

# OSMOND GENERAL HOSPITAL FINANCIAL ASSISTANCE POLICY

## **PURPOSE**

The purpose of this policy is to further the charitable mission of Osmond General Hospital (the "Hospital") by providing financially disadvantaged and other qualified patients with an avenue to apply for and receive free or discounted care consistent with requirements of the Internal Revenue Code and implementing regulations.

## **I. ELIGIBILITY CRITERIA**

The following classes of individuals and categories of care are eligible for financial assistance under this policy:

### **A. Financially Indigent**

To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or less than 100% of Federal Poverty Level; provided, however, that patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of Two Hundred percent (200%) of total outstanding medical bills do not qualify as Financially Indigent. The following definitions apply to such eligibility criteria:

**"Uninsured"**: A patient who (i) has no health insurance or coverage under governmental health care programs, and (ii) is exempt from the Affordable Care Act (ACA) and not eligible for any other third party payment such as worker's compensation or claims against others involving accidents.

**"Underinsured"**: A patient who (i) has limited health insurance coverage that does not provide coverage for hospital services or other medically necessary services provided by the Hospital, (ii) has exceeded the maximum liability under his/her insurance coverage.

**"Household Income"**: The total income of all adult members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

**"Net Worth"**: Net asset value (assets minus liabilities (excluding Hospital liabilities)) of all adult members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.]

### **B. *Failure to Apply for Medicaid***

Patients who may be eligible for Medicaid and fail to apply for Medicaid within thirty (30) days of the Hospital's request are not considered eligible for financial assistance under this policy.

#### **D. Categories of Care Eligible for Financial Assistance**

Provided that the patient qualifies as Financially Indigent, the following classes of care are eligible for financial assistance under this policy:

- Emergency medical care
- Medically necessary care

#### **II. COVERED PROVIDERS**

Care provided by the Hospital and Hospital-employed physicians and practitioners is covered by this policy, as well as care provided at any of the four Hospital owned medical clinics.

Care provided by independent community physicians and other independent service providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance.

Patients may obtain a current list of providers who are and are not subject to this policy at no charge by visiting Osmond General Hospital Patient Financial Services, 402 N. Maple St. Osmond, NE 68765, 402-748-3393 or visiting [www.osmondhospital.org](http://www.osmondhospital.org).

#### **III. LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED**

Patients who are deemed to be eligible for financial assistance under this policy will not be charged for care covered by this policy more than Amounts Generally Billed by the Hospital to individuals who have health insurance covering such care. Discounts granted to eligible patients under this policy will be taken from gross charges.

##### **A. Calculation of Amounts Generally Billed**

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Hospital determines its AGB utilizing the method detailed below.

The Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is the Hospital's gross charges multiplied by the AGB Percentage. Patients may obtain the Hospital's most current AGB Percentage and a description of the calculation in writing free of charge by visiting the Hospital's patient financial services office at 402 N Maple St. Osmond, NE 68765, or by calling 402-748-3393 ext. 127.

The Hospital calculates its AGB Percentage on an annual basis. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.

## B. Amount of Financial Assistance/Discount

Patients who qualify for financial assistance as **Financially Indigent** are eligible for financial assistance on a sliding scale based upon household income compared to federal poverty level (FPL). See chart below.

Level of Discount	100%	90%	80%	70%	60%	50%
Family Size	FPL	110%	120%	130%	140%	150%
1	\$11,770	\$12,947	\$14,124	\$15,301	\$16,478	\$17,655
2	\$15,930	\$17,523	\$19,116	\$20,709	\$22,302	\$23,895
3	\$20,090	\$22,099	\$24,108	\$26,117	\$28,126	\$30,135
4	\$24,250	\$26,675	\$29,100	\$31,525	\$33,950	\$36,375
5	\$28,410	\$31,251	\$34,092	\$36,933	\$39,774	\$42,615
6	\$32,570	\$35,827	\$39,084	\$42,341	\$45,598	\$48,855
7	\$36,730	\$40,403	\$44,076	\$47,749	\$51,422	\$55,095
8	\$40,890	\$44,979	\$49,068	\$53,157	\$57,246	\$61,335

If financial assistance provided to the patient results in a charge of greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

## IV. APPLICATION PROCESS & DETERMINATION

Patients who believe they may qualify for financial assistance under this policy are required to submit an application on the Hospital's financial assistance application form during the Application Period. Completed applications must be returned to:

Patient Financial Services  
Osmond General Hospital  
402 N. Maple St.  
Osmond, NE 68765

For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 240<sup>th</sup> day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date the Hospital provides the patient the requisite final notice to commence extraordinary collection actions ("ECAs").

Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial assistance application free of charge by mail by calling Patient Financial Services at 402-748-3393 ext. 127, or in person at patient financial services at Osmond General Hospital 402 N. Maple St. Osmond, NE 68765.

#### **A. Completed Applications**

Upon receipt, the Hospital will suspend any ECAs taken against the patient and process, review and make a determination on completed financial assistance applications submitted during the Application Period as set forth below. The Hospital may, in its own discretion, accept complete financial assistance applications submitted after the Application Period.

Determination of eligibility for financial assistance shall be made by the Chief Executive Officer. Unless otherwise delayed as set forth herein, such determination shall be made within 14 days of submission of a timely completed application. Patients will be notified of the Hospital's determination as set forth in the Billing and Collection provisions detailed herein. To be considered "complete" a financial assistance application must provide all information requested on the form and in the instructions to the form.

The Hospital will not consider an application incomplete or deny financial assistance based upon the failure to provide any information that was not requested in the application or accompanying instructions. The Hospital may take into account in its determination (and in determining whether the patient's application is complete) information provided by the patient other than in the application.

For questions and/or assistance with filling out a financial assistance application, the patient may contact patient financial services at Osmond General Hospital 402 N Maple St. Osmond, NE 68765. Ph. 402-748-3393 ext. 127.

If a patient submits a completed financial assistance application during the Application Period and the Hospital determines that the patient may be eligible for participation in Medicaid, the Hospital will notify the patient in writing of such potential eligibility and request that the patient take steps necessary to enroll in such program. In such circumstances the Hospital will delay the processing of the patient's financial assistance application until the patient's application for Medicaid is completed, submitted to the requisite governmental authority, and a determination has been made. If the patient fails to submit an application within thirty (30) days of the Hospital's request, the Hospital will process the completed financial assistance application and financial assistance will be denied due to the failure to meet the eligibility criteria set forth herein.

#### **B. Incomplete Applications**

Incomplete applications will not be processed by the Hospital. If a patient submits an incomplete application, the Hospital will suspend ECAs and provide the patient with written notice setting forth the additional information or documentation required to complete the application. The written notice will include the contact information (telephone number, and physical location of the

office) of patient financial assistance. The notice will provide the patient with at least 14 days to provide the required information; provided, however, that if the patient submits a completed application prior to the end of the Application Period, the Hospital will accept and process the application as complete.

### **C. Presumptive Eligibility**

The Hospital reserves the right to provide financial assistance even though an application has not been submitted, in which case the patient will be provided the maximum possible level of financial assistance.

## **V. COLLECTION ACTIONS**

Patients will be provided a plain language summary of the financial assistance policy upon admission to the Hospital. Furthermore, all billing statements will include a conspicuous written notice regarding the availability of assistance, including the contact information identifying where the patient may obtain further information and financial assistance-related documents and the website where such documents may be found.

The Hospital or its authorized representatives may refer a patient's bill to a third party collection agency or take any or all of the following extraordinary collection actions ("ECAs") in the event of non-payment of outstanding bills:

- Reporting to credit bureaus
- Legal suit
- Selling the account to a third party
- Garnishment of wages

The Hospital may refer a patient's bill to a collection agency 90 days from the date the first bill for care was provided to the patient. The Hospital will not take ECAs against a patient or any other individual who has accepted or is required to accept financial responsibility for a patient unless and until the Hospital has made "reasonable efforts" to determine whether the patient is eligible for financial assistance under this policy. The CEO is responsible to determine whether the Hospital has engaged in reasonable efforts to determine whether a patient is eligible for financial assistance.

### **A. No Application Submitted**

If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and
2. Provides at least thirty (30) days' notice to the patient that:

- Notifies the patient of the availability of financial assistance;
  - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and
  - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;
3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and
  4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.
  5. If the patient has been granted financial assistance based on a presumptive eligibility determination, the Hospital has provided the patient with the notice required in the financial assistance policy.

## **B. Incomplete Applications**

If a patient submits an incomplete financial assistance application during the Application Period, "reasonable efforts" will have been satisfied if the Hospital:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information (telephone number, and physical location of the office) of the Hospital department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 14 days to provide the required information; and
2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, the Hospital must suspend ECAs and make a determination on the application.

## **C. Completed Applications**

If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if the Hospital does the following:

1. Suspends all ECAs taken against the individual, if any;

2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and
3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If the Hospital has requested that the patient apply for Medicaid, the Hospital will suspend any ECAs it has taken against the patient until the patient's Medicaid application has been processed or the patient's financial assistance application is denied due to the failure to timely apply for Medicaid coverage.

If a patient is eligible for financial assistance other than free care, the Hospital will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the AGB for the care provided;
2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to the Hospital (unless such amount is less than \$5); and
3. Take reasonable measures to reverse any ECAs taken against the patient.

## **VI. EMERGENCY MEDICAL CARE**

Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under the financial assistance policy. The Hospital will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with Hospital policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

Associated Documents:      Patient Financial Assistance Policy Plain Language Summary  
   Patient Financial Assistance AGB Calculation  
   Patient Financial Assistance Checklist  
   Patient Financial Assistance Application  
   Patient Financial Assistance Determination Decision