	Title: Financial Assistance Policy 1.1.2020 Updated		Document Owner: Joe Wanner	
			Effective: 1/1/2020	Reference #: 1078
	Department: Administration		Last Review: 01/28/2020	Version #: 5

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WALLOWA COUNTY HEALTH CARE DISTRICT

ADMINISTRATIVE POLICY

January 1, 2020

SUBJECT: Financial Assistance Policy

PHILOSOPHY: It is the practice of Wallowa Memorial Hospital to provide emergency or other medically necessary care, without discrimination, to all patients regardless of ability to pay.

Wallowa Memorial Hospital is committed to granting *financial assistance* when the patient is unable to pay for treatment and services. It is the intent of this policy to comply with all federal, state and local regulations. If any regulation conflicts with this policy the regulation will supersede the policy.

POLICY:


These guidelines are to be followed consistently in reviewing and approving applications for financial assistance for patients unable to pay.

Any self-pay or uninsured patient who indicates an inability to pay will be offered an application for financial assistance. In addition, any insured patient who indicates an inability to pay their deductible and co-insurance will also be offered an application for financial assistance.

Application Period: This period begins on the date care is provided to the patient and ends on the 240th day after the patient is provided with their first billing for care.

Eligibility Requirements: The Federal Poverty Level guidelines will be used to determine income guidelines based on household/family size only.

- Household is defined as: A single individual; or Spouses, domestic partners, or a parent and child under 18 years of age, living together' and Other individuals for whom a single individual, spouse, domestic partner or parent is financially responsible.
- Income includes: earnings, unemployment compensation, workers' compensation, Social Security, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, education assistance, alimony, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

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- Medically necessary is defined as: Necessary to prevent, diagnose or treat an illness, injury, condition or disease, or the symptoms of an illness, injury, condition or disease; and meeting accepted standards of medicine.
- Patient Cost is defined as: the portion of charges billed to a patient for care received at a hospital or a hospital-affiliated clinic that are not reimbursed by insurance or a publicly funded health care program, taking into account the requirements of section 501(r)(5) of the Internal Revenue Code that: Prohibit a nonprofit hospital from billing gross charges; and Limit amounts charged for emergency or other medically necessary care, to a patient who qualifies under the nonprofit hospital's financial assistance policy, to no more than amounts generally billed to a patient who has insurance that reimburses all or a portion of the cost of the care.
- Medical debt is defined as: an amount owed by a patient to a hospital or a nonprofit hospital-affiliated clinic for medically necessary services or supplies.
- Debt collector is defined as: a person that by direct or indirect action, conduct or practice collects or attempts to collect a debt owed, or alleged to be owed, to a creditor.

A sliding scale will be used to determine discounts when gross family income is between 200 and 400% of FPL. Financial assistance will be granted based on the following eligibility criteria and discount percentages, which such percentages will be applied as described immediately below chart.


Effective 1/1/2020 to 12/31/2020

Family Income as a % of FPL	% Discount
0% - 200%	100% of Patient responsibility
200% - 300%	38% of Patient responsibility
300% - 350%	25% of Patient responsibility
350% - 400%	13% of Patient responsibility

No patient determined to be eligible for financial assistance for care will be personally responsible for having paid or paying more for the care than the Amounts Generally billed to Medicare and Commercial Insurance carriers.

As a condition for providing financial assistance, a patient will be required to:

- Respond to requests from the patient's insurer as necessary for the insurer to adjudicate any claims for reimbursement.

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- Provide information concerning any potential third party liability for the cost of services including but not limited to :
 - Information about the coordination of benefits between insurers that cover the patients care
 - Accident reports
 - Worker's compensation claims or benefits.

Presumptive Eligibility: Presumptive eligibility for Financial Assistance for uninsured patients will be determined on the basis of certain factors that indicate financial need as outlined below:

- Patient is deceased with no estate;
- Patient is mentally or physically incapacitated and has no one to act on his/her behalf;
- Patient is enrolled in the Women, Infants and Children Nutrition Program (WIC);
- Patient is enrolled in the Supplemental Nutrition Assistance Program or Food Stamp Program;
- Patient is presumed eligible for Medicaid under the Medicaid presumptive eligibility guidelines; or
- Hospital has evidence from an independent third-party report agency that indicates family income 200% or less FPL.


Catastrophic Medical Expenses: Wallowa Memorial Hospital, at its' discretion, may grant charity in the event of a catastrophic medical expense. These patients will be handled on an individual basis.

Covered Providers: This Financial Assistance policy will apply to the following providers:

- Wallowa Memorial Hospital
- Mountain View Medical Group
- Emergency Services

The following providers provide services at Wallowa Memorial Hospital and will bill for their services separately. This financial assistance policy does not apply to their services.

- Central Oregon Radiology
- Winding Waters Medical Clinic
- Olive Branch Medical Clinic
- Dr. Heisinger
- Dr. Petrussek

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- Dr. Hampton
- Dr. Bronstein
- Dr. Jackson
- Dr. Funk
- Dr. Ferraro
- Dr. McCarthy
- Dr. Giebel

How to file: The application for Patient Financial Assistance can be downloaded from the hospital web site (wchcd.org), or picked up at the hospital in Registration, Billing, or at any of our clinic locations. Availability of these documents is included in each statement. The patient may also call 541.426.5304 and have the application mailed to them. All pages of the application need to be completed. Documents that need to be included with the application include proof of income (W-2 or payroll stubs), the last income tax return that was filed (1040); and the last three bank statements. If there are multiple bank accounts, statements need to be included for each account. This information will be kept confidential by the hospital. When the information is complete it needs to be submitted to the Patient Accounts Specialist (541.426.5304) at 601 Medical Parkway, Enterprise, Oregon, or other available staff in the Business Office or Registration. The hospital and hospital-affiliated clinics will conduct an eligibility screening upon request, before unpaid charges are transferred to a debt collector, and/or before unpaid amounts are referred to collection.

Notification Period: Begins the 1st day of care and ends on the 120th day after first billing statement. The notification period is completed when the application is received. If the patient fails to submit the financial assistance application by the end of the notification period, extraordinary collection efforts may begin.

Notification is met if:

- Summary of financial assistance policy is distributed or offered to patient before discharge
- Summary of financial assistance policy is included with 3 billing statements
- The patient is informed orally about the policy; and
- Written notice is provided 30 days before the end of the notification period that includes the collection efforts that will occur if hospital does not receive an application.

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Application Period: Begins the 1st day of care and ends on the 240th day after the first billing statement. If a complete or incomplete application is received during this time any extraordinary collection efforts must be suspended while the application is processed. If additional information is needed a written notification must be sent to the patient asking for the specific information. A notice must be provided to the patient (with an incomplete application) listing the collection efforts that will be taken if a completed application isn't received by the deadline. The notice must be provided at least 30 days before the application period ends.

Billing Procedures: A summary of the Financial Assistance Policy must be included with each of the first 3 billing statements that are mailed to the patient. Extraordinary collection efforts (garnishing wages, liens on property, beginning civil actions, etc) cannot be started until after the third statement. If a completed application is received during the application period the following procedures will be followed:

- Extraordinary collection efforts will be ceased;
- A determination of eligibility will be made; and
- The applicant will be notified in writing the determination and the basis for the determination

If an incomplete application is received during the application process:


- Extraordinary collection efforts will be suspended
- A written notice will be sent that describes the additional information required
- A written notice will be provided about the collection actions that may be taken if a completed application isn't received; and
- A notice will be provided at least 30 days before the deadline of the application period ends.

Extraordinary Collection Efforts (ECE): ECE include, but are not limited to the following:

1. Commence a civil action against an individual;
2. Placement of lien on an individual's property;
3. Garnish wages and bank accounts.

Amounts Generally Billed (AGB) Discount: The Accounting Department will use the look back method to include Medicare fee-for-service and commercial payers AGB Discount that may apply. The current effective AGB discount is 28.8%

If Portion of Bill written off for Financial Assistance:

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In cases where the patient will owe a portion of the bill after receiving Financial Assistance, the patient will not be responsible for paying more for the care than the AGB. A summary of the current calculation and how it was derived can be requested from the Patient Accounts Specialist (541.426.5304) or other available staff in the Business Office or Registration.

Patients without Required Documentation:

In some cases when the patient is unable to provide documentation for verifying income; they do not file income taxes, or they do not have bank accounts, the hospital will attempt to verify the information presented. Public assistance or verification by a caregiver or friends will be taken into account. The application needs to be signed in this case attesting to the accuracy of the information. If a patient is unwilling to provide the required information financial assistance will not be offered. Expired patients may be deemed to have no income for purposes of meeting the requirements if there are no assets to satisfy the account.

Review of Applications:

The Patient Accounts Specialist and CFO will review applications and patients will be notified within 21 days of the completion of the application. *Initial approval of Financial Assistance will be valid for 3 months. Patients will be asked to validate their information at this point. If a subsequent approval is granted, it will be valid for another 6 months.*

Larry Davy, CEO

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 Revised: December 16, 2019
 Approved:
 Effective: July 1, 2014
 Author: Joe Wanner