Parkview Medical Center POLICY

Financial Assistance Policy

Board **Official** (Rev: 1)

PURPOSE:

In accordance with its stated mission and vision to provide quality healthcare services to improve the health of the people we serve Parkview Medical Center (PMC) is committed to providing healthcare services regardless of a person's ability to pay. Financial Assistance is a component of Parkview's vision of service as it provides for the healthcare needs of the community and region.

Parkview publishes a community needs assessment every 3 years. Based on the information gathered, access to healthcare was listed as a prominent community need. A comprehensive financial assistance policy that reaches out to the uninsured and under insured will assist in achieving that goal.

Furthermore in providing healthcare services and education, Parkview Medical Center believes that financial matters are secondary to the rendering of these services. No person who seeks emergency or medically necessary care will be turned away. PMC assists patients who have no ability to pay, patients with insufficient resources to adequately cover their care and those with the ability to pay but require the extension of credit are all eligible to apply for financial assistance. This assistance is accomplished by the following:

- Assessing the financial status of all self-pay patients
- Matching eligible individuals to payers sources
- Establishing mechanisms for financing and discounts if eligible
- Providing financial assistance if other avenues for payment are not feasible

POLICY:

Consistent with the stated purpose and as a 501(c)(3) organization Parkview Medical Center will provide a financial assistance policy (FAP) that is in compliance with IRS code 501(r) and Colorado Revised Statute 25-3-112 which requires the following:

1. Procedures that provide financial assistance for patients unable to pay all or part of their healthcare expenses.
2. Define the specific eligibility criteria for Charity Care.
3. Establishes discount procedures for financial assistance eligible patient's balances that assure they are not billed more than the Average Generally Billed (AGB) amounts.
4. Defines the methodology to determine AGB
5. Takes steps to publicize the medical center FAP to assure that patients are informed of the FAP.
6. Inform the patient of the medical center FAP prior to any extraordinary collection actions (ECA) and stop any ECAs if the patient petitions for assistance within the IRS mandated time frames.

Patient Financial Assistance

Business Office, Admissions and Financial Counselling are responsible for providing financial assistance and assuring that patients are informed that financial assistance is available. Each department will develop and enact procedures that carry out these functions.

Financial Assistance Eligibility

Patients receiving financial assistance will be required to undergo means testing in order to establish eligibility. The following review criteria are necessary in order to establish means:

A. Fail to meet the requirements for eligibility with either Colorado Medicaid or Colorado Indigent Care Program (CICP)

B. Prove an inability to meet hospital financing options, which include hospital financed payment plans at 12 months or bank financed loans for longer periods.

C. Have income above but not limited to the maximum thresholds for CICP (300% of the federal poverty guidelines) and prove an inability to develop a payment plan

D. Prove to be actively working with the Parkview Medical Center financial services staff to resolve any or all accounts receivable account balances

Self-Pay and Financial Assistance Discounting

Parkview will reduce all self-pay balances to be the lowest contracted discount that the hospital gives any managed care insurance plan. This discount will be computed annually and adjusted as necessary in order to comply with Colorado Revised Statute 25-3-112 (2015).

When a patient becomes eligible for financial assistance the charges will be re-adjusted to reflect the AGB discount rate. No patient eligible for financial assistance will be expected to pay more than the AGB rate.

Each January, Parkview will use the IRS look back method for AGB determination. This will be accomplished by taking an aggregated average of all Medicare, Medicaid and contracted payer claims from the previous 12 months. See IRS code 501 (r) published December 29, 2014.

Discounts for High Deductibles Co-Insurance and Copays

Insurance plans that have high patient out of pocket maximums will not be considered for the self-pay discount. Reasons for this are because the contracted payer has already claimed a discount as part of the contracted allowable. Patients with high deductibles must use the eligibility process of means testing in order to receive financial assistance.

The Business Office is assigned the responsibility to assure that discounts are applied correctly and timely.

FAP Publicity

The Board will delegate to Business Office, Registration and Financial Services the responsibility to enact procedures that will inform the patient that financial assistance is available.

These measures should include but not be limited to the following:

1. Informing patients that there is a FAP at the time of registration.
2. Making paper copies of the FAP available to patients and the public upon request.
3. Allow members of the community access to the FAP
4. Post the FAP and related procedures on the hospital web site
5. Create a plain language summary of the FAP
6. Translate the FAP and related procedures into Spanish

Extraordinary Collection Actions (ECA)

The medical center will limit ECA to only credit reporting and legal action to invoke wage garnishment. PMC will prohibit property liens, property foreclosure, arrest and other extraordinary means to collect debt in its collections practices and will prohibit any contractor assisting with debt collections to act likewise.

The business office will be tasked with implementing policies and procedures that assure that each patient will receive notification of the FAP prior to any extraordinary collection actions.

DEFINITIONS:

Financial Counseling – The process of working with the patients or guarantors in a compassionate and confidential manner in order to identify options for resolving their PMC financial obligations.

Financial Assistance – The end result of working with the patients or guarantors to provide a mechanism that facilitates the resolution of their financial obligation to PMC. Financial assistance may be as simple as establishing a payment plan for the patient or as complex as helping them to become eligible for Medicaid, Colorado Indigent Care or Charity.

Discounts – Amounts or percentages that reduce the patient's billed charges to a contracted or a legally mandated amount. Discounts refer to amounts given to Medicare, Medicaid, and contracted payers and reductions to the overall charges for patients without insurance.

Extraordinary Collection Actions – Actions used to collect medical debts. These include credit reporting, lien placement, arrests, foreclosure, wage garnishment, or any other civil action. The medical center is given a 120-day period in which to notify the patient of the financial assistance policy prior to taking any extraordinary collection action.

Allowable – The rate contracted between the payer and the provider that restricts charges from being the actual billed amount. Deductibles and co-insurance (patient responsibility) are calculated from this amount. The provider is not required to discount charges more than the allowable, and in most cases is legally required to collect the deductibles and co-insurance.

Co-insurance – A percentage of the allowable that an insurance payer requires the patient to pay. The provider is contractually obligated to collect this amount calculated by the payer from the patient.

Deductible – A fixed amount that an insurance payer requires the patient to pay. The provider is contractually obligated to collect this amount calculated by the payer from the patient when the provider has an agreement with the payer.

Means Testing – The process of determining a patient's level of financial assistance. It involves the patient or guarantor working with financial services to determine Medicaid or CICP eligibility and/or completing a Resource Application to determine if the hospital will provide charity.

Community Health Needs Assessment – A federally mandated assessment that must be completed every year that details the initiatives that the hospital will focus on for that period of time. It is developed in collaboration with local government and community organizations to identify and categorize the specific needs of the community. The IRS recommends that the CHNA be used in the development of the financial assistance policy

Average Generally Billed (AGB) – An IRS mandated procedure for assuring that patients with no insurance are not charged/billed for amounts that are higher than the Medicare, Medicaid and contracted insurance rates. The look back method compiles the previous 12 months of claims and the average allowable for all 3 blocks of payers (Medicare, Medicaid and contracted Insurance) to compute a percentage that is applied to the gross charges of a self-pay patient. The look back method allows for patient responsibility (allowable not just average reimbursement) to be included in the calculations.

Collection Actions – Procedures and actions taken against a patient in order to secure payment from the patient. PMC's collection actions are but not limited to 3 patient statements, 1-2 phone call attempts, 1 final notice letter and placement with a collection agency. Agency actions are restricted to collection notices and letters, phone calls, credit reporting and lawsuits for garnishment of wages. All collection actions must follow restrictions as defined in the Fair Debt Collections Practices Act (FDCPA). The only Extraordinary Collection Actions that the medical center allows is credit reporting and seeking judgement for wage garnishment.

Resource Application – Financial Assistance Application or a formal request for the hospital to assist with medical services because the patient does not qualify for any other form of state or federal assistance

Uninsured – Patients or guarantors that have no third party insurance at the time of admission.

Underinsured – Patients or guarantors that have third party insurance but do not have the means to pay for residual healthcare balances after the third party pays.

Presumptive Assistance Eligibility – Circumstances existing for the patient that would allow them to receive financial assistance without completing the application or providing income documentation. Situations that would include but not be limited to for presumptive eligibility are:

1. The patient was eligible for Medicaid in either the month prior to or after services was provided.
2. The patient provides written documentation that their current residence is a homeless shelter. I.e. A letter from the shelter.
3. The patient is deceased and there is documentation that details the lack of an estate or remaining assets.

Household Income – Is the adjusted income of all working members of a household excluding teenage dependents.

Financial Assistance Policy (FAP)

Plan Language Summary

Parkview Medical Center is committed to providing quality medical services to all regardless of ability to pay. No person who seeks emergency or medically necessary care will be turned away.

Patients who will receive or have received care at Parkview are encouraged to visit with a Parkview Financial Counsellor to better understand their financial needs and to seek out eligibility for Medicaid or Colorado Indigent Care (CICP). If these programs are not possible then any patient may apply for financial assistance. Financial Counsellors may be contacted at (719)584-4508.

Full or partial financial assistance may be obtained by completing a Financial Resource Application and by providing supporting documentation as instructed. This application and the complete policy and procedure for the FAP can be found on-line at www.parkviewmc.com/financial-assistance/ or you can get one by calling the Business Office at (719) 584-4045.

Once the Business Office has your application and verification of your income, they will process it within 30 days of receipt. Eligibility requirements will be based on the size of your hospital bill, any asset that might enable you to pay your bill and your ability to make monthly payments.

For questions please contact the Business Office at (719) 584-4045.