Financial Assistance
Administrative House Wide Policy and Procedure

Applicable Campus	Department Name	Approval Authority
Salem Health and West Valley Hospital	Finance	System Director, Revenue Cycle

Effective Date: July 2024	Next Review Date: June 2027

List Stakeholders Position or Committee	Document Status	Date of Approval
Revenue Cycle Workflow Coordinator	Reviewed	05/2024
VP, Finance	Reviewed	06/2024
Chief Financial Officer	Reviewed	06/2024
Board of Directors	Revised	07/2024
System Director, Revenue Cycle	Revised	07/2024
Final Approval Date SH & WVH	**Final Approval**	**07/2024**

Describe briefly the most recent revision made to this policy, procedure, or protocol and why:
Added presumptive charity discount from Other Self-Pay Discounts (now Uninsured (Self-Pay) Discounts policy. Added in prescreening process for presumptive eligibility. Added additional income sources. Edited appeal process details/options. Clarified hospital practices on Extraordinary Collection Activities. Rearranged the sections. Updated in accordance with House Bill 3320.

Policy Content

Purpose/Policy Statement:
This policy is written to ensure an equitable and comprehensive system of distributing financial assistance to the financially burdened within the available resources of Salem Health while ensuring that Salem Health is financially capable of providing the highest quality healthcare to the community.

Salem Health will attend to the needs of those that are financially disadvantaged and act with integrity in all endeavors, treating all patients with dignity, respect, and compassion.

Revenue Cycle staff will work to improve cash flow and efficiency related to patient liabilities by collecting co-payments, co-insurances, and uninsured balances/prior balances by establishing flexible and equitable payment arrangements, when needed, without placing an undue burden on patients/guarantors.

Salem Health provides a variety of options to assist patients/guarantors in resolving their accounts, including screening patients for eligibility for viable funding sources, financial assistance, other discounts, and extended payment plans. Patients/guarantors who submit a Financial Assistance application and are determined at or below 400% of federal poverty level qualify for charity assistance. See details in the procedure section of the policy. Patients/guarantors may qualify for other discounts such as presumptive charity, catastrophic charity, or uninsured, see financial matrix below. Salem Health may choose to apply additional Financial Assistance to past due accounts prior to collection activities when independent and/or additional sources indicate an inability to pay.

Steps/Key Points Procedure

Screening Patients for Paying Funding Sources
Patients who are uninsured, under insured or “otherwise unable to pay for their care" are screened for eligibility through the Oregon Health Plan (OHP/Medicaid), Workers Compensation, Third Party Liabilities, or any other potential funding source at the point of scheduling, patient registration or while inpatient. Salem Health or its representative will review the patient’s current resources and work with them to gain eligibility for any of these programs as appropriate.

Patients that are not eligible for OHP or the other programs listed above, and have financial constraints that inhibit their ability to pay, will be assessed for the uninsured discount (see the Uninsured (Self-Pay) Discount policy for the current discount rate) as well as the additional financial discounts, as outlined below.

Application Process for Financial Assistance

The Hospital has developed an application process for determining initial interest in and qualification for financial assistance. Requests for financial assistance will be accepted from the patient directly, or others on the patient's behalf. This could include but is not limited to, the patient's representative, or hospital staff.

A request for financial assistance may be made before, during, or after the provision of care.

The application may be:

- Accessed and submitted online through Salem Health's MyChart mobile application or on our website: salemhealth.org/financialassistance
- Downloaded from our website: salemhealth.org/financialassistance
- Obtained in the Emergency Department, and in registration areas.
- Requested via mail from: Financial Counseling, Salem Health, PO BOX 14001, Salem OR 97309-9976
- Requested via telephone by calling 503-562-4357
- Requested via email by contacting financialcounselors@salemhealth.org.

Salem Health's Financial Assistance Policy, Plain Language Summary, and Billing and Collections Policy can also be downloaded from our website. Paper copies may be requested from: via mail from Financial Counseling, Salem Health, PO BOX 14001, Salem OR 97309-9976, via telephone by calling 503-562-4357, or via email by contacting financialcounselors@salemhealth.org.

To qualify for financial assistance, the application must be complete.

Eligibility Criteria Financial Assistance

Financial Assistance is based on the determination of a patient's ability to pay, not their willingness to pay. In order to capture total 'allowable medical expenses' or those expenses that qualify to be totaled and assessed against a patient's ability to pay, financial counselors will total the outstanding balances on all hospital accounts less any services not meeting pre-defined medical necessity. Salem Health abides by the government's published standards for medical necessity. Eligibility for Financial Assistance will be determined regardless of race, color, sex, religion, age, national origin, sexual orientation, or immigration status.

Circumstances where a patient has declined enrollment in an insurance program requiring premiums will not be a basis for denying financial assistance. If the patient has insurance, all insurance benefits, including co-op community programs, should be exhausted and only the patient liability is eligible to receive discounts or adjustments. Financial Assistance is the option of last resort. A patient/guarantor must cooperate with the approval process of any funding solution that would pay the patient's bills in order to be eligible for Financial Assistance.

Services not covered are cosmetic and/or elective procedures that are not medically necessary, or any services deemed ineligible within the Financial Clearance Policy. Self-pay package pricing is also not eligible for Financial Assistance. (e.g., a pre-determined package pricing for a procedure would not be eligible for Financial Assistance)

Unpaid balances on all emergent and other medically necessary services are eligible for financial assistance.

Criteria considered in determining eligibility include, but are not limited to:

- The household's* gross income.
- Family size (persons legally responsible for the patient bill and their dependents)
- The family's monthly out of pocket expenses for medical supplies and services.

Eligibility may be contingent upon patient cooperation with the application process. Salem Hospital may accept information provided on an Oregon Health Plan (OHP) application, OHP eligibility, Probate Estates determination, or documentation of homeless status, or reliable third-party credit information to aide in eligibility determination upon a financial assistance application request.

*The definition of 'household's gross income' includes the combined gross monthly income of all persons legally responsible for patient bill or balance.

Supporting documentation may include the following:

Patient must provide documents to support all sources of income, including but not limited to:

- Current year federal tax filing including all pages and schedules
- Non-filing verification letter from the IRS
- Most recent three (3) months wage stubs from their employer
- Current year Social Security Administration award letter
- Current year pension benefit award letter
- Veterans Affairs award letter
- Annuity award letter
- Unemployment benefits letter
- Child support award letter
- Alimony award letter or court documents
- Student financial aid award letter
- Short term disability benefits award letter
- Long term disability benefits award letter
- A "Basic Needs" letter that indicates how persons with no income are meeting their day-to-day basic living needs. "Basic Needs" letter must only be considered a secondary supporting document after the Financial Counselor or Clerk validates the information.

Household incomes based on the annual Federal Poverty Guidelines (FPG) will be eligible for Financial Assistance upon submission of an application as outlined below and in the FPG Financial Matrix:

Financial Matrix

Financial Assistance Category	Percentage Discount
0-300% Income as a Percentage of Federal Poverty Level	100%
301-400% Income as a Percentage of Federal Poverty Level	65%
Catastrophic Discount	100% of balances greater than 20% Gross Family Income

*** Minimum charity discount is based on AGB as described below and will be reviewed annually and revised if necessary to comply with IRS Section 501(r).*

AGB or Amounts Generally Billed represents the typical reimbursement amount of patients who have insurance covering their care. A patient eligible for Financial Assistance may not be charged more than AGB for emergency or other medically necessary care. Hospital facilities must calculate their AGB percentages at least annually by dividing the sum of the amounts of all its claims for emergency or other medically necessary care that have been allowed by the certain health insurers during a prior 12-month period divided by the sum of the associated gross charges for those claims. AGB has been determined using the Look-back method using Medicare fee-for service and all private health insurers paying claims to the hospital facility; as outlined in IRS Section 501(r)(5).

Determination for Financial Assistance

The hospital will make a determination based upon written information received from the patient, the patient's representative, or a third-party charity scoring vendor. The determination can be made at any time prior to the closure of the account. Hospital personnel will communicate this initial determination to a patient or the patient's representative. A subsequent determination can be made if patient provides sufficient documentation to meet eligibility criteria for a different level of financial assistance. A "Notice of Determination" letter will be sent to all applicants within 21 days of receipt of a completed application and supporting documentation. If additional information is required to process the application, patients/guarantors will be informed of those requirements and of their rights to appeal in the letter. Applicants will have 45 days to provide additional information or appeal the decision.

Financial Assistance determinations are valid for 12 months. Coverage will begin two years prior to Salem Health receiving the signed financial assistance application and end the last day of the twelfth month from which the approval is processed. Financial assistance will be applied to accounts with open balances within this coverage period. All prior patient payments will be reviewed for accuracy, and any credits generated by financial assistance will be refunded for amounts over $5. You may contact us to request a refund less than $5.

If Salem Health determines eligibility incorrectly (that the patient did not qualify for financial assistance for the services based on information provided by the patient), the hospital will pay the patient interest on the amount of financial assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such as legal expenses and fees, incurred by the patient in securing financial assistance based off the time of the incorrect determination.

Appeal Process for Financial Assistance

A guarantor/patient may submit a written request or provide supporting documentation to appeal the determination. Appeals can be made for up to 45 days from the date of the "Notice of Financial Assistance Determination" letter. A review by the hospital's Chief Financial Officer or a designee may also be requested. The appeal process will include a review of the financial assistance application and any new financial documentation provided.

To submit an appeal request/supporting documentation:

- By e-mailing: financialcounselors@salemhealth.org
- By faxing: 503-814-1998
- By mailing: Attn: Financial Counselor Team, PO Box 14001, Salem, OR 97309-5014
- By presenting In-Person to: Information Desk in Bldg A at Salem Health's main campus or at West Valley front desk in the lobby

Screening for Presumptive Eligibility

Salem Health will screen any patient/guarantor without public or private health insurance coverage, any patients/guarantors enrolled in a state medical assistance program, or any patient/guarantor that will owe the hospital $500 or more on a single statement, prior to them receiving a statement. Salem Health will screen all patients/guarantors prior to sending to collections.

Presumptive charity discounts are determined based on the Federal Poverty Guidelines (FPG) and Oregon House Bill 3076 as well as Oregon House Bill 3320 legislation. A charity scoring vendor is utilized to determine the patient/guarantor Federal Poverty Level (FPL) percentage. There is no negative impact to the patient's credit score in using the third-party software. Based on the result, the following adjustment will be applied to the patients/guarantors account prior to receiving a billing statement:

Income as a percentage of Federal Poverty Level	Percentage Discount
Less than or equal to 200%	100%
201% - 300%	75%
301%-350%	50%
351%-400%	25%

If the third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital will review existing patient data per OAR 409-029 (HB3320) to make a good faith effort to determine the patient's presumptive eligibility status, including, but not limited to:

(a) Existing patient records;
(b) Information routinely collected during patient registration or admission;
(c) Information voluntarily supplied by the patient;
(d) Previous financial assistance adjustments; and
(e) Existing eligibility for assistance programs. Examples include, but are not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), free lunch or breakfast programs, low income home energy assistance programs, or any other program which are means tested and would reasonably reflect the approximate patient household income.

Salem Health will send all patients, regardless of the outcome, a “Notice of Presumptive Eligibility” letter to provide the results if and what adjustment was made.

Catastrophic Discount

Catastrophic discounts are determined when evaluating financial assistance applications. If a patient’s medical expenses exceed 20% of gross family income, the hospital will waive the excess billing.

Family income is determined as provided below (**income considered available to pay patient’s medical expenses):**

1. The hospital will multiply the annual family income and assets by 20%.
2. The hospital will determine the patient’s allowable medical expenses based on eligibility criteria defined in this policy.
3. The Hospital will compare 20% of the annual family income to the total of the patient’s allowable medical expenses for twelve months. If the total of the allowable medical expenses is greater than 20% of the family income, then the patient meets the catastrophic discount qualification. The Hospital will limit patient liability for medical expenses to 20% of the family’s income. Amounts that exceed this limit will be eligible for discount. For Example: Family income of $70,000 per year and allowable medical expenses of $45,000. Twenty percent of the family’s annual income is $14,000; the family’s medical expenses of $45,000 exceed this amount. The family would therefore be eligible for a discount of $31,000.
4. The Catastrophic Discount is based on Annual income and annual medical expenses.
5. Catastrophic coverage is effective from oldest date of service per household and will end the last day of the twelfth month from which the approval is processed.
6. Catastrophic discount may supplement financial assistance coverage discount.

If a patient feels they may qualify based on subsequent patient bills or a change in financial status, an appeal may be submitted for reevaluation.

Communications to the Public

Information on the Hospital’s Financial Assistance shall be made publicly available in the following manner:

- Notices are posted in key areas of the Hospital, including Admitting, the Emergency Department, Outpatient Department registration areas, and Patient Financial Services.
- The Conditions of Admission Form informs the patient of their right to apply for financial assistance.
- Written information shall be available in English, Spanish, Russian and Vietnamese. The Hospital will provide the appropriate interpretation services for patients/guarantors who do not speak English.
- Front-line staff will be trained to answer financial assistance questions effectively and will direct any that cannot be answered to Financial Counselor’s in a timely manner.
- This policy will be posted on Salem Health’s web site. Written information about this policy will be made available upon request.
- All patient billing statements will include a notice that financial assistance is available and contact information if they want to learn more.

Emergency Medical Care

Salem Health has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act (EMTALA)) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Financial Assistance will not be implemented in contradiction of any state or federal regulations including, but not limited to, EMTALA.

Applicable Providers

Financial assistance determination will be applied to any balance(s) owed to Salem Health or employed providers of the Salem Health Medical Group. Non-employed providers rendering services within our facility are not required to honor our financial assistance determination.

Extraordinary Collection Activities (ECAs)

Section 501(r)(6) requires a hospital organization to make reasonable efforts to determine whether an individual is eligible for assistance under the hospital organization's financial assistance policy (FAP) before engaging in extraordinary collection actions (ECAs) against an individual. ECAs are defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that

- involve selling an individual's debt to another party,
- involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"),
- involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP, or
- require a legal or judicial process.

In accordance with our philosophy of "No Patient Harm is Acceptable to Us," Salem Health Hospitals and Clinics does not engage in Extraordinary Collection Activities against our patients.

Definitions – Insert N/A if not applicable
N/A
Equipment or Supplies - Insert N/A if not applicable – N/A
N/A
Form Name and Number or Attachment Name - Insert N/A if not applicable – N/A
Provider Participation https://www.salemhealth.org/about/financial-assist
Expert Consultants Position
N/A
References (Required for clinical Documents and within the last five years):
N/A
Related CBT's, Policy, Procedure or Epic Protocol Cross Reference Information – Insert N/A if not applicable
Salem Health and Salem Health West Valley Plain Language Summary Billing and Collections Policy Uninsured (Self-Pay) Discount Policy Financial Clearance Policy
Computer Search Words
Financial Assistance, Charity, Catastrophic, Presumptive, Prescreening
Is there a Regulatory Requirement? Yes
Yes, ORS, IRS 501(r), HB3076, HB3320

Review and Revision History		
History	Review or Revision	Date
Added presumptive charity discount from Other Self-Pay Discounts (now Uninsured (Self-Pay) Discounts policy. Added in prescreening process for presumptive eligibility. Added additional income sources. Edited appeal process details/options. Clarified hospital practices on Extraordinary Collection Activities. Rearranged the sections. Updated in accordance with HB3320.	Revision	07/2024
Updated financial/charity assistance coverage period from 6 months to 12 months. Added catastrophic discount from Other Self-Pay discounts policy. Updated Criteria of what is considered for income eligibility such as Cobra payments, non-liquid assets, ect. Removed Hawthorne address reference.	Revision	09/2022
The Financial Assistance Policy (FAP) has been updated to comply with the	Revision	01/2020

Oregon Association of Hospitals and Health Systems recommendations, IRS 501(r) requirements, in accordance with HB 3076. Specific changes include the following key points: 1. Revised verbiage highlighting submission of application for eligibility into Salem Health's Financial Assistance Policy 2. Added verbiage that "Salem Health may choose to apply additional Financial Assistance to past due accounts prior to collection activities when independent and/or additional sources indicate an inability to pay."		
Updated policy to reflect 3 year review cycle.	Revision	01/2018
The Financial Assistance Policy (FAP) has been updated to comply with Oregon Association of Hospitals and Health Systems recommendations, IRS 501(r) requirements, and recommended best practices. Specific changes include the following key points: 1. Formatted using current policy template 2. Revised threshold for 100% Financial Assistance from 200% of the Federal Poverty Level(FPL) to 300% FPL 3. Moved Catastrophic Discount and Uninsured Discount to Other Self-pay Discounts Policy 4. Added Workers Compensation and Third Party Liability to Screening Patients for Paying Funding Sources 5. Added Russian and Vietnamese translations to the English and Spanish versions of Financial Assistance documents 6. Added Emergency Medical Care section affirming compliance with EMTALA 7. Added contact Information including: website address, phone number, physical address, mailing address. 8. Added Application Period section 9. Added clarifying language to Eligibility Criteria section 10. Supporting Documentation section was updated to include Probate Estates determination 11. Financial Matrix was updated to current criteria 12. Added required language describing Amounts Generally Billed (AGB) methodology	Revised	12/2016
	Review	04/2015
The Financial Assistance Policy (FAP) has been updated to comply with Oregon Association of Hospitals and Health Systems recommendations, IRS 501(r) requirements, and recommended best practices. Specific changes include the following key points. 1. Removed Attachment A, Table for Determining Financial Assistance and embedded Financial Matrix table in body of policy. 2. Removed all other attachments from document 3. Removed the term 'Charity Care' from the document. This term has been replaced with the phrase 'Financial Assistance' throughout. 4. Modified the percentage of family income that is utilized as the threshold for 'collectable medical expenses' from 30% to 20%. Any allowable medical expenses greater than 20% of family income should qualify for 100% financial assistance 5. Modified the asset test to exclude any and all equity related to primary residence when performing asset test against total allowable medical expenses for determination of financial assistance. 6. Added language that denies Financial Assistance to patients who refuse to cooperate in applying for a viable funding solution found by Salem Health Financial Counselors 7. Added language stating that cosmetics and elective procedures that are not medically necessary will not be eligible for Financial Assistance.	Revised	04/2014
	Review	01/2014
	Revised	01/2013
	Revised	01/2012
	Revised	01/2011

	Review	10/2009
	Review	08/2006
	Review	05/2006
	Review	04/2006
	Review	03/2006
	Review	04/2005
	Review	07/2004
	Review	02/2004
	Review	02/2000
	Review	11/1997
	Review	07/1996
	Review	06/1995
New Policy	New	03/1994