	Valley Regional Hospital Patient Accounting	
	Policy Date Issued	11/27/2007
	Policy Date Reviewed	2/08, 2/10, 2/14
	Policy Date Revised	02/09, 2/11, 3/12, 3/13, 4/14, 2/15, 3/16, 9/16

Policy: Financial Assistance

Policy Statement/Purpose: The Financial Assistance Program has been established to provide financial assistance relief to those who are unable to meet their financial obligation to Valley Regional Hospital. This policy outlines the following with respect to all emergency or other medically necessary care provided by Valley Regional Hospital and Valley Regional Owned Physician Clinics:

- eligibility criteria for financial assistance;
- method by which patients may apply for financial assistance;
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care; and
- measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be changed from time to the extent required by applicable law.

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

Charity Care: Healthcare services that have or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: 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.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), parents claimed on adult child's claim on a tax return.

Family Income: Family Income is determined by using the following income sources:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, rents, royalties, income from estates, trusts, alimony, child support, food stamps, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as fuel assistance and housing subsidies) do <u>not</u> count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family and is claimed as a dependant on the head of household's tax return, it includes the income of all family members (Non-relatives, such as housemates, do not count).

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

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

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

- 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,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part, or
- with respect to a pregnant woman:
    - inadequate time to effect a safe transfer to another hospital before delivery, or
    - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Medically necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Procedure:

A. Services Eligible Under this Policy. The following healthcare services are eligible for charity:

1. Medically necessary services.
2. Preventative care services
3. Some elective services, evaluated on a case-by-case basis at the hospital's discretion. Please see **Exhibit A** of excluded services, located at the end of this policy.

B. Eligibility for Charity. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government

health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Eligibility – Patient eligibility will be based on the following information:

A. Patient must be a resident of New Hampshire or Vermont, except instances where presumptive charity guidelines are used.
B. All inpatient and outpatient accounts are eligible for charity with the exception of Priority Care services.
C. Crisis stabilization services rendered in the Emergency Room which are considered non-covered by VT Medicaid, when performed by a LCSW, will be considered eligible for charity assistance.
D. If a patient has exceeded their maximum number of allowed Emergency Visits under Medicaid, Medicaid eligibility is verified and the balance can then be adjusted to Financial Assistance at 100%.
E. The application includes:

    1) Income disclosure from all sources (see above).
    2) Number of dependents.
    3) A copy of the most recent federal income tax forms, employment pay stubs for the last 2-3 pay periods, a copy of social security disclosure/check (or bank statement showing deposit of funds from US Treasury), statement of pension balance (if available), federal w-2 form.
    4) 2-3 most recent bank statements from all accounts.

F. Deductible and co-insurance amounts are eligible for charity benefits if financial circumstances warrant.

Note that individuals with the financial capacity to purchase health insurance are required 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. Likewise, applicants must demonstrate compliance with the requirements to apply for qualified health plan coverage through the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs. Exceptions to this requirement must be approved by the Revenue Cycle Director and/or Chief Financial Officer and may include:

- Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
- Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

C. Determination of Financial Need:

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 reasonable efforts 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; and
- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
- Due to Regulation 501(r)(6) limitation on the use of liens, applicants who own their own home will not be required to apply for Medicaid prior to approval of financial assistance.

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle.

3. Eligibility may be determined in one of three ways:
   1. Standard Application Process
   2. Presumptive Eligibility
   3. ED Quick Application: A one-time approval for patients who complete the pre-qualification application and are determined to meet the financial criteria as stated in this policy
      a. Patients who reside outside of Valley Regional's catchment area (more than 30 miles away)
      b. Have not been seen at Valley Regional or a VRH owned practice
      c. Sign an attestation that the information that they have provided in the pre-qualification application is true and accurate to the best of their ability.

D. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for charity care, the hospital can use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down, QMB);
7. Participation in other state Medicaid programs for which the hospital is not considered a participating provider;
8. Dates of service rendered prior to any Medicaid coverage period, or if timely filing requirements were not met due to non-disclosure by the patient;
9. Low income/subsidized housing is provided as a valid address; and
10. Patient is deceased with no known estate.

E. Program Administration: The Financial Assistance Program will be administered according to the following guidelines:

1. The application information, along with the federal income tax forms, will be reviewed and verified by patient accounts personnel. The applicant must return applications to Valley Regional Hospital within ten-(10) days of receipt. Failure to comply may result in denial.
2. If the patient/guarantor qualifies for 100 percent (100%) charity, he/she will be notified within thirty-(30) days of receipt of the application, and the account will be written off per procedures.
3. If the patient/guarantor qualifies for a reduction in liability, he/she will be notified of payment arrangements made for the non-write-off amount.
4. Falsification of application or refusal to cooperate will result in denial of charity benefits.
5. Valley Regional Hospital will maintain complete confidentiality of all information received.
6. Financial Assistance will be extended past the expiration date to include hospital stays that begin while covered under the Financial Assistance Program.
7. Patient's receiving financial assistance must reapply at 6-month intervals.

Patients living on fixed incomes such as social security will need to reapply each year. The patient or family member must complete the financial assistance application *except* if a NH Health Access Network (NH HAN) approval has been given by another hospital; however, we reserve the right to request a copy of the full application from the partner hospital in the event of an audit.

Valley Regional Hospital will not impose extraordinary collections actions, such as sending to collections or other legal actions, for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Revenue Cycle Director and/or the Chief Financial Officer. **Exhibit B** (Credit and Collection Policy) defines the actions Valley Regional Hospital may take in the event of nonpayment, including extraordinary collection actions and reasonable efforts to determine eligibility for assistance. A copy of the Credit and Collection Policy is available at the end of this document, or can be requested at the Patient Accounting Offices, or can be mailed to you by calling (603) 543-5693.

F. Program Guidelines:

Valley Regional Hospital determines eligibility using the national Federal Poverty Income Guidelines, which are published on a yearly basis.

You may be granted Financial Assistance for any date of service before your effective date with Vermont or New Hampshire Medicaid. The hospital will apply current Medicaid guidelines to show proof of household income.

To be eligible for 100% approval for the Valley Regional Hospital Financial Assistance Program, family income must be less than or equal to 200% of the Federal Poverty Income Guidelines.

To be eligible for 75% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 201%-225% of the Federal Poverty Income Guidelines.

To be eligible for 50% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 226%-250% of the Federal Poverty Income Guidelines.

To be eligible for 25% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 251%-275% of the Federal Poverty Income Guidelines.

If your family exceeds 275% of the Federal Poverty Income Guidelines, you are not eligible for assistance through the Valley Regional Hospital Financial assistance Program.

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied.

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Valley Regional Hospital applies a discount against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay. The discount is based on the "Look Back" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn't apply to any copayments, coinsurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

Communication Regarding the Financial Assistance Policy to Patients and Within the Community:

Information regarding financial assistance from Valley Reginal Hospital includes this policy, a plain language summary of this policy, an application form and information concerning Valley Regional's credit and collection policies and procedures, will be available to the public and to VRH patients through at least the mechanisms described below:

- On the Valley Regional Hospital website at www.vrh.org
- Posted in patient care areas,
- Available in other public spaces as determined by VRH,
- Included on the back of each patient statement, and
- Provided in the primary languages spoken by the population serviced by VRH

Providers Accepting VRH Financial Assistance:

Please see **Exhibit C** for a listing of both providers who accept financial assistance and those that do not.

Valley Regional Hospital
Financial Assistance Program
2016 Guidelines

It is the policy of Valley Regional Hospital to provide financial assistance to those patients who are unable to pay for all or part of the cost of their care that is not covered by other sources of funding. Valley Regional Hospital's Financial Assistance Program is a program that assists uninsured and under-insured patients who meet specific income, geographical and Valley Regional Hospital Guidelines.

Valley Regional Hospital's Financial Assistance Income Guidelines Per Year

Household Size	100% Federal level	VRH 100% = 200% FPL	VRH 75% = 225% FPL	VRH 50% = 250% FPL	VRH 25% = 275% FPL
1	$ 11,880.00	$ 23,760.00	$ 26,730.00	$ 29,700.00	$ 32,670.00
2	$ 16,020.00	$ 32,040.00	$ 36,045.00	$ 40,050.00	$ 44,055.00
3	$ 20,160.00	$ 40,320.00	$ 45,360.00	$ 50,400.00	$ 55,440.00
4	$ 24,300.00	$ 48,600.00	$ 54,675.00	$ 60,750.00	$ 66,825.00
5	$ 28,440.00	$ 56,880.00	$ 63,990.00	$ 71,100.00	$ 78,210.00
6	$ 32,580.00	$ 65,160.00	$ 73,305.00	$ 81,450.00	$ 89,595.00
7	$ 36,730.00	$ 73,460.00	$ 82,642.50	$ 91,825.00	$ 101,007.50
8	$ 40,890.00	$ 81,780.00	$ 92,002.50	$ 102,225.00	$ 112,447.50

ea add'l person $4,160.00

In addition to having it's own Financial Assistance Program, Valley Regional Hospital is a participating provider with the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to health care for uninsured and under-insured children and adult residents of the State of New Hampshire only.

NH Health Access Network Income Guidelines Per Year (Please note this program has been suspended in light of coverage through the Exchange & NH Health Protection Program – aka expanded Medicaid)

Household Size	100% Federal level	NHHAN 100% = 125% FPL	NHHAN 75% = 150% FPL	NHHAN 50% = 175% FPL	NHHAN 25% = 200% FPL
1	$ 11,880.00	$ 14,850.00	$ 17,820.00	$ 20,790.00	$ 23,760.00
2	$ 16,020.00	$ 20,025.00	$ 24,030.00	$ 28,035.00	$ 32,040.00
3	$ 20,160.00	$ 25,200.00	$ 30,240.00	$ 35,280.00	$ 40,320.00
4	$ 24,300.00	$ 30,375.00	$ 36,450.00	$ 42,525.00	$ 48,600.00
5	$ 28,440.00	$ 35,550.00	$ 42,660.00	$ 49,770.00	$ 56,880.00
6	$ 32,580.00	$ 40,725.00	$ 48,870.00	$ 57,015.00	$ 65,160.00
7	$ 36,730.00	$ 45,912.50	$ 55,095.00	$ 64,277.50	$ 73,460.00
8	$ 40,890.00	$ 51,112.50	$ 61,335.00	$ 71,557.50	$ 81,780.00

ea add'l person $4,160.00

Effective 4/1/16-3/31/17

Exhibit A - Excluded services – The following services are excluded from coverage of financial assistance:

Elective cosmetic procedures
Hearing Aids and repairs
DOT Examinations
Sports Physicals
Gait Analysis
Dry Needling

Exhibit B – Credit and Collections Policy

Exhibit C – Providers accepting or not accepting VRH Financial Assistance:

Providers accepting: All employed providers of VRH including all VRH Owned Physician Clinics, including:

Asscociates in Medicine
Valley Primary Care
Valley Regional Orthopedics
Valley Regional Surgical Associates
Valley Regional Urology
Valley Regional Primary Care Physicians in Newport
Valley Regional Womens' Health

The following independent providers also accept VRH Financial Assistance:

Valley Family Physicians
Valley Radiologist – restrictions apply
John Tomlinson (Anesethesiology) – partial coverage available
Dartmouth Hitchcock – VRH will share an applicant's application and supporting documentation upon request.

Providers Not accepting: Any area independent provider group.

Keady Family Practice
Charlestown Family Medicine

Please note that Valley Regional Hospital will, ***upon applicant's request***, share their application and supporting documentation with any hospital that the applicant requests.