VAIL HEALTH

FINANCIAL ASSISTANCE POLICY

PURPOSE

As a non-profit organization, Vail Health, including Vail Health Clinics, provides financial assistance to patients who may not have sufficient financial resources to pay for services.

Eligibility is based on household income and assets. Vail Health provides financial assistance on a sliding scale to individuals with an annual household income up to 500% of the annually published Federal Poverty Guidelines (FPG).

The Vail Health financial assistance program is only applicable for Vail Health medical bills. Services conducted by a different medical provider other than Vail Health (even if performed in a Vail Health facility) fall outside of the policy scope and are not eligible for Vail Health financial assistance. Examples include Vail Valley Surgery Center, The Steadman Clinic, Vail-Summit Orthopaedics & Neurosurgery, Colorado Mountain Medical, an anesthesiologist physician, etc.

Our financial counselors are available to assist patients going through the financial assistance application process and can be reached Monday through Friday, from 8:00 am to 5:00 pm at (970) 477-3116. The financial counselors can also be reached in the following ways:

- **MAIL:** PO Box 40,000 Vail, CO 81657 | Attn: Financial Assistance Department
- **IN PERSON:** (call to set up an appointment)
  Vail Health Hospital - Admissions Deptartment 181 W Meadow Dr, Vail, CO 81657
  Edwards Pavilion 320 Beard Creek Rd., Edwards, CO 81632

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 and 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 Health offers a 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 the hospital.

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 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 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 this time period to orally notify an individual about the Vail Health 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 qualification is considered based on one of the following types of eligibility:

1. Presumptive Eligibility

There are instances when a patient may qualify for financial assistance, however a full application is not on file. Certain circumstances provide sufficient information to qualify the patient for financial assistance without the fully completed application, and are deemed presumptively eligible. Presumptive eligibility may be determined on the basis of the individual life circumstances that include one or more of the following:

- Homelessness: Self-attestation required
- Deceased with no estate: Verification of no estate with Clerk's office in the county of death
- Medicaid eligibility: Not active for a date of service prior to the Medicaid effective date
- Mental incapacitation: No one to act on patient's behalf. Documentation required*
- Enrollment in assistance programs for low income individuals: Proof of eligibility is required.
  * Examples include:

    Women, Infants & Children program (WIC)

    Free Lunch Program

    Low Income Energy Assistance Programs

    Low Income Housing Assistance

    Medicaid QMB eligibility (Medicaid pays Part B premium)

* An application is required for these programs to establish eligibility with documentation of the above which supports eligibility.

2. Catastrophic Financial Assistance Eligibility (per episode of care)

Applicants who are not qualified based on the presumptive eligibility will be reviewed for catastrophic financial assistance. Any amount over 20% of the annual household income, after average generally billed is applied, will be discounted.

3. 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 Federal Poverty Level must be 200% or below

ASSETS ANALYSIS

If deemed not qualified for presumptive eligibility, an application for financial assistance must be submitted to be considered. If an application qualifies under the income analysis, it must also meet the assets analysis to be eligible for financial assistance.

1. Income Analysis

Financial assistance applications will be considered for individual or household unit income up to 500% of the federal poverty level. 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 chart on the Vail Health website, **www.vailhealth.org/financialassistance**.

2. Assets

Individual or household unit net worth up to $250,000 (excluding primary home residence). This policy provides for the protection of a minimum of $10,000 in cash and investments, one automobile per licensed family member living within the applicant's household, retirement plan accounts including IRA, 401k and 403b balances, irrevocable trusts for burial purposes, and/or federal and state administered college savings plans. All other assets will be considered available for payment of healthcare expenditures. 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 for emergent or urgent medical care (non-elective) who meet one of the following conditions:

- US citizen
- Living in the United States on a work Visa and reside in Eagle or Lake County for six months or more
- Undocumented and reside in Eagle or Lake County for six months or more

DETERMINING ELIGIBILITY

Financial assistance is also available for individuals obtaining services from Vail Health facilities outside of Eagle County for individuals who meet the above residency requirements. Elective services are not covered. Examples of elective services include teeth extractions, voluntary sterilizations, cosmetic surgery and routine eye exams.

Services for Howard Head Sports Medicine will be limited based on the State of Colorado Medicaid program guidelines for physical and occupational therapy. (**https://www.colorado.gov/pacific/hcpf/outpatient-ptot-benefits**)

Vail Health 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. 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, the Vail Health patient financial services department (PFS) and financial counselors will assist the patient in determining if he/she is eligible for government-sponsored programs (including referral to outside resources), and to educate and assist in understanding insurance coverages offered through the Colorado health insurance exchange.

The financial assistance application located on the Vail Health website, **www.vailhealth.org/financialassistance**, 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 will 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.

- **Net worth:** By reviewing an individual's net worth through applicable supporting documentation such as bank statements, investment statements, loan documents, etc. 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. 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. The Vail Health Patient Access department 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.

REVIEW AND APPROVAL

Financial assistance must be documented on the financial assistance application and approved by the Vail Health financial counselor for amounts up to $2,500, the director of patient financial services for amounts of $2,501 to $15,000, 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 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 sixty (60) days of receiving the financial assistance application, 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 do the following:

- 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, 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 sixty (60) days of the application in excess of amounts approved for financial assistance in accordance with the separate patient refund policy.
- 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 marketplace. If the patient chooses not to purchase insurance coverage through the Colorado health insurance marketplace and does not quality for Colorado Medicaid, then the patient will be required to submit a financial assistance application. 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. 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 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:

- Thirty (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 as follow:

- **Presumptive eligibility:** Emergent or medically urgent services provided within six months from date of approval for Eagle and Lake County resident
- **Catastrophic:** Emergent or medically urgent services provided per episode of care
- **Income and assets:** Emergent or medically urgent services provided within six months from date of approval for Eagle and Lake County Residents. Emergent or medically urgent services provided to US Residents per episode of care

If 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 provide a self-attestation of no changes to eligibility for the program. Receipt of the above will extend the approval for an additional six months. If this is found to be falsified, any current approvals will be revoked. Vail Health may provide reasonable estimation regarding if the patient can afford to purchase insurance coverage through the Colorado health insurance exchange and the period for which such coverage can be obtained is 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/her job or had some other financial hardship occur and became unable to pay under the plan, then 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 or Lake County that are uninsured and have an individual or family net assets of $250,000 or less (excluding equity 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 amount (effectively the amounts Vail Health collects from insurance companies and Medicare). This amount will be determined by doing a yearly review of payment percentages from commercial payers and Medicare (including copayments and deductibles paid by patients). Separate payment percentages will be calculated to develop separate average generally billed (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 Vail Health'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 Vail Health Board of Directors each year for updates to the AGB. The AGB limitation applies to all individuals eligible for assistance under the hospital facility's financial assistance policy, without specific reference to the individual's insurance status.

Average generally billed discount amounts calculated for fiscal year 2019 (November 1, 2019 through October 31, 2020) are as follows:

- Vail Health Hospital 37%
- Vail Health Clinics 47%

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 Health Hospital campus and the Vail Health Edwards Medical 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.

Patients may refer to the Vail Health website, **www.vailhealth.org**, for a list of Vail Health providers in the doctor directory. Please note that certain providers not associated with Vail Health may perform services at Vail Health facilities, but are not covered by Vail Health's financial assistance policy. To obtain a copy of the separate Vail Health Billing and Collections Policy, please contact our patient financial services department at (888) 356-1916.

REFERENCES

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