

NORTHERN MONTANA HEALTH CARE POLICY AND PROCEDURE

NUMBER (S):	BUS-P130
DEPARTMENT OF ORIGIN:	Finance
SUBJECT/TITLE:	NMH Financial Assistance
CMS/REGULATORY REFERENCE:	
FORM REFERENCE:	BUS 0158; BUS 0159

POLICY: It shall be the policy of Northern Montana Health Care (NMHC) including all of its providers to provide emergency care and medically necessary primary health care services to inpatients and outpatients, regardless of ability to pay. The Hospital may make available services without charge or at a reduced charge, based on the ability to pay as determined by the Hospital. The amounts charged for medically necessary care provided to individuals eligible for financial assistance will not be more than the amounts generally billed (AGB) to individuals who have insurance covering the same care. Financial assistance may be granted to all persons regardless of race, color, sex, religion, age, or national origin.

PURPOSE: The purpose of this policy is to establish guidelines for Financial Assistance (Charity Care) available at NMHC and to outline the process for determining eligibility for Financial Assistance.

DEFINITIONS:

Family: A group of two or more people who reside together and who are related by birth, marriage, or adoption, unmarried or domestic partners. If the patient claims someone as a dependent on their income tax return, they may be considered a dependent for the purposes of the provision of financial assistance if Federal income tax returns are provided as proof of same.

Family/Household Income: Family Income uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
- Noncash benefits (such as food stamps and housing subsidies) do not count.
- Determined on a before-tax basis.
- Excludes capital gains or losses.
- If a person lives with a family, it includes the income of all family members. (Non-relatives, such as Classmates, do not count.).

Amounts Generally Billed: (AGB) means the gross charges multiplied by the percentage derived by dividing the sum of the amounts of all claims for emergency or other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers by the sum of the associated gross charges for those claims.

Uninsured: The patient has no level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. to assist with meeting his/her payment obligations for health care services received from NMHC.

Underinsured: The Patient has some level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. but still has an out-of-pocket expense that exceeds his/her financial ability to pay for healthcare services at NMHC.

Minor Children/Divorced Parents: Both parents/legal guardians are responsible parties, and information regarding both parents will be required to complete the Financial Assistance Application for financial assistance.

Financial Assistance is not considered an entitlement, and each determination of eligibility stands on its own. Past acceptance of an account for financial assistance does not guarantee future accounts will also be accepted as a patient's financial situation may change over time.

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

PROCEDURE:

I. Description of Eligibility Criteria

Financial assistance is generally secondary to all other financial resources available to the patient, including group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

In those situations where appropriate primary payment sources are not available, patients shall be considered for financial assistance under this NMHC policy based on the following criteria as calculated for 12 months prior to the date of request:

- A. The full amount of NMHC charges shall be determined to be financial assistance for any patient whose gross family income is at or below 250% of the current federal poverty level.
- B. The schedule in Appendix A (BUS 0159) shall be used to determine the amount which shall be written off for patients.
- C. Catastrophic Financial Assistance: Patients not qualifying for Financial Assistance and whose bills are considered catastrophic (charges exceeding 25% of household income) will be considered for financial assistance based on individual circumstances. If an individual has no identified means to pay the bill in full, the following guidelines may be utilized: The amount of patient liability will not exceed 25% of the family's gross income used to determine financial assistance.
 - Other factors, such as total medical debt, future earnings potential, loss of wages and total debt may be considered to increase or reduce the amount of Financial Assistance.
 - Accounts with reduced amounts under this section of the policy must have the patient liability portion paid within 90 days from the time of Financial Assistance determination.
 - All cases under this section must be approved by the CEO or Chief Financial Officer.
 - The CEO of NMHC as well as the Chief Financial Officer may make exceptions to this policy.

II. Process for Eligibility Determination

A. Identification of Potential Financial Assistance Patients:

1. Initial Determination

During the patient registration or collection process, NMHC shall make an initial determination of eligibility based on verbal or written application for financial assistance. Pending final eligibility determination, NMHC shall not initiate collection efforts or requests for deposits, provided that the responsible party is cooperative with the NMHC's efforts to reach a determination of status, including return of application (BUS 0158) and documentation required by NMHC within fourteen (14) days of receipt. If there is missing documentation, the patient will be given an additional 14 days to respond to the request.

NMHC shall use an application process for determining initial interest in and qualification for financial assistance. Should patients not choose to apply for financial assistance, they shall not be considered for financial assistance unless other circumstances or intent become known to NMHC. If the NMHC becomes aware of factors which might qualify the patient for financial assistance under this policy, it shall advise him/her of this potential and make an initial determination that such account is to be treated as financial assistance.

2. Final Determinations

Prima Facie Write-Offs: NMHC may choose to grant financial assistance based solely on the initial determination. In such cases, NMHC shall not complete full verification or documentation of any request.

Financial assistance application and instructions shall be furnished to patients when financial assistance is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether indicated by the patient or NMHC, shall be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:

- a. W-2 withholding statements for all employment during the relevant time period.
 - b. Pay stubs from all employment during the relevant time period.
 - c. An income tax return from the most recently filed calendar year.
 - d. Forms approving or denying unemployment compensation; or
 - e. Written statements from employers or welfare agencies.
3. **Incomplete Applications:** Incomplete applications may be denied until or unless they are completed. NMHC will retain the incomplete application and send a letter to the patient outlining the information needed and how to submit the necessary paperwork.
 4. **Payment arrangements after final determinations** on any outstanding balances will be required. Patients are responsible for making mutually acceptable payment plan

arrangements with NMHC within 30 days of receiving their Notice of Determination Letter for Financial Assistance.

5. Time Frame for Final Determination and Appeals

NMHC shall provide final determination within thirty (30) days of receipt of all application and documentation material.

6. Denials/Appeals and Dispute Resolution:

Denials shall be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for financial assistance by providing additional verification of income and family size in writing to the Executive Director of Revenue Cycle within thirty (30) days of receipt of notification. The Executive Director of Revenue Cycle shall review all appeals. If this determination affirms the previous denial of financial assistance, written notification shall be sent to the patient/guarantor.

7. Limitation of Charges/Amounts Generally Billed

The Hospital limits the amounts charged for medically necessary services provided to individuals eligible for assistance under this Policy to not more than the amounts generally billed to individuals who have insurance coverage for such care. The AGB is derived using a look-back method of calculating the AGB by multiplying the hospital facility's gross charges for that care by one or more percentages of gross charges, called AGB percentages.

III. Documentation and Records

- A. Confidentiality: All information relating to the application shall be kept confidential. Copies of the documents that support the application shall be kept with the application form.
- B. Documents pertaining to financial assistance shall be retained for seven (7) years.

IV. Notification

- A. NMHC is committed to making information regarding financial assistance and patient billing practices readily accessible. The NMHC Financial Assistance Policy (FAP), Financial Assistance Application, Plain Language Summary, and related policy documents are available free of charge on the NMHC website <https://nmhcare.org> and may also be obtained by mail or in person upon request. The full Financial Assistance Policy is available online at: <https://nmhcare.org/wp-content/uploads/2026/09/FA-Full-Policy.pdf>.
- B. In addition, NMHC's Billing and Collections Policy, which describes the actions that may be taken in the event of nonpayment and the safeguards and reasonable efforts undertaken before any Extraordinary Collection Actions (ECAs) are initiated, is publicly available on the NMHC website <https://nmhcare.org>. Printed copies of these documents will be provided without charge upon request to any patient, family member, or authorized representative.

V. Presumptive Financial Assistance Eligibility:

- A. NMHC recognizes that not all patients are able to complete the financial assistance application or provide the required documentation. There may be instances when financial assistance is warranted and the patient qualifies for assistance, despite the lack of formal applications and income assessment described in this policy. In the normal course of assessment of a patient's ability to pay, NMHC, in its sole discretion, may declare the patient's account uncollectible and classify the account as meeting eligibility criteria.
- B. When presumptive financial assistance eligibility is established, typically a 100% discount will be available, but not guaranteed.

VI. Other Presumptive Eligibility:

- A. For patients who are non-responsive to NMHC's application process, other sources of information, such as estimated income and family size provided by a predictive model or information from a recent Medical Assistance application, may be used to make an individual assessment of financial need. This information will enable NMHC to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.
- B. For the purpose of helping financially needy patients, NMHC may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for NMHC. The predictive model enables NMHC to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process.
- C. Information from the predictive model may be used by NMHC to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Where efforts to confirm coverage availability have been unsuccessful, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.
- D. In the event a patient does not qualify for the highest level of financial assistance under the presumptive rule set, the patient may still provide the requisite information and be considered under the traditional financial assistance application process.
- E. Presumptive screening provides benefit to the community by enabling NMHC to systematically identify financially needy patients, reduce administrative burdens, and provide financial assistance to patients who have not been responsive to the financial assistance application process.

The VP of Revenue Cycle shall annually review this policy.