
Purpose

As a non-profit organization, Vail Health, including Vail Health Diversified Services (collectively referred to as "Vail Health"), provides financial assistance to patients that may not have sufficient financial resources to pay for services.

Procedure

Communication of Financial Assistance Policy to Public

At each patient registration/admission interaction, and in all oral communications regarding the amount due that occur during the Notification Period (defined below), Vail Health shall advise the patient of the availability of Vail Health's financial assistance program, where to obtain additional information about eligibility, and how to apply. In addition, all public areas of the hospital, including at a minimum, points of check-in/registration areas for the hospital and hospital owned physician practices, patient waiting areas, as well as emergency department locations, shall have written paper materials regarding the financial assistance program and such information shall be offered to every inpatient and surgery patient.

Applications shall be located in a conspicuous place easily viewable and accessible by patients.

Vail Health's full financial assistance policy, along with a **plain language summary** (see Appendix A) shall be available on the hospital's website and patient portal with an ability to download and print the financial assistance application without any special hardware or software. The **plain language summary** must include the physical location within the hospital where patients can obtain a copy of the financial assistance policy and application, as well as the contact information of the specific office or department of Vail Health that can provide assistance with the financial assistance process. Vail Health shall translate financial assistance program documents, including the full financial assistance policy and applications, into Spanish.

Conspicuous notice of financial assistance availability shall be noted on every patient billing statement sent out from Vail Health, which shall include notice about and how to get a copy of the financial assistance program policy. The Notification Period is defined as the period during which the hospital must notify an individual about its financial assistance policy in order to have been deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Notification Period begins the first date that an episode of care is provided and ends the 120th day after Vail Health provides the first billing statement to the patient for the care. Vail Health must provide patients with written notice within 30 days of the end of the Notification period that the Notification Period is ending, and make reasonable efforts during the Notification Period to orally notify an individual about Vail Health's financial assistance program, including how the individual may obtain assistance with the financial assistance process.

Written notice shall include a description of any extraordinary collection actions that Vail Health intends to initiate. Efforts are deemed reasonable if Vail Health notifies the patient about its financial assistance program as described above, and follows the requirements for incomplete and complete financial assistance applications described in the Review and Approval section below. Written notification shall be deemed to have been provided at the date when mailed.

Vail Health's financial assistance program shall be widely publicized within the community in a manner that will reasonably reach those who are most likely to require financial assistance. This shall generally be accomplished by information about the program being periodically included in the local newspaper, and at Mountain Family Health Centers locations. In addition, information about Vail Health's financial assistance program shall be displayed (in both English and Spanish) in a conspicuous public display of noticeable size throughout all Vail Health locations where visitors are likely to see it. Written materials about our financial assistance program shall include non-discrimination language as appropriate.

Eligibility Requirements

Financial assistance is provided on a sliding scale basis, based on the following eligibility criteria:

- Individual or **household unit income** – up to 350% of the federal poverty level ("FPL"). Employment status shall be considered when determining income levels. Prior **income** levels may not meet the established poverty level guidelines; however, recent unemployment should be considered as the current source of income.

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- Individual or **household unit** net worth – up to \$250,000 (excluding net worth in primary homes of up to \$500,000). When reviewing net worth, other financial obligations, such as high medical bills, should be considered. Patients with high net worth that would otherwise disqualify them for financial assistance may be considered for eligibility if they have, for example, **uninsured** catastrophic health care costs that would significantly reduce their net worth.

Financial assistance is available to all individuals for emergent or urgent care regardless of where they live, and to individuals with a primary residence (live in for over 6 months out of the year) in Eagle County for all services provided by Vail Health, except elective services such as teeth extractions, voluntary sterilizations, cosmetic surgery and routine eye exams. Financial assistance is also available for individuals obtaining services from Vail Health that are offered at Vail Health locations outside of Eagle County for individuals with a primary residence in the county in which Vail Health services are provided. Guidelines for determining eligibility for financial assistance shall be applied consistently. Vail Health shall not discriminate against patients applying for financial assistance based on race, color, national origin, sex, age, or disability. In determining a patient's eligibility for financial assistance, Patient Financial Services ("PFS") and Vail Health's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Colorado health insurance exchange.

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, Vail Health 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.

Financial assistance of \$5,000 or more may include documentation supporting other financial obligations, such as living expenses, child support, and other health care bills. 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. Such notice shall include contact information for the facility or department that can provide assistance with the financial assistance process, a copy of the plain language summary, and information about potential **extraordinary collection actions** Vail Health may initiate. Any **extraordinary collection actions** in progress at the time an incomplete application is received must be suspended. Such collections may be initiated or resumed if a completed application is not received or after a request for additional information is not received after 30 days of notification. Patient Access and PFS will create a tracking document on the shared drive to monitor all applications.

The required supporting documentation described above may be waived in lieu of information Vail Health obtains through use of technology tools or other methods of presumptive assumptions as predictive measures of a patient's ability to pay and financial status. Financial assistance may not be denied based on information that is not specifically listed as required in the Financial Assistance Application Form.

Review and Approval

Financial assistance must be documented on the Financial Assistance Application Form and approved by the financial counselor for amounts up to \$999, the Director of Patient Financial Services for amounts of

\$1,000 to \$9,999, and by either the Chief Executive Officer or Chief Financial Officer 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 30 days of receiving the Financial Assistance Application Form, should be typewritten and should include the following information:

- Patient name
- Account number(s) for both hospital and physician accounts
- 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)
- Detail of arrangements to pay for any remaining balance on the account after financial assistance is provided
- Appeal process if request for financial assistance was denied

Upon approval of a financial assistance request, Vail Health shall:

- If any amount is due from patient, provide a billing statement to the patient showing the amount due, how the AGB (see definition in the Charge Limitation section below) was determined, and how the amount due was arrived at;
- Include all patient due amounts covered by the Financial Assistance Policy in the approval.
- Refund any payments made by the patient within 60 days of the application in excess of amounts approved for financial assistance in accordance with the separate patient refund policy; and
- Take reasonable measures to vacate or reverse any **extraordinary collection actions**, such as lifting a lien and removing adverse information on credit reports.

Approval of financial assistance will be denied if Medicaid or other health and welfare eligibility application is refused by patient if Vail Health reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with Vail Health in reviewing affordable insurance coverage options offered through the Colorado health insurance exchange. If the patient chooses not to purchase insurance coverage through the Colorado health insurance exchange and does not qualify for Colorado Medicaid, then the patient will be required to submit a Financial Assistance Application Form.

Assignment to Vail Health of all insurance payments, including liability settlements, is required, up to the amount of gross charges on a patient's bill.

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 Patient Financial Services within thirty (30) days of being received. If the Director of Patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer 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 be scanned into the patient's accounts in the patient billing system.

Notwithstanding the above, Vail Health must accept and process a financial assistance application for a period up to 240 days after Vail Health provides the first billing statement to the patient (defined as the Application Period). Vail Health 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 any earlier than the later of:

- 30 days after Vail Health provides written notice that the additional information is required, or
- The last day of the Application Period

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 rendered by Vail Health for six months subsequent to approval, except as follows:

- There is a change in financial status as described below. After six months, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.
- In Vail Health's reasonable estimation, patient can afford to purchase insurance coverage through the Colorado health insurance exchange and the period for which such coverage can be obtained is in less than six months from the time financial assistance is granted by Vail Health.

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, Vail Health will not reverse the amount of financial assistance granted.

Changes in Patient Financial Status

Patients may have unexpected changes to their ability to pay that occur after the time service is rendered and after either a payment plan or financial assistance has been granted. If a patient agreed to a payment plan (see separate Patient Payment Plans policy) that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job or had some other financial hardship occur and became unable to pay under the plan, the patient may apply for financial assistance under the guidelines of this policy.

Alternatively, if a patient who was granted financial assistance but subsequently experiences a positive change to his or her ability to pay for the services rendered, Vail Health may bill the patient for the services rendered and advise the patient of their change in status.

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 County that are **uninsured** and have an individual or family net worth of \$250,000 or less (excluding net worth in primary homes of up to \$500,000) and have applied for financial assistance but do not qualify, will not be charged more than the lesser of the lowest negotiated rate from a private health plan, or the Average Generally Billed (AGB) amount (effectively the amounts Vail Health collects from insurance companies and Medicare). This amount will be determined by doing a yearly look-back of payment percentages from commercial payers and Medicare (including copayments and deductibles paid by patients). Separate payment percentages will be calculated to develop separate AGB amounts for inpatient, outpatient, and physician practice/clinic services. AGB amounts shall be calculated by the 45th day after October 31st each year for the 12-month period ended October 31st. The billing

statement to a patient may state the standard hospital **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 Vail Health's financial assistance policy. The difference between the hospital'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.

AGB amounts calculated for fiscal year 2017 (November 1, 2016 through October 31, 2017) are as follows:

- Inpatient – 21%
- Outpatient – 31%
- Physician practice/clinic – 66%

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.

Other

Generally the determination that a patient stay qualifies for financial assistance will be made upon pre-admission, admission or as soon as possible thereafter. A patient financial counselor is available at both the Vail main campus and the Edwards campus to assist patients with settlement of their accounts including applications for financial assistance, government sponsored programs and referral to outside resources. However, in some cases qualification for financial assistance may be made after rendering services and in some circumstances even after rendering of the bill. Collection efforts, including the use of a collection agency, are part of the information collection process and can appropriately result in identification of eligibility for financial assistance.

Please refer to Appendix D for a list of providers, other than the hospital facility itself, that are and are not covered by Vail Health's financial assistance policy.

Vail Health's separate Billing and Collections policy may be obtained on Vail Health's website at www.vailhealth.org.

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 hospital'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.

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- Plain Language Summary – A statement written in clear, concise and easy to understand language notifying individuals that Vail Health 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 insurance as determined and documented by the hospital.

Health Care Financial Management Association Principles and Practices Board Statement 15, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts.

American Hospital Association Hospital Billing and Collection Practices Statement of Principles and Guidelines May 5, 2012

Patient Protection and Affordable Care Act

IRS Notice 2014-2 issued on December 30, 2013

IRS CFR Parts 1,53, and 602 (issued December 29, 2014)

Colorado SB14-50, Hospital Financial Assistance

CRS 25-3-112

Affordable Care Act Section 1557

Also refer to the policy entitled "Billing and Collection Practices"