MID-COLUMBIA MEDICAL CENTER 1700 East 19th Street The Dalles, OR 97058	SCOPE: All MCMC Providers and Facilities
SUBJECT/TITLE: ***FINANCIAL ASSISTANCE***	
DEPARTMENT: Finance	OWNER: Director, Revenue Cycle

Purpose and/or Policy Statement:

a) This policy provides guidelines for managing requests for financial assistance from patients receiving care at Mid-Columbia Medical Center (MCMC). This policy applies to MCMC patients receiving care in inpatient, outpatient and clinics operated by MCMC.

Definitions:

For purposes of this policy, the following definitions apply:

Financial Assistance:

b) Full financial assistance that is provided to patients with a demonstrated inability to pay who have received medically necessary services and who have family income not in excess of 200% of the Federal Poverty Level;
c) Partial financial assistance based on a sliding fee schedule for patients who have received medically necessary services and who have family incomes in excess of 200% but not exceeding 400% of the Federal Poverty Level;
d) In rare cases, when household income exceeds 400% of the Federal Poverty Level, Financial Assistance may be given if circumstances indicate severe financial hardship or financial loss;
e) Balances that remain after Financial Assistance is applied may be paid on a monthly payment plan over a period of 12 months. MCMC may opt to extend payment plans beyond 12 months if necessary.

Financial and Medicaid Specialist: An individual trained to assist patients in identifying sources of healthcare coverage, determining eligibility for such coverage, and assisting in completing necessary applications for that coverage. Oregon Health Plan Presumptive Eligibility and Oregon Health Plan application assistance is available by calling 541-296-7221 and setting up an appointment with the Patient & Visitor Services Financial Care Advocate.

Medically Necessary Services: MCMC uses the Oregon Health Plan (OHP) - Division of Medical Assistant Programs (DMAP) "Prioritized List of Health Services" when determining if a service is medically necessary and eligible for financial assistance.

Procedure:

MCMC's Philosophy is to humanize, personalize, and demystify the healthcare experience for patients and their families. Our Values are high quality, cost-effective healthcare services for every patient regardless of their ability to pay. In keeping with this Philosophy, we recognize that medical bills for medically necessary services are often unexpected and, at times, difficult to pay. MCMC's Financial Assistance program offers financial support and guidance to support our mission of providing outstanding patient care to the Mid-Columbia region.

In accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, no patients shall be screened for financial assistance or payment information prior to the rendering of a medical screening examination and to the extent necessary, services needed to treat the patient or stabilize them for transfer as applicable.

FINANCIAL ASSISTANCE

Request for financial assistance may be made at any point before, during, or after the provision of care. For non-urgent care patients are required to apply prior to receiving services or a deposit may be required. MCMC offers an application process for determining initial interest in and qualification for financial assistance.

MCMC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, religion, sex, gender identity and/or expression.

Financial assistance is not automatic. A patient or responsible party must apply for financial assistance to be considered.

Financial assistance will require periodic screening for changes in eligibility. Financial Assistance is granted for medically necessary procedures only. MCMC uses the Oregon Health Plan (OHP) - Division of Medical Assistance Programs (DMAP) "Prioritized List of Health Services" as a guideline for determination of covered services. The Prioritized List of Health Services may be found at https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx.

Financial assistance is secondary to all other financial resources available to the patient including insurance, government programs, third-party liability, medical cost sharing programs, and liquid assets. MCMC assists patients with financial need by waiving all or part of the charges for services provided by MCMC.

Uninsured patients receiving medically necessary services automatically receive a Hospital Billing discount or Professional Billing discount from gross charges. The discount percentages are updated annually. If a patient also qualifies for financial assistance, the discount will be applied to the remaining balance. The self-pay discount applies to all patients nationally, regardless of state of residence. The self-pay discount does not apply to international patients. Discounted Balances for patients without any insurance coverage is computed as the amount of discounts for Medicare, Medicare HMO's, and private health insurers for a prior 12-month period divided by gross patient charges for those payers.

The community of Financial Assistance discount eligible patients served by MCMC includes all State of Oregon residents and patients residing in State of Washington counties adjacent to Oregon (Benton, Cark, Klickitat, Skamania, and Walla Walla). Proof of Residency accepted documentation may include utility bills, rental agreement, mortgage statement for residence, driver's license or identification card. Additional proof of residency may be requested depending on individual circumstances. For patients outside of the service areas above, see MCMC Self-Pay Discount policy. Oregon or bordering Washington county residency requirements will be waived in situations where the patient is a resident of the U.S. and has received unscheduled emergent services.

A patient is eligible for Financial Assistance consideration based upon the results of the Financial Screening process and meeting certain income eligibility criteria as established by the ASPE U.S. Federal Poverty Guidelines. The current ASPE U.S. Federal Poverty guidelines may be found at http://aspe.hhs.gov/poverty/.

Balances that remain after Financial Assistance is applied may be paid on a monthly payment plan over a period of 12 months. MCMC may opt to extended payment plans beyond 12 months if necessary. Discounts for single payment balance pay-off after insurance payment may be offered for qualifying payment amounts.

Excluded Services include but are not limited to:

a) Any service considered non-covered or not medically necessary by the Oregon Health Plan (OHP) - Division of Medical Assistance Programs (DMAP) as identified by the Oregon Health Evidence Review Commission (HERC) healthcare condition and treatment pairing commonly known as the "Prioritized List of Health Services". These pairings have been ranked by priority from most important to least important and subsequently assigned a line number from 1 to 710. Services prioritized as most important are funded by the State. The funding level is set at a line designated by the State. This means any pairing that occurs above the line is considered funded. Any pairing that occurs below the line is not funded. Below the line services are typically categorized as treatments

that do not have beneficial results, treatments for cosmetic reasons, and conditions that resolve on their own. In addition some medical services are excluded from funding by ORS statute 410-120-1200 "Excluded Services and Limitations".

b) Services provided to a patient who chooses to come to MCMC out of their insurance plan network are generally not covered. Exceptions may be made when appropriate out of network authorizations are obtained and after payment is received from the insurance company;
c) Copayments under insurance plans, with the exception of copayments in excess of $500 per date of service;
d) Patients who are not responsible for the bill due to Community or Agency funded support;
e) Patients who have insurance but choose not to utilize coverage;
f) Elective cosmetic surgery procedures;
g) Other Elective medical treatment (eg., include but are not limited to infertility services, andrology services, sterilization (with the exception of in-house postpartum bi-lateral tubal ligation), reversal of sterilization, circumcision, LASIK eye surgery, and routine vision exams);
h) Take home prescriptions or supplies issued by the Pharmacy;
i) Medical Equipment. For example, eyeglasses and contact lenses.

This Financial Assistance policy does not apply to independent physicians, practitioners, and provider bills such as radiologist, anesthesiologists, pathologists, emergency medicine and other specialists.

Patient or Responsible Party

To determine patient ability to pay, the patient or responsible party must complete a "Statement of Financial Resources" (SFR) and return the application along with supporting documentation in the envelope provided.

The SFR packet contains an instruction sheet that provides resources and phone numbers for patients needing assistance in completing the SFR application. This application should be submitted prior to receiving services.

If there is a material change in circumstances that impacts eligibility, the patient or responsible party should immediately notify the Business Office at (541) 296-7619.

If the patient becomes eligible for coverage under a state or federal program the patient will be required to apply for coverage prior to any additional assistance being approved. Oregon Health Plan Presumptive Eligibility and Oregon Health Plan application assistance is available by calling (541) 296-7221 and setting up an appointment with the Patient & Visitor Services Financial Care Advocate.

If a patient is still receiving care beyond the approved eligibility period the patient or responsible party must re-apply for continuation of financial assistance.

If the patient qualifies for a partial discount the patient will be required to pay their financial portion at the time of service.

Non-Urgent Appointments

For non-urgent appointments, patients will be directed to the Business Office prior to scheduling the office visit or procedure in order to compete the financial screening process.

a) This allows patients to be informed of their financial liability prior to receiving services.
b) If the patient prefers not to wait, they will be required to pay a deposit prior to service for non-urgent outpatient services.
c) The patient may still complete the financial screening process, however, there is no guarantee that they will qualify.
d) Patients who do not qualify will be responsible for any remaining balances.

e) If the patient is approved for a financial allowance the amount collected as a deposit that exceeds the patient responsibility will be refunded.

EMTALA and Patient Treatment

Once EMTALA requirements are met, patients identified through the registration process as being without Medicare/Medicaid, other local health care financial assistance or adequate health insurance, shall receive a Statement of Financial Resources packet.

Application Review

The initial application review process to determine the level of financial assistance will include screening for:

a) Accurate and complete information on the SFR;
   - o Copies of all required documents;
   - o Proof that eligibility based on residency requirements has been met. Individuals residing in the United States on a student or temporary visa are not considered to have met residency requirements.

b) Consideration for assistance will include a review of the responsible party's:
   - o Household earning history;
   - o Family size;
   - o Number of dependents;
   - o Liquid assets;
   - o Potential review of credit history.

c) Acceptable verification of income and liquid assets includes but is not limited to the following:
   - o Payroll stubs for the three full calendar months prior to the application date;
   - o A copy of pertinent Federal or Oregon income tax return;
   - o Verification of Social Security or unemployment benefits;
   - o Verification of income from any other sources;
   - o In the absence of income and support an affidavit of no income will be required;
   - o A letter of support from individuals providing for the patient's basic living needs may also be required.
   - o Current documentation of liquid assets such as current statements from banking and credit union accounts, current values of CDs, stocks, bonds, or investment accounts.

ASPE U.S. Federal Poverty Guidelines

Financial assistance percentage is based on household size and income as per the Office of the Assistant Secretary for Planning and Evaluation (ASPE) U.S. Federal Poverty Guidelines. The current ASPE U.S. Federal Poverty guidelines may be found at http://aspe.hhs.gov/poverty/.

SLIDING FEE SCHEDULE	
Income as a Percentage of Federal Poverty Level	Financial Assistance Sliding Scale Adjustment Percent
0-200%	100%
201-220%	90-99%
221-240%	80-89%
241-260%	70-79%
261-280%	60-69%

281-300%	50-59%
301-320%	40-49%
321-340%	30-39%
341-360%	20-29%
361-380%	10-19%
381-400%	0-9%

Program Awareness

MCMC's Financial Assistance program is available to our patients by, but not limited to, the following means:

a) Brochures explaining the billing process, insurance and financial arrangements;
b) MCMC advertises the existence of Financial Assistance on our website https://www.mcmc.net/, on the Oregon Hospital Guide website http://oregonhospitalguide.org/,and in this policy;
c) Billing statements include information regarding the availability of Financial Assistance;
d) MCMC staff may share Financial Assistance information with a patient during their stay with MCMC;
e) MCMC offers Financial Assistance customer service Monday thru Friday with confidential voicemail by calling (541) 296-7500 or (541) 296-7504;
f) Oregon Health Plan Presumptive Eligibility and Oregon Health Plan application assistance is available by calling 541-296-7221 and setting up an appointment with the Patient & Visitor Services Financial Care Advocate.

References:

ASPE U.S. Federal Poverty Guidelines: http://aspe.hhs.gov/poverty/
Health Evidence Review Commission: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/index.aspx
Prioritized List of Health Services: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

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