



Title: Financial Assistance Policy
Section: Governance
Dept. of Origin: Patient Financial Services
Effective Date: 01/01/2019
Revision Date: 12/14/2018

DEPARTMENT POLICY or PROCEDURE

Signature: Administrator

I. POLICY STATEMENT

In accordance with Mangum Regional Medical Center, it is the policy of MRMC, as a non-profit, to provide care to patients who are not able to meet the financial obligation (in part or total) due to their income restrictions. Consistent with the mission, MRMC strives to ensure that a patient's financial situation does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with MRMC procedures for obtaining financial assistance. Implementation of this policy shall comply with all federal, state and local laws, rules and regulations to comply with IRS 501(r) and the guidelines of MRMC

II. PURPOSE

This policy is intended to comply with the financial assistance and emergency care policies required by the Internal Revenue Section 501(r) and shall be interpreted to so comply. This policy applies to all medically necessary care and emergency care provided by MRMC and any substantially related entity of MRMC.

III. DEFINITIONS

Gross Charges: Total charges of the facilities established rates for the provision of patient care services before revenue deductions are applied

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 139dd)

Uninsured Patient: A person receiving healthcare services who does not have private healthcare insurance and is not qualified to participate in a governmental program which provides healthcare benefits to its eligible participants

Underinsured Patient: A person receiving healthcare services who is not qualified to participate in a governmental program which provides healthcare benefits to its eligible participants and is not eligible for any type of payer discount and non-discounted payor coverage provides 50% or less reimbursement of total patient charges and/or patient's financial obligation.

IV. PROCEDURE:

Upon registration, and after all EMTALA requirements are met, hospital patients without Medicare, Medicaid, third-party insurance, or other local health care financial assistance or

adequate health insurance shall receive financial counseling assistance from hospital and business office staff, including a packet of information that addresses the financial assistance policy and procedures and an application for financial assistance (if requested).

Patients requesting financial assistance will be required to complete the Financial Assistance Application Form to establish eligibility. In certain situations, the application process may be initiated by facility staff and/or business office staff. Requests for financial assistance will be honored up to 240 days after the date the first post-discharge billing statement is sent to the individual either by mail or electronic bill presentment.

It is the patient/guarantor's responsibility to provide, to the best of their knowledge, accurate, honest and complete information regarding their application and billing information. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance, Medicare, Medicaid, Workers Compensation, third-party liability (e.g. auto accident or personal injury) and other programs.

All available financial resources shall be evaluated before determining financial assistance eligibility. Mangum Regional Medical Center will consider financial resources not only of the patient and other members of the household, but also of other persons having legal responsibility to provide for the patient.

The financial assistance assessment methodology shall consider income of the patient/guarantor/household, assets, family size, historical financial profile, current available resources and the likelihood of future earnings sufficient to pay for health care services (See Eligibility Criteria/Basis for Calculating Amounts Charged to Patients below).

Presumptive Eligibility:

Individuals who are uninsured may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application (FAA), and provided 100% charity if:

- Individual is homeless
- Individual is deceased and has no known estate able to pay hospital debts
- Individual is incarcerated for a felony (verified on OSCN.net website)
- Individual has received Medicaid benefits. Service dates for up to one-year, previous accounts with dates of service prior to the Medicaid qualification eligibility date, and six months past the Medicaid eligibility date (accounts will be considered for Financial Assistance).

A credit report may be generated for identifying additional expense, obligations and income to assist in developing a full understanding of the individual's financial circumstances. A third party scoring tool may be used to justify financial assistance eligibility. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the presumptive eligibility and will extend an additional six months into the future.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in the section and throughout this policy would apply as if the individual had submitted a completed a Financial Assistance Application.

Approved Financial Assistance:

Patients/Guarantors will be notified by U. S. mail when the financial counselor determines the amount of financial assistance discount eligibility related to emergency or other non-elective medically necessary services provided by the facility. This eligibility does not extend to services provided by non-facility employees or other independent contractors (physicians, physician practices, anesthesiologists, radiologists, pathologists, etc.) unless noted in the attached addendum that the provider is participating in this policy. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the application approval and will extend an additional six months into the future. After that, a new verification of financial status shall be required to continue financial assistance discounts. Accounts will be adjusted at the time the financial assistance is approved.

Denied Financial Assistance:

Patients/Guarantors will be notified by U. S. mail if financial assistance is denied along with a brief explanation of the reason for the determination and instructions to appeal the decision.

- The appeal process, on denied applications, will be handled by the business office to review and recommend a final decision to the appeal board.
- The appeal board will consist of the facility administrator, business office manager, financial counselor, and revenue cycle manager.

Eligibility Criteria/Basis for Calculating Amounts Charged to Eligible Patients:

Charges for emergency or other non-elective medically necessary care provided to patients eligible for financial assistance under the policy will be limited to not more than the amounts generally billed (AGB), via the Medicare Prospective Method, to those individuals who have insurance. Charges, as defined in this policy, are considered the amount the patient is personally responsible for paying, after all deductions, discounts and insurance reimbursements have been applied. Discounts under this policy will be applied according to the following sliding scale:

Annual Household Income	Discount Amount %
Up to 200% of FPG	100%
201% - 300%	75%

Actions under Billing and Collection Policy in the Event of Non-Payment:

Mangum Regional Medical Center will not engage in extraordinary collection actions (ECA) for up to 120 days after the date of the patient's first statement. During that time, the business office staff will make reasonable efforts to determine whether an individual who has an unpaid amount from Mangum Regional Medical Center is eligible for financial assistance.

Reasonable efforts collection actions include:

- 3 Balance Due Statements and 3 Phone Attempts or 2 Contacts
- 1 Final Letter (ECA Notification)
- Reasonable efforts will be monitored by the CBO SELFPAY Representative to confirm statements and calls have been provided before extraordinary collection activity begins

Extraordinary collection actions include:

- Reporting a patient's delinquent debt to a credit bureau
- Selling a patient's debt to a third party

- Placing a lien on a patient's real estate property
- Attaching or seizing a patient's bank account or other personal property
- Commencing a civil action against a patient
- Garnishing a patient's wages

Mangum Regional Medical Center will publicize the availability of financial assistance. Also, notices will be printed on statements to the patient/guarantor, directing the patient/guarantor to contact the Cohesive RevOps (Central Business Office) to discuss financial arrangements and the availability of financial assistance.

Also, the patient/guarantor will be sent a written notice 30 days after the initial statement that extraordinary collection efforts (ECA) may be initiated if a complete financial assistance application is not submitted, the bill is not paid, or an arrangement to pay the bill has not been agreed to by both patient and provider within 120 days after the first billing statement. Although the facility may undertake ECAs after this 120-day period, if we have not yet determined whether an individual is FAP-eligible, we will still accept and process an FAP application for an additional 120 days. The total period during which the facility must accept and process FAP applications is 240 days from the date of the first billing statement. If the facility receives an FAP application during the application period, we will suspend any ECAs we have started until we have processed the application and determined eligibility. If the individual is FAP-eligible, we will reverse the ECAs. While debts may be referred to third parties to assist with collection actions at any time, including during the initial 120-day notification period, they will not be sold to third parties during the notification period unless and until an eligibility determination has been made.

Publicizing the Availability of Financial Assistance:

- Health Network facilities will post complete and current versions of the following on the facility website:
 - Financial Assistance Policy (FAP)
 - Financial Assistance Application Form (FAA)
 - Plain Language Summary of the Financial Assistance Policy (PLS)
 - Contact information for Cohesive Healthcare Financial Counselors
 - Signs will be posted in English to advise patients of the availability of financial assistance. Signage will be displayed in all points of admission and will contain the following:
 - website address where the FAP, FAA, and PLS may be accessed
<http://www.mangumregional.org>
 - Telephone number and physical location that individuals may call or visit to obtain copies of the FAP, FAA and PLS or to obtain more information:
 - Paper copies of this information will be available upon request at all points of admission.
 - Documents by mail: Central Business Office, Cohesive RevOps, 2510 E Independence Suite 101 Shawnee, Ok 74804.
 - A notice will be included on billing statements that notifies and informs recipients about the availability of financial assistance for eligible individuals under facility FAP and includes the telephone number of the Financial Counselor department

who can provide information about the FAP and application process and the website address where copies of the FAP, FAA and PLS may be obtained.

- Provide FAP and PLS in Spanish version and utilize Other Language phone line to assist Patient/Customers through the application process.

Provider / Entities that are not covered by this Policy:

Commented [VF1]: Are there any entities that work intermittent providers or business partners that will not be covered in this policy

V. APPROVAL

Committee/Department	Original Approval	1 st Review	2 nd Review	3 RD Review	4 th Review	5 th Review