



"Friends Healing Friends"

FALLON MEDICAL COMPLEX

PO Box 820
202 South 4th Street West
Baker, MT 59313-0820
(406) 778-3331
FAX (406) 778-2488
www.fallonmedical.org

FMC Patient Care Financial Assistance Policy

APPENDIX A: COVERED MEDICAL PROVIDER PROFESSIONAL SERVICES

Any provider contracted to provide medically necessary healthcare services at & billed by Fallon Medical Complex Critical Access Hospital, Community Clinic, Wibaux Clinic, or Home Care including the following:

Allen PA-C, Travis
Breihahn, PA-C, Leanne (aka Garcia)
Ceremuga DO, George
Espeland DO, Darryl
Mencel PA-C, Mark
Olson PA-C, Teresea
Streit PA-C, Edna
Sullivan MD, Brian
Trivisonno MD, Dominick
Wheeler PA-C, Paul
Any Locum provider covering for the above staff for which FMC would bill.

EXCLUDED PROVIDERS

Alzheimer MD, Daniel
Campbell DDS, James
Holkup DC, Jacob
Jaszczak MD, Leszek
Williams MD, Jeffery
Harris MD, John
Fallon County Ambulance Services
Hearing Aid Institute
NON FMC Providers of care via Telemedicine
Or any other visiting specialist not directly contracted by FMC

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Patient Care Financial Assistance

I. Policy Statement:

It is the policy of Fallon Medical Complex (FMC) as a non-profit charitable organization to provide health care to all persons in our community, including those with an inability to pay for those services. Fallon Medical Complex strives to ensure that financial issues do not prevent patients from seeking or receiving care. Fallon Medical Complex will provide, without discrimination, the care of emergency medical conditions and care that is medically necessary to individuals regardless of their eligibility for financial assistance.

Financial assistance is not to be considered a substitute for personal responsibility. Patients must cooperate with Fallon Medical Complex procedures for obtaining financial assistance. Patients are expected to contribute to the cost of their care based on their ability to pay. Individuals with the financial means to purchase health insurance shall be urged to do so. This assures access to health care services and protects their assets.

This policy provides assistance to responsible parties who desire to pay for their medical services but who do not have the financial ability to do so. The policy does not provide assistance to responsible parties who refuse to pay for medical services rendered to themselves or family members. It is also a community service, and as such, may be denied if charges were incurred while participating in any type of illegal activity. This financial assistance program is intended to be the last option for payment after exhausting all other alternatives.

In order to allow Fallon Medical Complex to provide a fair level of assistance to the greatest number of persons in need, the Board of Directors establishes the following policies for financial assistance.

II. Definitions:

For the purposes of this policy, the terms below are defined as follows:

Amount Generally Billed (AGB): The amounts generally billed for emergency or medically necessary care provided to patients who have insurance.

After FAP eligibility has been determined, FMC will limit amounts charged the FAP eligible patient for emergency or other medically necessary care to not more than the amounts generally billed (AGB) to individuals with insurance covering that care.

AGB will be determined annually by using a 12 month measurement period utilizing the look back method. The AGB calculations will be based upon claims allowed during the previous fiscal 12 month period divided by the gross charges for the same period. The calculation will provide a sliding scale of discounts based upon Medicare and other Commercial insurance claims. FMC's fiscal year is July to June and the calculated AGB's will be effective for 12 months starting September 1. If more information is needed about how FMC calculates the AGB percentages, please contact FMC's Chief Financial Officer at 406-778-3331, ext 103.

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Eligibility Period: The period during which FMC will accept and process Financial Assistance applications. This period will be, at least, from the date of service until 240 days after FMC provides the patient with the first billing statement for the care provided.

Emergency Medical Condition: Defined within the meaning of section 1867 of the Social Security Act (42 USC 139dd).

Extraordinary Collection Actions (ECA's): Those actions that FMC may take in event of non-payment following the expiration of the notification period. These may include referral to an external collection agency, the reporting of adverse information about the individual to consumer credit reporting agencies or credit bureaus, garnishment of an individual's wages, and/or commencement of a legal civil action against an individual.

Federal Income Poverty Guidelines: The most recently published federal income poverty guidelines for a household, which shall be revised and attached to this policy as they are published by the US government.

Financial Assistance: Healthcare services that have been or will be provided by FMC but are not expected to be paid by the patient. Fallon Medical Complex policy will provide healthcare services free or at a discount to individuals who meet this policy's criteria.

Household: A household consists of all persons who occupy the same housing unit as the applicant whether they are legally related to each other or not, and would be recognized as being in the same household under the Federal income poverty guidelines. FMC will consider income to make a determination of financial assistance under this program.

Household Income: Household Income is determined using the following factors:

- Includes household earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Determined on a before-tax basis;
- Excludes noncash benefits (such as food stamps and housing subsidies);
- May in some instances exclude certain sources of household income at FMC's exclusive discretion.

Medically Necessary Services: As defined by Montana Medicaid; Medically Necessary Care is a service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

- Endanger life;
- Cause suffering or pain;
- Result in illness or infirmity;
- Threaten to cause or aggravate a handicap; or
- Causes physical deformity or malfunction

A service or item is medically necessary only if there is no other equally effective, more conservative, or subsequently less cost course of treatment medically appropriate for the patient requesting the service, or when appropriate, not treatment at all.

Minor Children/Divorced Parents: Both legal parents/guardians will be responsible for the payment of medical services provided to minor children. Both households will be required to complete a Financial Assistance Application. However, if after reasonable efforts, circumstances prevent obtaining financial information from both households, the residing household of the minor child/children will be used to make the determination.

Notification Period: The period of time during which FMC will make every reasonable effort to inform the patient of the availability of financial assistance under this policy prior to initiating extraordinary collection actions. This period shall be from the date of service until, at least, 120 days after FMC provides the patient with the first billing statement for the care provided.

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Underinsured: The patient has some level of insurance but still has out-of-pocket expenses that exceed his/her financial abilities.

Uninsured: The patient has no level of insurance or third-party assistance to aid with meeting his/her payment obligations.

III. Procedures

A. Services Eligible under this Policy

For purposes of this policy, “financial assistance” refers to healthcare services provided by FMC without charge or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance:

1. Services provided for an emergency medical condition in an emergency room setting.
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
4. Medically necessary services, evaluated on a case-by-case basis at FMC’s discretion.
5. This policy covers only charges incurred at Fallon Medical Complex Critical Access Hospital, FMC Home Care, Community Clinic, Wibaux Clinic, and /or FMC Emergency Room.
6. Services provided by FMC providers of care as listed in Appendix A. Services excluded include cosmetic procedures, DOT/ICC/FAA physical exam, Marijuana eligibility exams, and any FMC Long Term or Swing Bed intermediate care.

Assistance will be secondary to all third party payers and financial resources available to the patient. This policy covers only charges incurred at Fallon Medical Complex.

B. Eligibility for Financial assistance

Financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care. Eligibility will be based upon a determination of financial need in accordance with this Policy. It shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. Financial assistance is secondary to all other financial resources available. Refusal to access other available funding, such as Medicaid, MT HELP Program, or the Insurance Marketplace, will disqualify the patient for eligibility under this policy.

C. Determination of Financial Need

1. Financial need will be determined in accordance with procedures that involve an assessment of such need, and may:
 - Include an application process, in which the patient or the patient’s guarantor are required to cooperate and supply information and documentation relevant to making a determination of financial need,
 - Include the use of external publically available data sources that provide information on a patient’s or a patient’s guarantor’s ability to pay (such as credit scoring),
 - Include a review of the patient’s outstanding accounts receivable and the patient’s payment history.
2. All applications for financial assistance shall require the applicant to meet or exceed the criteria for two separate tests:
 - Income Test – which takes into consideration all income sources in the applicant’s household, and

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- Alternative Payer Test – which provides assurances that reasonable efforts have been made to explore alternative sources of payment and coverage from public and private payment programs such as Medicaid or the Insurance Marketplace.
3. The following types of documentation should accompany the completed application:
 - Payroll check stubs or other monthly income sources for the last three (3) months for all persons in your household (whether legally related to you or not).
 - A copy of your most recently completed calendar year IRS tax return with supporting schedules.
 - Three months of all bank account statements
 - A copy of your bank financial report, if you are a business owner, farmer, rancher, etc.
 - Notice of ineligibility from other assistance programs such as Medicaid, SSI/SSDI, Crime Victims Assistance, Health Insurance Marketplace, etc.
 - Notice of ineligibility for unemployment or worker's compensation benefits, as appropriate.
 - A statement detailing your need for financial assistance, including a detail of other medical bills owed.
 4. It is preferred but not required that a request for financial assistance and approval of financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle. Financial assistance will be considered for FMC account balances no more than 12 months in arrears or 60 days beyond the date of the application. FMC must pre-approve any charges within the 60 days post application date. FMC may consider older balances at their discretion.
 5. Once a determination has been made on those account balances, whether assistance is provided or not, they cannot be considered again under future applications. Accounts assigned to an outside collection agency or attorney may not be eligible for financial assistance.
 6. Once a patient has been determined by FMC to be eligible for financial assistance, that patient will not be billed more than amounts generally billed (AGB) for emergency or medically necessary care while financial assistance is being provided. Please see definition above.
 7. Requests for financial assistance shall be processed promptly. FMC shall notify the patient in writing within 30 days of receipt of a completed application. Collection activity will be suspended while a financial assistance application is under review. Normal collection efforts will resume if the application is not returned in a timely fashion or after the write-off is complete and the patient owes a balance.
 8. In the event that FMC receives an incomplete application, the patient will be notified with a written notice that describes the additional information required, a deadline of no more than 30 days for response, and informs the patient of any extraordinary collection actions that may resume if requested information is not returned.

D. Income Test

The amount of assistance offered to an applicant will be based on the level of household income relative to the Federal Income Poverty Guidelines. Financial assistance will be offered to those who qualify according to the sliding fee scale described below:

1. Patients whose household income is at or below 150% of the Federal Poverty Level (FPL) are eligible to receive free care.
2. Patients whose family income is above 150% but not more than 200% of the (FPL) are eligible to receive a discount of 50% of their account balance. This discount is larger than the percentage that FMC receives from the Medicare program.
3. Patients whose family income exceeds 200% of the FPL but not more than 250% of the FPL are eligible to receive a discount of 15% of their account balance. This discount is larger than the discount given to FMC by its largest commercial insurers. If the applicant falls into this category, FMC may require a net asset test for discounts.

E. Alternative Payer Test

All applicants will be required to pursue alternative sources of payment, such as the Health Insurance Marketplace, public assistance programs, etc., and may be required to provide proof of being denied coverage. Refusal to pursue alternative payer sources may disqualify the applicant from receiving financial assistance under this Policy. In all circumstances, FMC shall only consider any balances for services remaining after alternative payers have paid their portion of the bill.

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F. Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for discounts, but there is no financial assistance form on file. If there is adequate information to determine a need for assistance, the following situations would be eligible for a discount off the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless
- Participation in Women, Infants, and Children programs (WIC)
- Food stamp eligibility
- Eligibility for other state or local assistance programs that such as Medicaid, HELP, or MBCHP
- Proof of Low income/subsidized housing
- Patient is deceased with no known estate
- Bankruptcy filing

G. Medically Indigent

Some applicants may be determined to be “medically indigent” due to an inability to pay some or all of their medical bills because their medical bills exceed a certain percentage of household income (for example, due to catastrophic costs or conditions). Even though the applicant may have income that otherwise exceed the applicable eligibility requirements for free or discounted care under this Policy, assistance of up to 50% of the account balance may be considered by FMC.

H. Communication of the Financial Assistance Program to Patients and the Public

Notification about financial assistance from FMC shall be communicated by various means. These may include the publication of notices in patient bills, posting notices in the emergency room, registration and admission desk, clinic waiting room, hospital family room, and other public places that FMC may elect. The full policy, a Plain Language Summary (PLS), and application will also be posted on the FMC website, www.fallonmedical.org. Referral of patients for financial assistance may be made by any member of the FMC staff, medical staff, or FMC’s collection agencies. A request for financial assistance may be made by the patient, a family member, or friend of the patient.

I. How to Apply

To apply for Financial Assistance, patients must complete a Financial Assistance Application and provide the requested documents. Application forms and printed versions of our financial assistance policies (in English, Spanish, or a plain language summary) can be accessed from the links below. They are also available at FMC’s Emergency Department, Patient Registration areas or at the FMC Business Office, 202 South 4th Street West, Baker, Montana. Or call (406) 778-3331, ext 115 to have these documents mailed to you at no cost.

Completed Financial Assistance Applications can be mailed or delivered to:

Fallon Medical Complex
Attn: Business Office Manager
202 South 4th Street (for hand delivery)
PO Box 820 (for mailing)
Baker, MT 59313

For more information or assistance completing the Financial Assistance Application, contact the FMC Business Office Manager at (406) 778-3331, ext 115 or the FMC Social Worker at (406) 778-3331, ext 203 during business hours of Monday – Friday, 8AM – 5PM. Their office is located at the Business Office and may be reached by using the Community Clinic entrance at Fallon Medical Complex in Baker, Montana.

J. Relationship to Collection Policies

Fallon Medical Complex’s management has developed policies and procedures for internal and external collection practices (including actions FMC may take in the event of non-payment, such as collection action and reporting to credit agencies). These policies take into account the extent to which the patient qualifies for financial assistance, a

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patient's good faith effort to apply for a governmental program or for financial assistance from FMC, and a patient's good faith effort to comply with his or her payment agreements with FMC.

For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, FMC may offer extended payment plans, delay the sending of unpaid bills to outside collection agencies, and cease all collection efforts. FMC will not impose extraordinary collections actions such as, reporting to a credit agency accounts placed for collection, wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for assistance under this financial assistance policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the facility;
2. Documentation that FMC has attempted to offer (both orally and/or in writing) the patient the opportunity to apply for financial assistance pursuant to this policy, and that the patient has not complied with the hospital's application requirements;
3. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

For additional information, please see the FMC Collection Policies as stated on www.fallonmedical.org.

K. Appeals

1. Applicants who qualify for a lower level of assistance than they feel is merited may request assistance at a higher level than otherwise established in this policy. FMC will consider the following circumstances and other similar circumstances in evaluating that request:
 - extraordinary non-discretionary expenses relative to the amount of medical expenses,
 - the responsible party's income potential, and
 - the applicant's ability to make payments over a determined period of time.

Similarly, applicants who do not qualify for any financial assistance under this policy may make an appeal under similar circumstances.

2. The applicant must provide a letter requesting an appeal as well as any additional information to the Business Office within 14 calendar days of receipt of the letter of determination. All appeals will be reviewed by the Chief Financial Officer and/or the Chief Executive Officer for a final determination within 30 days. If the final determination affirms the previous denial of financial assistance, written notification will be sent to the applicant.
3. If an appeal is filed within 14 calendar days of final determination, any collection efforts will be suspended pending the final outcome of the appeals process.

L. Administration

1. This policy shall be supervised by the Business Office Manager who shall be responsible for administering the program, assuring that determination for financial assistance meets requirements of this policy, and notifying the applicant of the final determination.
2. The Business Office Manager may approve applications up to \$5,000. All applications over \$5,000 will require the approval of the Chief Financial Officer or Chief Executive Officer.
3. FMC may establish a maximum amount of financial assistance that can be offered to all patients collectively during any given fiscal year. FMC reserves the right to disallow further financial assistance once that limit has been reached.

Appendix A

Please refer to the most current **Appendix A** for the most current list of FMC medical providers whose services are eligible under FMC's Patient Care Financial Assistance Policy.