SAN LUIS VALLEY HEALTH
REVENUE CYCLE
FINANCIAL ASSISTANCE POLICY

I. Purpose

To provide a framework to identify and assist San Luis Valley Health (SLVH) patients who may qualify for financial assistance.

II. Policy

SLVH is committed to providing excellent quality health care while serving the diverse needs of those living within our service area of the San Luis Valley (SLV). SLVH offers medically necessary healthcare to all, without discrimination, regardless of ability to pay, gender, geographic location, cultural background, or physical mobility. In some cases, a patient will not be financially able to pay for the services received. In the event third-party coverage is not an option, financial assistance may be available for such patients. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of admission, by a patient financial counselor.

III. Definitions

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

Allowed Amount **-** Total charges less contractual adjustments

Amounts Generally Billed (AGB) - AGB is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charges for those claims. AGB is calculated for each qualifying entity on an annual basis.
AGB % = Sum of Claims Allowed Amount $ / Sum of Gross Charges $ for those claims

Elective – defined as cosmetic surgery, and/or services with pre- determined pricing. These services are scheduled in advance and may be medically important but are not urgent or emergent.

Emergent/Urgent Care - Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

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 the Internal Revenue Service, if the patient claims someone else as a dependent on their income tax return, they may be considered as a dependent for the purposes of the provision of financial assistance.

Financial Assistance – a reduction from the full or standard amount of total charges for services rendered. This is in contrast to bad debt, where the patient or guarantor has demonstrated unwillingness to resolve a bill.

Look-Back Method – Method for calculating AGB using a twelve (12) month period and includes Medicare fee for service and all private health insurers that pay claims to SLVH. Excluded payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, motor vehicle, liability and worker's compensation claims.

Medically Necessary - A covered health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.

Uninsured – The patient has no level of insurance or other third party assistance to assist with meeting payment obligations for healthcare services.

Urgent Care – Medically necessary care to treat medical conditions that are not immediately life-threatening, but could result in the onset of illness or injury, disability, death or serious impairment or dysfunction if not treated within 12-24 hours.

IV. Procedure

A. As a non-profit, charitable, community-based healthcare provider, SLVH will offer an opportunity for uninsured and underinsured patients to apply for financial assistance through Hospital Discounted Care, Medicaid/CHP+ (PEAK or PE), foundation funds, victims of crime, and payment arrangements and estimates.

B. The following healthcare services are eligible for financial assistance:
    a. Emergency medical services provided in an emergency room or inpatient room setting;
    b. Conditions which could lead to an adverse change in the health status of a patient if not promptly treated;
    c. Non-elective services provided in response to life-threatening circumstances, and;
    d. Medically important services, not deemed to be urgent, as recommended by an SLVH Provider on a case-by-case basis.

C. Patients who use SLVH's emergency room, are hospitalized, or plan to use outpatient services and are identified as uninsured or underinsured may receive a Financial Assistance brochure directing them to meet with a Patient Financial Counselor (PFC). Admission staff will communicate with the PFC to identify such individuals.

D. Any individual who is considered for a discount under the financial assistance policy (FAP) must provide financial information and family size to determine eligibility and promptly notify SLVH of any change to their financial situation.

E. If an applicant does not have any of the listed documents to prove household income, he or she may call the hospital facility's financial assistance office and discuss other evidence that may be provided to demonstrate eligibility.

F. SLVH's website, posters, flyers, and brochures will convey the FAP in plain language. A Plain Language Summary (PLS) will be offered to patients in both English and Spanish.

G. Patient statements also refer to the FAP with contact information for PFC's.

H. Discharge packets will include a Financial Assistance brochure.

I. Most providers at SLVH as well as hospitalists and Emergency Room doctors managed by INNOVA, are covered under the FAP and are listed on the website, www.sanluisvalleyhealth.org.

J. Services from outside providers, pathologists, and radiologists are not included in SLVH's charges, discounts, or financial assistance programs.

K. The amounts charged for services to patients qualifying for financial assistance will not be more than the amount generally billed (AGB) to patients with insurance. The basis for calculating preservice estimates of charges for patients will be the look-back method.

L. Attempts to assist patients to apply for financial assistance as well as reasonable efforts to collect payments will be recorded in the system patient note section and will be reviewed by the management team of the Business Revenue Cycle before engaging in Extraordinary Collection Actions (ECA). A written notice informs the patient that the hospital may take action to report adverse information to consumer credit reporting agencies if the patient does not pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

M. If a patient submits a financial assistance application before the end of 181 days after the date of service or date of discharge, whichever is later, any ECAs will be suspended and reasonable measures will be taken to reverse the ECA if the patient is eligible for financial assistance.

N. Patients who default on previous balances may or may not be considered for future discounts. This will be reviewed on a case by case basis by the Revenue Cycle Director.

O. The management team of the Business Revenue Cycle will maintain documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

P. A Community Health Needs Assessment will be conducted every three years and the results will be posted on the company website.

Financial Assistance Program Guidelines for Eligibility

Patients will be considered for Hospital Discounted Care in accordance with financial need, as determined by Federal Poverty Levels (FPL). The basis for calculating the amount of financial assistance offered to qualifying patients is as follows:

Calculated % of FPL	Discount
$\leq$ 250%	Determined by the State of Colorado