SUBJECT: FINANCIAL ASSISTANCE	EFFECTIVE: 01/20/2020
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AUTHORED BY: REVENUE CYCLE MANAGER	REVISED: 06/2022

POLICY:

Coquille Valley Hospital (CVH) is committed to providing financial assistance to people who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

CVH provides financial assistance for people with financial need by waiving all or part of the charges for services provided by CVH. CVH will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

- The Financial Assistance Policy (FAP) includes eligibility criteria for financial assistance
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how the hospital will publicize the policy within the community served by the hospital
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to the Amount Generally Billed by CVH. See Appendix A

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with CVH's process for obtaining charity care or other forms of payment or financial assistance and to contribute to the cost of their care based on their individual ability to pay.

In order to manage its resources responsibly and to allow CVH to provide the appropriate level of assistance to the greatest number of persons in need, the hospital establishes the following guidelines for the provision of financial assistance.

In extenuating circumstances, Coquille Valley Hospital may at its discretion approve financial assistance outside the scope of this policy. Uncollectible/presumptive charity is approved due to but is not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of non-compliance, and non-payment of account(s). All documentation must support the patient/guarantor's inability to pay and why collection agency assignment would not result in the resolution of the account.

DEFINITIONS:

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

Charity Care and Financial Assistance: Healthcare services that have been or will be provided for free or at a discount to individuals who meet established criteria.

Family: Using the Census Bureau definition, 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 for purposes on their income tax return, they may be considered a dependent for purposes of the provisions of financial assistance.

Family Income: Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines.

- Includes earnings, business income, 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 assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Determined on a before-tax-basis
- Non-cash benefits (such as food stamps and housing subsidies) **are excluded**
- If a person lives with family, includes the income of all family members (Non-relatives, such as housemates, are not included)

Amounts Generally Billed: The Amounts Generally Billed (AGB) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a charity or other discount which is equal to the average amounts historically allowed as a percentage of billed charges for Medicare-fee-for-service and private health insurers, including portions paid by insured individuals for a 12-month look-back period calculated in accordance with IRS 501(r).

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 provision of patient care services before any deductions are applied.

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

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

Application period: The time period that begins with the date of the first billing statement and ends 240 days thereafter.

Guarantor: The patient or other individual who is financially responsible for the patient's payment obligations.

PROCEDURE:

- **Services Eligible under This Policy -** For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by CVH for free or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance:
  - Emergency medical services provided in an emergency room setting
  - Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual
  - Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting, and
  - Other medically necessary services

- **Excluded Services:**
  - No-fault/Workers Compensation
  - Third Party Liability
  - Pending law suites
  - Elective, non-medically necessary services

- **Eligibility for Financial Assistance -** Eligibility for financial assistance 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 on the determination of financial need in accordance with this Policy. The granting of financial assistance shall be based on an individualized determination of financial need and does not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. Financial Assistance will not be granted to an individual who refuses to cooperate in seeking affordable health coverage or apply for services upon the advisement of CVH staff.

- **Method by Which Patients May Apply for Financial Assistance:**
  Financial need will be determined in accordance with procedures that involve an individual assessment of financial need and will:
  - Include an application process in which the patient or patient's guarantor is required to cooperate and provide personal, financial, and other information and documentation within the application period.
  - Include reasonable efforts by CVH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. If the patient is advised to apply for coverage and refuses, the patient will automatically be ineligible for Financial Assistance.

- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

- **Required Documentation for Coquille Valley Hospital financial assistance**

  To be considered complete, a submitted application must include the following:
  - Complete and signed Financial Assistance application ("FAP Application")
  - Complete copy of the most recently filed IRS Form 1040 and all supporting schedules
  - Complete copy of the most recently filed Oregon (or other state tax filing) Form 40 and all supporting schedules
  - Current pay stubs (3 months)
  - Last three months of bank statements
  - Social Security 1099 Form (if applicable); or
  - Unemployment or workers' compensation award letters (if applicable); or
  - Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
  - Approval/denial of eligibility for unemployment compensation.

- When a determination of eligibility for Financial Assistance has been made, all of the Patient's accounts will be handled in the same manner for 6 months following the date of such determination, without the need for completing a new application for Financial Assistance, in addition, CVH will consider patients eligible for Financial Assistance discounts on all self-pay balances 240 days from the first post-discharge billing statement. A new application will be required for services provided six months or more after the initial (or other prior) determination or if indications are received that the Patient's financial status has significantly changed from the original evaluation period.

- For services that are not identified as an Emergency medical condition, it is preferred, but not required that a request for financial assistance and a determination of financial need occur prior to rendering services. However, the determination may be done at any point before, during, or after receiving care.

- If an individual submits a FAP application during the application period that is incomplete, the hospital will provide the individual with written notice that describes the additional information and/or documentation required under the FAP or FAP application form that must be submitted to complete the FAP application. If the FAP application is subsequently completed during the application period, the individual will be considered to have submitted a complete FAP application during the application period.

- CVH's respect for human dignity and responsibility for stewardship shall be reflected in the application process, financial need determination, and granting of financial assistance. Requests for financial assistance shall be processed promptly and CVH shall notify the

patient or applicant in writing within 30 days of receipt of a completed application and all documentation necessary to make a determination.

- **Presumptive Financial Assistance Eligibility -** There are instances when a patient may appear eligible for financial assistance discounts but there is no Financial Assistance Application on file due to a lack of supporting documentation. Often there is adequate information provided by the patient 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 financial assistance, CVH may use outside agencies in determining estimated 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, a 100% adjustment of the account balance will be granted.

  Presumptive eligibility is determined on the basis of individual life circumstances that may include:
  - State-funded prescription programs
  - Homelessness or care received from a homeless clinic
  - Participation in Woman, Infants and Children's Program (WIC)
  - Food stamp eligibility
  - Subsidized school lunch program eligibility
  - Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
  - Low income/subsidized housing provided as a valid address, and
  - Patient is deceased with no known estate

- **Eligibility Criteria and Amounts Charged to Patients -** Services eligible under this policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect or, when the medically necessary services were provided. Once a patient has been determined by CVH to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

- **The basis for the amounts CVH will charge patients qualifying for financial assistance is as follows:**
  - Patients whose family income is at or below 200% of the FPL are eligible to receive full financial assistance.
  - Patients whose family income is above 200% but not more than 400% of the FPL are eligible to receive services discounted on a sliding fee schedule. Services will be discounted to an amount no greater than the Amount Generally Billed by CVH.
  - Financial Assistance may also include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

- See Appendix A for the calculation of the Amount Generally Billed (AGB) and the FPL Chart
- See Appendix B for CVH participating physicians

- **Communication of the Financial Assistance Policy to Patients and Within the Community-** Notification about financial assistance available from CVH shall be disseminated by CVH by various means, which will include, but are not limited to, the publication of notices in patient statements/letters and by posting notices in emergency rooms, admitting and registration departments, hospital business offices, and patient financial services offices that are located on CVH campuses, and other public places as CVH may elect.

  CVH will publish the FAP, FAP Application Form, and the Plain Language Summary of the FAP on the CVH website. CVH will make available and without charge, copies of the FAP, FAP Application Form, and the Plain Language Summary of the FAP in public locations in the hospital as well as by mail. CVH will widely publicize the FAP, FAP Application Form, and the Plain Language Summary of the FAP within the community served by the hospital as CVH may elect.

  The FAP, FAP Application Form, and the Plain Language Summary of the FAP shall be provided in the primary languages spoken by the population served by CVH. These documents are available in English and Spanish. A copy of the Plain Language Summary is included in the discharge packets provided to patients, Information regarding the FAP and how to obtain copies of the FAP materials is included in each billing statement/letter. Referral of patients for financial assistance may be made to any member of the CVH staff or a family member, close friend, or associate of the patient, subject to applicable privacy laws. A copy of this policy may be requested by mail, free of charge, or by calling Patient Financial Services at (541) 824-1234, or in person at 940 E. 5th St., Coquille, OR 97423.

- **Relationship to Patient Billing and Collection Policies** - CVH management shall maintain policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment) that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith to resolve their discounted hospital bills.

  CVH will publish the Patient Billing and Collection Policy on the CVH website. CVH will make available without charge copies of the Patient Billing and Collection Policy in public locations throughout the hospital. A copy may be requested by mail, free of charge, by calling Patient Financial Services at (541) 824-1234, or in person at 940 E. 5th St., Coquille, OR 97423.

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Appendix B - Provider Participation List

Providers who participate in Coquille Valley Hospital's Financial Assistance program.

Provider Name	Specialty
Rachel Davisson	Emergency Services
Robert Melton	Emergency Services
Shane Weare	Emergency Services
Rebecca Brisco	Orthopedic- Physician Asst.
Patrick Edwards	Physician Services
Megan Holland	Physician Services
Michael Invanitsky	Orthopedic Physician Services
Vanessa Mohrbacher	Family Nurse Practitioner
Jithu Pradeep	Physician Services
Adharsh Ravindran	Physician Services
Adam Clark	Licensed Clinical Social Worker
Philip Keizer (CVH Services Only)	Radiology Services
Stephan Quinn (CVH Services Only)	Radiology Services

Physicians not listed above do not participate in Coquille Valley Hospital's Financial Assistance Program. Patients should contact the non-participating physicians directly regarding Financial Assistance.

Appendix A - Amounts Generally Billed Calculation

- **AGB Percentage**
  - The AGB Percentage is calculated annually at the close of the fiscal year by dividing the Payments for claims paid to Coquille Valley Hospital during the fiscal year by the sum of the associated Gross Charges for those claims.
  - The AGB Percentage is applied to all types of services received by individuals who qualify for financial assistance under this policy.
  - The AGB Percentage is calculated not later than the 120th day after the end of the fiscal year. The AGB percentage will be applied to all applicable Hospital bill Reductions for the coming fiscal year. The latest AGB Percentage in use by CVH is listed in this Appendix A, Amounts Generally Billed Calculation.
  - For uninsured patients, the AGB Payment for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying the Gross Charges for that care by the AGB Percentage.
  - For underinsured patients, the AGB Payment for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by multiplying the AGB Percentage by the patient's out-of-pocket portion of the bill.

On an Annual basis the AGB is calculated for the hospital:

- Look Back Method is used. A twelve (12) month period is used
- Includes Medicare Fee-for-Service and Commercial payers
- Excludes payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, motor vehicle and liability, and workers' compensation

Fiscal Year	**Percentage of Amounts Generally Billed**	**Effective Date**
2019	39% discount = 61% AGB	10/01/2018
2020	42% discount = 58% AGB	10/01/2019
2021	44% discount = 56% AGB	10/01/2020
2022	46% discount = 54% AGB	10/01/2021
2023	50% discount = 50% AGB	10/01/2022

Below is the FAP Eligibility Percentage and the latest published Federal Poverty Level (FPL) Guideline:

Size of Household	**100% Waiver 200% of FPL**	**AGB & 75% Waiver 201 – 300% FPL**	**AGB & 50% Waiver 301 – 350% FPL**	**AGB & 25% Waiver 351 – 400% FPL**	
1	$27,180	$40,776	$47,565	$54,360	
2	$36,624	$54,936	$64,085	$73,248	
3	$46,068	$69,096	$80,605	$92,124	
4	$55,500	$83,256	$97,125	$111,000	
5	$64,944	$97,416	$113,645	$129,888	
6	$74,388	$111,576	$130,165	$148,764	
7	$83,820	$125,736	$146,685	$167,640	
8	$93,264	$139,896	$163,205	$186,528	

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