OTSEGO MEMORIAL HOSPITAL DATE: 03/07
Gaylord, Michigan

REVIEWED REVISED

POLICY AND PROCEDURE MANUAL 07/08, 09/10
05/11, 03/12

DEPT/AUTHOR: Physician Financial Services/Kevin Wahr 07/12, 02/13
DISTRIBUTION: Physician Financial Services, Physician Services 07/13, 01/14
07/14, 10/14
01/15, 12/15
03/16, 02/17
12/17, **01/18**

RE: Financial Assistance Code # PPFS.f.04 RHC

Key Words: Insurance, third-party payer, unable to pay, uninsured, self-pay, assistance

OBJECTIVE: To establish consistent guidelines and procedures for identifying patients who are not fully covered by insurance or other third-party payers, and to establish appropriate eligibility requirements for financial assistance, for those who are unable to pay for some or all of their healthcare service due to genuine financial need.

POLICY:

A. All patients presenting for emergency care will be served regardless of residence or ability to pay. Non-emergent medically necessary care will be provided to all patients within the Hospital's service area without regard to ability to pay and consistent with the Hospital's financial resources.

B. The Hospital will pursue payment from the patient/guarantor for all deductibles, co-pays, coinsurance and/or service not covered by insurance or other third-party payer.

C. Physician Services Only – For exceptions to this rule see policy "patient termination letter procedure", Code # PPC.p.05.

D. The Hospital has established Financial Assistance Policy (FAP) for providing financial support to uninsured/underinsured patients who are unable to meet personal payment responsibilities and who meet established criteria. The determination that a patient or patient's guarantor needs Financial Assistance for their financial responsibilities may be made after services are rendered and is at the sole discretion of Otsego Memorial Hospital.

E. The Hospital will pursue all forms of third party payment such as insurance, state Medicaid programs, Affordable Care Act Marketplace plans and county indigent care programs before granting Financial Assistance.

F. The key elements of this policy will be widely publicized through a "Plain Language Summary" of the policy, the Financial Assistance Application, and full Policy posted to the website, and available at all Patient Access sites in the Hospital and Medical Group clinics. All Billing statements will include a conspicuous written notice about the availability of

assistance, and the telephone number of our offices providing application information. The Emergency Department and all Patient Access points in the Hospital and Medical Group clinics will maintain a "conspicuous" display of a "noticeable size" publicly informing patients of the Financial Assistance Policy (FAP). All patients will be offered a hardcopy of the Plain Language summary of the FAP at each patient access point of the hospital or reception desk at any of the Medical Group clinics. The form will be offered to patients and documented using the consent form for hospital intake and the demographic form for Physician Services.

G. The FAP policy will be reviewed annually by a "delegated body" of the hospital's Board. The Chief Financial Officer (CFO) is a delegated body of the Board. He will review the policy annually, and report to the Finance Committee, (also a delegated body of the Board) and the approval of the policy will be noted in the minutes of the Finance Committee meeting.

DEFINITIONS:

Amounts Generally Billed (AGB)

As a numerator, the average amount allowed by insurance for patients covered under Medicaid, Medicare or Commercial insurance (looking back one year) divided by the gross charges for all the same services as the denominator. The 501r rule requires that patients who "may be eligible for the FAP will not be Charged more than this amount". This percentage will be multiplied by the charge amount in our system to derive the maximum billed amount. The calculation of the AGB will be updated annually within the 120-day period following the anniversary date of the initial AGB calculation.

Charges or Charged

Term refers to the gross amount the patient or insurance is expected to pay.

Extraordinary Collection Actions (ECA)

ECAs include: Selling a debt to another party; reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus; deferring or denying, or requiring payment before providing, medically necessary care because of an individual nonpayment of one or more bills for medically necessary care previously provided (outstanding balances); actions that require a legal or judicial process such as liens or civil actions.

Family

a) A group of two or more people who reside together and who are related by birth, marriage, adoption, and may include extended family members such as adult children and elderly relatives.
OR
b) Two or more people who reside together and operate a household together as a unit such as an unmarried couple and any children residing in their household. According to the Internal Revenue Service (IRS) rules, if the patient claims someone as a dependent on their income tax

return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income
Family income may include all income attributable to all members of the family in the residence, other than minimal amounts earned by minors. Family income includes the following when computing federal poverty income level (FPL) guidelines:

Household Resources (as defined by Michigan's Homestead Property Tax form MI-1040CR):

- Includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, educational assistance, alimony, child support, assistance from outside the household , and other miscellaneous sources, gifts or expenses paid on your behalf, net business income;
- Determined on a before-tax basis;
- Excludes capital gains or losses.

501r Rule
Regulations that provide guidance regarding the requirements for charitable hospital organizations added by the Patient Protection and Affordable Care Act of 2010.

Plain Language Summary
A summary of the Financial Assistance Policy must be written in simple terms to make it clear and understandable by the general public as required by IRS 501r

Uninsured
The patient has no level of insurance or third party assistance to assist with meeting their payment obligations.

Underinsured
Not having sufficient insurance to cover loss or damage. Remaining out of pocket deductible and/or coinsurance creating a significant financial hardship for a patient.

PROCEDURE:

1. Financial Assistance cases will be reviewed according to the following guidelines:
    a. Patients must supply supporting information, such as Federal income tax returns, pay stubs or income statements.
        - The income and household size is compared to the FPL guidelines and financial assistance is considered based on those factors.
2. Services eligible under this policy:
    a. Emergency or other medically necessary care:
        - Repeated non-emergent services sought out and provided in the

Emergency Department setting are not eligible.
  - Services for a condition, which, if not promptly treated, would lead to an adverse change in the health status of an individual.
  - Non-elective medically necessary services provided in a non-emergency room setting.

b. Financial assistance may be revoked if abuse is suspected.

c. If the patient does not meet their financial obligation after being approved for assistance they will not be eligible for future assistance. They may be reinstated after seven years, or if the original unsatisfied financial obligation is paid **in full, they may be reinstated one year from that payment date**.

d. **If a submitted application is deemed fraudulent, the application will automatically be denied.**

e. **If previously submitted application is subsequently found to be fraudulent:**
  - **All previously adjusted accounts under the fraudulent application will be recalculated, and adjusted according to the discount guidelines for that date of service.**
  - **A final notice letter will be sent for the new balance owed after the recalculation.**
  - **All recalculated balances must be paid in full within 30 days, or accounts turned over to a collection agency.**
  - **The patient will no longer be eligible for future assistance, except under the following conditions:**
    - **a. Seven years from the date turned over to collections, OR**
    - **b. One year from the date the balances are paid in full**

f. Financial assistance is not to be granted for “Elective” services. Please see Patient Financial Clearance Policy (PPFS.p.06 and HPFS.p.04)

g. The services only include those billed by OMH or OMH Medical Group. Other services, such as Pathology, physicians not employed by OMH and radiology interpretations provided by an organization other than OMH, are not eligible under the FAP.

3. Key criteria to consider in determining eligibility for Financial Assistance include:

a. Income below 350% of the federal poverty guideline, as revised and published annually (see Chart)

b. Medicaid denial or prior consultation with the Certified Application Counselor (CAC)

c. Disability (as documented)

d. Patient’s effort to pay any portion of dollars owed

e. Financial and personal consideration of others in the household

f. Management discretion may be used to determine appropriateness of financial assistance, and may be used to presumptively determine eligibility based on previously granted financial assistance waiving the application and documentation requirements.

g. Patient must work or reside within the OMH immediate service area as

described below:

- Gaylord, Johannesburg, Vanderbilt, Wolverine, Lewiston, Atlanta, Alba, Frederic, Elmira, Boyne Falls, Indian River.
- Others must be reviewed on a case-by-case basis
- Patients moving to the service area within the last year will be considered on a case-by-case basis with approval required by the Chief Revenue Officer (CRO)
- If an out-of-service area patient is being routinely treated by an OMH provider, he/she is considered eligible for assistance

4. Patient financial discount will be considered based on the Federal Poverty Guidelines (FPL) according to the schedule listed below along with the criteria from section 3. The schedule is subject to change. Amount owed by patients approved for the Otsego Memorial Assistance program will not be less than $10 per visit. Other key considerations:
    a. No patient determined eligible under the FAP will be charged more than the “Amount Generally Billed” (AGB) for emergent or medical necessary care. The AGB discount will be applied if a patient meets the requirements for financial assistance according to this policy. A patient may be eligible for a greater discount if the criteria for a larger discount is met. Once approved AGB will be added to the patient’s account as an “insurance” to ensure accounts will be charged according to the AGB adjustment rate in effect.
    b. Patient’s eligible for the State of Michigan required 115% of Medicare discount, those with incomes up to 250% of the FPL, will be “**income** tested” to determine eligibility for the discount. Those meeting the guidelines will be eligible for the sliding scale discount prescribed in this policy. The discount is a minimum of 75%. Emergency Room Physician and Anesthesiologists charges will be discounted 50%.
5. Financial Assistance may be requested up to 240 days from the first post-discharge statement and a “Reasonable Period of Time” of two (2) calendar weeks is allowed for the completion of the form and return of any additional required documentation/information. If this is after the time the account has been submitted for an ECA to a Collections company, request to have the account placed on hold by the company until the FAP review is completed. Approved applications are good for a six (6) month period from the date of approval for services within the scope of this policy.
6. Oral communication of the FAP will be made at least once 30 days or more prior to an ECA. This will be accomplishing by including a scripted message as part of the automated collection calls and as part of the PFS voice message prior to pick-up for each call to the department.
7. For outstanding balances the Financial Advocate may make payment arrangements with the patient or guarantor. If a payment plan is necessary it will be administered according to the following guidelines:
    a. For payment plans, including employee payroll deductions, patients will be

offered a monthly plan that will not exceed 12 months interest free. Payment arrangements will only be made after the account balance is transferred to the patient or guarantor and a statement is submitted.

b. If a patient defaults on his or her payment plan, the payment plan will be terminated, and the remaining balance will be immediately due.
c. Payment plans are to be made according to the following guidelines:

<= $50	Paid in one payment or one payroll deduction **(>=$100)**
$51 - $100	Paid in 60 days from first patient balance statement
$101 - $600	Paid in 180 days
$601 and Over	Paid in 12 months*

d. Employees may request payroll deductions by completing the Employee Payroll Deduction form (See attachment)
   - Employees must initial to consent to each payroll deduction instance identified on the Employee Payroll Deduction form
   - *Contingent staff are not eligible for employee payroll deductions in payment of healthcare services*
   - At no time will the employee's cumulative deduction reduce her/his gross hourly wages paid to a rate lower than the minimum rate as defined in the minimum wage law of 1964, 1964 PA 154, MCL 408.381 to 408.398 plus a 10% additional margin above the minimum rate
   - Upon request by PFS, the Payroll department staff will verify deductions do not cause an employee to fall below the minimum wage threshold (plus an additional 10% cushion) based on the employee's current gross wages
   - Upon employee request, notify the Payroll Manager by email of any new accounts not included in the original agreement. Ask for her input, and complete a new Employee Payroll Deduction form. An appropriate new payment amount will be set.
   - Deductions must be at least **$100** and no deductions will be allowed for accounts in bad debt.

*Any exceptions to the 12-month rule or other guidelines must be authorized by the Chief Revenue Officer (CRO) on a case-by-case basis.

Otsego Memorial Financial Assistance Fee Schedule based on Federal Poverty Guidelines

Fee Schedule for Financial Assistance Eligible Patients					
Persons in Household	**2018 Federal Poverty Guidelines (Annual Household Income)** Note: Approved at 0-100% of FPL = 100% Discount				
	101 to 150%	**150% to 200%**	**200% to 250%**	**250% to 300%**	**300% to 350%**
1	**$12,140 – 18,210**	**$18,211 - $24,280**	**$24,281 - $30,350**	**$30,351 - $42,490**	**$30,351 - $42,490**
2	**$16,460 - $24,690**	**$24,691 - $32,920**	**$32,921 - $41,150**	**$41,151 - $57,610**	**$41,151 - $57,610**
3	**$20,780 - $31,170**	**$31,171 - $41,560**	**$41,561 - $51,950**	**$51,951 - $72,730**	**$51,951 - $72,730**
4	**$25,100 - $37,650**	**$37,651 - $50,200**	**$50,201 - $62,750**	**$62,751 - $87,850**	**$62,751 - $87,850**
5	**$29,420 - $44,130**	**$44,131 - $58,840**	**$58,841 - $73,550**	**$73,551 - $102,970**	**$73,551 - $102,970**
6	**$33,740 - $50,610**	**$50,611 - $67,480**	**$67,481 - $84,350**	**$84,351 - $118,090**	**$84,351 - $118,090**
7	**$38,060 - $57,090**	**$57,091 - $76,120**	**$76,121 - $95,150**	**$95,150 – $133,210**	**$95,150 – $133,210**
Discount %	**95%**	**85%**	**75%**	**50%**	**50%**
For each additional person, add **$4,320**					

Note: The Federal Poverty Guidelines change annually. Updated amounts are usually posted by the end of January of each year. Guidelines may be found at the following link: http://aspe.hhs.gov/poverty/index.shtml

Revised by: Kevin Wahr

Date: January 2018

Approved: ______________________________________

Administrative Representative

Date: _________________

Signed copy on file in Administration

Otsego Memorial Hospital Financial Assistance Approval Form

Patient Name____

As of Date________________	Facility	Physician	Total
Account Balance			
Patient Payments Made			
% Assistance Recommended			
Patient Balance			

	Months	Amount	
Payment Plan			

- Household Income and documented facts/circumstances:
- Dependents:
- Case Narrative (include any patient history or situation relevant to determining appropriate Financial Assistance):
  ____
  ____
  ____
  ____
  ____
  ____
  ____

Required Attachments:

- Account histories from Meditech and Intergy
- Financial Assistance Application
- Medicaid determination letter, Unemployment determination letter
- Note screens from Meditech and/or Intergy if relevant
- Tax documents (Complete Federal return)
- Bank statements or Search America printout

Approval Levels:

Financial Advocate	Up to $1,000
Chief Revenue officer	Over $1,000
Chief Financial Officer	Over $5,000
CEO	Over $25,000

Approvals:

Financial Advocate ______________________________ Date________________________

Chief Revenue Officer____________________________ Date________________________

Chief Financial Officer___________________________ Date________________________

EMPLOYEE PAYROLL DEDUCTION

Otsego Memorial Hospital

Hospital or Medical Group Deduction: ____________________

I,_________________________, hereby agree to have $________________deducted from my paycheck every two weeks to be applied to the following account

numbers____

until the amount of $_______________has been paid in full.

______________________________	__________________________________
Employee Name – Please Print	Employee Signature
______________________________	__________________________________
Employee Number	Date
______________________________	__________________________________
Witness Signature	Date
______________________________	__________________________________
Lisa Mackowiak, Payroll Dept.	Date

Pay Ending	***Amount to be Deducted***	***Employee Consent (Initials)***	***Pay Ending***	***Amount to be Deducted***	***Employee Consent (Initials)***

- **This agreement is for the above accounts only. It does not include future balances. If new balances are incurred you will need to contact Patient Financial Services for a new agreement for those expenses**
- **Payroll deductions less than or equal to $100 must be paid in one (1) payroll deduction.**
- **Minimum wage law requirement – At no time shall the cumulative amount of the deduction reduce the employee's gross wages to a rate less than the minimum rate as defined by the minimum wage law of 1964, 1964 PA 154, MCL 408.381 to 408.398. Contact Patient Financial Services to discuss wage changes affecting your gross wages to the extent you think you will be paid less than the minimum wage**

Otsego Memorial Hospital
Financial Assistance Application

Deadline for receipt of Financial Assistance Application for services – The later of: 30 days after the date written notice of financial assistance is provided, or 240 days after the first post-discharge billing statement for previous care. Application and requested documentation must be returned within 14 calendar days.

I. RESPONSIBLE PARTY				
LAST NAME	FIRST NAME	MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS				
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?	HOME PHONE
EMPLOYER'S NAME AND ADDRESS			YEARS EMPLOYED	DATE OF BIRTH

II. SPOUSE OR SIGNIFICANT OTHER		
NAME		SOCIAL SECURITY #
EMPLOYER'S NAME AND ADDRESS	YEARS EMPLOYED	DATE OF BIRTH

III. HOUSEHOLD INFORMATION (ALL OTHER PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP
TOTAL PERSONS IN HOUSEHOLD:		

IV. MONTHLY INCOME		
RESPONSBLE PARTY'S MONTHLY INCOME		$
SPOUSE/SIGNIFICANT OTHER'S MONTHLY INCOME	+	$
TOTAL MONTHLY INCOME:	**=**	**$**

V. MEDICAID APPLICATION (CHECK APPROPRIATE ANSWER)	Approved ________________ Denied_______________
FILL IN SPENDDOWN AMOUNT IF APPLICABLE	APPROVED SPENDDOWN AMOUNT __________________

VI. MISCELLANEOUS INCOME PER MONTH – complete All fields with gross monthly amount or N/A if not applicable			
DIVIDENDS, INTEREST	$	PENSIONS	$
PUBLIC ASSISTANCE/FOOD STAMPS	$	INVESTMENT/RENTAL INCOME	$
SOCIAL SECURITY	$	GRANTS	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	Other	$
CHILD SUPPORT/ALIMONY	$		

TOTAL MONTHLY MISCELLANEOUS INCOME:	$		
MONTHLY INCOME:	+ $		
TOTAL MONTHLY INCOME:	= $	**ANNUAL:**	**$**

ALL INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED AND FOLLOW THE PROCEDURE GUIDELINES DEFINED IN THE FINANCIAL ASSISTANCE POLICY UNDER PROCEDURE: section 2, paragraph E.

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY OTSEGO MEMORIAL HOSPITAL OR ITS AGENTS.

SIGNATURE/ DATE: ____________________________________/__________________

RELATIONSHIP IF OTHER THAN PATIENT: ____________________

FOR OFFICE USE ONLY			
APPROVED/DENIED	%	$	DATE:
APPROVED BY:			

Approved applications will be effective for services covered according to Financial Assistance Policy guidelines for up to six (6) months from the approval date.

The following documents are required (if applicable):

***Proof of current Health Insurance AND Medicaid denial for secondary insurance coverage**

OR

***Medicaid Insurance information including any monthly deductible / spendown amounts**

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Tax Return & W-2's (Federal)**
***Four (4) most recent pay stubs.**
***Cash or Food Assistance through DHS**

OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM

Financial Assistance Policy – Plain Language Summary

Otsego Memorial Hospital (OMH) and OMH Medical Group's Financial Assistance Policy (FAP), exists to provide eligible patients partial or fully discounted emergent or medically necessary care. Patients who will be seeking Financial Assistance must apply for the program, which is summarized below.

Eligible Services – Emergent and/or medically necessary healthcare services provided by OMH and OMH Medical Group providers. The services only include services billed by OMH or OMH Medical Group. Other services, such as Pathology, physicians not employed by OMH and radiology interpretations provided by an organization other than OMH, are not eligible under the FAP.

Eligible Patients – Patients receiving Eligible Services, who submit a completed Financial Assistance Application including all required documentation/information, and who are determined to be eligible for Financial Assistance according to the policy guidelines.

How to Apply – Financial Assistance Applications (including Plain Language and full Financial Assistance Policy) may be obtained /completed/submitted as follows:

- Obtain an application at the hospital Information Desk or at the front desk of any Hospital owned clinic.
- Request an application be mailed to you, by calling 989-731-7777 for Physician or 989-731-2198 for Hospital Billing.
- Request an application by visiting in person: OMH Administrative Services Building, 271 W. McCoy Rd., Gaylord, MI 49735.
- Download an application from the OMH website at: www.myomh.org/patient-assistance-program
- Mail Completed applications (with all required documentation/information specified in the application instructions) to OMH Financial Assistance, 271 W. McCoy Rd., Gaylord, MI 49735. Specify hospital assistance of physician assistance.

Determination of Financial Assistance Eligibility – Generally, Eligible persons are eligible for Financial Assistance using a sliding scale, when their family income is at or below 350% of the Federal Government's Federal Poverty Guidelines (FPG). Eligibility for Financial Assistance means that Eligible persons will have their care fully covered or partially, and they will not be billed more than "Amounts Generally Billed" (AGB) to insured persons (AGB, as defined by IRS Section 501(r)). Financial Assistance levels based solely on Family income and FPG are:

FPG	0 to 100	100 to 150%	150% to 200%	200% to 250%	250% to 300%	300% to 350%
Discount %	100%	95%	85%	75%	50%	50%

Note: Other criteria beyond the FPG are also considered, including: The availability of other program coverage for the services; Medicaid denial or prior consultation with our Certified Application Counselor (CAC); residence within the OMH immediate service area; management discretion.

The following documents are required if applicable:

<u>Proof of current Health Insurance AND Medicaid denial for secondary insurance coverage</u>

OR

*<u>*Medicaid Insurance information including any monthly deductible / spendown amounts</u>*

**SSA 1099 (Social Security proof)*   **Pension Proof*   **Unemployment Proof*

**Child Support/Spousal Support stubs*   ** Federal Tax Return & W-2's*   **Four (4) most recent pay*

**Cash or Food Assistance (DHS)*

A determination will be made within one (1) week of receipt if all pertinent information is returned with the application.

For questions or help: Call Hospital Billing during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:00 p.m. at 989-731-2200 or 800-322-3664 ext. 2200 if your last name starts with A-L, or 989-731-6228 or 800-322-3664 ext. 6228 if your last name starts with M-Z; for Physician Billing call 989-731-7777.