

Policy	Financial Assistance Policy	
Pawnee Valley Campus	Department(s): Administration	
Approved By: George Harms, Kendra Barker		Approval Date: 11/30/2018

Purpose

This policy establishes the framework by which Pawnee Valley Community Hospital fulfills its statutory mandate and continues its tradition of care to medically indigent citizens of its service area. Further, this policy will provide the guidance necessary to assist patients who do not otherwise have the ability to pay fully for medically necessary health care as prescribed by their physician. PVCH is committed to delivering high quality healthcare services and striving to ensure that lack of financial capacity does not deter those in our service area from seeking or receiving medically necessary care.

The financial assistance provided by PVCH is not a substitute for personal responsibility. Patients are expected to cooperate with PVCH's procedures for obtaining financial assistance or other forms of payment, and when able, all financial assistance applicants are expected to contribute to the cost of their care.

Responsibility

The Revenue Cycle Director is responsible for developing, implementing, and managing (maintaining) this policy. The Chief Financial Officer and the Administrator are responsible for approving this policy.

Scope

This Financial Assistance Policy (FAP) applies to all patients who receive medically necessary services at Pawnee Valley Community Hospital and who meet certain financial guidelines. PVCH will serve the emergency health care needs of patients who present to the Emergency Department of PVCH, regardless of their ability to pay for care. Application of the policy will be made regardless of age, sex, religion, or national origin.

Services covered under this policy include:

- A. Emergency medical services provided in an Emergency Department setting
- B. Non-elective services provided in response to life-threatening circumstances in a non-Emergency Department setting

Exclusions to this policy include:

- A. Patients who are not United States Citizens or Permanent Resident Aliens
- B. Patients receiving experimental and investigational procedures

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Definitions

Alien – Any person not a citizen or national (a person owing permanent allegiance to a state) of the United States.

Amount Generally Billed (AGB) – The average amount allowed on gross charges by Medicare and Commercial insurance payors. No individual eligible for financial assistance under this policy will pay a rate higher than the AGB.

Extraordinary Collection Actions (ECA) – The actions taken by the hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that involves selling an individual's debt to another party, reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus, deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP, or require a legal or judicial process.

Emergency Medical Conditions – Defined within the meaning of section 1867 of the Social Security Act (42.U.S.C. 139dd).

EMTALA – Emergency Medical Treatment and Active Labor Act

FAP – Financial Assistance Program

Federal Poverty Guidelines (FPG) – In February of each year the Federal Government releases an official income level for poverty called the Federal Poverty Guidelines. The benefit levels of many low-income assistance programs are based on these poverty figures. For purposes of this policy, the hospital will use The Federal Poverty Guidelines that are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Family Income – Defined by the Census Bureau which includes:

1. Earnings, unemployment compensation, worker's 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
2. Noncash benefits (such as food stamps and housing subsidies) do not count
3. Determined on a pre-tax basis
4. Excludes capital gains or losses
5. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count)

Financially Indigent Patients – patients who are (1) uninsured or underinsured and (2) whose gross income is from 0% to 300% of the Federal Poverty Guidelines, are referred to as Financially Indigent Patients.

Gross Charges – Total charges at the hospital's full established rates for the provision of patient care services before deductions from revenue are applied

Guarantor – Person responsible for paying the medical bill if all other payment options (e.g., Medicaid, Medicare, personal health insurance, a driver's motor vehicle coverage) fall short of covering the full cost of treatment. If the patient is under 18, the patient's guardian is the guarantor.

Look Back Method – Look Back Method is a prior twelve month period used when calculating Amounts Generally Billed.

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Medically Indigent Patients – Patients, who are (1) uninsured or underinsured and (2) whose incurred medical liabilities owed to the Health System are equal to, or exceed, 50% of their gross annual income, are referred to as Medically Indigent Patients.

Medically Necessary Services – Services that are reasonable or necessary for the diagnosis or treatment of an illness or injury

Non-Resident Alien – An individual granted permission by the United States Government to enter the United States on a temporary basis as a non-immigrant for purposes which include tourism, business, education, medical care, or temporary employment.

Permanent Resident Alien – An alien admitted to the United States as a lawful permanent resident. An illegal alien who entered the United States without inspection is not a permanent resident alien. Lawful permanent residents are legally accorded the privilege of residing permanently in the United States.

Uncompensated care – Healthcare services that have been or will be provided but are never expected to result in cash. Financial assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established financial criteria.

Underinsured – Patient has some form of third party assistance but still has out-of-pocket expenses that exceed his/her ability to pay

Uninsured – Patient has not form of third party assistance to assist with financial responsibility for medical services

ELIGIBILITY CRITERIA

Financial assistance is not considered a substitute for personal responsibility. A patient's eligibility for financial assistance is not determined until activities to identify and secure payment from all third party payment sources and non-hospital aid programs such as Medicare, Medicaid, other government programs, other funded programs, medical insurance, auto insurance personal injury protection (PIP) or med pay, liability liens, estate claims or any other possible appropriate source for payment are exhausted. (Deductible and co-insurance amounts are eligible for consideration, provided the eligibility criteria are met.)

Financial assistance is to be considered the adjustment of last resort. The patient's/guarantor's family income and all other financial resources and assets will be considered in making a financial need determination. Examples of assets and resources are, but not limited to, savings and checking accounts, IRA's, CD's, certificates of deposit, stocks, bonds and real estate as well as funds available as a result of third party liability for the medical expenses. Resources in excess of a reasonable amount may be looked at as a possible payment source.

Patients/guarantors are expected to comply with hospital procedures for screening for eligibility for assistance. Patients/guarantors who would appear to qualify for state, federal or other benefits that would cover all or part of the cost of their care are expected to cooperate with Pawnee Valley Community Hospital or its vendors regarding the application and screening process. Individuals with the financial capacity to purchase health insurance will be encouraged to do so, as a means of assuring access to health care services.

The granting of financial assistance will be based on an individualized determination of financial need and will not take into account age, gender, race, social status, sexual orientation, or religious affiliation. Eligibility for financial assistance is determined by the patient's family income, assets, and family size. Services eligible under this policy will be made available to the

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patient on a sliding scale in accordance with financial need as determined in reference to the FPG in effect at the time of the determination. A patient must be Financially Indigent or Medically Indigent at the time of application. The financial assistance discount is based on a sliding scale of between 0-300% of the FPG for the current year, as follows:

Additional Considerations:

1. Nothing in this Policy shall prohibit Pawnee Valley Community Hospital from offering further discounts or more favorable financial assistance than that set forth above based upon the circumstances.
2. A Patient must have complied with all insurance requests for information such that lack of response to their insurance company requests for information is not the reason for any lack of coverage for the services being requested through the FAP.
3. A Patient must receive medically necessary services (for example, eligibility is not available for elective services such as cosmetic surgery). In general, coverage guidelines will mirror Medicare coverage guidelines.
4. Patients whose family income exceeds 300% of the FPG may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of PVCH.
5. The applicant must have U.S. citizenship and/or legal residency status in the hospital's service area.

BASIS FOR CALCULATING AMOUNTS GENERALLY BILLED – HOSPITAL ACCOUNTS ONLY

After the patient's account is reduced by the financial assistance adjustment based on this policy and guidelines, the patient is responsible for no more than amounts generally billed to individuals who have Medicare fee for service and private health insurers for emergency and other medically necessary care. The Look Back Method is used to determine AGB. The AGB Summary document describes the calculation and states the percentage used by the hospital (See Addendum A).

APPLICATION PROCESS

1. A patient/guarantor may apply for financial assistance by completing the assistance application and submitting it, along with the required documents listed on the application form and any other documentation relevant to making a determination of financial need, to HaysMed, 2220 Canterbury, Hays, KS 67601 or Pawnee Valley Campus, 923 Carroll, Larned, KS 67550
2. A copy of this policy, or a summary policy, and/or an application form may be requested from the locations shown above or by calling HaysMed Customer Service Department at (785)623-5100 or PVCH at (620)285-3161
3. A patient/guarantor may view the financial assistance policy and may also download an application from the PVCH website: https://www.haysmed.com/wp-content/uploads/2018/01/FinancialAssistanceApplication_HOSPITAL.pdf

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PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY

Pawnee Valley Community Hospital (PVCH) recognizes that not all patients, or patients' guarantors, are able to complete the financial assistance application process or to provide the generally required documentation. For those patients, or patients' guarantors, PVCH may provide assistance based on other financial need criteria. In particular, presumptive eligibility may be based on life circumstances including but not limited to the following:

1. homelessness
2. deceased patient with no known estate
3. eligibility for another state's Medicaid program
4. approved eligibility within the last six months
5. Incarcerated and no apparent income
6. Elderly with limited income
7. Poverty situation with no apparent income

LEVEL OF ASSISTANCE

Once the applicant is deemed eligible for assistance, the actual level of assistance will be determined, in part, by comparing the applicant's income to the FPG, as follows:

- **100% discount**, if income is 0% to 130% of FPG
- **50% discount**, if income is 131% to 200% of FPG
- **30% discount**, if income is 201% to 300% of FPG

If income is over 300% of the FGP, a patient/guarantor may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Pawnee Valley Community Hospital Financial Assistance Associates.

NOTIFICATION OF ASSISTANCE DETERMINATION

The hospital will notify the patient/guarantor in writing of the financial assistance determination and the basis for it within 60 days of receipt of the fully completed application form and all requested supporting documentation from the patient/guarantor. If it is determined the patient/guarantor is eligible for assistance, the hospital will provide a new billing statement with an AGB to patients with insurance. The hospital will refund any excess payments that may have been made and will take reasonable steps to reverse any ECA action taken.

FINANCIAL ASSISTANCE POLICY AVAILABILITY TO PATIENTS

Patients/guarantors who may be in need of financial assistance will be actively sought out and advised of Pawnee Valley Community Hospital's (PVCH) FAP through the financial clearance process, the pre-registration process, and the registration process. Information about the availability of financial assistance appears on patient statements and is posted on signs in the emergency department and hospital admissions/registration areas. The financial assistance policy, plain language summary, and financial assistance application form with instructions are available on the PVCH website. Additionally, patients/guarantors will be given a summary notice of the policy in written and oral communication relating to billing during the notification period defined by government regulation as beginning on the date care is provided and ending 120 days after the hospital provides the patient/guarantor with the first billing statement. At least

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three statements, with a summary policy included, will be issued to the patient/guarantor during the notification period.

APPLICATION OF DISCOUNT

1. If the patient/guarantor qualifies for 100% financial assistance, the hospital will:
 - a. write off the full balance of the account
 - b. refund any excess payments made
 - c. take reasonable steps to reverse any ECAs undertaken
2. If the patient/guarantor qualifies for partial assistance, the hospital will:
 - a. determine the AGB
 - b. provide a new billing statement to the patient/guarantor, indicating the AGB and any amount owed after application of the assistance discount
 - c. refund any excess payments
 - d. take reasonable steps to reverse any ECAs undertaken
 - e. enter an adjustment transaction on the account(s) to write-off the amount of the discount applied

PATIENT BILLING AND COLLECTION

If a patient/guarantor fails to submit either an application for assistance or the amount due, a final notice will be issued to the patient/guarantor informing him/her of the ECAs the hospital may take and the date the action will be taken. These actions will include, but are not limited to, the reporting of adverse information to consumer credit reporting agencies and legal or judicial processes that may be undertaken. The hospital will continue to accept and process financial assistance applications during the 240 day period from the date of the first billing statement, as required by regulation. Once a financial assistance application is submitted, the hospital will not commence, or will suspend, any ECAs.

ESTABLISHMENT OF A PAYMENT PLAN

1. The hospital staff will work with the patient/guarantor to establish a payment plan by reviewing the application and making a determination of what can reasonably be expected as monthly payment.
2. The patient's income and monthly expenses will be considered when establishing a payment plan.
3. If the balance can be paid off within 10 months, generally, a financial assistance application is not required.
4. Generally, smaller balances will be expected to be paid off within three months to 24 months.
5. Larger balances will be expected to be paid off within at least 84 months.
6. De-default of the monthly payment agreement may result in the account(s) being referred to an outside agency for collection.
7. In the event of non-payment of any amount determined to be the responsibility of the patient/guarantor, and in the absence of an application for assistance, the hospital may refer the account(s) to an outside collection agency. Such action may result in an adverse entry on the patient's/guarantor's credit rating or the initiation of legal proceedings.

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PROVIDERS NOT COVERED BY THIS POLICY

Physicians or medical professionals provide care to patients or assist with patient treatment by reading lab work, interpreting medical tests, performing medical tests and individual patient physician services. The physicians and medical professionals not employed by Pawnee Valley Community Hospital or HaysMed are not covered by this Policy. For a list of covered and non-covered providers please see Addendum B.

EXCLUSION

Pawnee Valley Community Hospital reserves the right to deviate from the guidelines contained in this policy because of unusual situations and when a consensus to do so has been reached by the Patients Accounts Manager, the Revenue Cycle Director, and the Chief Financial Officer or their designees.

INFORMATION SOURCES

For additional information on financial assistance or to ask questions, inquirers may call or visit

- HaysMed at (785)623-5100 or at 2220 Canterbury Drive, Hays, KS
- PVCH at (620)285-3161 or at 923 Carroll, Larned, KS 67550

Related Documents

1. Forms –
 - a. Financial Assistance Application (BUS116a in Access eForms)
 - b. Financial Assistance Policy form (BUS116 in Access eForms)
2. Work Instructions – N/A
3. Policies –
 - a. [Collection Instructions](#)
 - b. [Authenticating Patient's Identity, Citizenship, and Residency](#)
 - c. [Financial Clearance](#)
 - d. [EMTALA - Emergency Medical Screening, Treatment, Transfer, and On-Call Roster](#)
4. Source(s) – N/A

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ADDENDUM A

AMOUNTS GENERALLY BILLED CALCULATION

Amounts Generally Billed 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 % = Sum of Claims Allowed Amount \$ / Sum of Gross Charges \$ for those claims

Allowed Amount = Total charges less Contractual Adjustments If no contractual adjustment is posted then total charges equals the allowed amount. Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

Pawnee Valley Community Hospital

On an annual basis the AGB is calculated for each 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, motor vehicle and liability, and worker's compensation.

Effective: January 1, 2018

Pawnee Valley Community Hospital 43%

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ADDENDUM B

COVERED AND NON-COVERED PROVIDERS

Pawnee Valley Hospital Financial Assistance Policy Covered and Non Covered Entities and Provider Group List

Last Updated November 2018

Pawnee Valley Community Hospital and HaysMed Entities Covered by this Policy:

DeBakey Heart Institute
Emergency Department Physicians
HaysMed Orthopedic Institute
Pawnee Valley Medical Associates
Pulmonology Associates of Hays
Special Nursing Services
Southwind Surgical of Hays
Western Kansas Urological Associates
Wound Healing and Hyperbaric Center

Entities and Providers Not Covered by this Policy:

Physicians or medical professionals provide care to patients or assist with patient treatment by reading lab work, interpreting medical tests, performing medical tests and individual patient physician services. The physicians and medical professionals not employed by Pawnee Valley or HaysMed are not covered by this Policy. The following are not covered by this policy:

Anesthesiology Associates of Hays
Dr. Mark Van Norden
Dr. Son Truong, Sleep and Diagnostic Center
Dr. Trent Smith, DDS
Eye Specialists of Hays
Renal Care Group of the Midwest, Inc. (Fresenius Medical Care)
Radiology Associates of Hays
Quest Diagnostics

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