PATIENT FINANCIAL SERVICES

FINANCIAL ASSISTANCE PROGRAM

Department: Patient Financial Services/Central Business Office **Policy No.** CSF.001

Responsibility: Customer Service/AR Specialist

Frequency: Daily

Forms and Documents: FAP Application/Letters/

Referenced Procedures: CICP Policy

Definition:

1. **Medically Necessary Care** means health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
   a. in accordance with generally accepted standards of medical practice;
   b. clinically appropriate in terms of type, frequency, extent, site and duration; and
   c. not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.

2. **Emergent services** are deemed to be Medically Necessary.

Policy:
Valley View (VVH) is committed to providing health care for all community members who are suffering from illness and do not have a means to pay for their care. The Patient Financial Services Department (PFS) will administer the Financial Assistance Program (FAP) following the American Hospital Associations guiding principles:

- Treat all patients equitably, with dignity, with respect, and with compassion.
- Serve the emergency healthcare needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all of the medically necessary (non-elective) care they receive; and
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospital doors open for all who may need care in a community.

This policy establishes a framework for the PFS Department to identify patients that may qualify for financial assistance, provide financial assistance for Valley View accounts, and administer financial assistance in accordance with the hospital's policies and procedures. There will be no discrimination based on race, color, creed, religion, gender, sexual orientation, citizenship, age

disability or national origin.

Scope: The financial assistance program covers medically necessary services provided by Valley View. VVH hospital reserves the right to exclude or limit non-urgent, elective or not medically necessary services from the FAP.

FAP will provide benefits as a last resort. All other payment options including but not limited to private insurance, Medicare, Medicaid, CHP, liability, Crime victims, CICP must be explored for eligibility and secured where eligible prior to the application of FAP. Eligible accounts include Valley View final billed accounts with balances. Co-pay and deductible balances may be eligible unless precluded by law or contractual agreements.

Accounts turned to bad debt remain eligible for FAP consideration as long as the complete application and documentation are submitted prior to 240 days from the date of the initial account statement, under which circumstances any Extraordinary Collection Actions (ECA's) will be suspended. ECA's include: reporting debts to a credit bureau; selling patient debt to a third party; authorization for possible legal action by a collection agency for which the account has been assigned; and requiring payment prior to delivery of care. ECA's will not be initiated by VVH or by an outside collection agency acting on behalf of VVH until at least 120 days after the initial guarantor account statement has been mailed.

MEASURES TO PUBLICIZE THE FINANCIAL ASSISTANCE POLICY:
Notice of the hospital's FAP availability is posted conspicuously in public areas throughout the hospital. The availability of FAP is printed on each patient account statement that is mailed or electronically delivered. A summary of available Federal, state and hospital provided programs; along with a financial assistance application is automatically mailed to every self-pay account guarantor with a hospital balance greater than $500. FAP applications and program summaries are also publicized and available at facility registration areas or the hospital's website at https://www.vvh.org/financial/financial-assistance/ . In order to maximize community outreach, this information is provided in English and Spanish.

The availability of FAP is also advertised periodically throughout the year by the VVH Public Relations and Marketing staff. A plain language FAP summary is provided to SP guarantors at registration and is provided (by mail or electronically) with the Final Notice letter at least 30 days prior to an account being referred to an outside collection agency. The FAP plain language summary is available upon request or on the hospital website in English and Spanish languages.

Procedure:
The Directors and Managers of Valley View Hospital's Patient Financial Services department (PFS) will administer the VVH Financial Assistance Program. They will ensure that each employee is competent and knowledgeable in all matters related to the Financial Assistance Policy.

Records relating to application and determination of the program will be maintained at least 7 years.

Application/Notification
Application for benefits under this Program will be accepted in all PFS departments and forwarded to the Financial Counselors. Applicants may apply in person, by mail or by appointment with the Financial Counselors.

Policies and procedures will be in place to readily determine eligibility. The applicant will be notified in writing of approval or denial within 30 days of the completed application. The notification of denial will include the reason for the denial.

Request for Reconsideration
An applicant denied under the program has the right to appeal that decision in writing with the PFS Director, within 30 days of the receipt of the denial.

Failure to Cooperate
The applicant is responsible for providing all the required information within 14 days of the application date. Failure to furnish the requested information in the time requested may result in a Program denial. The patient may, if denied for lack of documentation, appeal or reapply with complete documentation. Misrepresentation or falsification of information will be cause for the FAP to be withdrawn retroactively and currently.

Duration of Eligibility
Benefits under this Program will not exceed twelve (12) months. The term of benefits granted will be subject to the financial and medical circumstances of the applicant. The hospital reserves the right to re-evaluate the recipient's eligibility if there is a change in income during this period. The hospital reserves the right to re-evaluate eligibility when hospital care is required in order to determine the recipient's eligibility for other aid or third party coverage.

Eligible participants will receive cards to be presented when registering for Valley View services to document eligibility.

Special Circumstances
Relatives or guardians may apply for an incapacitated individual.

Presumed Eligibility

Patients are presumed to be eligible for the Valley View Financial Assistance Program, without income verification or request, in the following situations:

- CICP eligible patients that receive services at a non-CICP participating VVH Physician Practices will receive the applicable FAP discount on eligible charges according to their CICP income level rating.
- Patient may not be CICP*, CHP+* or Colorado Medicaid eligible for this date of service but has been or became CICP*, CHP+* or Colorado Medicaid eligible during a period of time not to exceed 6 months before the date of service, or
- Patient or surviving spouse becomes CICP*, CHP+* or Colorado Medicaid eligible after the date of service. If CICP*, CHP+* or Colorado Medicaid eligibility occurs more than 240 days after the initial guarantor account statement, an FAPAE

adjustment will only apply to any unpaid balance and no prior account payments will be eligible for guarantor refund.

- Patient is eligible for CICP*, CHP+* or Medicaid but incurs a non-covered service, or
- Patient is eligible for out-of-state Medicaid and Valley View does not participate in that state's Medicaid program, or
- Patient is deceased and has left no estate.

Income Determination

Gross personal and business income will be used to determine eligibility. Calculation of gross income will be consistent with the CICP program guidelines. Income for all members of the household and legally responsible parties not in the household will be considered in the determination of income levels.

Income includes, but is not limited to, wages and salaries, disability benefits, retirement or pension benefits, Social Security, rental income, oil and gas royalties, unemployment compensation, VA benefits, child support, alimony, interest, dividends, workers' compensation, support-in-kind, and other information as requested.

Income will be indexed to current published Federal Poverty Guidelines. Family units consist of parents with children living in a nuclear family or an adult child supporting a parent within a single household. Multiple family units may be sharing a household and will be counted separately, including adult children living with parents.

Income Verification

Valley View Hospital will request that the patient provide verification of income.

Income may be verified through an IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, Social Security, workers' compensation, unemployment compensation, determination letters, or bank statements.

A credit report will be run on all applicants and the results reviewed in light of the financial picture presented in the application. Discrepancies noted will be addressed with the patient before final approval for the discount.

Resources

Household net assets cannot exceed $20,000 or three (3) times the amount owed to Valley View, whichever is lower. The applicant may spend down his assets to the $20K and then reach eligibility status. Assets include cash, stocks & bonds, trusts, annuities, life insurance policy with cash value, asset value in homestead that exceeds $500,000 plus any other real property and its appraised value, and vehicles in greater number than the number of drivers in the household.

Determination of Guarantor's Responsibility

Federal Poverty Guidelines	Discount

Level 1	Presumed eligibility	100%
2	≤ 199%	100%
3	200% to 299%	80%
4	300% to 399%	50%
5	400% to 500%	50%

Total payment due on all accounts during the 12-month FAP eligibility period will be capped at no more than 10% of the gross annual household income.

Amount Generally Billed (AGB)

VVH limits the amount charged for care it provides to any individual who is eligible for assistance under its Financial Assistance Policy (FAP). The amounts billed for emergency and medically necessary medical services to patients eligible for Financial Assistance are calculated based on the look-back method and will not be more than the AGB to individuals with insurance covering such care. VVH is using the "look-back" method based on actual past claims paid to the hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals). VVH calculates an AGB percentage for each clinic and Hospital and uses that average percentage for all entities, which is 52.09%. The AGB percentage will be reviewed and updated by the 31st of December after the 12 month period the hospital facility used in calculating the AGB percentage. The 12 month period is measured from October through September; therefore the AGB percentage will be updated by December 31st every year for VVH.

The Financial Assistance Policy is adopted and approved by the Valley View Hospital Board of Directors this 22nd day of January, 2019.

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Brian Leasure,
Chair, Valley View Hospital Board of Directors

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PREPARED BY: Sarah Moore
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REVIEWED/REVISED BY: Bill Wentzel, Sarah Moore, Charlie Crevling
REVISIONS APPROVED BY: Valley View Hospital Board of Directors