

**POLICIES/PROCEDURES**

<b>TITLE:</b>	<b>FINANCIAL ASSISTANCE (CHARITY CARE)</b>
<b>SECTION:</b>	<b>Administrative (System-Wide)</b>

<b>REFERENCE:</b>		<b>CURRENT DATE:</b>	<b>11/24/15</b>
<b>CONTRIBUTORS:</b>	Business Office / Patient Financial Services, Compliance, Legal	<b>REPLACES:</b>	5/05, 1/06, 10/06, 1/07, 1/08, 8/09, 5/11, 2/14, 10/13/15,11/23/15
<b>APPROVED BY:</b>	Board of Trustees	<b>REVIEWED:</b>	

**PURPOSE**

Bozeman Health and its subsidiaries are committed to providing access to emergency and medically necessary affordable healthcare services to all patients regardless of their ability to pay. The intent of this policy is to establish a process for use in circumstances in which Financial Assistance, compliant with all federal, state and local laws, shall be offered to those receiving Bozeman Health Deaconess Hospital, Bozeman Health Big Sky Medical Center, or Bozeman Health Urgent Care services. The policy addresses:

- Patient Notification of Financial Assistance
- Financial Assistance Eligibility Criteria
- Instructions for Applying for Financial Assistance
- Determination and Patient Notification
- The method of calculating amounts charged to individuals who qualify for assistance under this policy
- Measures to widely publicize the policy.

**SCOPE**

This policy applies to all emergency and medically necessary inpatient and outpatient services provided to patients who qualify for assistance in accordance with the terms and conditions listed in this policy. A determination of qualification of Financial Assistance will cover services provided on an inpatient and outpatient basis. For these purposes, the policy also covers the rendering of professional services by physicians and other employed or contracted providers, as listed on the "Providers Providing Care at BDHS Covered by this Policy" document. Any other physician or providers of care is not subject to this policy and each patient will be responsible for satisfaction or resolution of any bills issued by such physicians or providers for their professional services.

Health care services will be provided to those in need of emergency or medically necessary care, regardless of the ability of the patient to pay for such services and regardless of whether such patients may qualify for Financial Assistance under this policy.

Actions that discourage individuals from seeking emergency medical care are not engaged, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

Any services that are deemed as not Medically Necessary are not eligible for Financial Assistance.

**DEFINITIONS**

**Medically Necessary Health Care Services:** Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Medicare. Medically necessary services do not include, but are not limited to: (i) non-medical services such as social and vocational services; or (ii) elective cosmetic surgeries (for these purposes, plastic surgery procedures designed to correct disfigurement caused by injury, illness, or congenital defect or deformity are not considered "elective").

**Amounts Generally Billed (AGB):** The amounts generally billed for emergency or Medically Necessary Health Care Services provided to patients who have insurance. AGB will be determined annually by using a 12 month measurement period utilizing the look back method excluding services provided by Big Sky Medical Center. The AGB for services provided at Big Sky Medical Center, will be determined utilizing the prospective method for the first year of operation and each subsequent year the look back method will be utilized.

**Eligibility Period:** The period during which applications for Financial Assistance are accepted. This period will be from the date of service until 240 days after the patient is provided with the first post-discharge billing statement for the care provided.

**Extraordinary Collection Actions:** Those actions that may be taken in the event of non-payment following the expiration of the notification period. These may include the reporting of adverse information about the individual to consumer credit reporting agencies or credit bureaus, garnishment of an individual's wages, and/or commencement of a legal civil action against an individual.

**Financial Assistance:** Either full or partial reduction in charges to patients for emergency or Medically Necessary Health Care Services, in the case of patients who have qualified for Financial Assistance, Medically Indigent, or are Presumptively Eligible as those terms are defined in this policy. Financial Assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles, or both.

**Medically Indigent:** A Patient who's medical or hospital bills after payment by a third-party payer exceed 50% of the patient's annual family income, and who is financially unable to pay the remaining bill. A patient who incurs catastrophic medical expenses is classified as medically indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

**Notification Period:** The period of time during in which every reasonable effort will be made to inform the patient of the availability of financial assistance under this policy prior to initiating extraordinary collection actions. This period shall be from the date of service until 120 days after the patient is provided with the first post-discharge billing statement for the care provided.

**Patient(s):** The person who receives services and/or the person who is legally responsible for payment for such services.

**Presumptively Eligible:** A patient who has not submitted a completed Application for Financial Assistance, but who nonetheless is subject to one or more of the following criteria:

- Homeless
- Deceased with no estate
- Mentally incapacitated with no one to act on his or her behalf
- Medicaid eligible, but not on the date of service or for non-covered services
- Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines
- Incarceration in a penal institution
- Patients referred for services by Community Health Partners (CHP) shall automatically qualify for the same "slide" as allowed by CHP. CHP will provide information regarding its patients when the referral is made.

The Credit Supervisor will routinely review the foregoing criteria with patients, before asking patients to complete the Application for Financial Assistance. Software programs or automated systems may also be utilized to determine presumptive eligibility. Patients who meet any of the foregoing criteria for presumptive eligibility will be deemed to be eligible for a 100% discount, and will not be asked or required to submit an Application for Financial Assistance.

## **POLICY**

**Patient Notification:** All reasonable efforts will be made to notify a patient regarding the availability of Financial Assistance under this policy by:

1. Attempting to determine whether a patient has third-party coverage for any part of the emergency or Medically Necessary Health Care service provided.
  - a. If a patient does not have third-party coverage, a patient advocate will screen all inpatient cases and any outpatient cases exceeding \$1,000 in total charges to determine if the patient qualifies for third-party funding.
  - b. If a patient does not have or qualify for third-party funding the patient advocate will explain the Financial Assistance Policy, provide an Application for Financial Assistance, and provide assistance with completing the Application, if desired.
2. Offering the Patient a plain language summary of the Financial Assistance available under this policy at the time of admission or before discharge.

3. Providing the information during the Notification Period about the availability of Financial Assistance on at least three (3) post-discharge billing statements and all other written communications to the patient;
4. Informing patients during the Notification Period about the availability of Financial Assistance during oral communications regarding the amount due for the care that occurred;
5. Providing the patient, either directly or through its contracted collection agency with at least one written notice informing the patient about the Extraordinary Collection Actions that we intend to take if the patient does not submit an Application for Financial Assistance or pay the amount due by at least thirty days following the date of the notice. The notice will include a copy of the plain language summary and will not be mailed or delivered to a patient earlier than 30 days prior to the end of the Notification Period; and
6. No Extraordinary Collection Actions will be undertaken during the 120 day Notification Period, during which time we will take reasonable efforts to determine whether the patient is eligible for Financial Assistance. After the 120 day Notification Period, an Extraordinary Collection Action will be undertaken only if the patient has received the 30 day written notice described above.

**Patient Eligibility Criteria:** Financial Assistance will be given for emergency or Medically Necessary Health Care services to patients who qualify based on information provided via the Application for Financial Assistance or to patients who have been determined to be Presumptively Eligible. In addition, Financial Assistance may be provided in other circumstances on a case-by-case basis as determined by the System Chief Financial Officer.

The System Credit Supervisor will oversee the Financial Assistance application process. Financial Assistance under this policy is a resource of last resort and is provided to patients with a demonstrated inability to pay. If a patient provides information that is inaccurate or misleading, the patient may be deemed ineligible for Financial Assistance and, accordingly, may be expected to pay their bill in full.

Patients desiring consideration under the Financial Assistance Policy must apply for Financial Assistance and are required to complete the Application for Financial Assistance to the fullest extent possible disclosing the required financial information.

1. Exceptions:
  - a. If a patient has been previously approved for Financial Assistance under this policy, they shall be deemed eligible for six (6) months following the date of service for which the application is submitted. Patients must re-apply for Financial Assistance every six (6) months, except as otherwise determined.
  - b. Patients referred for services by Community Health Partners (CHP) shall automatically qualify for the same “slide” as allowed by CHP. CHP will provide information regarding its patients when the referral is made.
  - c. If a patient has been determined to be Presumptively Eligible for Financial Assistance under this policy.
2. Application for Financial Assistance can be obtained from the following locations:
  - a. Website: <http://www.bozemandeaconess.org/Our-Services/Financial-Services.aspx>;
  - b. by e-mail request to [businessoffice@bozemanhealth.org](mailto:businessoffice@bozemanhealth.org);
  - c. or in person at Patient Financial Services (PFS), 1600 Ellis Street, Bozeman, MT 59715 (across Highland Blvd from the Hospital in the Legacy Building); at Patient Financial Services (PFS) Customer Service, 915 Highland Blvd, Bozeman, MT 59715 (in the lobby of Patient Registration near the Emergency Department).
3. Patients needing assistance for completing the Application for Financial Assistance should contact the Credit Supervisor at:
  - a. 406-414-1015;
  - b. by e-mail to [businessoffice@bozemanhealth.org](mailto:businessoffice@bozemanhealth.org);
  - c. or in person at Patient Financial Services (PFS), 1600 Ellis Street, Bozeman MT 59715 (across Highland Blvd from the Hospital in the Legacy Building).
4. Patients seeking Financial Assistance under this policy may be required to apply and may request assistance in applying for Medicaid or other government programs prior to submitting an Application for Financial Assistance.
5. Completed applications for Financial Assistance must be returned during the Eligibility Period in any of the following ways:
  - a. In person at Patient Financial Services Customer Service, 1600 Ellis Street, Bozeman, MT 59715 (across Highland Blvd from the Hospital in the Legacy Building) or;
  - b. by mail to Patient Financial Services Customer Service, 1600 Ellis Street, Bozeman, MT 59715; or
  - c. by FAX to ATTN: Credit Supervisor at (406) 414-5423.

## Patient Application Process:

1. **Completed Applications:** In the event that a completed Application for Financial Assistance is received during the Eligibility Period, Extraordinary Collection Actions will be suspended. The application must be complete and be accompanied by the supporting documents listed on the Application for Financial Assistance.

Failure to provide this information may result in the denial of Financial Assistance under this policy. Patient assistance will not be denied under this policy for the failure to provide information that was not required to be submitted in either this policy or the Application for Financial Assistance.
2. **Incomplete Applications:** In the event that an incomplete Application for Financial Assistance is received during the Eligibility Period, Extraordinary Collection Actions that may be in effect will be suspended, while the following takes place for no more than 30 days:
  - a. Provide the patient with a written notice that:
    - i. describes the additional information required to make a determination of eligibility and a plain language summary of this policy;
    - ii. informs the patient about the Extraordinary Collection Actions that may be initiated or resume if the Application for Financial Assistance is not completed; and
    - iii. allows the patient 30 days to respond to the written notice.
  - b. If after the written notice as provided above, the patient fails to complete the Application for Financial Assistance within 30 days, Extraordinary Collection Actions may be initiated or resumed.

**Patient Notification of Determination:** The patient shall be notified in writing of the determination within thirty (30) days of receipt of the completed application. The notification will include the following:

1. If approved for Financial Assistance under the provision of this policy:
  - a. Discount gross charges to the AGB as described in the "Method of Charging" section of this policy;
    - i. Financial Assistance discounts will then be applied to the AGB in accordance with the Discount of AGB Charges Schedule described in the "Discounts" section this policy
  - b. Provide patient with a billing statement that indicates the amount patient owes, if they are not eligible for free care;
  - c. Refund any excess payments made by the individual on eligible accounts, if necessary and
  - d. Take all reasonably available measures to reverse any Extraordinary Collection Actions that occurred.
2. If not approved for Financial Assistance under the provision of this policy:
  - a. Provide the patient with instructions on how to set up a payment plan and deadline to avoid initiating any Extraordinary Collection Actions;
  - b. Provide the patient with a written notice of the Extraordinary Collection Actions that may be taken or resumed in the event of non-payment of the amount(s) owing and
  - c. Include instructions for appeal or reconsideration.

**Method of Charging:** If a patient is determined to qualify for Financial Assistance under this policy, the patient's billed charges will be no more than the same Amounts Generally Billed (AGB) for emergency or other Medically Necessary Health Care Services as patients who have insurance coverage.

The AGB will be determined by using the Internal Revenue Services' prescribed "look back method". The AGB will be applied by multiplying full charges for medically necessary care provided to an eligible patient by the AGB percentage.

The AGB percentage is calculated annually as follows:

- Sum of all allowed claims (including payment from beneficiaries and insurers) by Medicare fee-for-service, Medicaid, and private payers during a prior 12 month period divided by the sum of gross charges for those claims.
- The AGB percentage for a 12 month period will begin to be applied no later than 120 days following the end of the 12 month measurement period.
- The AGB will be established as of October 1<sup>st</sup> of each year.

Big Sky Medical Center will determine the AGB by using the Internal Revenue Services' prescribed "prospective method" by adjusting full charges for medically necessary care provided to an eligible patient to the amount that would be charged to a patient covered under

Medicaid for the covered service. This method will be utilized for the first year of operation; subsequent years will utilize the “look back” method described above.

If you wish to obtain information on AGB percentage and how the percentage is calculated you may

- Visit our website: <http://www.bozemandeaconess.org/Our-Services/Financial-Services.aspx>
- Contact: Chief Financial Officer, (406) 414-1036

**Financial Assistance Discounts:**

**1. Federal Poverty Guidelines Discount:**

- The Patient’s annual household income is compared to the most current published “Annual Update of the HHS Poverty Guidelines” that are in effect, please refer to the most current federal poverty guidelines and current income levels listed on our website: <http://www.bozemandeaconess.org/Our-Services/Financial-Services.aspx> . AGB charges for inpatient and outpatient services will be discounted by the following percentages in relation to poverty guidelines:

Financial Assistance Guidelines	
Income Level (of FPL)	Discount of AGB Charges
150%	100%
151-160%	90%
161-170%	80%
171-180%	70%
181-190%	60%
191-200%	50%
201-250%	40%

**2. Medically Indigent Discount:**

- Available to patients who have a large balance remaining after all third party payments have been taken into account. The balance under consideration is that amount which is deemed to be the patient’s financial responsibility. If the patient’s financial responsibility is greater than 50% of the family’s gross annual household income and the patient is otherwise unable to pay, the excess amount will be treated as Catastrophic Financial Assistance discount and written off of the patient’s account.
- This Financial Assistance is available to patients without respect to Federal Poverty Guidelines but they must follow the same process as all other patients seeking Financial Assistance based upon Federal Poverty Guidelines.

Nothing in this policy shall prevent the offering of reduced or more favorable Financial Assistance based upon the circumstances. All decisions regarding the interpretation and application of Financial Assistance offered under this policy are the sole discretion of Patient Financial Services and are subject to review by the Chief Financial Officer to ensure compliance.

**Appealing A Financial Assistance Determination:** The patient may appeal a denial of eligibility for Financial Assistance by providing additional verification of income or family size to the Credit Supervisor within 30 calendar days of receipt of notification. The Director of PFS will review all appeals for final determination. Written notification of the final determination will be sent to the patient.

**Community Notification:**

- This policy, Application for Financial Assistance form, a plain language summary of the policy, and any notices or publications regarding the policy will be made available on our website: <http://www.bozemandeaconess.org/Our-Services/Financial-Services.aspx>; in English, Spanish, and in any other language spoken by the lesser of 1,000 or 5% of the residents of the community served as determined using the most current data published by the Census Bureau.
- This policy, Application for Financial Assistance form and plain language summary shall be available upon request, without charge at the Patient Financial Services (PFS) Customer Service Department, Emergency Department, Registration Areas, and by mail.
- A plain language summary shall be conspicuously displayed in the patient waiting areas, Emergency Department, and in the PFS Customer Service Departments in a manner that is reasonably calculated to attract visitor’s attention.
- A plain language summary of this policy will be offered to all patients upon admission or discharge.

5. The plain language summary of the policy will be provided to Community Health Partners and the Community Care Connect mobile screening bus to ensure those that are most likely to require Financial Assistance are aware of the policy.
6. The plain language summary of the policy will be published in Health News on at least an annual basis and may be publicized using other media at the option of administration.