VETERANS MEMORIAL HOSPITAL
Waukon, Iowa 52172
563 568-3411

Policy

Subject	Financial Assistance
Index Number	25.100
Section	Revenue Cycle
Subsection	N/A
Category	Finance
Contact	Roxane Schleich
Last Revised	1/28/2020

References

Self-Pay Billing & Collection Policy
EMTALA - Collection of Financial Information
Federal Poverty Guidelines, US Department of Health and Human Services
IRS Notice 2015-46 and 29 CFR §§1.501(r) (4) – (6)
26 CFR 250 (31 Dec 2014) p78954-79016

Applicable To

This policy applies to all individuals who seek and receive healthcare services from our hospital and that incur a financial obligation to Veterans Memorial Hospital City of Waukon IA, dba Veterans Memorial Hospital (VMH).

Detail

VMH's mission is to enhance the lives of those we serve by providing an exceptional healthcare experience with compassion.

In service to this mission, VMH is committed to providing emergency and medically necessary healthcare services to patients regardless of their insurance status or ability to pay. Patients qualifying for assistance under this policy will receive a discount for care received from qualifying VMH providers. VMH shall operate in accordance with all federal and state requirements for the provision of emergent health care services, including screening, treatment, and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

In order to manage its resources responsibly and to allow VMH 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, payment programs and collection functions.

Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy's application procedures and those of public benefit or coverage programs that may be available to cover the cost of care.

Implementation

DEFINITIONS

The following definitions are applicable to all sections of this policy.

Amount Generally Billed (AGB): The amount generally billed is the expected payment for emergency or medically necessary services from patients, and/or a patient's guarantor. For qualifying patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method described in §1.501(r)-5(b) (3) of the Internal Revenue Code. The Look Back Method will be based on actual past claims paid to VMH by Medicare together with all private health insurers paying claims. The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts for co-insurance, co- payments and deductibles will be included in the numerator along with the Medicare payment, together with all allowed claims from private health insurers. The gross charges for said claims will be included in the denominator.

Application Period: The period during which applications will be accepted and processed for financial assistance. The application period begins on the date the care is provided and ends on the 240th day after the date that the first post-service billing statement is provided.

Discounted Care: Financial assistance that provides a discount, for eligible medical services provided by VMH, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes between 200-300% of the Federal Poverty Level and assets at or below three times the Federal Poverty Level.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part; or
4. With respect to a pregnant woman who is having contractions:
    a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Income: An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parent or parents and/or step-parents, or caretaker relatives. Family income is determined using the Census Bureau definition, which include the following

income when computing federal poverty guidelines:

1. 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 stipends, alimony, child support,
2. Noncash benefits (such as food stamps and housing subsidies) do not count;
3. Determined on a before-tax basis;
4. Excludes capital gains or losses

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at http://aspe.hhs.gov/POVERTY/.

Financial Assistance: Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for emergency or medically necessary care provided by VMH.

Free Care: A 100% waiver of patient financial obligation for eligible medical services provided by VMH for eligible patients, or their guarantors, with annualized family incomes at or below 200% of the FPL with assets below the equivalent of 300% of the FPL.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

Gross Charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Homeless: As defined by the Federal government, and published in the Federal Register on December 5, 2011 by HUD: An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

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

Medicare Fee-For-Service (FFS): Health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 USC 1395c – 1395w-5).

Payment Plan: A payment plan that is agreed to by both VMH and a patient, or patient's guarantor, for

out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

Presumptive Eligibility: Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need.

Private Health Insurer: Any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.

Qualification Period: Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to all eligible accounts incurred for services received six months prior to application date.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured discount, for eligible services provided by VMH under this policy, at the time that the undiscounted charges are rendered.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance available to cover the cost of a patient's healthcare expenses.

Underinsured Patient: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by VMH.

ELIGIBLE SERVICES

Services eligible under the VMH financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:

1. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a patient's condition.
2. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.
3. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as "covered items or services."
4. Services of providers employed by VMH are covered under this policy.

Services not eligible for financial assistance include the following:

1. Elective procedures not medically necessary, as well as services typically not covered by

Medicare or defined by Medicare or other health insurance coverage as not medically necessary.

2. Services received from care providers not employed by VMH (e.g. private and/or non-VMH medical or physician professionals, ambulance transport, etc.). Patients are encouraged to contact these providers directly to inquire into any available assistance and to make payment arrangements. See Appendix 3 for full listing of providers not covered under this policy.
3. Deductibles and coinsurance associated with medically necessary services provided to patients out-of-network as defined by their insurers.

ELIGIBILITY CRITERIA

Financial assistance will be extended to uninsured and underinsured patients, or a patient's guarantor, who meet specified criteria, as defined below. These criteria will assure that this financial assistance policy is consistently applied across VMH. VMH reserves the right to revise, modify or change this policy as necessary or appropriate.

Payment resources (insurance available through employment, Medical Assistance, Indigent Funds, Victims of Violent Crimes, etc.) must be reviewed and evaluated before an account is considered for financial assistance to assure that VMH resources are prudently managed in providing financial assistance. If a patient appears to be eligible for other assistance, VMH will refer the patient to the appropriate agency for assistance with completing the necessary applications and forms. Applicants for assistance are required to exhaust all other payment options as a condition of their approval for financial assistance.

Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by VMH as possible sources of payment for care, may be denied financial assistance. Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

Patients, or patient's guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial that was received within the previous six (6) months of applying for VMH financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.

The criteria to be considered by VMH when evaluating a patient's eligibility for financial assistance include family income, assets, and medical obligations. VMH's financial assistance program is available to all patients meeting the eligibility requirements set forth in this policy, regardless of geographic location or residency status. Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws.

Financial assistance will be offered to eligible underinsured patients, providing such assistance is in accordance with insurer's contractual agreement. Financial assistance is typically not available for patient co-payment or balances after insurance in the event that a patient fails to comply reasonably

with insurance requirements such as obtaining proper referrals or authorizations. Generally, out of network balances may be reviewed on a case by case basis. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account, will be expected to utilize account funds prior to being granted financial assistance. VMH reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of VMH.

FINANCIAL ASSISTANCE

Based on an assessment of an applicant's family income, assets, and medical obligations, eligible applicants may receive the following assistance.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured discount at the time that the undiscounted charges are rendered. This applies to patients with no coverage for payment from health care insurance and/or other third party payors.

Patients, or patient guarantors, granted the uninsured discount, are not precluded from applying and qualifying for additional financial assistance provided herein.

Full Free Care: The full amount of VMH charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 200% of the current federal poverty level with assets below the equivalent of 400% of the FPL threshold.

Discounted Care:A sliding scale discount will be provided for VMH charges for services covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income and asset values are greater than 200% but less than or equal to 300% of the current federal poverty level. Discounts will be provided, according to the following schedule, based on the family income and assets of the patient, or the patient's guarantor:

1. Family income above 200% FPL but equal to or less than 225% FPL are eligible to receive a 75% discount on the patient balance due.
2. Family income above 225% FPL but equal to or less than 250% FPL are eligible to receive a 50% discount on the patient balance due.
3. Family income above 250% FPL but equal to or less than 275% FPL are eligible to receive a 25% discount on the patient balance due.
4. Family income above 275% FPL but equal to or less than 300% FPL are eligible to receive a 15% discount on the patient balance due.

Payment Plans: Payment in full is expected, for balances due, within 30 days of the initial patient statement. If unfeasible for a patient, or guarantor, to pay in full within this timeframe, a payment plan may be used to extend payment on any remaining balance. A reasonable payment plan will be established between VMH and the patient. The term of the payment plan will be based on the applicant's outstanding medical bills, family income and any extenuating circumstances. If approved, the

plan will be interest-free.

Patients are responsible for communicating with VMH anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

PRESUMPTIVE ELIGIBILITY

VMH understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by VMH to determine whether a patient's account is uncollectible and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

1. Patients or guarantors who have declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off.
2. Patients or guarantors who are deceased with no estate in probate.
3. Patients or guarantors determined to be homeless.
4. Accounts returned by the collection agency as uncollectible due to any of the above reasons.
5. Patients or guarantors who qualify for State Medicaid programs, will be eligible for assistance for any cost-sharing obligations associated with the program or uncovered services.

VMH understands that certain patients may be non-responsive to VMH's application process. Under these circumstances, VMH may utilize other sources of information to make an individual assessment of financial need. This information will enable VMH to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, and will not be included in the hospital's bad debt expense.

EMERGENCY MEDICAL SERVICES

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations. VMH may request that patient cost-sharing payments (i.e. co-payments) be made at the time of service, provided such requests do not cause a delay in a medical screening examination or necessary stabilizing care for an identified emergency medical condition (See Policy 12.061).

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

The amount generally billed is the expected payment from patients, or a patient's guarantor, eligible for

financial assistance. For qualifying uninsured patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method.

The Look Back Method will be based on amounts allowed under Medicare together with all private health insurers paying claims to VMH. The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-For-Service together with all private health insurers paying claims. The gross charges for said claims will be included in the denominator. The AGB will be calculated annually. The percentages will be applied by the 120th day after the end of the calendar year used by VMH to calculate the AGB percentage(s).

If you have any questions regarding the AGB percentages, please contact the CFO at (563) 568-3411. Information on AGB will be provided free of charge.

Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under VMH financial assistance policy.

APPLYING FOR FINANCIAL ASSISTANCE

Eligibility for financial assistance will be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, VMH may seek additional information.

Reliable evidence to support the need for financial assistance is required.

The following income documentation is required from patients, or their guarantors, to determine eligibility:

1. Copy of the Federal tax return, and all attached Schedules, from the most recent tax year
2. Current Proof of Income (copy of most recent pay stubs or other documentation)
3. Proof of other income, including unemployment, workers' compensation, child support, alimony, trust income, veteran's benefits, social security, rental income, self-employment, etc.
4. Current Bank Statements

The following asset documentation is required from patients, or their guarantors, to determine eligibility:

1. Checking accounts
2. Savings accounts
3. Money market accounts
4. Certificates of deposit
5. Annuities
6. Non-retirement investment accounts
7. Retirement accounts, including pensions
8. Real estate
9. Other assets

Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement.

If an application is incomplete, or there has been a request for additional information, the application will remain active for thirty (30) days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the thirty (30) day timeframe, the application will be denied.

During the period in which the fully completed Financial Assistance Application (FAA) is being reviewed, there will be a stay of all collection proceedings. The FAA will be documented in the patient record or scanned and the account will be noted. The normal billing process is to continue while the FAA is reviewed and considered. If a complete, conforming FAA is approved by the appropriate VMH representative, this will be noted in the patient's file and the account balance will be written-off to the appropriate code. Financial assistance applications are to be submitted to the following office:

Veterans Memorial Hospital
ATTN: CFO
40 1st Street SE
Waukon, IA 52172
(563) 568-3411

If denied financial assistance, the patient or patient's guarantor may re-apply any time there has been a change of income or status.

ELIGIBILITY DETERMINATIONS, APPEALS AND DISPUTE RESOLUTION

Patients must be notified of the decision in writing regarding their FAA within forty-five (45) days of submitting a completed application. An applicant determined eligible for 100% financial assistance will be refunded payments in excess of the amount determined owed by the patient or guarantor on the accounts for which they have been granted assistance under the VMH financial assistance policy. Refunds apply to excess payments of $5.00 or more. In accordance with this policy, financial assistance is generally not extended for co-payments or balances after insurance when a patient fails to obtain proper referrals or authorizations, or if such assistance is not in accordance with insurer's contractual agreement, therefore such payments received will not be refunded.

Patients may appeal this decision in writing within thirty (30) days of receiving notification to:

Veterans Memorial Hospital
ATTN: CFO
40 1st Street SE
Waukon, IA 52172
(563) 568-3411

Appeals must be filed within thirty (30) days of the date of the original decision. The CFO will review the appeal for further consideration. Decisions of the CFO will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, VMH will grant financial assistance for a period of six (6) months. Financial assistance will also be applied retroactively to all unpaid bills for eligible accounts incurred for services received six (6) months prior to application date. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on the VMH financial assistance policy and instructions on how to contact VMH for assistance and further information, as well as information on payment options, will be posted in hospital and clinic registration and admitting locations, and in the hospital emergency department. This information may also be obtained from Patient Account Representatives.

The VMH financial assistance policy, application and a plain language summary of the policy will be available on the system's website at www.veteransmemorialhospital.com. This information is also available, free of charge, by contacting (563) 558-3411. If you need help in completing the financial assistance application, you may call Patient Business Services at (563) 568-3411 to talk with a Patient Account Representative.

REGULATORY REQUIREMENTS

VMH will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that VMH track financial assistance provided to ensure accurate reporting.

RECORD KEEPING

VMH will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

POLICY APPROVAL

The VMH financial assistance policy has been provided to and approved by the VMH Board on January 28, 2020. This policy is subject to periodic review. Any substantive changes to the policy must be approved by the VMH Board.