McKenzie Health
FINANCIAL ASSISTANCE PROGRAM

Watford City, North Dakota

Effective Date: 12.13.2019

Subject: Financial Assistance Policy

Administrative Policy/Procedures

Reviewed/Revised: 09.2023

Purpose

McKenzie Health (MH) recognizes, as a not-for-profit health care delivery system, its obligation to provide financial assistance to patients in need of such. MH is dedicated to a mission of public financial assistance through providing care for members of our society who benefit from its services without regard to race, sex, creed, national origin, or station in economic or social life. It is committed to making available, in such ways as to preserve human dignity and worth, the full resources of the health system to those persons unable to pay. At the same time, MH must operate its facilities in the most efficient and economical manner possible to assure a strong future financial position necessary for the replacement and expansion of facilities, payment of its debts, establishment of adequate reserves for emergencies, the provision of future technological developments, and needed medical services.

Policy

Under these principles, the Board of Directors of McKenzie Health is committed to the provision of financial assistance to patients who are in need of care, have selected MH for such care, and a determination has been made that the facility is the most appropriate facility for rendering such care of service and there is no other more suitable facility or program available to such patient where compensated care could be rendered.

It is necessary to adhere to an "open door" philosophy of furnishing adequate diagnostic and therapeutic services for emergencies to avoid claims of improper rejection, inappropriate transfers or lack or recognition of cases requiring immediate attention in the emergency room. MH conforms with existing EMTALA laws and provides treatment for emergency medical conditions. Further, this policy prohibits MCHS from engaging in actions that discourage individuals from seeking emergency medical care, such as demanding payment before receiving treatment for Emergency medical conditions or by permitting debt collection activities that interfere with providing emergency medical care.

Procedure

The following guidelines will be followed in providing financial assistance:

1) Financial assistance is provided in the following ways:
   a) Uncompensated Services
   b) Reduced Compensated Services
   c) Discount Services

2) Each request for financial assistance will be evaluated on its own merits utilizing established patient accounts procedures based on this policy. Evaluation of the need for a particular patient will likely include such factors as: a) income, b) family size, c) availability of other forms of reimbursement whether insurance, social programs or other financial resources, and d) the suitability of the facility for the patient's particular needs and whether a more appropriate facility is available at which some form of payment would be available. Requests for financial assistance may come from doctor's offices, clinics, clergy, board of directors, hospital administration and/or any other community-minded interested party. Each requestor will be required to fill out the MH financial assistance application unless the requesting party can show that a like form has been completed for the applicant.

3) All patients should be offered a financial assistance application at the time of registration and/or discharge from the facility. If this evaluation is not conducted until after the patient leaves the facility, or in case of outpatients or emergency patients, a financial counselor will mail a financial assistance application to the patient for completion. In addition, the hospital will provide a plain language summary of the financial assistance policy to the patient with all billing statements and communications within the first 120 days (about 4 months) following the first billing statement.

4) Uninsured patients and patients will not be charged for emergency or other medically necessary care at rates higher than the "amounts generally billed" to third-party payers. The use of gross charges to such patients is prohibited. For purposes of this policy, MH uses the "look back" method to determine the amounts billed.

5) Uncompensated/Reduced Compensation Services will be limited to those patients whose family income is below two hundred and forty-eight percent (248%) of the national poverty guidelines. The prevailing national poverty guidelines will be the basis for determining eligibility and can be requested in writing, free of charge from the hospital or at www.acf.hhs.gov

6) Uncollectible accounts, accounts that were not reviewed by financial counselors at time of admission, and/or questionable collectible accounts may qualify for financial assistance during the collection process if they meet the above criteria.

7) In the following situations (known as presumptive financial assistance), a patient is deemed to be eligible for 100% reduction of charges:
   a) If the patient is currently eligible for Medicaid but was not eligible on a prior date of service. The facility will apply its financial assistance policy retroactively for the previous six months.
   b) If the patient states they are homeless and the facility, through its own diligence, does not find any contrary evidence.
   c) If the patient is mentally or physically incapacitated and has no one to act on his/her behalf.

8) In the event of a patient's death, the family of the deceased patient will be given the opportunity to complete an application for financial assistance which will be processed according to this Policy.

9) MH will provide any member of the public or state governmental entity with a copy of its financial assistance policy and application upon request, free of charge. The policy can be requested by calling the McKenzie Health Patient Financial Services Office at 701-444-8606 or by writing to the Patient Financial Services Office, 709 4th Ave. NE, Watford City, North Dakota 58854. The policy will also be available on the hospital website at https://www.mckenziehealth.com/about/billing/ and all points of registration within the facility and will be provided by mail to anyone requesting it at no charge. A plain language summary of the policy will be available in these locations, too. Notices of this Financial Assistance Policy will also be included on billing statements.

10) This Financial Assistance Policy applies only to MH Hospital/Clinic charges and does not include charges not billed by MH. This policy only applies to emergency and medically necessary services and does not apply to elective procedures. See attached list of providers covered by this policy.

11) This Policy will be applied equally to all patients regardless of payer source. Applications that do not meet the criteria set forth in this Policy may, in extraordinary circumstances, be approved by the Chief Financial Officer.

McKenzie Health

Administration of Financial Assistance Policy

PURPOSE

To ensure that requests for uncompensated service, reduced compensation services, and discount services are handled consistently, accurately, and timely.

POLICY

1) MH provides uncompensated, reduced compensation or discount services to all eligible persons unable to pay.

2) Eligibility for uncompensated services is limited to persons whose verifiable family income is equal to or less than one hundred and seventy-five percent (175%) of the current poverty income guidelines as established by the Department of Health and Human Service.

3) Eligibility for reduced compensation services is limited to persons whose verifiable income is greater than 175% of the current poverty income guidelines but not greater than 248% of the current poverty income guidelines as established by the Department of Health and Human Services.

4) Accounts placed with a third-party collection agency are eligible for benefits if they meet appropriate guidelines. If approved, the account will be pulled from the agency and reinstated for charitable consideration.

5) Acceptable income verification includes:
   A. Most recent Federal income tax return, if application is presented within the first quarter of the year.
   B. Most recent Federal income tax return, plus employers' verification of earnings for current year, if application is presented after the first quarter of the year.
   C. For self-employed individuals, most recent Federal income tax return and a copy of all current quarterly returns.

6) MH reserves the right to pursue collections activity on the unpaid balance if the patient or representative does not meet the agreed upon schedule.

7) MH sends account statements to patients on a monthly (30 day) cycle. The first statement is sent to the patient 30 days (about 4 and a half weeks) after discharge. If no payment is received, a second statement is issued 30 days (about 4 and a half weeks) after the first

statement. If no payment is received, a final notice is mailed to the patient stating that payment must be received within 30 days (about 4 and a half weeks) of notice to prevent assignment to a collection agency. Accounts with no payment within 30 days (about 4 and a half weeks) of final notice are reviewed by MH Patient Financial Services Office staff to ensure all reasonable efforts to determine eligibility for financial assistance have been met before assignment to a collection agency. MH will make reasonable efforts to orally notify the patient about its financial assistance policy and how they may obtain assistance with the process before the account is place with an agency. Any collection agency utilized by MH will agree to refrain from abusive collection practices. "Reasonable efforts" includes notifying individuals of this Financial Assistance Policy upon admission, discharge, and in written and oral communications with the individual concerning his or her bill. Extraordinary collection efforts include filing lawsuits, placing liens on residences, reporting adverse information to consumer credit reporting agencies or credit bureaus, arrests, body attachments, and similar activities.

RESPONSIBILITY

Patient Financial Services Associates

PROCEDURE

1. Process Steps
   - A. Patient or representative requests financial assistance.
   - B. Patient or representative completes application. If the applicant cannot provide the required financial information, they may call the Patient Financial Services Office to discuss other evidence that may be provided to demonstrate eligibility.
   - C. Patient Financial Services reviews application for completeness within thirty (30) days of receipt. If it is not properly completed, the patient or representative is contacted for needed information. If needed information is not provided within a reasonable time, the application is denied.
   - D. Patient Financial Services reviews income verification documentation. If such documentation is not present or does not meet required guidelines, the patient or representative is contacted for such documentation. If the necessary documentation is not provided, the application is denied within a reasonable time.
   - E. Patient Financial Services reviews services provided to verify eligibility. If the service is covered by other third-party payers, the patient or representative is contacted, and these avenues are pursued. If the question of extraordinary circumstances arises, the account is referred to appropriate management for determination of eligibility. Based upon management decision, the account is either returned for processing or denied. If denied, payment options are discussed with the patient or representative.
   - F. Patient Financial Services reviews to determine if an account is placed with a collection agency. If the account is being serviced by an agency, the patient may obtain a financial assistance application and collection efforts will be suspended while determination is being made.
   - G. Patient Financial Services compares family income to current Department of Health and Human Services poverty guidelines. If the family income is at or below 175% of said guidelines, the account is discounted 100% and notification is sent to the

patient or representative. Determination of eligibility will be provided within approximately 60 days (about 2 months).

H. If the family income exceeds 175% of the Department of Human Services poverty guidelines, Patient Financial Services compares family income to the reduced compensation schedule as outlined in procedure #2. If the family income meets the requirements, the patient or representative is notified of acceptance, details of discount Procedure is explained, payment plan is established, the account is discounted appropriately and notes detailing discount are placed on the patient's account record.

I. If the account is ineligible for reduced compensation benefits, the patient or representative is notified of denial. A payment plan with an appropriate discount is established.

J. If an individual has applied for and received financial assistance at MH within the previous six (6) months and the individual's financial situation has not changed, the individual will be deemed to be eligible for financial assistance without having to submit a new application for financial assistance.

K. All applications for financial assistance will be maintained for one (1) year.

2. Reduced Compensation Service Schedule – see attached

RELATED MATERIALS

1. Department of Health and Human Services Poverty Guidelines
2. Reduced Fee Discount Table

DISTRIBUTION

Patient Financial Services
Administration

McKenzie Health

McKenzie Health Financial Assistance Sliding Scale Balance Reduction Program

			Percentage of reduction based on income and assets						
2023 FEDERAL POVERTY GUIDELINES			**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**Percent of reduction**
BASED ON FAMILY SIZE			**175%**	**188%**	**200%**	**218%**	**230%**	**248%**	**Percentage over poverty guidelines**
Number in household	1	14,580	25,515	27,410	29,160	31,784	33,534	36,158	
Number in household	2	19,720	34,510	37,074	39,440	42,990	45,356	48,906	
Number in household	3	24,860	43,505	46,737	49,720	54,195	57,178	61,653	
Number in household	4	30,000	52,500	56,400	60,000	65,400	69,000	74,400	
Number in household	5	35,140	61,495	66,063	70,280	76,605	80,822	87,147	
Number in household	6	40,280	70,490	75,726	80,560	87,810	92,644	99,894	
Number in household	7	45,420	79,485	85,390	90,840	99,016	104,466	112,642	
Number in household	8	50,560	88,480	95,053	101,120	110,221	116,288	125,389	

Add $5,140 for each additional person over 8

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines