



**FINANCIAL
ASSISTANCE POLICY**

PURPOSE

The purpose of Forrest Health Financial Assistance Plan is to help patients understand how to apply for assistance when needed. The plan will help by sharing how, when and why a patient could apply for help.

MISSION

The mission of Forrest Health is to provide high quality health care services that are accessible and available to the residents of South Mississippi.

RESPONSIBLE PERSONS

Responsible employees include Patient Registration Representatives, Patient Financial Services, Business Office staff and business partners. The patient and/or patient's designee is responsible for certain aspects by cooperating with requests for documentation and by sharing information with hospital staff.

UNDERLYING PRINCIPLES OF FINANCIAL ASSISTANCE

1. The hospital expects timely payment for its services.
2. The hospital's calculated Amount Generally Billed (AGB) is fair and represents a value.
3. Financial assistance is available to those in need.
4. The dignity and confidentiality of patients will be maintained.
5. As a part of Forrest Health's mission, we will provide:
 - A. Uncompensated care (financial assistance) to patients who are without financial means to pay for emergent and medically necessary hospital services. (See additional information in the Financial Assistance Guidelines section, item 5 and definition in the Definition Section).
 - B. Patient care without regard to race, creed, color, or national origin and in accordance with EMTALA requirements.
 - C. Emergent and/or medically necessary care for those who financially or medically indigent will receive care on a non-discriminatory, objective basis in keeping with our continuing mission of good stewardship of limited medical and financial resources.
 - D. Financial assistance for patient balances that are considered qualified charity but do not meet 100% financial assistance will be based on the Amount Generally Billed (AGB) to all patients for that service.

6. According to federal regulations covered by the Affordable Care Act and 501(r) final regulations, potential candidates for financial assistance will be made aware of the existence of the hospital's Financial Assistance Policy (FAP), at minimum, within the federally-prescribed 120-day "Notification Period" and as follows:
 - A. Registration or discharge areas within the hospital.
 - B. Hospital website.
 - C. Hospital Business Office or Patient Financial Services areas.
 - D. Telephone numbers.
 - E. Through written correspondence (billing statement, summary statement, collection letter, etc.).
 - F. Through telephone communication.

MANAGEMENT GUIDELINES

Management will set processes in place according to the following general guidelines:

1. Patients are expected to seek financial assistance when they recognize they are unable to pay their portion of the hospital charges.
2. Patients are eligible based on documentation provided and their income based on Federal Poverty Level (FPL).
3. Patients who are financially or medical indigent (uninsured or underinsured) are eligible to apply for financial assistance. The definition of underinsured that will be used for this policy follows as an adult who has:
 - A. Out-of-pocket costs, excluding premiums, over the 12 months are equal to 10% or more of the household income; or
 - B. Out-of-pocket costs, excluding premiums, are equal to 5% or more of household income if income is under 200% of the FPL (federal poverty level).
 - C. Deductible is 5% or more of household income.

The out-of-pocket cost component of the measure is only triggered if a person uses his or her health insurance plan. The deductible component provides an indicator of the financial protection the plan offers and the risk of incurring costs even before a person uses the plan. The definition does not include people who are at risk of incurring high costs because of other design elements, such as exclusion of certain covered benefits and copayments. It therefore provides a conservative measure of underinsurance in the United States.¹

4. Forrest Health may have to alter its pool of available financial assistance due to extreme financial hardship.

5. Collection agencies will be used in accordance with the 501(r) regulations and according to business need. Extraordinary collection actions (ECA) will be used only after patients have been informed in writing that such actions will commence, if no payment or applications for financial assistance has taken place by given date.
 - A. Patients will be notified by way of conspicuous notice on their financial statement that if they cannot afford to pay for care, they may apply for financial assistance.
 - B. These ECAs will not be put into action until a period after 120 days from the first financial statement after discharge has been sent.
 - C. Should a patient begin the financial assistance process at any time during the collection period, all ECAs will cease until the application eligibility decision is complete.
 - D. Collection agencies will be responsible to both train any new employees and to comply with the 501(r) requirement.
 - E. Forrest Health will initiate an addendum to contracts that states the vendor will adhere to 501(r) regulations in their processes and actions.
6. The health system will allow patients thirty (30) days to fully comply with the requested information and return completed applications along with any additional documentation that has been requested by Forrest Health.
7. In the event an account receives a system-applied true self-pay discount and subsequently qualifies for any portion of medical or financial indigence/charity, the true self-pay discount will be reversed in an amount equal to the indigence/charity amount.
8. Forrest Health's Financial Assistance Policy (FAP) operates in accordance with all EMTALA laws and requirements.

FINANCIAL ASSISTANCE GUIDELINES

The Board of Trustees supports the following principles. These principles will be honored in all aspects of dealing with, both financially or medically, indigent patients:

1. The hospital will provide education regarding patient responsibility and may then discuss collections before service, at time of service, and after discharge.
2. Partial awards for assistance may be contingent upon patients resolving the remaining affordable obligation. The partial award for assistance will be based on an approved methodology and will be communicated to the patient.

3. The hospital may consider income, assets, and credit capacity, when determining patient financial need and payment affordability.
4. The hospital may institute a presumptive eligibility process based on certain known factors related to a patient's ability to pay their medical bills.
5. The hospital may automatically grant unsolicited discounts considered uncompensated care on true self-pay balances where the patient is uninsured. This discount amount will be equivalent to the current AGB (Amount Generally Billed) discount percentage utilized for Charity care consideration.
6. Financial assistance may be extended to patients with third party or governmental coverage based on their proven ability to pay, according to financial assistance application guidelines and requirements stated in the Financial Assistance Eligibility Determination section of this policy.

The Board of Trustees expects that management will:

1. Ensure the processes in place will support the hospital's mission.
2. Approve established eligibility tables to compute an affordable balance due.
3. Periodically compare the hospital's Financial Assistance processes to ensure the processes are fair and provide fiduciary protection for Forrest Health.
4. Provide consistent and fair application of policy.
5. Accommodate special circumstances through management review.
6. Audit consistency of policy application and provide reports to Trustees.

PATIENT RESPONSIBILITIES

The patient is responsible for:

1. Cooperating with the Hospital and/or Agents to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for health care, such as a Qualified Health Plan as a result of the Affordable Care Act (ACA), Medicare, Medicaid, third-party liability, etc.
2. Providing the Hospital and/or Agents with financial and other information needed to determine eligibility for financial assistance as soon as possible. Under this policy, this means completing the application form required and cooperating fully with the information gathering and assessment process. Accurate information

and documentation necessary to establish eligibility under this policy is expected in order to base the amount needed appropriately.

3. Cooperating with the Hospital in establishing a reasonable payment plan and making good-faith efforts to honor the payment plan for the discounted Hospital bills if applicable.
4. Promptly notifying the Hospital of any change in financial status so that the impact of this change may be evaluated under this financial assistance policy, the discounted Hospital bills or provisions of payment plans.
5. Informing the Hospital, in subsequent inpatient admissions or outpatient encounters, that the patient has previously received health care services from the Hospital and was determined to be eligible for discounted care, if applicable.

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION

1. Locations and phone numbers for assistance in application process include:
 - A. Forrest General Hospital;
 - 1) Office location – 1414 South 28th Avenue, Hattiesburg, MS 39402, Patient Accounts Office.
 - 2) Phone number – 601-288-2032.
 - B. Highland Community Hospital;
 - 1) Office location – 130 Highland Parkway, Picayune, MS 39466, Business Office on 1st Floor.
 - 2) Phone number – 601-358-9480.
 - C. Jefferson Davis Community Hospital;
 - 1) Office location – 1102 Rose Street, Prentiss, MS 39474, Business Office front lobby.
 - 2) Phone number – 601-792-4276.
 - D. Marion General Hospital;
 - 1) Office location – 1560 Sumrall Road, Columbia, MS 39429, Business Office on 1st Floor.
 - 2) Phone number – 601-740-2150.
 - E. Walthall General Hospital;
 - 1) Office location – 100 Hospital Drive, Tylertown, MS 39667, Business Office front lobby.
 - 2) Phone number – 601-876-0408.
2. Eligibility for Financial Assistance is based on:
 - A. Number of persons residing in a household and their combined gross annual Household Income, plus Other Factors.
 - B. Other Factors include - Other assets, amount and frequency of medical expenses, current vs. future earning capacity, etc.
 - C. Qualifying Population Categories;

- 1) Financially Indigent - Determining Financial Indigence is based upon an affordability calculation that considers the interaction between household gross income, household size, affordability guidelines and balance of the self-pay bill. Annually-updated Federal Poverty Level guidelines are the basis for determination on patients in the Financially Indigent category.
 - 2) Financially Indigent refers to a patient whose annual household gross income is less than 200% of FPL.
 - 3) Partially indigent patients have income between 200% and 400% of FPL with the allowable charity discount applied on a sliding scale as listed on the hospital's Financial Assistance Qualification Table.
 - a) Medically Indigent – Refers to a patient with a catastrophic illness or injury where the patient's balance exceeds 20% of the annual gross household income.
 - b) Definition of Catastrophic Illness according to CMS - A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.²
 - c) Huge amount of unexpected medical debt (with no coverage or after benefits with coverage) is 20% or greater than the patient's annual gross household income. The patient balance that exceeds 20% of their income will be considered charity.
3. Affordability Guidelines:
- A. Affordability Guidelines are developed from the Federal Poverty Guidelines, amount owed and Forrest Health's calculation of Amounts Generally Billed (AGB).
 - B. The Affordability Guideline calculates the amount that the patient can afford to pay for healthcare services at Forrest Health in a twenty-four (24) month period using AGB as the starting point for discounting health care charges.
 - C. The calculated amount owed by the patient is due in full, or may be paid in up to twenty-four (24) monthly installments, with a minimum payment of \$50 per month. This amount may be referred to outside collection agencies if not paid in the manner agreed upon by the patient and Forrest Health.
 - D. At the patient's request when they have subsequent services, the Affordable balance may be added to existing balances and the time period or payment extended accordingly. For example, if a patient had an account with installment payments with 10 months remaining and had a subsequent admission, the next account would add 12 months of affordable payments for a total of 22 months.
 - E. Medicaid Benefits - Persons qualified for Medicaid by the Mississippi Department of Human Services will automatically be deemed

presumptively eligible for Financial Assistance when they have exhausted their annual benefits, qualify only for Family Planning benefits or have any deductible/co-insurance/co-pay or patient responsibility due from a Medicaid adjudicated claim.

- F. Presumed Indigent - This term refers to patients/guarantor who do not provide the detail documentation necessary to be classified as Financially or Medically Indigent but who, to the best of Forrest Health's knowledge, would be eligible for Financial Assistance under the program guidelines had the person completed the documentation. This patient population would include, but is not limited to;
 - 1) Decedents with no estate or known family.
 - 2) Persons whose identity cannot be established - The Patient Accounts Director must approve these accounts for Financial Assistance.
 - 3) Transient, homeless persons.
 - 4) Persons estranged from family and who have no effective support group or are socially dysfunctional.
 - 5) Persons presumed eligible based on reliable third party propensity to pay scores or persons categorized as likely to be financially needy.
- G. Failure to provide information necessary to complete a financial assessment may result in not being eligible for financial assistance.
 - 1) However, Patient accounts may reconsider the account upon receipt of the required information. Determination of eligibility for Financial Assistance may be made without a complete assessment if the patient or information is not reasonably available and eligibility is warranted under the circumstances.
 - 2) All efforts to obtain financial qualification data will be exhausted prior to affirming financial assistance status under this scenario. The Patient Accounts Director must approve these accounts for Financial Assistance and document reasons in the Patient Accounts system in a memo.
- H. Financial Assistance forms may be submitted at any time during the federally-mandated 240-day "Application Period". Requests for financial assistance may be submitted by a variety of sources, including the patient, a family member, a community organization, a church, a collection agency, caregiver, Hospital administration and others.
- I. Financial Assistance will be authorized for a six (6) month period. However, Forrest Health reserves the right to review every case at any time to determine a patient's eligibility for financial assistance, whether or not such assistance was requested by the patient.
- J. Forrest Health also reserves the right to process and approve any eligible patient for Financial Assistance without any action taken by the patient to include the patient's completion of the Financial Information form (FIF)
- K. Within thirty (30) working days of receipt of a completed FIF, Patient Accounts will review the FIF and calculate the patient's eligibility for

- Financial Assistance based on the Affordability Guidelines.
- L. Forrest Health will use the “Financially Indigent” or “Medically Indigent” service codes for Financial Assistance discounts.
(Storing of Financial Assistance Applications - The Patient Accounts department will store a copy of financial applications for a minimum of five years).
- M. Internal Audit - Subject to the Board of Trustees and/or CFO’s request, Internal Audit may perform an audit of the Financial Assistance write-offs to ensure compliance of this policy.
- N. Collection Agencies - Payment Plans/Collection Activity:
- 1) The provisions of this Section apply to Hospital’s collection of any self-pay balance. Thirty days prior to pursuing collection against a Self-pay Patient, Hospital will notify the patient in writing give the Self-pay Patient the opportunity to apply for financial assistance, including the phone number and address of the location where they can apply.
 - 2) All collection activities on a patient’s account, including those accounts referred to a third party for collection, will be suspended for those patients who have submitted an application for financial assistance while the application is being reviewed and considered. In the event the Hospital refers the patient account to a third party, the third party will:
 - a) Refrain from engaging in extraordinary collection activities during the 240-day Application Period until the Hospital has exhausted all reasonable efforts to determine the patient’s eligibility for financial assistance under this policy.
 - b) Take reasonable measure to cease any extraordinary collection activities against the patient if the patient’s application is completed and/or approved. If the application is denied, ECA could be reinstated.
 - c) The following are requirements that all collection agencies must abide by;
 - 1) Adhere to the Fair Debt Collection Practices Act.
 - 2) With written permission from Patient Accounts management, may file suit against the guarantors, and garnish their wages to fulfill their payment obligations.
 - 3) Forrest Health does not, under any circumstances, obtain liens on personal property (except on estates of deceased patients).
- O. Should a patient be approved for financial assistance after they have made payment on an account, the payment will be applied to any non-qualified outstanding balance. If this results in the need to refund an amount to the patient, that activity will be handled by the hospital financial services, as expeditiously as possible.

- P. For extenuating circumstances, Forrest Health may, on an individual basis, provide additional support under the Director's discretion.

AREAS COVERED BY THIS PROCEDURE

1. Emergent and medically necessary services will be covered by this Financial Assistance Plan.
2. Excluded service examples are:
 - A. Pine Grove's Specialty Programs.
 - B. Bariatric Services.
 - C. Any elective services considered cosmetic in nature.
 - D. Non-medically necessary treatment or procedures.
 - E. Home Health.
 - F. Hospice Services.
 - G. Extended care hospital/nursing home
Professional services, including attending physicians in both the Inpatient and Outpatient care units, Emergency Department physician services, pathologist, and radiologist services.

THIRD PARTY PAYER PROCEDURES

1. All third party, governmental or any other coverage known and applicable to the services rendered at the time of final billing will be billed to that payer, according to their specific timely filing requirements. Any charge item non-covered according to the patient's plan benefits is ultimately the responsibility of the patient, unless otherwise stipulated in a contracted agreement between Forrest Health and that payer.
2. All claims filed on insurance coverages provided is done so as a courtesy to the patient and the patient/guarantor is ultimately responsible for payment of services rendered.
3. Contracted payers will have claims prorated at the time of final billing when contract terms are available and in production in the computer system's contract management system. This will net-down the balance due by the expected contractual adjustment amount to the amount expected in cash so that any variance between expected cash and actual cash will be identified and presented in a workflow for follow-up of that variance. Variance tolerance limits will be set by management and adjusted as needed for efficient operational flow.
4. Claims filed with non-contracted payers will retain the full charge balance on the account until payment is received and any contractual discount that is required will be posted at the time of payment posting.

5. Interim claims will be generated monthly for recurring outpatient services and no less than every 45 days for inpatient stays, as allowed by payer requirements.
6. Forrest Health reserves the right to refuse acceptance of third party coverage only when there is evidence from past experience that the particular payer will not respond to claims filed in an acceptable timeframe, according to Mississippi Prompt Payment of Claims regulations.
7. Requests for settlement or prompt payment of claims discounting by non-contracted payers will be evaluated on a case-by-case basis by the PFS Director or Manager. Consideration to such requests will include, but not limited to, prior history of requester's behavior and adherence to agreed-to settlements, actual cost of services rendered, Amount Generally Billed (AGB) calculation.

FINANCING OPTIONS AND OTHER DISCOUNTS

1. Forrest Health self-pay balances to be paid in full or acceptable payment arrangements can be made as follows:
 - A. Cash.
 - B. Money Order.
 - C. Personal Check.
 - D. Check-by-phone.
 - E. Credit/Debit Card.
 - F. E-Payment.
 - G. Benefit Card.
2. Payment plan arrangements cannot exceed 24 months or be less than \$50 per month. Exceptions to this requirement will be evaluated on a case-by-case basis by the PFS Director.
3. Forrest Health employees who do not pay their self-pay balance in full within 30 days from the notice of balance due will automatically be setup for payroll deduction at \$25 per pay period. Other payment arrangements may be made by contacting the PFS office before the 30 day limit has expired.
4. Uninsured Emergency Room patients are eligible for the ER Now Pay discount.
 - A. Patients who elect this discount will be given a 50% discount off all charges incurred at the time of E/R discharge and are expected to pay the remaining 50% at the time of discharge.
 - B. All charges incurred or posted after discharge will be discounted at 100%. Exceptions to these requirements can be considered by the Director of Registration.

DEFINITIONS

Definitions that apply to this policy are:

1. Forrest Health – A health system to increase access to quality health care and improve the services and stability of local community hospitals.
2. Forrest Health includes the following hospitals;
 - A. Forrest General Hospital (FGH) is an acute care hospital in Hattiesburg, MS.
 - B. Highland Community Hospital (HCH), an acute care hospital located in Picayune, Mississippi.
 - C. Jefferson Davis General Hospital (JDGH), a critical access hospital located in Prentiss, Mississippi.
 - D. Marion General Hospital is an acute care hospital in Columbia, MS.
 - E. Walthall General Hospital (WGH) is a critical access hospital located in Tylertown, Mississippi.
3. Hospital Services – Services provided by, or at the location of, the acute care hospital, are billed as part of the hospital bill. This does not include “professional services.”
4. Professional Services – Services provided by a physician, or approved provider, who can legally bill for those services separately from the hospital services. These services do not include “hospital services.”
5. Medically Necessary Services – Is defined as “any service that is reasonably necessary to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction.”³
6. Amount Generally Billed (AGB) is the amount that has been arrived at using a consistent methodology. Forrest General will implement a retrospective approach using Medicare minus Medicare Advantage plus all commercial payers as the basis for their methodology.
 - A. The average of past fully adjudicated/paid Medicare and all major commercial payers’ claims in the most recent full calendar year will be calculated each October.
 - B. This calculation will be completed for all hospitals including:
 - 1) Forrest General.
 - 2) Highland Community.
 - 3) Jefferson Davis Community.
 - 4) Marion General.
 - 5) Walthall General.

- C. The calculation of AGB will be calculated every year, and both the methodology and actual calculations will be documented in the Patient Financial Services (PFS) department.
 - D. The hospital will calculate one average AGB percentage for Inpatient Accounts and one for Outpatient Accounts, for each hospital separately.
 - E. The AGB calculation methodology will be the sum paid on total remitted claims divided by the total gross charges submitted.
 - F. This number will be considered the AGB for the following year.
7. Uncompensated Care refers to any discount applied to a patient account where there is no reasonable expectation for third party, governmental or debtor payment in full. Examples include, but are not limited to, medically indigent discounts, financially indigent discounts, true self-pay and uninsured discounts, under-insured discounts and Medicaid-qualified patients regardless of the type of Medicaid coverage they have.
8. The methodology to determine “Affordable Balance” considers the patient’s position over the Federal Poverty Level threshold. These parameters are outlined in the hospital’s *Financial Assistance Qualification Table*, and it is updated annually.
9. Ability to Pay - The patient is considered able to pay if;
- A. The assistance guidelines are not met and,
 - B. The balance is considered by hospital to be “affordable” (the “Affordable Balance from affordability worksheet”).
10. Household Size - The number of verifiable people living in the same house or apartment as the patient and have their financial needs met by either the patient or guarantor.
11. Household Income;
- A. Any and all forms of revenue entering the household.
 - B. Household Income is “gross income” not considering tax withholdings. Household Income includes income from all sources including but not limited to; employment, disability, unemployment, Social Security, self-employment, rental income, pensions, royalties, alimony, sales of assets, etc., including income not reported to taxing authorities.

12. Forrest Health uses national credit bureau databases to estimate Household Income or to verify Household Income reported by patients, in the application.
13. Managed Care – Refers to third-party payers who have a formalized contract with a Forrest Health facility.
14. Insurance - Third-party payers, who do not have a formalized contract with a Forrest Health facility.
15. Governmental - Forrest Health will adhere to provisions of current rules and regulations established by appropriate government agencies.

References:

¹ <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance>.

² <http://www.cms.gov/apps/glossary/search.asp?Term=catastrophic+illness&Language=English&SubmitTermSrch=Search>.

³ <http://www.nashp.org/medical-necessity>.

Patient Accounts		Policy Type: Non-Patient Related	Approved: 11-1999
Med Exec Approval	Board Approval	Page Number and Section	Explanation of Change
11-14-2005	11-18-2005		Date before implemented Revision Chart.
Operations Approval 9-18-2014	10-28-2014	Policy replaced	To comply with requirements of Affordable Care Act.

Chief Approval	Board Approval	Page Number and Section	Explanation of Change
9-27-2016	9-27-2016	Entire document	Policy revised to meet 501(r) regulations.
3-26-2018	3-27-2018	Page 1 Underlying Principles of Financial Assistance	#5A Added – “see additional information in the Financial Assistance Guidelines section, item 5 and definition in the Definition Section.
		Page 3 Management Guidelines	Added #7 - In the event an account receives a system-applied true self-pay discount and subsequently qualifies for any portion of medical or financial indigence/charity, the true self-pay discount will be reversed in an amount equal to the indigence/charity amount.
		Page 4 Financial Assistance Guidelines	Added #5 -The hospital may grant unsolicited discounts considered uncompensated care on true self-pay balances where the patient is uninsured. This discount amount will be equivalent to the current AGB (Amount Generally Billed) discount percentage utilized for Charity care consideration. Added #6 - Financial assistance may be extended to patients with third party or governmental coverage based on their proven ability to pay, according to financial assistance application guidelines and requirements stated in the Financial Assistance Eligibility Determination section of this policy.

Chief Approval	Board Approval	Page Number and Section	Explanation of Change
3-26-2018	3-27-2018	Pages 7-9 Financial Assistance Eligibility Determination	#3E Deleted Exhausted, Added-qualify only for Family Planning benefits or have any deductible/co-insurance/co-pay or patient responsibility due from a Medicaid adjudicated claim. #3L Added- or “Medically Indigent.”
		Page 11 Third Party Payer Procedures	Added- Entire section.
		Page 12 Definitions	Added #7 Definition of Uncompensated Care.