



## **Frisbie Memorial Hospital's Financial Assistance Policy**

### **I. PURPOSE:**

To set forth the procedure by which a patient may apply for financial assistance for medically necessary and emergency care provided by Frisbie Memorial Hospital and its employed providers. This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Service (IRS) Code 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be updated from time to time to the extent required by applicable law.

### **II. SCOPE:**

This financial assistance policy applies to eligible services delivered and billed by the Frisbie Memorial Hospital. Throughout this policy, Frisbie Memorial Hospital is referred to as either "Frisbie Memorial Hospital" or the "Hospital." Under this policy, "eligible services" are defined as (a) trauma and emergency medical services provided in an emergency setting; (b) medically necessary services; (c) services for a condition that, if not treated promptly, would lead to an adverse change in health status of a patient; (d) treatment or services provided in response to life-threatening circumstances in a nonemergency room setting; and (e) medical services and supplies that are reasonable and necessary for the diagnosis and treatment of illness or injury. Examples of services that are generally not considered eligible for financial assistance under this policy include, (a) cosmetic services or surgery; (b) dental implants; (c) retail pharmacy; and (d) other non-medically necessary services.

Services delivered at the Hospital by the providers listed in Section B of Exhibit A are not subject to this policy and these providers may or may not offer financial assistance. Questions regarding whether a particular provider is subject to this policy may be directed to Corporate Compliance by calling (603) 332-3100 X8999.

A copy of this policy is posted on the Hospital's web site at <https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/>.

The Hospital also maintains a separate billing and collections policy which sets forth the actions that the Hospital may take in the event of non-payment of amounts determined to be a patient's responsibility, a free copy of which can be obtained by contacting our Financial Advocates at (603) 335-8109.

### **III. POLICY:**

The Hospital is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. It is the policy of the Hospital to accept all patients for emergency and medically necessary care, regardless of their ability to pay and to offer financial assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations, including indigence and excessive medical debt. The Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, gender identity, sexual orientation, age or disability in providing health care services. A Hospital financial counselor, designated business office



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representative, or committee with authority to offer financial assistance will review each individual case and make a determination of financial assistance that may be offered.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance;
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy;
- Describes the method by which patients may apply for financial assistance;
- Describes how the hospital will widely publicize the policy within the community served by the hospital;
- Describes the limit on amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to Amounts Generally Billed (as defined on Exhibit E).

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with the Hospital procedures for obtaining financial assistance or other forms of payment or external financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

#### IV. DEFINITIONS:

For the purpose of this policy the following terms (whether capitalized or not) are defined:

**Emergency Medical Condition:** An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in -- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. (42 U.S.C. § 1395dd)

**Family:** A family includes spouses, individuals with civil unions, parents and minor children regardless of residence. If a patient is claimed as a dependent on a person's income tax return, according to the IRS rules, then that person's income will be considered for purposes of determining eligibility for financial assistance.

**Federal Poverty Guidelines:** Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

**Gross Charges:** The Hospital's fully established rates and total charges for the provision of patient care services before contractual allowances (the difference between what the health



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insurer allows for a service and what the provider charges for that service), other deductions from revenue, or negotiated discounts are applied.

**Guarantor:** An individual other than the patient who is responsible for payment of the patient's bill or debt if the patient fails or is unable to pay the bill or debt.

**Household Income:** Household income shall include the salaries, unemployment compensation, child support, any medical support obligations, alimony, social security income, disability payments, pension or retirement income, rents, royalties, income from estates and trusts, legal judgments, dividends, equity in real property, capital gains, inheritances, non-cash benefits, interest/dividends, liquid assets, and all other taxable income under the IRS regulations. A household for purposes of calculating a patient's household income shall include all family members living in the residence.

**Medically Necessary:** Health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a patient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;
- Not primarily for the convenience of the patient or the patient's family, caregiver, or health care provider;
- No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- Not experimental, investigative, cosmetic, or duplicative in nature. (N.H. Admin. Rules, He-W 530.01)

### V. PROCEDURE:

- a. Patient Eligibility Criteria: To receive financial assistance from the Hospital, a patient must first meet the following criteria:
  - i. Income & Assets. Eligibility for full financial assistance will be determined based on a combination of household income and assets.
    - Patients, or their guarantors, with an annual household income, during the past 12 months, below 300% of the Federal Poverty Guidelines and whose liquid assets do not exceed \$5,000 for an individual or \$10,000 for a family are eligible for full financial assistance. Full financial assistance is a complete write-off of the Hospital's charges for eligible services.
    - The Federal Poverty Guidelines in effect at the time the financial assistance determination is made will be used to determine if a



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patient's household income is below the applicable 300% of the Federal Poverty Guidelines. The current Federal Poverty Guidelines and the Hospital's asset guidelines are set forth on the attached Exhibit B.

- ii. Medicaid Ineligible. In order to qualify for financial assistance, all other payment options must be exhausted, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties. Patients must apply for coverage to, and be denied in writing from, Medicaid prior to being considered for financial assistance. Failure or refusal to apply for Medicaid will result in an automatic denial for financial assistance. The Hospital's Financial Counselors will be available to provide assistance in completing the Medicaid coverage application.
  - iii. Eligible Services. Financial assistance will be considered only for eligible services. Elective procedures, such as cosmetic surgery, typically are not eligible services. The Hospital will consult with the admitting provider and/or the provider advisor appointed by the Hospital when questions arise as to whether a service is deemed an Eligible Service.
  - iv. Application. Patients must submit a completed financial assistance application and provide all necessary documentation as outlined in Exhibit C of this policy. Applications will remain active for six (6) months. After that date, patients must submit a new application to the Hospital. A financial assistance application is attached to this policy as Exhibit D.
- b. Application Process. Applications for financial assistance should be submitted to a Hospital financial counselor together with all required supporting documentation as set forth on Exhibit C, for final approval from the Manager of Patient Accounting, according to the process set forth in this section. Applications for financial assistance are available on the Hospital's website at [http://www.frisbiehospital.com/wp-content/uploads/2018/06/frisbie\\_financial-assistance-form.pdf](http://www.frisbiehospital.com/wp-content/uploads/2018/06/frisbie_financial-assistance-form.pdf) Additionally, the financial assistance application is attached to this policy as Exhibit D.
- i. Care management staff and financial counselors may inform patients of the availability of financial assistance for eligible services at any time during the preadmission, admission or the billing and collection cycle when a patient indicates inability to pay for care received from the Hospital. Additionally, the Hospital staff will offer each patient a paper copy of the plain language summary of this policy as part of the intake or discharge process.
  - ii. A plain language summary of the Hospital's financial assistance policy is provided to each patient that summarizes the availability of financial assistance at the Hospital and describes the application process. A copy of



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this policy, a plain language summary of this policy, and request/application forms for financial assistance will be widely available to prospective patients and their guarantors at no charge in Patient Accounting and Registration. The Hospital will make this policy, the financial assistance application and a plain language summary of this policy available in languages required by applicable law.

- iii. Completed applications for financial assistance may be made prior to the receipt of eligible services and post discharge. Applicants should make every attempt to submit completed financial assistance applications within 240 days from the receipt of their first bill. Eligibility will be effective back to the oldest date of Eligible Service with a patient balance.
- iv. A financial counselor will assist and verify the completion of the financial assistance application prior to the final approval by the Manager, Patient Accounting. Every effort will be made to obtain alternative sources of payment before financial assistance is approved.

c. Determination of Financial Assistance:

- i. Financial assistance applications for the Hospital are generally reviewed within sixty (60) days of receipt of all necessary documentation.
- ii. All patients will receive a written notice once a determination of eligibility has been made. The written notice shall include the basis upon which the Hospital has made its determination. Approval letters will be sent by a financial counselor.
- iii. If a patient or guarantor is denied financial assistance, he or she, or the patient's or guarantor's agent, may appeal the decision within thirty (30) days. The patient or guarantor, or his or her agent, must write an appeal letter to the Manager of Patient Accounting, as indicated in the denial letter. The patient's appeal letter must explain why the decision by the Hospital, to deny financial assistance is inappropriate. The appeal letter will be reviewed by the Hospital and a final decision will be made.
- iv. The Manager of Patient Accounting may approve any application for financial assistance if the application is complete and meets the income and asset guidelines, regardless of amount.
- v. The Manager of Patient Accounting may request approval from the Chief Financial Officer for a waiver of the eligibility requirements on a case-by-case basis as needed to prevent a medical hardship to a patient, as determined solely by the Hospital. The Hospital is under no obligation to grant a waiver.



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- vi. Once a patient or guarantor has been determined by the Hospital to be eligible for financial assistance, the patient or guarantor will not be charged more than the Amounts Generally Billed (AGB) by the Hospital to individuals with insurance covering care for eligible services. A description of the Hospital's methodology is attached as Exhibit E to this policy.
- vii. A log will be maintained of financial assistance provided, indicating patient name, address, in/out patient, dollar amount, and whether it was from endowment funds or operating accounts.
- viii. The Director Finance may direct that financial assistance be charged against restricted funds established for charity care purposes.

### **VI. PRESUMPTIVE ELIGIBILITY:**

The Hospital recognizes that not all patients are able to complete the financial assistance application or provide required documentation. There may be instances where a patient's qualification for financial assistance is established without completing the formal financial assistance application. The Hospital may utilize other information to determine that a patient's account is uncollectible and classify the account as meeting eligibility criteria.

For example, only, Presumptive Eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

- A. Homelessness or receipt of care from a homeless clinic;
- B. Participating in Woman, Infants and Children programs (WIC);
- C. Receiving SNAP (Supplemental Nutritional Assistance Program) benefits;
- D. Deceased patient with no known estate;
- E. Annual household income, during the past 12 months, below 250% of the Federal Poverty Guidelines; or
- F. Annual household income, during the past 12 months, from 250-300% of the Federal Poverty Guidelines with an Acumen Probability Score <700.

This information will enable the Hospital to make an informed decision on the financial need of patients utilizing the best estimates available in the absence of information provided directly by the patient.

For purposes of helping financially needy patients, the Hospital may utilize a third-party to review patient 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, assets 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 the Hospital. The predictive model enables the Hospital to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process.



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Information from the predictive model may be used by the Hospital to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. After efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

The predictive technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This enables the Hospital to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic review will constitute adequate documentation of financial need under this policy.

When predictive modeling is the basis for presumptive eligibility, financial assistance will be granted for eligible services for retrospective dates of service only. Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. These accounts will not be sent to collection and will not be included in bad debt expense.

### **VII. DISTRIBUTION/PUBLICITY:**

This policy shall be distributed to the President, Senior Management, Care Management, and Patient Accounting and Finance, in addition, this financial assistance policy, the application and plain language summary will be conspicuously posted on the Hospital's website at <https://www.frisbiehospital.com/patients-and-visitors/billing-insurance/financial-assistance/> and available in and available in languages required by applicable law. The documents will be printable from the website and available in the emergency department and admission areas of the Hospital. This information will also be made available upon request and free of charge from Patient Accounting and Registration and by mail. The Hospital's community staff are educated about this financial assistance Policy, and are instructed to inform and notify their community constituents of the availability of financial assistance at the Hospital.

### **VIII. FILING INSTRUCTIONS:**

This policy shall be filed in the Patient Accounting section of the Hospital Policy Manual and supersedes any and all previous policies issued relative to this subject.



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### **EXHIBIT A PROVIDER LIST**

- A.** With the exception of those providers listed in **Section B** below, eligible services billed by the Hospital on behalf of its employed providers are eligible for financial assistance under the Hospital's financial assistance policy. These eligible providers include:
1. Emergency department providers;
  2. Internal medicine providers;
  3. Oncology providers;
  4. Urology providers; and
  5. Surgery providers.
- B.** Eligible services provided at the Hospital by the providers listed below are not eligible for financial assistance under the Hospital's financial assistance policy. These providers may or may not have financial assistance policies of their own.
1. Anesthesia North American Partners;
  2. Salmon Falls Pathology;
  3. Seacoast Radiology;
  4. Surgical Associates of Rochester;
  5. Atlantic Digestive Associates;
  6. Seacoast Orthopedics Sports Medicine;
  7. Eyesight (Dr. Goldblatt);
  8. Granite State Labs; and
  9. Skyhaven ASC.

### **EXHIBIT B**



# Frisbie Memorial Hospital's Financial Assistance Policy

## INCOME AND ASSET GUIDELINES

The 2019 Federal Poverty Guidelines are as follows:

### 300% Of the Federal Poverty Guideline

For families/households with more than 8 persons, add \$12,960 for each additional person.

Persons in Family/Household	Poverty Guideline
1	\$37,470.00
2	\$50,730.00
3	\$63,990.00
4	\$77,250.00
5	\$90,510.00
6	\$103,770.00
7	\$117,030.00
8	\$130,290.00

A. The Hospital's household income and asset guidelines are as follows:

- Financial assistance is available to patients, or their guarantors, with annual household income, during the past 12 months, below 300% of the Federal Poverty Guidelines and whose liquid assets do not exceed \$5,000 for an individual or \$10,000 for a family. The following shall be excluded from household income: up to \$100,000, for patients under 55, and \$150,000 for patients over 55 in equity in a primary residence and up to \$5,000 in cash savings per patient and \$10,000 in cash savings per family. For patients under the age of 18 years of age, family income includes that of the parents and/or step-parents, unmarried or domestic partners, or guardians, who may or may not live with the minor, regardless of whether the step-parent adopted the minor patient.
- If patient or guarantor is a homeowner, the Hospital will require a copy of the most recent Mortgage Statement.
- Self-employment will be calculated using the patient or guarantor's tax return. Lines 8, 13, 24a, 24b, 30 and 31 will be added to compute gross income.



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### **EXHIBIT C FINANCIAL ASSISTANCE APPLICATION REQUIRED ADDITIONAL DOCUMENTATION**

The following additional documentation must accompany the completed financial assistance application:

- Complete copy of the most recent Federal Income Tax Return and all schedules;
- Copies of W-2 forms and 1099 for the previous year;
- Copies of the 3 most recent, consecutive paycheck stubs or statement from employer;
- Copies of all of the patient's 3 most recent bank statements, including but not limited to savings, checking, money market, IRA and 401K accounts;
- Copies of unemployment or disability compensation benefits;
- Copies of pension benefits;
- Copies of social security income (yearly statement, check or direct deposit);
- Copy of Food Stamp allocation;
- Copies of government assistance notices (including Department of Health and Human Services); and
- Letter of financial condition.



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## EXHIBIT D FINANCIAL ASSISTANCE APPLICATION

**Frisbie Memorial Hospital**  
*It's about People. Technology. Trust.*

**NH Health Access NETWORK**  
*financial help - for your health*

### Financial Assistance Application

**1. Patient's Information:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Single  Married  Civil Union  
 Separated  Divorced  Widowed

**2. Person Responsible for Paying the Bill**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address if Different From Patient's \_\_\_\_\_ Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

**3. \*\*Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed**

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY#	DOCTOR'S NAME
1	Self			
2				
3				
4				
5				
6				

4. Is this application for future or past services?  Future  Past Date(s) of Services: \_\_\_\_\_

5. Has anyone in your household applied for Children's Medicaid or Medicaid?  Yes  No Who: \_\_\_\_\_

6. Have you applied for financial assistance at another facility?  Yes  No If yes, where: \_\_\_\_\_

7. Is anyone in your household pregnant?  Yes  No

8. Has anyone in your household served in the military?  Yes  No Who: \_\_\_\_\_

9. Have you recently filed a workers' compensation or motor vehicle accident claim?  Yes  No Date: \_\_\_\_\_

10. Is anyone in your household eligible for Social Security benefits?  Yes  No Who: \_\_\_\_\_

11. Please check if anyone in your household is covered by health insurance \_\_\_\_\_, health savings account \_\_\_\_\_  
Medicare Part A \_\_\_\_\_ Medicare Part B \_\_\_\_\_ Receives assistance to pay Medicare Part B \_\_\_\_\_ Who: \_\_\_\_\_

12. Does anyone else claim you on their income tax return?  Yes  No Who: \_\_\_\_\_

NH/NH Application Revised 3/05, 9/06, 2/06, 12/07, 8/09, 10/10, 5/11

**13. HOUSEHOLD INFORMATION**

	PERSON 1	PERSON 2	PERSON 3
<b>Name of each household member:</b>	_____	_____	_____
<b>Name of employer:</b>	_____	_____	_____
<b>Monthly Income From:</b>			
Employment:	\$ _____	\$ _____	\$ _____
Self-Employment:	\$ _____	\$ _____	\$ _____
Investment Accounts:	\$ _____	\$ _____	\$ _____
Real Estate rentals:	\$ _____	\$ _____	\$ _____
Unemployment: (since ___/___/___)	\$ _____	\$ _____	\$ _____
Retirement:	\$ _____	\$ _____	\$ _____
(Soc. Security, Pension, Annuity)	\$ _____	\$ _____	\$ _____
Alimony/Child Support:	\$ _____	\$ _____	\$ _____
Public Assistance, Food Stamps:	\$ _____	\$ _____	\$ _____
Other Income:	\$ _____	\$ _____	\$ _____
<b>Savings and investments:</b>			
Checking Account Balances	\$ _____	\$ _____	\$ _____
Savings & CD Account Balances	\$ _____	\$ _____	\$ _____
IRAs, 403B, 401K:	\$ _____	\$ _____	\$ _____
Specify _____	\$ _____	\$ _____	\$ _____
Other savings and investments:	\$ _____	\$ _____	\$ _____
Specify _____	\$ _____	\$ _____	\$ _____
<b>Other:</b>			
Automobile: Year, Make, Model?	_____	_____	_____
Recreational Vehicle: Year, Make, Model?	_____	_____	_____

**14. HOUSEHOLD EXPENSES**

Monthly Rent Payment: \$ \_\_\_\_\_ or Mortgage Payment: \$ \_\_\_\_\_ Mortgage Loan Balance \$ \_\_\_\_\_

Property Tax Amount Not Included in Payment Amount Above: \$ \_\_\_\_\_ Value of Home: \$ \_\_\_\_\_

Do You Own Property Other Than Primary Residence?  Yes  No If Yes, Value \$ \_\_\_\_\_ Mortgage balance \$ \_\_\_\_\_

If other property is a business, list address: \_\_\_\_\_

Monthly Loan Payment: \$ \_\_\_\_\_ Paid to: \_\_\_\_\_ For: \_\_\_\_\_

Medicare Part D deducted from Social Security check:  Yes  No Amount \$ \_\_\_\_\_

Utilities	Insurance (Auto/Life/Property)	Other
\$ _____	\$ _____	\$ _____
Alimony/Child Support	Health Insurance	Other
\$ _____	\$ _____	\$ _____
Child Care	Healthcare Bills	Other
\$ _____	\$ _____	\$ _____
Living (gas, food, clothes)	Medications	Other
\$ _____	\$ _____	\$ _____

**15. ASSIGNMENT OF RIGHTS Read Carefully**

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_ CO-Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_



# Frisbie Memorial Hospital's Financial Assistance Policy

## EXHIBIT E AMOUNTS GENERALLY BILLED

The Hospital determines Amounts Generally Billed by using the “look-back method.” The AGB calculation is as follows:

1. The AGB is calculated by reviewing all past claims paid in full to the Hospital for emergency and medically necessary care by Medicare fee-for-service and all private health insurers, including co-insurance, copayments, and deductibles, during a specified 12-month period.
2. The AGB for emergency and medically necessary care provided to a financial assistance eligible individual is determined by multiplying gross charges for that care by one or more AGB percentages.
3. Frisbie Memorial Hospital annually calculates its AGB percentages by dividing the sum of certain claims paid by Medicare fee-for-service and private insurers by the associated gross charges for those claims.
4. AGB percentages are applied by the 45<sup>th</sup> day after the end of the 12-month calendar year period Frisbie Memorial Hospital used in calculating the AGB percentages.

The calculation of AGB is determined as follows:

Payer Group	Total Inpatient and Outpatient Gross Charges	Total Inpatient and Outpatient Claims Paid	AGB Percentage
Medicare & Private Health Insurers	\$140,000,000	\$70,700,000	50%

In the above example, the blended AGB percentage is equivalent to 50%. Therefore, the discount off gross charges, will be no less than 50%. The AGB discount will be recalculated annually.