

Department: Patient Financial Services

Title: Financial Assistance Policy

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Approver(s): Lindsay Rynearson (Executive Assistant)	Date Approved: 12/19/2024

Printed copies of this policy are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish a standardized approach to governing Grande Ronde Hospital, Inc. (“Corporation”) Financial Assistance Program.

POLICY:

Corporation will offer a Financial Assistance Program for medically necessary services. Eligibility will be determined on an individual basis using specific criteria to evaluate applicant(s) income and household size.

PROCEDURE:

Here to Assist You

All patients receiving care at Corporation are notified of our Financial Assistance Policy in key areas including the patient access department, emergency department, and outpatient registration offices. Financial Assistance Offices are located in the hospital lobby and Pavilion, where Financial Counselors and interpreters are available to assist with the financial assistance application process.

Following discharge from care, patients will receive information on the Financial Assistance Policy with their billing notifications and in verbal communications with Corporation staff during the first 120 days of a billing cycle.

All Corporation Financial Counselors, patient access staff, and case managers are trained to answer questions about the Corporation Financial Assistance Program. Anyone in the community may request and receive a copy of the Financial Assistance Policy and application at any point during the 240 day application period.

How Does This Work?

Each calendar year, Corporation publishes an Annual Income Thresholds by Sliding Scale document. The document outlines the discount that would be applied, to the cost of medically necessary healthcare services, provided to a qualifying patient during the application period, which starts on the date care is provided and ends on the 240th day after the first billing for care.

Corporation defines medically necessary services as those covered by the Oregon Division of Medical Assistance Programs (Oregon Medicaid) with the exception of sterilization procedures, preventative care, and medications, which are not covered by Financial Assistance.

How Discounts Are Calculated and Applied

Discounts are calculated based on household income and the number of individuals living in the household (unborn children will not be counted). Monetary assets will not be used to determine eligibility if a patient or guarantor's household income is at, or below, 200% of the federal poverty standard.

The sliding discount scale includes 40%, 60%, and 100% reductions for medically necessary services. Qualifying income levels range from 0% to 400% of Federal Poverty Guidelines. The discount is calculated based on the information provided in the Financial Assistance Application.

Financial assistance discounts are applied to qualifying accounts after all other paying resources including, medical insurance, government programs, health savings accounts (Health Savings Accounts/Health Reimbursement Arrangement/Flexible Spending Account), community or faith based collaborative, third party liability coverage, and qualifying assets.

Federal Poverty Income Guideline Exceptions

An exception to the Federal Income Guideline may be granted for a household that exceeds the Corporation financial assistance guidelines. To be considered for this exception a letter disclosing the circumstances affecting their ability to pay should be provided along with the completed Financial Assistance Application. All exception requests will be reviewed for approval by Corporation's Senior Director Finance/Chief Financial Officer (CFO).

If after all paying resources have paid, the balance remaining on the account is greater than 20% of the patient's annual household gross income, the patient should notify a Corporation Financial Counselor for further assistance.

Uninsured Notification

Uninsured patients need to notify their provider or Corporation staff during the check in or discharge process.

Prompt Pay Discount

Uninsured patients may qualify for a 34% prompt pay discount if the full balance due is paid within 30 days of the first statement mailing date, as recorded in the Corporation Health Information System.

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Qualification Requirements

A 100% discount of all qualified charges is available if the patient meets any of the following six (6) guidelines: (1) the patient was the only individual in the household and is deceased with no money or property, (2) the patient is the only individual in the household and is mentally or physically incapable to act on his own behalf and has no one to represent him/her, (3) the household is enrolled in the Women, Infants and Children Nutrition Program, (4) all household members are enrolled in the Supplemental Nutrition Assistance Program, (5) all household members are presumed eligible for Medicaid under the Medicaid presumptive eligibility guidelines, or (6) Corporation has evidence from an independent reporting agency that indicates the patient's family income is 200% or less of the applicable Federal Poverty Income Guidelines.

Eligible Service Providers

Corporation publishes a list, on its website, of healthcare providers who practice at the hospital and its facilities. This list indicates whether or not the providers' services are covered under the Financial Assistance Program.

Presumptive Eligibility Prescreening Process

Effective July 1, 2024, the state of Oregon requires all hospitals to prescreen any patient for presumptive financial assistance eligibility; if a self-pay balance of at least \$500.00 remains after all third party payments have been applied. Each patient account will be prescreened using any financial information accessible to the hospital such as prior Financial Assistance Application information. If it is determined that the patient is eligible for assistance, an approval letter will be mailed to the patient. The approval letter will indicate (1) the discount reduction percentage approved, (2) the date reapplication is needed, (3) instructions on how to apply for additional assistance if the approved reduction is less than 100%, and (4) contact information for the Financial Counselors, if there are questions.

If eligibility cannot be determined based on financial information accessible to the hospital, a denial letter will be mailed to the patient. The denial letter will indicate (1) how ineligibility was determined, (2) provide instructions on how to apply for additional assistance through our standard application process, and (3) contact information for the Financial Counselors, if there are questions.

Applying For Financial Assistance

To apply for Financial Assistance Program, contact a Financial Counselor Monday through Friday at (541) 963-2845 or visit www.grh.org/patients-visitors/patient-financial-services to print a Financial Assistance Application and checklist, review the Financial Assistance Policy Summary & Frequently Asked Questions, and Provider Coverage Guide.

Application Requirements

To complete the Financial Assistance Application you will need to list all members of your household, their employment information, and provide year to date income information with supporting documentation. Asset information is requested, but not required. Asset information will be used for internal purposes only, to determine which award amounts can be included in the Corporation annual cost report.

Supporting financial documentation, verifying your financial situation, must be submitted with your completed Financial Assistance Application. This includes and is not limited to: documentation of all income sources, including three (3) months of current pay stubs and bank statements, your most recent tax returns, W-2 forms, proof of social security benefit, Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), housing assistance, unemployment compensation or financial aid for schooling. Self-employed applicants must provide a complete copy of current business tax returns.

If you have no income to report, then you must submit a “letter of support” from individuals who are paying for your basic living needs. Any special circumstances that are affecting your ability to pay, such as a lack of income, should be included in this letter.

If you are an uninsured patient, you will be asked to apply for insurance coverage before the Corporation financial assistance application is processed.

Application Submission and Evaluation Process

All financial assistance applications and supporting financial documents are kept confidential to the extent allowed by law. You can drop your application and supporting document off at any Corporation location or mail it to:

*Grande Ronde Hospital
Attention: Financial Assistance Program
PO Box 3290
La Grande, OR 97850*

Your application will be date stamped upon receipt. A complete application will be processed and a determination letter, our Financial Assistance Policy, and Frequently Asked Questions will be mailed to you within 20 calendar days. Incomplete applications will be put on hold and a financial counselor will try to contact you for the missing information. If contact is not made a written notification will be sent outlining what information is needed to complete the application. A response must be received within 45 calendar days of the notification. If a response is not received the application will be denied and your financial information, along with a letter explaining how to reapply, will be mailed to you.

Payment Collection During Application Processing

All collection efforts will be halted while the application is under consideration. Once the application has been processed, collections will resume on any balance remaining.

Application Approval Process

The Patient Financial Services Manager or the Director of Business Services must approve determinations that meet income guidelines and the account balance does not exceed \$5,000. Accounts over \$5,000 and exceptions for earnings over the poverty guidelines must be approved by the Director of Business Services and the Senior Director Finance/CFO.

Approvals are active for nine (9) months from the approval date, after which the patient or guarantor may reapply with current supporting documentation.

Application Denial

If an application is denied, notification will be sent within 10 business days of the denial. The notification will provide the specific criteria not met and instructions on how to file an appeal.

Appeal Process

Appeal requests must be received within 45 days of the denial notification. Written notification will be sent confirming receipt of the appeal request and confirming the suspension of all collection activity.

If a written appeal of a denial ruling is received. The appeal request will be reviewed by the Director of Business Services and Senior Director Finance/CFO.

A written determination on the appeal will be will be issued by registered mail or through the patient portal within 30 days of the appeal request.

Balance Adjustment

Upon approval for financial assistance, billing account will be adjusted to reflect the after-discount balance owed, if any, and any discounted services will be recognized as charity care.

Payment Plans

If you have been approved for financial assistance and you have an after-discount balance owing, contact the Patient Financial Services Department at (541) 963-1400 to set up a payment plan. Payment plans generally do not exceed 36 months, unless it is authorized by the Patient Financial Services Manager or Director of Business Services.

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<u>Account Balance</u>	<u>Minimum Monthly Payment</u>
\$0.00 - \$1,000	\$50.00
\$1,000 - \$2,000	\$100.00
\$2,000.01 - \$4,000	\$150.00
\$4,000.01 - \$6,000	\$200.00
\$6,000.01 - \$8,000	\$250.00
\$8,000.01 - \$10,999	\$300.00
\$11,000 +	Balance divided by 36

Any payment(s) made on a qualifying account during the 240 day application period will be applied to any remaining balance. Any overpayments will be refunded.

Collection Process

When an account is unpaid or the minimum payment due is not received in the prior three (3) months it will be presumptively screened, if the account is found ineligible a 30-day collection notice will be sent to alert the patient or payer that the account will go to an outside collection agency.

An account may also be turned over to an outside collection agency if information is received which shows the account may be either uncollectible or difficult to collect.

Extraordinary Collection Efforts

Once the unpaid account has been turned over to an outside collection agency, the agency will take stronger actions to collect payment(s) on the past due account, including but not limited to a property lien, foreclosure on an individual’s land and buildings, attachment to a bank account or personal property, a civil action, a warrant for civil arrest or garnishment of wages.

LEVEL OF APPROVAL:

Policy Oversight Council – 10/30/2024

Community Benefit Subcommittee – 12/09/2024

Board of Trustees – 12/18/2024