Policies & Procedures **Policy Owner: Finance Department**
Glendive Medical Center Applies To: Facility Wide

SUBJECT: FINANCIAL ASSISTANCE

Written / Revised By: William Robinson, VP of Finance
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Approved By: 

Parker Powell, CEO

PURPOSE:
Glendive Medical Center (GMC) is a not-for-profit medical center that provides inpatient, outpatient and emergency services, committed to caring, healing and a healthier community. GMC provides quality rural health care to all patients who seek services, including those individuals who lack the ability to pay for such services. This policy sets forth the policy, process and guidelines by which such patients can access Financial Assistance including Uncompensated Care.

POLICY:
To fulfill its mission of providing compassionate and high quality rural healthcare to patients it serves, it must also achieve cost efficiency of those services through effective management of its resources. Therefore, it is the policy of GMC to maintain a process for proper identification of patients eligible for Financial Assistance.

This policy covers medically necessary health care services provided by GMC for inpatient and outpatient hospital care. GMC will provide, without discrimination, care of emergency medical conditions to individuals regardless of their ability to pay or their eligibility for financial or government assistance. It does NOT include extended care, respite care, swing bed, transportation costs, elective procedures and any services provided by outside vendors, including, but not limited to non-hospital based providers.

It is the policy of GMC to differentiate between the patients who are unable to pay from those who are unwilling to pay for all or part of their care. GMC will provide Financial Assistance including Uncompensated Care to those patients who are unable to pay based upon the eligibility criteria set forth herein in Appendix A-C. In order to conserve scarce healthcare resources, GMC will seek payment from all patients who do not qualify for Financial Assistance. While qualifications for Uncompensated Care is ideally determined at the time of service, GMC will continue to review all determinations as potential insurers or other financial resources are discovered during the billing and collection process.

GMC will furnish financial assistance information to every patient or responsible party of a minor patient and assist them to apply for financial assistance including Uncompensated Care.

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All patients and other responsible parties will be treated fairly, with dignity, compassion, respect and cultural sensitivity throughout this process.

As outlined in the separate Bad Debt policy, GMC may pursue collections actions against patients found ineligible for financial assistance, patients who received discounted care but are no longer cooperating in good faith to pay the remaining balance, or patients who have established payment plans but are not in compliance with the agreement after an opportunity to cure.

Definitions:

1. Uncompensated Care Financial Assistance: Uncompensated Care is free care provided to patients who are not covered by any medical or other insurance or other entity in whole or in part (co-payment, coinsurance, deductible, spend down, etc.), who are ineligible for any governmental coverage (for example, Medicaid,), who are liable for payment and meet the established hospital guidelines for Uncompensated Care.
2. Self-Pay Patient: Those patients who are liable for all or a portion of their care but are not eligible for Uncompensated Care. Self-pay patients may be eligible for financial assistance through installment payments and other programs.
3. Catastrophic Financial Assistance: Patient is not eligible for any other assistance and unable to pay the self-responsible portion of the account in 24 months or less based on set criteria as shown in Appendix C.
4. Amount Generally Billed (AGB):
   The average amount allowed on gross charges by Medicare and Commercial insurance payers for services at GMC as calculated semi-annually in July and December under the lookback method. No individual eligible for financial assistance under this policy will pay a rate higher that the AGB. Description of the AGB calculation can be readily obtained free of charge by contacting the collections department.

PROCEDURE:

A. The following will take place to insure all eligible patients/responsible parties are aware of the uncompensated care program:

1. Patients will be informed of the availability of this Financial Assistance program by the following means:
   - Signage posted conspicuously at admission/registration areas
   - Language in the hospital "Conditions of Admission"
   - Brochures conspicuously placed and provided to uninsured and underinsured patients at the point of admission/registration
   - Relevant information on the hospital's website www.gmc.org
2. Each patient (or their guarantor) of Glendive Medical Center except for ones receiving Nursing Home, Respite Care, Swing Bed, and clinic services will be provided information for Uncompensated Care, Installment Plans Assistance and Catastrophic Financial Assistance.
3. Any person may request and receive a copy of this policy as well as an Uncompensated Care application free of charge

B. The following requirements must be met by any patient to qualify for uncompensated care consideration:
   1. A completed application and required documentation must be received by the collection department within 240 days following the patient's first billing statement, before final determination can be made:
      a. Signed and Dated Application.
      b. All documentation requested on the documentation checklist.

C. Upon receipt of application, the date received will be stamped on the application and will be processed within 30 days.

D. If a patient, or a patient's guarantor, has been issued a financial assistance application, but has not returned the application and complete supporting documentation within a 30-day timeline, this may result in a denial of the application due to non-compliance. A denial letter shall be sent to the patient due to noncompliance. If it is determined that additional time is needed to submit the financial assistance application, the patient, or patient's guarantor, may request an extension of up to 15 days to remain compliant with the financial assistance process.

E. If a Medicaid Eligibility/Denial Determination is delayed, a Conditional Eligibility may be given if the applicant qualifies and that date should be shown on the application. When Conditional Eligibility is given, no further statements should be sent and no further collection proceedings should take place. A letter should be sent informing the applicant that they are eligible contingent upon Medicaid denial. Review and signature by CFO or their designee is required prior to sending the letter.

F. GMC recognizes that not all patients, or patients' guarantors, are able to complete the financial assistance application or provide required documentation. For those patients, or patients' guarantors, who are unable to provide required documentation but meet certain financial need criteria, GMC may grant financial assistance. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:
   - Homeless
   - Patient is deceased with no know estate
   - Patient has filed bankruptcy and funds are not available to satisfy the debt
   - Patient is unable/incompetent to comply with the application requirements but has no known financial resources

G. Final Determination will be made at the time all information has been received. If the applicant is Medicaid eligible, the account will be turned to the appropriate insurance biller for filing purposes. If the applicant qualifies, a letter will be sent to the applicant

stating at what level based on the current Federal mandated poverty levels per the current facility criteria in Appendix A and Appendix B.

If the applicant does not qualify, a letter will be sent stating the denial and the reason for that denial.

Review and signature by CFO or their designee is required prior to sending the final determination or the denial except when approval has been given for Conditional Determination.

H. An adjustment will be made to the accounts receivable accounts upon Final Determination. The accounts will be logged on the Uncompensated Care Log in the appropriate month.

I. Conditional or Final Determination will be given as follows:
   1. Requests (meaning completed application with all requested items attached except for Medicaid eligibility/Denial) received prior to Inpatient Discharge or outpatient services will be processed within two working days. "Working Days are the five working days each week that the collection department is open".
   2. Requests completed after Inpatient Discharge or Outpatient Services, will be processed no later than the end of the first "full" billing cycle following the request (again a completed application with all items attached except Medicaid Eligibility/ Denial.) (Example: Request received 5/15/16; determination will be made by 6/30/16.)

Files will be held in the Collection Departments files until compliance audits have been completed. Each fiscal year's files should be reconciled to the log and kept separate from other years. These files should contain the bills, copies of insurance vouchers, completed applications with all required items attached. If a balance is due from the patient, a copy of that account should be placed in the active file with the appropriate information.

Appendix A - Uncompensated Care Financial Assistance Guidelines

1. Notice of the availability of the Financial Assistance Program will be posted at patient registration sites, admissions/Business Office and emergency department within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance needs to complete a Financial Assistance application.
3. A preliminary application stating household size and household income will be accepted

and a determination of probable eligibility will be made within ten business days of receipt.

4. Proof of income must be provided with the final application. Acceptable proofs include:
    a. Prior year tax return;
    b. Current pay stubs;
    c. Letter from employer; and
    d. A credit bureau report obtained by the GMC's Patient Financial Services Department.
5. An individual will be eligible for Financial Assistance if the maximum household income level does not exceed 300% the Federal poverty guidelines, they do not own liquid assets exceeding $2,500 which should be available to satisfy their bills or their other assets values excluding their principal home and one vehicle do not exceed $2,500.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the Hospital.
8. Final eligibility for Financial Assistance will be determined within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The CFO or designated responsible party will approve the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient's accounts. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance will remain valid for a period of three (3) months for all necessary services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application.
11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of GMC.

Appendix B
Installment Payment Plan Financial Assistance Guidelines

General Conditions for Installment Payment Plan

1. Each person needs to complete Financial Assistance application

2. Patient is not eligible for any of the following:

a. Medical Assistance
b. GMC Uncompensated Care

3. Patient does not have the ability to pay the self-responsible portion of the account in full.

Factors for Consideration:

The following factors will be considered in evaluation Installment Payment Plan assistance:
1. Current Medical Debt
2. Liquid Assets (leaving a residual of $2,500)
3. Other Assets excluding Principal home and one (1) vehicle
4. Annual Income
5. Other Expenses including health insurance premiums

Evaluation Method and Process:
1. The Collection Clerk with review the Installment Plan Application and collateral documentation submitted by the patient/responsible party.

2. The Collection Clerk will then complete an installment plan worksheet to determine payment plan based on completed application.

3. Installment plan agreement will be presented to patient/responsible party stating amount and number of payments.

4. No interest payments will accrue during the repayment of this installment plan loan.

5. GMC may adjust payment terms if necessary to assist person/responsible party to meet their obligations.

Appendix C
Catastrophic Financial Assistance Guidelines

Purpose:
These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance for Uncompensated Care, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a GMC

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Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the medical bill is greater than the patient/guarantor's ability to repay with current income, liquid assets, and other assets over $2,500 excluding primary home and one vehicle in 24 months or less.

General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
   a. Medical Assistance
   b. The GMC Financial Assistance Program for Uncompensated Care
3. The patient cannot repay the self-responsible portion of the account in 24 months or less.
4. GMC has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a GMC Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration:

The following factors will be considered in evaluating a Catastrophic Assistance Application:

1. Current Medical Debt
2. Liquid Assets (leaving a residual of $2,500)
3. Other Assets excluding Principal home and one (1) vehicle
4. Living Expenses
5. Projected Medical Expenses
6. Annual Income
7. Spell of Illness
8. Supporting Documentation

Exceptions

1. GMC has the right to refuse financial assistance for elective procedures, which may result in catastrophic medical debt.
2. Administration may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Collection Clerk will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Collection Clerk will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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Definitions:

Current Medical Debt

Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are also considered.

Liquid Assets

Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.

Other Assets

Homes, Vehicles, Other Property

Living Expenses

Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.

Projected Medical Expenses

Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)

Take Home Pay

Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

Spell of Illness

Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis- related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.

Supporting Documentation

Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.