VAIL VALLEY SURGERY CENTER
POLICY AND PROCEDURE

TITLE: CHARITY CARE PROGRAM	Page **1** of **7**
DEPARTMENT: BUSINESS OFFICE	POLICY # 3027

PURPOSE

To define Charity Care (as distinguished from bad debt), and to establish consistent procedures that outline how to determine a patient's (or a patient's parent(s)/guardian as applicable. "Patient" is used hereinafter to refer to the patient and/or parent/(s) guardian) ability to pay and a patient's potential eligibility for financial assistance.

Definitions

- Extraordinary Collection Actions – Actions taken by the hospital against an individual related to obtaining payment of a bill for care covered under the hospital's financial assistance policy that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer reporting credit agencies or credit bureaus. Filing a claim in a bankruptcy proceeding is not deemed to be an extraordinary collection action.
- Gross Charge – An established price, listed on the surgery center's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any contractual allowances, discounts or deductions.
- Household Unit – one or more persons who reside together and are related by birth, marriage, or adoption (i.e. parents and children who are filed as dependents on their tax return); or reside together and share joint assets, such as credit cards, bank accounts or real estate. Patients over the age of 18, such as adult children living with their parents, siblings or friends are not considered part of the household unit unless such persons are legally obligated for the debts of the patient.
- Income – Income includes salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment compensation, business income, pensions and annuities, farm income, rentals & royalties, inheritance, strike benefits, and alimony payments. Income is also defined as payments from the state for legal guardianship or custody.
- Plain Language Summary – A statement written in clear, concise and easy to understand language notifying individuals that Vail Valley Surgery Center offers financial assistance program and describing the program.
- Uninsured – A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of Workers Compensation, automobile insurance, or other insurances as determined and documented by VVSC.

POLICY

It is the policy of Vail Valley Surgery Center (VVSC) to provide financial counseling services to patients which includes a determination of a patient's ability to pay and potential eligibility for financial assistance (FA) through the Charity Care Program. Written documentation regarding the program should be maintained, reviewed, and updated annually. Conspicuous notice of charity care program shall be noted on every patient billing statement sent out from VVSC, which shall include notice about and how to get a copy of the financial assistance program policy.

Eligibility Requirements
Financial assistance qualification is considered based on one of the following types of eligibility:

1. Catastrophic Financial Assistance Eligibility—Per Episode of Care

- Applicants will be reviewed for Catastrophic Financial Assistance. Any amount over 20% of the annual household income, will be discounted.

2. Uninsured/Underinsured Eligibility

- Eligibility is based on applicant's income and assets
- To be considered for financial assistance an account balance must be equal to or greater than $500 or the FPL must be 200% or below

An application for FA must be submitted to be considered. If an application for FA qualifies under the income analysis, it must also meet the assets analysis to be eligible for FA.

a. Income Analysis

FA applications will be considered for individual or household unit income up to 400% of the federal poverty level ("FPL"). Income will be based on the applicant's most recent full tax year and the two most recent pay stubs. Employment status shall be considered when determining income levels. If at the time of the application, the applicant has been unemployed for a continuous period of more than 90 days and is receiving or eligible to receive unemployment benefits, prior income will not be considered in the income analysis. See Financial Assistance Sliding Scale (Appendix A):

b. Household Net Assets ($250,000.00)

When evaluating net worth, the following are excluded:

- Retirement plan accounts including IRA, 401k and 403b balances, below $500,000.
- Irrevocable trusts for burial purposes
- Federal and state administered college savings plans.

Business ownership and self-employment will be used to determine net worth on an individual basis.

Residency Requirements:

Financial assistance applications are available to all individuals that are:

- US citizen OR living in the US on a work VISA and reside in Eagle or Lake County for 6 months or more.
- Patients must be able to verify continued residency. A Colorado driver's license or Colorado ID showing an Eagle or Lake County address is required.

Exceptions to the residency requirement may be made by the Director of Business Operations or Administrator.

Certain elective services are not covered. Examples of elective services are teeth extractions, voluntary sterilizations, cosmetic surgery, experimental procedures.

Account balances that have been written off to bad debt are not eligible for Charity Care.

VVSC may use third party solutions to evaluate the patient's ability to pay based on an evaluation of recent credit extension and current available credit.

Guidelines for determining eligibility for financial assistance shall be applied consistently. VVSC shall not discriminate against patients applying for financial assistance based on race, color, national origin, sex, age, or disability.

The Financial Assistance Application Form (see form in Appendix B) shall be completed for all requests for financial assistance, and be submitted to a financial counselor. All requests for financial assistance must be signed by either the patient or authorized patient representative attesting that the information provided on the application is true and accurate.

When possible, VVSC shall screen each uninsured patient for eligibility for financial assistance.

Verification of Information Provided

Data used to determine eligibility for financial assistance should be verified to the extent practical in relation to the amount of financial assistance involved and the significance of an element of information in the overall determination. In all cases, the minimum verification shall include:

- Income, by reviewing sources such as a W-2, recent pay stub showing year-to-date totals, tax returns, unemployment statements, notices of social security and retirement benefits.
- An individual's net worth, by reviewing applicable supporting documentation (bank statements, investment statements, loan documents). It should be specified to the patient that assets could be considered as a possible source of payment.

If a financial assistance application is received during the Application Period (as defined below) and deemed incomplete, a written notice to the patient/guarantor will be sent within 15 days of receipt of the

incomplete application requesting the missing information be returned within 30 days of the date of the notice.

Review and Approval

Financial assistance must be documented on the Financial Assistance Application Form and approved by the financial counselor for amounts up to $2,500, the Director of Business Operations for amounts of $2,501 to $15,000, and by the Administrator for any higher amounts. Documentation of receipt, review and approval of the Financial Assistance Application Form shall be made by the financial counselors. At the time a decision is made for the approval or denial of an account for financial assistance, a letter shall be sent to the patient or responsible party as notification of the decision made. The letter, which generally shall be sent within 60 days of receiving the Financial Assistance Application Form, should be typewritten and should include the following information:

- Patient name
- Account number(s)
- Current outstanding balance of the account(s)
- Dollar amount or number of days stay granted for financial assistance
- Any balance which will be due on the account (if only a portion of the account is covered by financial assistance)
- Appeal process if request for financial assistance was denied

Upon approval of a financial assistance request, VVSC shall:

- Provide a billing statement to the patient showing the amount due, and how the amount due was arrived at, if any amount is due from the patient;
- Include all patient due amounts covered by the Financial Assistance Policy in the approval.
- Refund any payments made by the patient within days of the application in excess of amounts approved for financial assistance in accordance with the separate patient refund policy.

Patients may be eligible regardless of whether they have other insurance or were eligible to purchase insurance but elected not to purchase it. If the patient has insurance, all insurance benefits should be exhausted and only the patient liability portion is eligible to receive Charity Care.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting reevaluation (see appeal form in Appendix C). The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred to and reviewed by the Director of Business Operations within thirty (30) days of being received. If the Director of Business Operations feels additional input is needed in making a determination, the Administartor will be asked to review and assist with the determination.
If subsequent to review and determination of financial assistance it is found that the information relied on was in error, the following shall occur:

- If the corrected information in a prior denial of financial assistance now qualifies the patient for financial assistance, the patient will be notified that they are now eligible for financial assistance and the account(s) will be processed as described above.
- If the corrected information in a prior granting of financial assistance now disqualifies the patient for financial assistance, the patient will be notified that they are not eligible for financial assistance and payment is expected on their account(s).

The completed Financial Assistance Application Form and all related supporting documentation will kept on file and retained for 7 years.

VVSC may initiate or resume **extraordinary collection actions**, i.e., transfer account to a collection agency, against an individual who has submitted an incomplete financial assistance application and who has not provided the missing information necessary to complete the application 30 days after VVSC provides written notice that the additional information is required.

Accounting for and Tracking Financial Assistance Data

Approved financial assistance, along with any write-offs as a result of applying average generally billed amounts, shall be classified and recorded as charity care, because, by definition, charity care is "demonstrated inability to pay". The amount of charity care provided will be reported separately in the monthly financial statements.

Financial Counselors will be responsible for maintaining the following data monthly:

- Number of applications for financial assistance received
- Number of individuals granted financial assistance
- Number of appeals received
- Percentage of appeals reviewed with a reversed decision

Finance shall calculate the cost associated with the services approved for financial assistance for disclosure in the annual financial statements and tax return.

Frequency of Re-Evaluation of Eligibility

Once a patient has been approved for financial assistance the patient will be deemed to have approval for services as follow:

- Catastrophic—
    - Medically necessary services provided per episode of care
- Income and assets—

- Medically necessary services provided within one year from date of approval for Eagle and Lake County Residents

If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, VVSC will not reverse the amount of financial assistance granted.

Charge Limitation

Individuals who qualify for financial assistance, or individuals with a primary residence (live in for over 6 months out of the year) in Eagle or Lake County that are **uninsured** and have an individual or family net assets of $250,000 or less and have applied for financial assistance but do not qualify, will not be charged more than the Average Generally Billed (AGB) amount (effectively the amounts VVSC collects from insurance companies). This amount will be determined by doing a yearly look-back of payment percentages from commercial payers (including copayments and deductibles paid by patients). AGB amounts shall be calculated by the 45th day after December 31st each year for the 12-month period ended December 31st. The billing statement to a patient may state the standard **gross charge**, but must show a write-off to get to the AGB if the write-off is greater than the discount otherwise being provided under VVSC's financial assistance policy. The difference between VVSC's standard **gross charge** and the AGB or financial assistance discount amounts will be accounted for as a charity care write-off. This policy is not required to be approved by the Board each year for updates to the AGB.

The AGB limitation applies to all individuals eligible for assistance under VVSC's FAP, without specific reference to the individual's insurance status.

AGB discount amounts calculated for fiscal year 2021 (January 1, 2020 through December 31, 2020) is 26%.

Medicaid Coverage

Medicaid copays not paid at the time of service will be billed to the patient. If unable to collect the copays by the end of the Application Period, the copays will be written off as a charity write-off. Patients who have Medicaid coverage and have balances due for service dates up to twelve months prior to the effective date of their coverage, will be granted 100% financial assistance on such balances without further review or documentation from the patient.

Appendix A

Sliding Scale Financial Assistance

Federal Poverty Level	200%	201-250%	251-300%	301-350%	351-400%
Household Size	Household Income Maximum				
1	25,760	32,200	38,640	45,080	51,520
2	34,840	43,550	52,260	60,970	69,680
3	43,920	54,900	65,880	76,860	87,840
4	53,000	66,250	79,500	92,750	106,000
5	62,080	77,600	93,120	108,640	124,160
6	71,160	88,950	106,740	124,530	142,320
7	80,240	100,300	120,360	140,420	160,480
8	89,320	111,650	133,980	156,310	178,640
Each Additional Family Member	9,080	11,350	13,620	15,890	18,160
Discount %	100%	80%	60%	40%	30%

NOTE: The AGB amount is the maximum amount that can be collected from patients that qualify for financial assistance or as otherwise allowed under this policy, regardless of the percentages shown above

The FPL for the current year can be obtained from the following website:

https://familiesusa.org/product/federal-poverty-guidelines

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INPUT AND/OR APPROVAL BY: VVSC Administrator, VVSC Director of Business Operations

APPROVED BY: VVSC Governing Council

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