

 Prairie View Policies and Procedures	Title: Financial Assistance	
Manual: Patients Accounts	POLICY	PROCEDURE
Scope: Prairie View	Approval Date: 7/1/2024	Approval Date: 7/1/2024
Origination Date: 05/2023	Approved By: Executive Team	Approved By: John Hydock, CFO
Replaces: N/A		

Policy:

Prairie View provides financial assistance to patients receiving emergency or other medically necessary services if they demonstrate financial need and satisfy the requirements outlined in this policy. The primary beneficiaries of this policy are intended to be uninsured and underinsured patients. This policy serves to meet the requirements of Internal Revenue Code Section 501(r).

Procedures:

Providers Included Under This Policy

This policy applies to all practitioners and outpatient locations within Harvey, Marion, and McPherson counties. This policy does not apply to the outpatient clinics located in counties where Prairie View is not the Community Mental Health Center, and does not apply to practitioners and providers who may provide services and are not employed by Prairie View (i.e. Wichita).

Emergency Medical Care

Prairie View will provide, without discrimination, care for emergency medical conditions without regard to the patient’s eligibility for financial assistance or ability to pay. Prairie View requires an appropriate screening be provided to any individual requesting treatment for a potential emergency medical condition. If following an appropriate screening, Prairie View determines that the individual has an emergency medical condition, Prairie View will provide services, within its capability, necessary to stabilize the emergency medical condition or will facilitate an appropriate transfer.

Prairie View prohibits any actions, such as demanding payment before receiving treatment for emergency medical conditions or conducting debt collection activities that may interfere with providing emergency medical care.

Eligible Services for Financial Assistance

Prairie View reserves the right to limit the services covered by this policy. Emergency services and medically necessary behavioral health services are covered under this policy. Medical necessity is determined through a clinical utilization review with the physician, case manager, clinician, and with the patient’s third party insurance if applicable.

If the patient is already receiving discounted services from Prairie View through a separate reduced rate arrangement, those services are ineligible for financial assistance under this policy. Services deemed not medically necessary or elective services are not covered under this policy.

Some examples of these include:

- “Out of Network” patient liability balances that result from the patient receiving non-emergent care at Prairie View rather than from an “in-network” provider.

- Assessments required by another agency with the purpose of determining competency that do not result in a diagnosis.
- Services that are not deemed requirements of a Certified Community Behavioral Health Center (CCBHC) or a Community Mental Health center (CMHC).
- For outpatient services, this policy does not apply to residents outside of Harvey, Marion, and McPherson County (i.e., counties where Prairie View does not operate as the Community Mental Health Center).

Patients who elect to continue with a service performed by an “out of network” provider will be required to sign a notice agreeing they were made aware of the potential out of pocket cost associated with such service, before the service occurs.

Services provided by Prairie View’s Psychiatric Residential Treatment Facility are not eligible for sliding scale financial assistance utilizing CMHS funding.

Limitations on Charges

For a patient receiving financial assistance, the patient will not be charged more than the amount generally billed (AGB). Prairie View calculates the AGB using the “look-back” method and includes Medicare fee-for-service and all private health insurers that pay claims to the organization. The result of those calculations for the AGB are 95%.

This AGB percentage is calculated by dividing the sum of the amounts allowed by Medicare and private insurers by the gross charges for emergency and medically necessary services during the 12 month period prior to the AGB calculation. The only claims utilized for purposes of determining the AGB are those that were allowed by health insurers during the period.

Financial assistance is available to uninsured and underinsured patients; underinsured is defined as those whose insurance requires a person to pay 50% or more for a service even with in-network coverage.

Financial Assistance Rate Schedule

Patients whose gross annual income is 200% or less of the federal poverty guidelines may receive discounted services according to the below sliding fee scale. For uninsured patients, the discount will be applied to gross charges. For insured patients, the discount will be applied to patient responsibility as determined by their insurance carrier. (See Resources for more detailed information).



ANNUAL Income Thresholds by Sliding Fee Discount Pay class % of Poverty

Family Unit Size	HARDSHIP	10% Pay 90% Discount	20% Pay 80% Discount	40% Pay 60% Discount	60% Pay 40% Discount	80% Pay 20% Discount	100% Pay 0% Discount
Poverty %	HARDSHIP	100%	125%	150%	175%	200%	201%
1	\$0-\$5	\$14,580	\$18,225	\$21,870	\$25,515	\$29,160	\$29,160
2	\$0-\$5	\$19,720	\$24,650	\$29,580	\$34,510	\$39,440	\$39,637
3	\$0-\$5	\$24,860	\$31,075	\$37,290	\$43,505	\$49,720	\$49,969
4	\$0-\$5	\$30,000	\$37,500	\$45,000	\$52,500	\$60,000	\$75,000
5	\$0-\$5	\$35,140	\$43,925	\$52,710	\$61,495	\$70,280	\$87,850
6	\$0-\$5	\$40,280	50350	\$60,420	\$70,490	\$80,560	\$100,700
7	\$0-\$5	\$45,420	\$56,775	\$68,130	\$79,485	\$90,840	\$113,550
8	\$0-\$5	\$50,560	\$63,200	\$75,840	\$88,480	\$101,120	\$126,400
9	\$0-\$5	\$55,100	\$68,875	\$82,650	\$96,425	\$110,200	\$137,750
10+	\$0-\$5	\$59,640	\$74,550	\$89,460	\$104,370	\$119,280	\$149,100

MONTHLY Income Thresholds by Sliding Fee Discount Pay class % of Poverty

Family Unit Size	HARDSHIP	10% Pay 90% Discount	20% Pay 80% Discount	40% Pay 60% Discount	60% Pay 40% Discount	80% Pay 20% Discount	100% Pay 0% Discount
Poverty %	HARDSHIP	100%	125%	150%	175%	200%	201%
1	\$0-\$5	\$1,215	\$1,518.75	\$1,823	\$2,126	\$2,430	\$2,442
2	\$0-\$5	\$1,643	\$2,054	\$2,465	\$2,875	\$3,286	\$3,302
3	\$0-\$5	\$2,072	\$2,590	\$3,108	\$3,626	\$4,144	\$4,165
4	\$0-\$5	\$2,500	\$3,125	\$3,750	\$4,375	\$5,000	\$5,025
5	\$0-\$5	\$2,928	\$3,660	\$4,392	\$5,124	\$5,856	\$5,885
6	\$0-\$5	\$3,357	\$4,196	\$5,036	\$5,875	\$6,714	\$6,748
7	\$0-\$5	\$3,785	\$4,731	\$5,678	\$6,624	\$7,570	\$7,608
8	\$0-\$5	\$4,213	\$5,266	\$6,320	\$7,373	\$8,426	\$8,468
9	\$0-\$5	\$4,592	\$5,740	\$6,888	\$8,036	\$9,184	\$9,230
10+	\$0-\$5	\$4,970	\$6,213	\$7,455	\$8,698	\$9,940	\$9,990

Hardship fee or waiver of the entire amount of fee is based on individual circumstances with approval of the Financial Assistance Committee. (Refer to “Determination of Financial Assistance” section for more information.)

Length of Financial Assistance

Financial Assistance, when approved, will be good for a period of 180 days. At the conclusion of 180 days, a new Financial Assistance Application will need to be completed and approved in order for Financial Assistance to continue. First time applicants may choose to have sliding fee applied to the past 30 days of services in addition to the 180-day term beginning with date of application being submitted.



Financial Assistance Application: In order to be considered for financial assistance under this policy, a patient must complete the Financial Evaluation form and submit the following documents to demonstrate financial need and proof of residence within Harvey, Marion, or McPherson County:

Proof of Residency (select one)

- Utility bill
- Most recent bank statement
- Letter from housing shelter
- Current lease or letter from landlord
- Letter from family or friend
- Prairie View Self Attestation Form

Proof of Income (select one)

- Two most recent pay stubs
- Unemployment letter or paystub
- Most recent bank statement
- Most recent W-2 or tax return
- Social Security or Disability award letter
- Prairie View Self Attestation Form

Prairie View is a qualified entity under KanCare Medicaid’s Presumptive Eligibility program and is able assist with determining Medicaid eligibility for all persons who request that service, regardless of their ability to pay or whether or not they are a patient. For uninsured patients applying for financial assistance, a denial letter from Presumptive Eligibility will be required in addition to proof of residency, proof of income, and the Financial Evaluation in a good faith effort to provide the patient with better coverage for services.

Failure to submit all required documentation within 30 days of the Financial Evaluation being provided, as indicated on the first page of the document, may render the application incomplete and disqualify the patient from receiving financial assistance.

Applying For Financial Assistance: Patients may apply for financial assistance in-person at Admissions or by meeting with a Financial Counselor. Applications for financial assistance may also be obtained online at Prairie View’s website. Prairie View may presume eligibility for financial assistance under this policy for a patient if it receives information outside of the Financial Assistance Application that leads it to believe the patient may be eligible, such as:

- Patient is unhoused (facing eviction and/or unsheltered)
- Patient is diagnosed with a severe and persistent mental illness, or a severe emotional disturbance (see Determination Of Financial Assistance)
- Patient balances have been discharged by a bankruptcy court
- Patient is deceased, and balance due remains after all assets in an estate have been distributed

Measures to Publicize the Financial Assistance Policy

Prairie View is taking the following measures to publicize this policy to the community it serves.

- Posting the Financial Assistance Policy, Plain Language Summary, and the Financial Assistance Application on the Prairie View website.
- Providing paper copies of the Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application upon request in Admissions or by a Patient Account Specialist.

Determination of Financial Assistance

Upon receipt of a completed Financial Evaluation form and required documents, the application will be reviewed to determine whether the patient qualifies for financial assistance. Patients will be notified whether their application was approved or denied (with a reason for denial) within 30 days of the receipt of the



application. If a patient's application is denied, they will have 30 days from the date of the denial to appeal in writing. The initial application, denial, and appeal will be reviewed by the Financial Assistance Committee. Within 30 days of receipt of the appeal, a final determination will be sent to the patient.

Special circumstances may allow for some patients to qualify for additional discounts. This is known as "hardship." During hardship a person may qualify for a set dollar amount per service ranging from \$0.00 to \$5.00. For a patient to qualify for hardship, one of the following criteria must be met:

- Effective 7/1/2024 Patient must have a Severe and Persistent mental Illness (SPMI) and be on medical necessity Level 4 or 5 as indicated by the DLA-20 to qualify for \$0.00 case management services for 180 days. (SPMI status must be updated yearly, and DLA-20 level of care must be updated every 90 days by the provider.)

Patient's financial circumstances warrant Hardship (\$0 per service) or Charity (\$5 per service). A few examples of circumstances for hardship/charity consideration: Homelessness, unemployed due to mental illness, recent loss of employment, addiction recovery, etc.

Billing and Collections Process: In order to be fiscally responsible and remain financially viable, Prairie View must receive payment for the services it provides. Prairie View will pursue collection of balances due, including Extraordinary Collection Actions (ECA), if patients do not pay balances due or make acceptable payment arrangements within 120 days of their first billing statement. Patients will receive monthly statements detailing balances due. At least 30 days prior to the initiation of any ECA, Prairie View will:

- Provide written notice to the patient that states financial assistance is available
- Provide the patient with a plain language summary of the Financial Assistance Policy
- Make a reasonable effort to orally notify the patient about the Financial Assistance Policy

If ECA are in place, and a completed Financial Assistance Application is received, ECA in progress will be suspended until a determination is made regarding financial assistance.

This information and resources can be used as an estimate for where a patient may fall on the sliding fee, and how much a patient might be expected to pay for particular services. The following information is not a guarantee of financial assistance or sliding fee benefits.

Resources:

Requirements for 501(c) (3) Hospitals under the Affordable Care Act – Section 501(r) | Internal Revenue Service (irs.gov) <https://www.irs.gov/charities-non-profits-/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section501r>

