substitute for personal responsibility. It is the patients’ responsibility to actively participate in the financial assistance screening process and where applicable, contribute to the cost of their care based upon their ability to pay. Outside debt collection agencies and the Hospital’s internal collection practices will reflect the mission and vision of the Hospital.

This Policy applies to all emergency and other medically necessary care provided by the Hospital or a substantially-related entity working in the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an emergency, inpatient or outpatient basis. A list of providers that deliver care in the hospital is available at www.missionrmc.org. This list specifies which providers are and are not covered by this Policy. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance.

II. Definitions:

“Amounts Generally Billed”: The amounts generally billed (“AGB”) for emergency or other medically necessary services to individuals eligible for the discounted payment program. The Hospital calculates the AGB for a patient using the prospective method as defined in the Treasury Regulations. Under the

prospective method, AGB is calculated using the billing and coding process the Hospital would use if the individual were a Medicare fee-for-service beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.

“Emergency and Medically Necessary”: Any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

“Extraordinary Collection Actions”: An Extraordinary Collection Action means any collection action involving certain sales of debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual’s nonpayment of one or more bills for previously provided care covered under the hospital’s Financial Assistance Policy, or any action requiring a legal or judicial process, including placing a lien, foreclosing on real property, attaching or seizing of bank accounts or other personal property, commencing a civil action against an individual, taking actions that cause an individual’s arrest, taking actions that cause an individual to be subject to body attachment, and garnishing wages, in each case as further described in Treasury Regulations Section 1.501(r)-6.

“Family”: (1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker, relatives, and other children under 21 years of age of the parent or caretaker relative.

“Financially indigent”: A financial indigent patient is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the Hospital’s eligibility criteria set forth in this policy.

“Medically Indigent”: A medically indigent patient is a person whose medical or hospital bills, after payment by third-party payors, exceed a specified percentage of the patient’s annual gross income, determined in accordance with the Hospital’s eligibility criteria set forth in this policy, and the person is financially unable to pay the remaining bill.

“Plain Language Summary”: The summary of the Financial Assistance Policy attached hereto as Exhibit 2, intended to comply with Treasury Regulations Section 1.501(r)-1(b)(24).

III. Procedure:

1. Eligibility for Financial Assistance

A. Self-Pay Patients

A patient qualifies for **charity care** as described in Section (III)2 below if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid, or is underinsured, as determined and documented by the hospital; (2) the patient’s injury is not a compensable injury for purposes of workers’ compensation, automobile insurance, or other insurance as determined and documented by the hospital; (3) the income of the Patient’s Family does not exceed two hundred percent (200%) of the

current Federal Poverty Level; **and** (4) the patient has monetary assets of less than ten thousand dollars (\$10,000.00).

A patient qualifies for the **discounted payment program** if all of the following conditions are met: (1) the income of the Patient's Family is greater than two hundred percent (200%) but less than four hundred percent (400%) of the current Federal Poverty Level; (2) the patient has monetary assets of less than ten thousand dollars (\$10,000.00); **and** (3) the patient has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred or paid in or out of any hospital) exceeding ten percent (10%) of Family income.

B. Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for charity care, but may qualify for the discounted payment program if he or she (i) has a Family income greater than two hundred percent (200%) but less than four hundred percent (400%) of the current Federal Poverty Level; and (ii) has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred or paid in or out of any hospital) exceeding ten percent (10%) of Family income. If eligible, the Medically Indigent patient's payment obligation will be an amount equal to the difference between what the Hospital receives from the insurance carrier and the Discounted Payment Maximum. If the amount paid by insurance exceeds the Discounted Payment Maximum, the patient will have no further payment obligation.

C. Other Circumstances

The Director of the Hospital's Patient Financial Services, (PFS) Department shall also have the discretion to extend charity care or the discounted payment program to patients under the following circumstances:

(i) The patient qualifies for limited benefits under the state's Medicaid program, i.e., limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital. This includes non-covered services related to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other care from the Hospitals);
- Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for charity care;
- Medicaid or other indigent care program denials;
- Charges related to days exceeding a length of stay limit; and
- Any other remaining liability for insurance payments.

(ii) The patient qualifies for a County Indigent Health Care Program but no payment is received by the Hospital.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the PFS Director has reason to believe that the patient would qualify for charity care or the discounted payment program, i.e., homeless.

(iv) A third party collection agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that charity care or the discounted payment program be offered.

D. Determination of Family Income

For purposes of determining eligibility for the discounted payment program, documentation of income of the patient's Family shall be limited to recent pay stubs or income tax returns.

In determining a patient's monetary assets, the Hospital shall not consider retirement or deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, the first ten thousand dollars (\$10,000.00) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars (\$10,000.00).

E. Federal Poverty Levels

The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's family or household. The Federal Poverty Levels as of 2018 are as follows:

SOURCE: Federal Register, Vol. 83, No. 12, January 18, 2018, pp. 2642-2644

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia		
Persons in Family/Household	Poverty Guideline	400% of Poverty Guideline
1	\$12,140	\$48,560
2	\$16,460	\$65,840
3	\$20,780	\$83,120
4	\$25,100	\$100,400
5	\$29,420	\$117,680
6	\$33,740	\$134,960
7	\$38,060	\$152,240
8	\$42,380	\$169,520
For families/households with more than 8 persons, see https://aspe.hhs.gov/poverty-guidelines .		

2. Charity Care and Discounted Payment Program

Financial assistance may be granted in the form of full charity care or discounted care, depending upon the patient's level of eligibility as defined in this Policy.

The patient balances for those patients who qualify for charity care, as determined by the Hospital, shall be reduced to a sum equal to zero dollars (\$0) with the remaining balance eliminated and classified as charity care.

The patient balances for those patients who qualify for the discounted payment program will be reduced; any discount will be applied against the gross charges for hospital services provided.

Discounted payments will be limited to the highest amount paid by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or any other government-sponsored health program in which the Hospital participates (the "Discounted Payment Maximum"). The discount payment policy shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Hospital and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family income and essential living expenses.

Once a complete financial assistance application is received, the Hospital must make a determination and provide a written notice of the decision and the basis relied on. If the patient is found eligible for assistance, a new billing statement will be sent which indicates how the discounted amount was calculated and states where to find the AGB. The Hospital will refund any amount collected in excess of the revised charges and reverse any Extraordinary Collection Actions that have been initiated. If a financial assistance application is received and is incomplete, the Hospital will provide written notice of the outstanding items and wait a reasonable period of time before initiating or resuming Extraordinary Collection Actions. If a complete application is received within the two hundred forty (240) day application period described below, any Extraordinary Collection Actions will be suspended while a determination of eligibility is made.

3. Application Process

Any patient who requests financial assistance will be asked to complete a financial assistance application. The financial assistance application form is attached as Exhibit 1 to this Policy. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. The Hospital shall ensure that all employees likely to encounter patients that may need financial assistance are fully informed of and have access to this Policy, the Plain Language Summary, and the financial assistance application, and shall provide reasonable assistance to patients with the application process.

A patient is expected to submit the financial assistance promptly following care. A patient has up to two hundred forty (240) days following the date of first post-discharge statement in which to submit an application for financial assistance.

The financial assistance application requests patient information necessary for determining patient eligibility under the Financial Assistance Policy, including patient or family income and patient's family size. The Hospital will not request any additional information other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they so choose. Qualification for financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

4. Resolution of Disputes

Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed and resolved by the Hospital's Chief Financial Officer.

5. Publication of Policy

In order to ensure that patients are aware of the existence of the Financial Assistance Policy, the Hospital shall widely disseminate the existence and terms of this Policy throughout its service area. In addition to other appropriate efforts to inform the community about the Policy in a way targeted to reach community members most likely to need financial assistance, the following actions shall be taken:

A. Written Notice to All Patients

Each patient who is seen at a Prime Healthcare nonprofit facility, whether admitted or not, shall receive the Plain Language Summary, which is attached hereto as Exhibit 2. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

B. Posting of Notices

The notices attached hereto as Exhibit 3:

- shall be clearly and conspicuously posted in locations that are visible to the patients in the following areas: (1) Emergency Department; (2) Billing Office; (3) Admissions Office; and (4) other outpatient settings.
- shall be printed in the Hospital's patient guide or other material that provides patients with information about the Hospital's admissions criteria.
- shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

C. Notices to Accompany Billing Statements

Every post-discharge statement shall include a copy of the notice attached hereto as Exhibit 4. Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include a statement of charges for services rendered by the Hospital and the notices attached hereto as Exhibits 4 and 5.

These notices shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy.

D. Availability of Financial Assistance Documents

The Hospital shall post a copy of this Policy, the Plain Language Summary and the financial assistance application on its website and make all such documents available for free download. Such documents shall be available in the emergency room and admissions office and by mail upon request. The Hospital shall also annually publish notice of the Hospital's financial assistance program and this Policy in a local newspaper of general circulation in the county served by the Hospital. The documents shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital as provided in section III(5)(E) of this Policy and in language readily understandable to the average reader.

E. Accessibility to Limited English Proficient Individuals

The Hospital shall make translations of this Policy, the Plain Language Summary, and the financial assistance application available in any language that is the primary language of the lesser of one thousand (1,000) individuals or five percent (5%) of the population of the communities served by the Hospital.

6. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid and CHIP

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to a patient including, but not limited to, the following:

(1) private health insurance, including coverage offered through the federal health insurance marketplace; (2) Medicare; and/or (3) the Medicaid program, CHIP, the Texas Children with Special Health Care Needs Program, or other state-funded programs designed to provide health coverage.

If a patient does not indicate that he/she has coverage by a third party payor or requests a discounted payment program or charity care then the patient shall be provided with an application for the Medicaid program, CHIP, or other governmental program prior to discharge.

7. Collection Activities

Prime Healthcare nonprofit facilities may use the services of an external collection agency for the collection of patient debt. No debt shall be advanced for collection until the Director of the Hospital PFS or his/her designee has reviewed the account and approved the advancement of the debt to collection. Prime Healthcare nonprofit facilities shall obtain an agreement from each collection agency that it utilizes to collect patient debt that the agency will comply with the requirements of this Policy and applicable state law. For accounting purposes, any account that qualifies for bad debt under the Hospital's internal policy, but is not deemed as bad debt (resulting from revenue recognition accounting standards), will be considered and reported as patient financial assistance as a reduction to Hospital revenue.

If a patient does not apply for financial assistance or is denied financial assistance and fails to pay their bill, the patient may be subject to various collection actions, including Extraordinary Collection Actions. Notwithstanding the foregoing, neither the Hospital nor any collection agency with which it contracts shall engage in any Extraordinary Collection Actions (i) at any time prior to one hundred fifty (150) days following the first post-discharge statement sent to a patient or (ii) without first making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. In addition, and even if the above two conditions are satisfied, Hospital or its contracted collection agencies must send a notice to the patient at least thirty (30) days before commencing any Extraordinary Collection Actions, which specifies the following: (i) collection activities the Hospital or contracted collection agency may take, (ii) the date after which such actions may be taken (which date shall be no earlier than thirty (30) days of the notice date, (iii) that financial assistance is available for eligible patients. A copy of the Plain Language Summary will be included with such notice. Reasonable efforts must be made (and documented) to orally notify patients of this Policy. If the patient applies for



financial assistance, any Extraordinary Collection Actions that may be in process will be suspended immediately pending the decision on the patient's application.

In addition, if a patient is attempting to qualify for eligibility under this Policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or making regular partial payments of a reasonable amount, the Hospital shall not send the unpaid bill to any collection agency.

The Hospital shall not, in dealing with patients eligible under this Policy, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

Exhibit 1 [Financial assistance application]

Exhibit 2 [Financial Assistance Plain Language Summary]Plain Language Summary of
Mission Regional Medical Center Financial Assistance Policy

Eligibility: Mission Regional Medical Center offers reduced or no charge services for emergency and other medically necessary care for individuals eligible under our Financial Assistance Policy. Eligibility is based on the Hospital's Financial Assistance Policy, which includes using the Federal Poverty Level guidelines, number of dependents, and gross annual income along with supporting income documents.

Income Guidelines: If meeting the Hospital's Financial Assistance Policy requirements, uninsured or underinsured patients with family income below 200% of the current Federal Poverty Level and less than \$10,000 in monetary assets will qualify for a 100% discount on their qualifying Hospital services. Patients with family income greater than 200% but less than 400% of current Federal Poverty Level, less than \$10,000 in monetary assets and excessive medical costs, and insured patients with family income less than 400% of current Federal Poverty Level and excessive medical costs, may qualify for partially discounted care and extended payment plans. Patients eligible for financial assistance will not be charged more than the amount generally billed for emergency or other medically necessary care to individuals having insurance coverage.

For More Information: The full Financial Assistance Policy and a Financial Assistance Application Form are available at our website, www.missionrmc.org, or by mail at no charge by calling 956-323-1800. Paper copies may be also obtained in person from our Billing Office at 900 S. Bryan Rd., Mission, TX, 78572. Applications are available in non-English languages spoken by large segments of the community. For further questions or assistance in completion of the Financial Assistance Application, please call our Billing Office at 956-323-1800.



**Exhibit 3 [Notices to be posted in Emergency Department, Billing Office, Admissions Office,
and other outpatient settings, and printed in hospital patient guide]**

CHARITY CARE & DISCOUNTED PAYMENT PROGRAM

PATIENTS WHO LACK INSURANCE OR HAVE INADEQUATE INSURANCE AND MEET CERTAIN LOW- AND MODERATE-INCOME REQUIREMENTS MAY QUALIFY FOR DISCOUNTED PAYMENTS OR CHARITY CARE. THE EMERGENCY DEPARTMENT PHYSICIANS AND OTHER PHYSICIANS WHO ARE NOT EMPLOYEES OF THE HOSPITAL MAY ALSO PROVIDE CHARITY CARE OR DISCOUNTED PAYMENT PROGRAMS. PLEASE CONTACT 956-323-1800 FOR FURTHER INFORMATION.

REPORTING OF FINANCIAL ASSISTANCE

In keeping with its mission, Mission Regional Medical Center prepares and submits an annual report of the Hospital's financial assistance program and information relating to the provision of government-sponsored indigent health care and other community benefits to the Texas Department of State Health Services. This report is public information and is available upon request from the Texas Department of State Health Services.

Exhibit 4 [Notice to be included in *all* post-discharge billing statements]**Charity Care & Discounted Payment Program**

Patients who lack insurance or who have inadequate insurance and meet certain low-and moderate-income requirements may qualify for discounted payments or charity care. Patients seeking discounted or free care must obtain and submit an application that will be reviewed by the Hospital. No patient eligible for financial assistance will be charged more for emergency or medically necessary care than amounts generally billed to individuals who have insurance covering such care. For more information, copies of documentation, or assistance with the application process, please contact the Hospital at 956-323-1800 or you may visit www.missionrmc.org or 900 S. Bryan Rd., Mission, TX, 78572 to obtain further information. Free copies of financial assistance documentation may also be sent to you by mail and are available in non-English languages spoken by a substantial number of the patients served by the Hospital. The Emergency Department physicians and other physicians who are not employees of the Hospital may also provide charity care or discounted payment programs. Please contact 956-323-1800 for further information.



**Exhibit 5 [Notice to be included in post-discharge billing statements
to patients who have not provided proof of insurance]**

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, CHIP, or other similar programs. If you have such coverage, please contact our office at 956-323-1800 as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, CHIP, coverage offered through the federal health insurance marketplace, the Texas Children with Special Health Care Needs Program, other state- or county-funded health coverage, or Prime Healthcare nonprofit facilities charity care or discounted payment program. For more information about how to apply for these programs, please contact the Prime Healthcare nonprofit facility PFS Designee at 956-323-1800 who will be able to answer questions and provide you with applications for these programs.

Patients who lack insurance or have inadequate insurance and meet certain low- and moderate-income requirements may qualify for discounted payments or charity care. Patients should contact the Prime Healthcare nonprofit facility or PFS Designee, at 956-323-1800 to obtain further information. If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a Prime Healthcare nonprofit facilities charity care or discounted payment program, neither application shall preclude eligibility for the other program.