SENTARA®

| | | | |
|---|---|---|---|
| **Policy:** | Financial Assistance Policy | | |
| **Division:** | Corporate Finance | **Original Date:** | August 2003 |
| **Department:** | Corporate Finance | **Review/Revision Effective Date:** | January 2019 |
| **Category:** | Compliance | **Adopted September 2015 By:** | The Board of Directors of Sentara RMH Medical Center |
| **Location(s):** | See below | **Owner:** | Patient Accounting |

Previous Review/Revision Dates: January 2009, March 2013, January 2016

## Policy Statement:

As part of the Sentara Healthcare ("Sentara") mission to improve health every day, Hospital Facilities are committed to providing Emergency Services and other Medically Necessary Services to all patients within their respective communities, regardless of a patient's ability to pay for such services.

## Purpose:

This Financial Assistance Policy ("Policy") establishes the policy to be followed by each Hospital Facility in: (1) determining the eligibility for Financial Assistance for those patients receiving Emergency Services and other Medically Necessary Services; (2) calculating amounts charged to a patient eligible for Financial Assistance; and (3) facilitating the patient application process for Financial Assistance. In addition, this Policy outlines Sentara's billing and collections practices for medical care services provided by Hospital Facilities, including the efforts that a Hospital Facility will make to determine a patient's eligibility for Financial Assistance prior to engaging in Extraordinary Collection Actions in the event of non-payment.

## Definitions:

**Amounts Generally Billed or AGB** – Amounts generally billed by a Hospital Facility for Emergency Services or Medically Necessary Services to individuals who have insurance covering such care, determined in accordance with Treas. Reg. Sec. 1.501(r)-5(b).

**Application Period** – Period of time commencing at the beginning of a patient's continuum of care through 240 days after the provision of the patient's first post-discharge billing statement.

**Covered Services** - Emergency Services and other Medically Necessary Services provided by a Hospital Facility.

**Emergency Services** – Care or treatment provided by a Hospital Facility for an "emergency medical condition," as such term is defined in EMTALA.

**EMTALA** – Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd; 42 C.F.R. § 489.24).

**Extraordinary Collection Actions or ECAs** – Extraordinary collection actions as defined in Treas. Reg. Sec. 1.501(r)-6(b).

**Federal Poverty Guidelines** - Federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. *See* http://aspe.hhs.gov/poverty/index.cfm for the current guidelines

**Financial Assistance** – A reduction in the amount of Hospital Facility Gross Charges for those patients who are eligible for financial relief under this Policy.

**Gross Charges** – A Hospital Facility's full, established price for medical care services that the Hospital Facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

**Hospital Facility–** A Sentara-operated hospital facility requiring hospital licensure under Title 32.1, Chapter 5 of the Code of Virginia. This Policy applies to the following hospital facilities of Sentara RMH Medical Center, a charitable hospital organization under Section 501(c)(3) of the Internal Revenue Code:

| | |
|---|---|
| Sentara RMH Medical Center | |
| | |

**Hospital Organization** – An organization recognized or seeking to be recognized as described under Section 501(c)(3) of the Internal Revenue Code that operates one or more Hospital Facilities.

**Household Income** – The annualized gross income for a patient and all members of his/her household being claimed on the same federal tax return.

**Insured Patients** – Individuals with any governmental, commercial, managed care, or private health insurance.

**Medically Necessary Services**– Reasonable and necessary services required for the diagnosis or treatment of an illness, injury, or pregnancy-related condition that are performed in accordance with recognized standards of care at the time of service and that are not primarily for the convenience of the patient or the patient's physician or other health care provider.

**Non-Hospital Facility** – A facility not requiring hospital licensure under Title 32.1 Chapter 5 of the Code of Virginia, including, but not limited to, the office of a physician owned and operated by a hospital organization that is exempted from hospital licensure requirements under Code of Virginia Sec. 32.1-124.

**Substantially-Related Entity** – With respect to a Hospital Facility operated by a Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides Covered Services in that Hospital Facility.

**Third-Party Liability Claims** – Any claim a patient may have against another individual, insurer, or entity responsible for covering the patient's cost of medical services.

**Uninsured Patients** – Individuals who do not have governmental, commercial, managed care, or private health insurance or whose insurance benefits have been exhausted.

## Covered Services:

Only Covered Services provided by a Hospital Facility or its Substantially-Related Entity are considered eligible patient care under this Policy. A Hospital Facility does not have the authority to offer Financial Assistance with respect to charges from physicians or other healthcare professionals who are not employed by the Hospital Facility.

A list of any providers, other than a Hospital Facility itself, delivering Emergency Services or other Medically Necessary Services in each Hospital Facility and whether or not their services are covered under this Policy is maintained in a separate document that may be obtained, free of charge: (1) from patient registration areas within each Hospital Facility; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Services provided at Non-Hospital Facilities are not covered under this Policy.

## Financial Assistance Disqualification:

Financial Assistance is not available for patients who fail to reasonably comply with applicable payor requirements, including, but not limited to, obtaining authorizations, referrals, or other requirements for claim adjudication.

Financial Assistance is not available when a related Third Party Liability Claim is available to the patient. Exceptions are determined by the applicable Hospital Facility on a case-by-case basis, based upon the particular facts and circumstances.

Financial Assistance will be denied if a patient or patient's responsible party/guarantor provides false information regarding his/her income, household size, assets, liabilities, expenses, or other resources available that might indicate a financial means to pay for Covered Services.

**Eligibility Criteria and Determination of Financial Assistance Amount:**

Patients are eligible to apply for Financial Assistance for Covered Services under this Policy at any time during the Application Period. Each patient's Household Income is evaluated in light of relevant facts and circumstances, such as reported income, assets, liabilities, expenses, and other resources available to the patient or patient's responsible party, when determining the level of Financial Assistance that an applicant qualifies for under this Policy.

Taking all of these other factors into account, the following Household Income criteria is used to determine what amount, if any, of the outstanding patient account balance related to Covered Services for a patient will be written off as Financial Assistance:

- Uninsured Patients with Household Income at or below 200% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of Hospital Facility Gross Charges related to Covered Services under this Policy.

- Insured Patients with Household Income at or below 200% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of any remaining patient responsibility balance after insurance has paid on Covered Services under this Policy.

- Uninsured Patients with Household Income above 200%, but at or below 400%, of the then-current Federal Poverty Guidelines qualify for a discount of 75% off of Hospital Facility Gross Charges related to Covered Services under this Policy.

- Uninsured Patients with a Household Income above 400% of the then-current Federal Poverty Guidelines are not eligible for Financial Assistance under this Policy. For these uninsured patients that are excluded from Financial Assistance under this Policy, an administrative adjustment equal to 30% of Hospital Facility Gross Charges will apply.

Applicants for Financial Assistance under this Policy may be required to submit any of the following documents to verify Household Income during the Application Period: three most recent pay stubs at time of application; most recent annual Federal tax return or W-2 at time of application; employer verification; governmental assistance documents; social security, workers compensation, or unemployment compensation determination letters; bank statements; or such other documents that provide proof of Household Income. A Hospital Facility may also utilize the income, asset, liability, expense, and other resource data from third-party credit inquiries and publicly available data sources as evidence in determining and validating an applicant's Household Income for Financial Assistance eligibility under this Policy.

A presumptive determination may be made by a Hospital Facility utilizing third-party credit inquiries and publicly available data sources to determine if a patient qualifies for Financial Assistance under this Policy. If this data suggests that such patient's Household Income is at or below 200% of the then-current Federal Poverty Guidelines, 100% of the patient's remaining balance for Covered Services may qualify to be written-off.

A patient's prior eligibility determinations with respect to Financial Assistance are not presumed to apply to new episodes of care for that patient. A new application for Financial Assistance must be completed.
Once a patient is determined to be eligible for Financial Assistance under this Policy, s/he will not be charged more for Covered Services under this Policy than AGB. AGB is determined by multiplying the Gross Charges for the provision of any Emergency Services or other Medically Necessary Services by a Hospital Facility's AGB percentage, which is based on all claims allowed under both Medicare and private health insurance. An information sheet stating the AGB percentages of each Hospital Facility covered under this Policy and how these AGB percentages were calculated may be obtained free of charge: (1) from patient registration areas within each Hospital Facility; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Uninsured Patients that do not satisfy the eligibility requirements for Financial Assistance under this Policy should contact Sentara as described in this Policy to determine if s/he may qualify for discounts offered outside of this Policy.

## Methods for Applying for or Obtaining Financial Assistance:

The Application for Financial Assistance is available at patient registration areas of each Hospital Facility and may also be downloaded from the internet free of charge at www.sentara.com/financialassistance. The Application for Financial Assistance may also be mailed free-of-charge to patients upon request by phoning 540-564-5866 or 888-389-1644, or by sending a written request to the following address:

Sentara Healthcare
Hospital Business Office
532 South Main Street
Harrisonburg, Virginia 22801

Completed Applications for Financial Assistance, along with proof of Household Income, should be mailed to the address set forth in this Policy. Alternatively, a patient may return a completed application, along with proof of Household Income, to any patient registration area of a Hospital Facility.

Patients who need additional information about this Policy, or who need assistance with the Financial Assistance application process, may call or visit the above location Monday through Friday during normal business hours to speak with a Sentara Financial Assistance Coordinator.

## Length of Eligibility:

Eligibility determinations under this Policy are effective for Covered Services rendered up to 240 days prior to the application for Financial Assistance final approval date, and do not apply to dates of service after this Financial Assistance final approval date.

## Actions Taken in the Event of Non-Payment (Collections):

Reasonable efforts are taken to determine a patient's eligibility for Financial Assistance under this Policy with respect to Covered Services prior to engaging in collection efforts with respect to such patient. Such efforts include notifying a patient about this Policy, helping a patient remedy an incomplete Application for Financial Assistance, and informing an applicant for Financial Assistance regarding his/her eligibility determination once a completed application has been received.

If, after reasonable efforts are taken, a patient is found to either not qualify for Financial Assistance under this Policy or is unresponsive to the Hospital Facility's efforts to obtain the information necessary to determine eligibility for Financial Assistance, the patient's account may be moved to bad debt and the delinquent account turned over to Sentara's collections department. ECAs may be taken by a Hospital Facility once an account has been turned over to Sentara's collections department. ECAs may include the outsourcing of the account to a collections agency that may report the delinquent account to one or more consumer reporting agencies (credit bureaus). In addition, a Hospital Facility may file lawsuits, take judgments, record judgments or deeds of trust, place liens on realty, and garnish wages and other assets.

After a reasonable period and prior to engaging in any ECAs, a Hospital Facility will also attempt to qualify a patient and write-off balances related to that patient's Covered Services under this Policy when a patient does not provide financial information or respond to attempts to provide Financial Assistance based on credit reporting data that assists in determining income and credit worthiness. When the credit data suggests that a patient's total Household Income is at or below 200% of the then-current Federal Poverty Guidelines, the account balance for that patient's Covered Services may be written-off to presumptive charity.

Prior to categorizing patient accounts as bad debt, a Hospital Facility, as part of its routine collections process, mails a series of three patient statements, and may also make attempts by phone to contact patients. Hospital Facilities also enlist the services of eligibility vendors to assist Uninsured Patients in applying for government programs, such as Medicaid. A Hospital Facility utilizes technology and other vendor services to help identify a patient's payor information when such information is not communicated to the Hospital Facility during the patient's registration process.

In the event of non-payment or the absence of any mutually agreed-upon payment arrangement, a Hospital Facility will consider an account to be bad debt and may undertake ECAs after 120 days from the provision of a patient's first post-discharge billing statement. A patient will be mailed an additional series of three patient statements when the account is considered to be bad debt. Any unpaid account(s) remaining at the end of this second series of statements to the patient will be reviewed for legal consideration or possible placement with an outside collections agency.

Patient balances are eligible for Financial Assistance evaluation during the Application Period. Upon receipt of an Application for Financial Assistance during the Application Period, any ECAs are suspended until a final eligibility determination is made by a Hospital Facility. An applicant for Financial Assistance who provides incomplete information during the Application Period is given a reasonable period of time, as determined by Sentara and based upon the particular facts and circumstances, to respond to a Hospital Facility's written notice describing the additional information and/or documentation required to complete the application. If the applicant does not respond to the request for additional information from a Hospital Facility within a reasonable period of time, as determined by Sentara and based upon the particular facts and circumstances, then ECAs may resume.

At least 30 days before any ECAs are initiated by a Hospital Facility, a patient is notified, in writing, regarding any ECAs a Hospital Facility intends to initiate to obtain payment, as well as the availability of Financial Assistance for eligible individuals. Along with this notice, the patient is provided a plain language summary of this Policy. A Hospital Facility will also make a reasonable effort to orally notify its patients about this Policy and how they may obtain assistance with the financial assistance application process during the period between mailing the ECA-initiation notice and resuming or initiating ECAs. ECA(s) may occur no earlier than 120 days from the provision of a patient's first post-discharge billing statement, as outlined in Treas. Reg. Sec. 1.501(r)-6(c)(3)(i).

The Director of Patient Accounting is responsible for determining that a Hospital Facility has made reasonable efforts to determine a patient's eligibility for Financial Assistance under this Policy before engaging in any ECAs.

## Exceptions to this Policy

The Director of Patient Accounting, Sentara Chief Collection Counsel, Vice President of Revenue Cycle, and Chief Financial Officer of Sentara are each granted the authority to provide eligibility and determination exceptions to this Policy on a case-by-case basis as appropriate to an individual patient's facts and circumstances. In no case will a patient be denied Financial Assistance if s/he meets the stated eligibility and determination requirements for Covered Services set forth in this Policy.