BAY AREA HOSPITAL Policies and Procedures	
Title: Financial Assistance	BAH ID: BUSS_0040
Start Date: 3/1/2018	Approval/Reviewed Date: 7/6/2026

PURPOSE:

Bay Area Hospital is committed to providing charity care to Oregon residents who have healthcare needs and are uninsured, under-insured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

Consistent with our mission to improve the health of our community every day, Bay Area Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

POLICY:

Bay Area Hospital provides, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or government assistance.

This Financial Assistance Policy (FAP):

- Establishes eligibility criteria for financial assistance
- Describes how amounts charged to eligible patients are calculated
- Outlines the application process and required documentation
- Explains how the policy is publicized to the community
- Provides an explanation of how Amounts Generally Billed (AGB) are determined

Amounts Generally Billed.

Following a determination of financial-assistance eligibility, an individual will not be required to pay more than the Amounts Generally Billed (AGB) for emergency or other medically necessary care provided to individuals with insurance or government payer programs, covering that care. At Bay Area Hospital, the AGB is determined by the "look-back" method, which is calculated as follows:

A. The AGB is calculated by reviewing all past claims that have been paid in full to Bay Area Hospital for medically necessary care by Medicare fee-for-service together with all private health insurers paying claims to Bay Area Hospital, in the prior fiscal year period. This amount includes payments by insurance/government payers, and patient coinsurance, co-payments, and deductibles (collectively, “Payments”).

B. AGB Percentage:
   1. The AGB Percentage is calculated annually, at the close of the fiscal year, by dividing the Payments for claims paid to Bay Area Hospital during the fiscal year, by the sum of the associated Gross Charges for those claims.

2. The AGB Percentage is applied to all types of services received by self-pay individuals who qualify for financial assistance under this policy.

C. The AGB Percentage is calculated not later than the 120th day after the end of the fiscal year. The AGB percentage will be applied to all applicable financial assistance applications for the coming fiscal year.
D. For uninsured patients, the AGB Payment for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying Gross Charges for that care by the AGB Percentage.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Bay Area Hospital's procedures for obtaining financial assistance or other forms of payment, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow Bay Area Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient financial assistance.

Definitions.

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

Amount Generally Billed (AGB): The amounts generally billed for emergency or other medically necessary care to individuals who have no insurance covering such care, determined in accordance with IRS regulations.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service 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 includes unmarried parents.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes 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;
- Non-cash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses.

Financial Assistance (FA): means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. "Financial Assistance" does not include bad debt, contractual allowances or discounts for quick payment.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied, associated with the net payments received during the previous fiscal year.

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Resident: an individual who lives within the geographic boundaries of the State of Oregon.

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

Uninsured Discount: A standard reduction applied to all hospital encounters for uninsured patients.

Under-insured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities.

ELIGIBLE SERVICES AND FACILITIES

- **Services Eligible under this Policy.** The following healthcare services are eligible for FA discounts for residents of Oregon:

    1. Emergency medical services provided in an Emergency Department setting;
    2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
    3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at Bay Area Hospital's discretion.

- **Covered Facilities**
  Bay Area Hospital includes the following facilities and service areas:

  1. The main Hospital and Emergency Department,
  2. Bay Area Cancer Center,
  3. Women's Imaging Center,
  4. Bay Area Orthopedics Prefontaine Cardiovascular Center,
  5. Bay Area Hospital Wound Care/Hyperbaric Medicine Center.

- **Excluded Services or Facilities.** This policy does not apply to the following services or facilities that may also provide healthcare services as part of the services provided at Bay Area Hospital:
  1. Physicians and other healthcare professionals not employed by Bay Area Hospital, including but not limited to Emergency Department physicians and physicians/providers from clinics not owned by the Hospital.
  2. Referral laboratories, including but not limited to, PeaceHealth Lab, Genoptix, Mayo Clinic and Pathology Consultants.
  3. Services that are not medically necessary, such as cosmetic procedures, elective reproductive procedures or procedures of convenience.
  4. Services that are not part of emergency care.

Eligibility Criteria.

Eligibility is based solely on financial need and is not affected by age, gender, race, color, national origin, disability, social or immigrant status, sexual orientation, gender identity, or religious affiliation.

Income Requirement: Patients in families with income at or below 450% of the federal poverty level (FPL) for their family size are eligible.

Residency Requirement: Applicants must be residents of Oregon.

Coverage Period: FA approval covers current accounts and services for nine (9) months from the approval date. Bay Area Hospital will not request a new application during this period.

Current calendar year federal poverty levels are found on the Federal Register website.

Application Process and Documentation.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may:Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need; Include tax returns of the patient or patient's guarantor;Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring or household income); include reasonable efforts by Bay Area Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. Take into account the patient's available assets, and all other financial resources available to the patient.

   All personal, financial, and medical information collected during the financial assistance determination process shall be maintained in accordance with applicable privacy laws, including HIPAA (45 C.F.R. Parts 160 and 164) and Oregon identity theft protection laws (ORS 646A.600-628). Financial information collected for the purpose of determining eligibility shall be used solely for that purpose and shall not be disclosed except as required by law or with the patient's written authorization.

2. When to Apply

Financial assistance applications may be submitted:

- Before services are rendered (preferred for non-emergent care)
- At any point up to 240 days following the first statement mail date

Financial assistance is valid for nine (9) months from the approval date; however, at any time additional information relevant to the eligibility of the patient for FA discount becomes known, a new FA application may be required.

3. Required Documentation

All applicants must provide:

1. Proof of Income (Choose ONE):

- Three (3) months of consecutive pay stubs, OR
- Most recent annual tax return

2. Bank Statements: Two (2) full months of consecutive bank statements for all accounts. Bank statements are required IN ADDITION to proof of income and cannot be substituted for pay stubs or tax returns.

4. Application Review

Applications are processed within twenty-one (21) days of receipt of complete documentation. Applicants are notified in writing of the outcome.

Additional information for the application process is available through Customer Service at (541) 269-8131.

5. Presumptive Financial Assistance Eligibility.
Pursuant to ~~3320~~Oregon Revised Statutes 442.614 (codifying Oregon House Bill 3320), all uninsured patients, those enrolled in state medical assistance programs, or patients who may owe more than $500 are screened for presumptive eligibility using a third-party vendor before receiving a bill.

Important: This screening does not affect credit scores. Patients may not opt out of this screening per Oregon regulations.

The presumptive eligibility screening uses a soft credit inquiry conducted in compliance with the Fair Credit Reporting Act (15 U.S.C. §1681 et seq.) and Oregon consumer protection laws. No hard inquiry will be placed on the patient's credit report.

Patients screened will receive written notification of results. If a patient did not qualify or disagrees with the amount they qualified for, they may still submit a formal application with required documentation.

Presumptive eligibility may be granted based on:

- Participation in state-funded prescription programs, WIC, food stamps, or subsidized school lunch programs
- Homelessness or care from a homeless clinic
- Low-income/subsidized housing
- Qualified Medicare Beneficiaries with SMB or SMF benefits
- Deceased with no known estate
- Third-party vendor verification of household income below policy thresholds

6. Payments Expected from Patients. AGB adjustments for services eligible under this Policy will be made prior to the FA adjustment. The FA adjustment is calculated using a sliding fee

scale, in accordance with Eligibility Criteria, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Any uninsured discount that was previously posted will be reversed and replaced by the AGB adjustment.

7. Financial Assistance Discount Structure

FA discounts applied based on this sliding scale:

Family Income	% of FPL	Discount
$0 - 200% FPL	≤ 200%	100% waiver
201% - 300% FPL	201-300%	75% waiver
301% - 350% FPL	301-350%	50% waiver
351% - 400% FPL	351-400%	25% waiver
401% - 450% FPL	401-450%	AGB only for uninsured patients, no FA waiver

Note: Uninsured patients with income not exceeding 450% FPL are eligible for the AGB discount. Uninsured Patients not eligible for AGB or FA under this policy receive a 25% discount from Gross Charges.

8. Appeals Process:
Patients who disagree with a financial assistance determination may appeal to the Chief Financial Officer (CFO) or designee. Appeals should include:

- Explanation of the disagreement
- Any additional documentation that was missed or omitted during the initial determination

The CFO may consider the relationship between the amount owed and the patient's total assets and income, regardless of income level.

In accordance with ORS 442.614, which requires hospitals to provide patients with information about financial assistance determinations, patients who are denied financial assistance, in whole or in part, shall receive a written notice of the determination that includes: (a) the reason for the denial; (b) the amount of any partial discount approved; (c) information about the right to appeal; and (d) contact information for the appeals process.

9. Policy Communication
Bay Area Hospital publicizes this policy through:

- Patient bills and statements (including contact information and website address)
- Plain Language Summary with FA applications
- Hospital website (www.bayareahospital.org/Financial-Services)
- Posted notices in Emergency Department waiting areas, hospital clinics, admitting/registration departments, business offices, lobbies, and patient waiting areas
- Available in primary languages spoken by the population served

For Assistance: Contact Patient Accounts Department at (541) 269-8131 or visit www.bayareahospital.org/Financial-Services for a free copy of the full policy.

Important: Bay Area Hospital does not charge interest on medical debt owed by patients who qualify for financial assistance under this policy.

10. Relationship to Collection Policies.
Bay Area Hospital's Billing and Collection Policy (BUSS_0111) governs collection practices. For patients who qualify for FA and cooperate in good faith, the hospital:

- Offers extended payment plans
- Will not send unpaid bills to outside collection agencies
- Ceases all extraordinary collection activities (ECAs)

10.1 Extraordinary Collection Actions

Bay Area Hospital will not impose ECAs (wage garnishments, liens on primary residences, or legal actions) without first making reasonable efforts to determine financial assistance eligibility. Reasonable efforts include:

1. Validating the patient owes the unpaid bills and all third-party payment sources have been billed
2. Documenting that the hospital offered the opportunity to apply for FA and the patient has not complied
3. Documenting that a payment plan was offered but not honored

10.2 ECA Procedures

Before initiating any ECA, Bay Area Hospital will:

1. Refrain from ECAs for at least 120 days from the first post-discharge billing statement
2. Provide written notice about the Financial Assistance Policy (including Plain Language Summary and oral notification) at least 30 days before ECAs

3. Accept completed FA applications for at least 240 days from the first post-discharge billing statement or twelve (12) months after payment

Regulatory Requirements. In implementing this Policy, Bay Area Hospital management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

Patients not eligible for AGB or FA under this Financial Assistance Policy. Bay Area Hospital offers a discount of 25% from Gross Charges to uninsured patients not eligible for AGB or 'Hospital Bill Reduction (HBR) under this FAP.

Other discounts. Please see BAH Billing and Collections policy, BUSS_0111, for additional information.

RELATED POLICIES:

Billing and Collections BUSS_0111

REVIEW:

REVIEWED DATES: 03/01/2018, 05/30/2018, 10/30/2019, 12/27/19, 11/16/20, 01/13/21, 03/30/22, 1/23/23, 6/10/24

References:
Internal Revenue Code 501(r)
ORS 442.601, 442.610, 442.612, 442.614, 442.618