CLARK FORK VALLEY HOSPITAL and Family Medicine Network	**POLICIES AND PROCEDURES** **PolicyStat ID 7125146**
TITLE:	**Financial Assistance Policy – 501 (r)**
Origination date:	**1/2016**
Revision date:	**4/2021**
Policy Owner:	**Shari Lyman, Revenue Cycle Manager**
Policy Area:	**Patient Financial Services**

PURPOSE:

Clark Fork Valley Hospital and Family Medicine Network (CFVH) is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, or otherwise unable to pay for medically necessary care based on their household financial situation. In setting forth this policy, CFVH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care and that the organization's limited resources are utilized in the most effective manner befitting our mission, vision and values.

POLICY:

This financial assistance policy (FAP) complies with applicable federal and state laws and regulations relating to emergency medical services, patient financial assistance and charity care, including but not limited to Section 1867 of the Social Security Act and Section 501(r) of the Internal Revenue Service code. CFVH will provide, without discrimination, care of emergency medical conditions to individuals regardless of their ability to pay or their eligibility for financial assistance or for government assistance.

CFVH will use the most current Federal Poverty Guidelines to determine eligibility under its financial assistance policy. Patients qualifying for financial assistance may receive fully discounted care or pay a discounted fee under this policy, based on a sliding scale according the household income, ranging up to 250% of the Federal Poverty Level (FPL). CFVH will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identify or expression, disability, veteran or military status, or any other basis prohibited by federal state, or local law when making financial assistance determinations.

Financial assistance shall be provided for medically necessary health care services to patients who meet program qualifications and reside within the CFVH service areas (Sanders and Mineral Counties). Financial assistance shall be provided, without discrimination, to patients from outside the CFVH services areas, who otherwise qualify for the program, and who present with an urgent, emergent or life-threatening condition. ***Note: Patient's county of residence is not a consideration for eligibility under the Family Medicine Network (FMN) Sliding Scale Financial Assistance Program.***

As a benefit to patients, CFVH provides financial counseling services to assist patients with identifying resources to assist with paying the cost of their care. Our Finance Specialists act as advocates for the patient in identifying coverage resources and, when applicable, assisting patients in the process of applying for assistance.

Financial assistance, as provided for in this policy, is secondary to all other financial resources available to the patient or guarantor, including but not limited to insurance, third party liability payers, government and outside agency programs. It is extended with the expectation that patients will cooperate with CFVH procedures for identifying and applying for such financial assistance or other forms of payment that may be available to the patient. Patient/guarantor will also contribute to the cost of their care according to their ability to pay.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance – fully or partially discounted care.
- Describes the basis for calculating amounts charges to patients eligible for financial assistance under this policy and limits the amounts that CFVH will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance.
- Describes the method by which patients may apply for financial assistance.
- Describes the methods to be used to widely publicize the policy within the communities serviced by CFVH sites.

I. **Scope:**

This policy applies to all services provided and billed by CFVH providers at CFVH facilities including: Clark Fork Valley Hospital, Plains Family Medicine, Thompson Falls Family Medicine, and Hot Springs Family Medicine. Certain independent providers of services to CFVH hospital patients and certain specialty providers of Non-RHC services in the FMN clinics are not governed by this policy and the patient or guarantor are encouraged to contact them directly to inquire about their financial assistance practices. Those providers are outlined in Exhibit C.

In order to manage its resources responsibly and to allow CFVH to provide the appropriate level of assistance to persons in need, the CFVH Board of Directors establishes the following financial assistance guidelines.

II. **Definitions:**

For the purpose of this policy, the following terms are defined:

Amount Generally Billed (AGB):

The average amount allowed on gross charges by Medicare and Commercial insurance payers for services at CFVH as calculated annually as of December 31 under the lookback method and effective April 1 of the following year (disclosed in Exhibit B of this policy). No individual eligible for financial assistance under this policy will pay a rate higher than the AGB.

Catastrophic Medical Debt:

Outstanding out-of-pocket debt incurred during a 12 month period at CFVH that exceeds $10,000 and 25% of the patient's annual family income. Patient accounts that are identified as meeting this criteria after all insurance payments and financial discounts have been applied will be reviewed by the Revenue Cycle Manager, CFO, and CEO, and may be eligible upon approval for additional discounting of amounts owed in excess of 25% of the patient's annual family income for that calendar year.

Discounted Care:
Financial assistance that provides care at a discount on gross charges to eligible patients with annualized family incomes between amounts greater than 100% but less than 250% of the Federal Poverty Guidelines. This type of financial assistance reduces the patient financial obligation on a sliding scale rate as illustrated below:

- 101-133% federal poverty level will receive 75% discounted care.
- 134-175% federal poverty level will receive 50% discounted care.
- 176-250% federal poverty level will receive Discounted care equivalent to the AGB (see Exhibit B).

Eligibility Determination Period:
For purposes of determining financial assistance eligibility, CFVH will review annual family income from the prior six-month period and/or the prior tax year as shown by recent pay stubs or income tax returns and other

information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate.

Eligibility Qualification Period:
Patients determined to be eligible may be granted financial assistance for a period of up to six months. However, eligibility may be reevaluated during that period if financial circumstances change. Financial assistance may also be applied to eligible accounts incurred for services received up to 240 days prior to the financial assistance application date, provided the services were received after 1/1/2016 and eligibility for that period is determined.

Family:
As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage or adoption. If a patient claims a dependent on their income tax return, according to the Internal Revenue Service rules, that individual may be considered a dependent for the purposes of determining eligibility. Any and all resources of the household are considered together to determine eligibility under the CFVH financial assistance policy.

Family Income:
Family income is determined using the U.S. Census Bureau definition when determining eligibility based on the Federal Poverty Guidelines.

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, Veterans' payments, survivor benefits, disability payments, pension or retirement income, interest, dividends, rents, royalties, income from estates and trusts, educational assistance, alimony, child support, financial assistance from outside the household, and other miscellaneous sources;
- Non-cash benefits (i.e. Medicare, Medicaid, and Supplemental Nutrition Assistance Program (SNAP) benefits, heat assistance, school lunches, housing assistance, need-based assistance from non-profit organizations, foster care payments, or disaster relief assistance) are not counted as income for making an eligibility determination for financial assistance;
- Capital gains or losses;
- Determined on a before-tax basis;

A person's family income includes the income of all adult family members. For patients under 18 years of age, family income includes that of the parents and/or step-parents, unmarried or domestic partners, or caretaker relatives.

Federal Poverty Guidelines:
Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines. Also see Exhibit A included in this policy.

Financial Assistance:
Assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medically-necessary services provided by CFVH and who meet the eligibility criteria for such assistance.

Fully Discounted (No Charge) Care:
A 100% waiver of patient financial obligation resulting from medically necessary services provided by CFVH. Uninsured and underinsured patients with annualized family incomes not in excess of 100% of the Federal Poverty Guidelines will be eligible for fully discounted care.

Guarantor:
An individual other than the patient who is responsible for payment of the patient's bill.

Gross Charges:
The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

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

Reasonable Payment Plan:
An extended payment plan that is negotiated between CFVH and patient for any balance remaining after application of financial assistance benefits. The payment plan shall take into account the patient's income and assets, the amount owed and any prior obligations, and is further described in the CFVH Credit and Collections Policy.

Uninsured Patient:
An individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Workers Compensation, or other third party assistance to assist with meeting his/her payment obligations.

Underinsured Patient:
An Individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by CFVH. Because "underinsurance" varies based on specific circumstances, requests for financial assistance by patients and guarantors who have other private or public healthcare coverage will be evaluated on a case by case basis. Financial assistance does not apply to routine co-payments which are part of a coverage design.

1. **Eligible Services**

Services and goods eligible under this financial assistance policy include the following:

- Trauma and emergency medical services provided in an emergency setting. Care will continue until the patient's condition has been stabilized prior to any determination of payment arrangements;
- Services for a condition that, if not treated promptly, would lead to an adverse change in the health status of a patient as determined by the ordering provider;
- Labor and Delivery services that require unplanned hospital services such as non-routine deliveries with complications.
- Other services ordered by a medical provider and deemed medically necessary as defined above.

Services not eligible for financial support including the following:

- Elective procedures not medically necessary including, and not limited to, cosmetic services.
- Routine Labor and Delivery services without complications (hospital).
- Other care providers not billed through CFVH (e.g. independent physician services, ambulance transport, etc.). Patients must contact the service providers directly to inquire about assistance and negotiate payments with these practices. See Exhibit C for a listing of these providers.

2. **Eligibility and Assistance Criteria**

Financial assistance shall be extended to patients, or a patient's guarantor, in accordance with the CFVH mission and values. Eligibility for financial assistance shall be considered for those individuals who are uninsured, underinsured and unable to pay for their care, based upon a determination of financial need in

accordance with this Policy. When determining patient eligibility, CFVH does not take into account race, gender, age, sexual orientation, religious affiliation, or social or immigrant status. CFVH shall provide financial assistance to patients, or a patient's guarantor, in compliance with federal, state, and local laws.

Patients residing outside the CFVH service area will not be eligible for financial assistance for non-emergent, scheduled hospital services that are available from providers in their county of residence. County of residence is not a qualifying criteria for eligibility for financial assistance in the FMN Clinics.

CFVH shall make affirmative efforts to help a patient, or patient's guarantor, apply for public and private programs.

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patients shall be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

The Federal Poverty Guidelines shall be used for determining a patient's eligibility for financial assistance. Eligibility for financial assistance will be based on a family income. Owned assets may be reviewed and considered if the request for financial assistance exceeds $1,000.

Presumptive Eligibility: CFVH recognizes that not all patients, or patients' guarantors, are able to complete the financial assistance application or provide required documentation. For those patients, or patients' guarantors, who are unable to provide required documentation but meet certain financial need criteria, CFVH may grant financial assistance. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless
- Patient is deceased with no known estate
- Patient is eligible for Medicaid in any state
- Patient has filed bankruptcy and funds are not available to satisfy the debt
- Patient is unable/incompetent to comply with the application requirements but has no known financial resources

3. **Amounts Billed to Patients Eligible for Discounted Care**

Bills for services provided by CFVH to patients eligible for assistance under this policy will be tendered at gross charges, less the applicable discount. The amounts to be collected from patients eligible for discounted care shall not exceed the AGB (Amount Generally Billed) as defined elsewhere in this policy. No patients found eligible for financial assistance will be expected to pay gross charges for eligible services while covered under the CFVH financial assistance policy.

4. **Notification about Financial Assistance**

Patients will be informed of the availability of this Financial Assistance program by the following means:

- Signage posted conspicuously at admission/registration areas
- Language in the hospital "Conditions of Admission"
- Brochures conspicuously placed and provided to uninsured and underinsured patients at the point of admission/registration

- Relevant information on the hospital's website www.cfvh.org

In addition to the methods noted above, CFVH will make a financial assistance policy summary available to patients, and patients' guarantors. Financial assistance information, including a contact number and website address shall be included in patient bills and through oral communication with uninsured and potentially underinsured patients at registration/admission and when attempting phone contact with the patient/guarantor during the collection cycle. CFVH will provide financial counseling to patients about their CFVH bills and will make the availability of such counseling known. It is the responsibility of the patient or the patient's guarantor to schedule assistance with a financial counselor and cooperate in the counseling process.

A request for financial assistance may be made by a patient, a patient's guarantor, a family member, close friend or associate of the patient, subject to applicable privacy laws. CFVH will also respond to any oral or written requests for more information on the financial assistance policy made by a patient or any interested party.

5. **Applying for Financial Assistance**

The patient/guarantor may obtain an application from hospital staff during registration, while a patient or from the hospital's website

Application and Documentation:

All applicants must complete the CFVH Financial Assistance application form and provide requested documents when applying for financial assistance. Documents may include:

- Income information such as recent pay stubs, supporting documentation for self-employed income, the most recent income tax return and bank statements

If the patient's hospital balances exceed $1,000 and/or a patient is requesting an extended payment plan, the patient may be asked to complete the application addendum which includes the following information:

- Monthly expense details
- Asset information

Note: Asset and expense information will NOT be considered when the request for financial assistance is limited to FMN clinic services.

CFVH will make affirmative efforts to help patients, or a patient's guarantor, apply for public or private programs, for which they may qualify and that may assist them in obtaining and paying for healthcare services.

Requests for financial assistance shall be processed promptly, and CFVH shall notify the patient or applicant in writing of their determination within 30 days of receipt of a completed application. If denied eligibility for financial assistance, the patient may re-apply whenever there has been a change of income or status. A financial assistance application may also be re-submitted at subsequent times of service if the most recent

financial assistance determination was made more than one year prior. An appeal process for those denied benefits under this policy is offered under Section IX.

6. **Timeline for Establishing Financial Eligibility**

   For non-emergency services, every effort will be made to determine the patient or guarantor's eligibility for financial assistance prior to, or at the time of admission or service. However, determination for financial support can be made during any stage of the patient's stay after stabilization of medical condition or during the collection cycle, up to 240 days following the patient's first billing statement.

   Requests for financial assistance shall be processed promptly, and CFVH shall notify the patient or applicant in writing within 30 days of receipt of a completed application. If eligibility is approved, the patient may be granted financial assistance for a period of six months. Financial assistance may also be applied to all eligible accounts incurred for services received eight months prior to application date.

   If a patient, or a patient's guarantor, have been issued a financial assistance application, but have not returned the application and complete supporting documentation within the 30-day required timeline, this may result in a denial of the application due to non-compliance. A denial letter shall be sent to the patient in the event of denial of financial assistance due to noncompliance. If it is determined that additional time is needed to submit the financial assistance application, the patient, or patient's guarantor, may request an extension of up to 15 days to remain compliant with the financial assistance process. The time requirements will be plainly stated in CFVH financial assistance policy, any financial assistance plain language summaries made available to patients or interested parties, and on the financial assistance application itself.

7. **Appeals and Dispute Resolution**

   Patients may seek a review from CFVH in the event of a dispute over the application of this financial assistance policy. Patients denied financial assistance may also appeal their eligibility determination.

   Disputes and appeals may be filed by contacting CFVH's CFO. The basis for the dispute or appeal should be in writing and submitted within 30 days of the patient's experience giving rise to the dispute or notification of the decision on financial assistance eligibility, addressed as follows:

   Chief Financial Officer
   Clark Fork Valley Hospital
   P. O. Box 768
   Plains, MT 59859

8. **Record Keeping**

   CFVH will document any and all requests for financial assistance and eligibility determinations, whether denied, granted fully discounted (no charge) care or discounted care, in order to maintain proper controls and meet all internal and external compliance requirements.

9. **Actions in the Event of Non-Payment**

   CFVH will make reasonable efforts to provide uninsured patients, and potentially underinsured patients, with information about our financial assistance policy, such as including a summary of it with billing statements, before CFVH and our collections vendors take certain actions to collect payment. CFVH Credit and Collections

Policy shall comply with federal and state regulations and laws governing healthcare billing and collections.

No extraordinary collection actions will be pursued against any patient within 120 days of issuing the initial bill or without first making reasonable efforts to determine whether that patient is eligible for financial assistance.

As outlined in the separate Credit and Collections policy, CFVH may pursue collections actions against patients found ineligible for financial assistance, patients who received discounted care but are no longer cooperating in good faith to pay the remaining balance, or patients who have established payment plans but are not in compliance with the agreement after an opportunity to cure.

EXHIBIT A

FEDERAL POVERTY GUIDELINES

HHS POVERTY GUIDELINES FOR 2021

The 2021 poverty guidelines are in effect as of April 1, 2021

See also the Federal Register notice of the 2021poverty guidelines, published January 13, 2021

2021 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

	Poverty guideline	133% Poverty	175% Poverty	250% Poverty
FAMILY SIZE	**100% DISCOUNT**	**75% DISCOUNT**	**50% DISCOUNT**	**42% DISCOUNT**
1	$12,880.00	$17,130.00	$22,540.00	$32,200.00
2	$17,420.00	$23,169.00	$30,485.00	$43,550.00
3	$21,960.00	$29,207.00	$38,430.00	$54,900.00
4	$26,500.00	$35,245.00	$46,375.00	$66,250.00
5	$31,040.00	$41,283.00	$54,320.00	$77,600.00
6	$35,580.00	$47,321.00	$62,265.00	$88,950.00
7	$40,120.00	$53,360.00	$70,210.00	$100,300.00
8	$44,660.00	$59,398.00	$78,155.00	$111,650.00
For families/households with more than 8 persons, add $4,480 for each additional person.				

EXHIBIT B

AMOUNT GENERALLY BILLED

Clark Fork Valley Hospital calculates it's "Amount Generally Billed" based on the total amount billed to Medicare, Medicaid, and all Commercial payers less all contractual adjustments attributed to those payers. The AGB is the percentage of the health care bill eligible for payment after application of adjustments. No patient eligible for Financial Assistance will pay a discounted rate more than AGB. The AGB is compiled annually at the end of December based on the previous year's total billings and Financial Assistance adjustment percentages will be changed, if necessary, by April 1.

As of December 31, 2020, the AGB for Clark Fork Valley Hospital was calculated as follows:

Financial Class Name	Sum of Total Charges	Sum of Total Insurance Adjustments
Commercial	$ 5,284,230	$ (1,258,919)
Medicaid	$ 7,966,043	$ (3,016,372)
Medicaid HMO	$ 98,464	$ (31,714)
Medicare	$ 16,744,576	$ (8,349,655)
Medicare HMO	$ 3,864,783	$ (1,897,823)
Other	$ 323,660	$ -
OTHER GOVERNMENT	$ 2,171,765	$ (1,072,106)
Worker's Comp	$ 443,204	$ (84,086)
Grand Total	**$ 36,896,725**	**$ (15,710,675)**

AGB Discount = $15,710,675/$36,896,725 = 42%

For the period April 1, 2021 to March 31, 2022 the minimum discount under the CFVH Financial Assistance Policy is 42%

EXHIBIT C

Independent Providers – Services provided by the following independent providers are not included in the CFVH Financial Assistance Program.

Northwest Imaging (Radiology)
(855) 777-1422

Vibrant Hearing, DO (Audiology)
(406) 549-1951

Paul Coats, FNP (Neurology)
(406) 752-5095

Dr. Sharon Hecker, MD, FACC (Cardiology)
(844) 500-6800

International Heart Institute (Cardiology)
(877) 444-5615

St Patrick Hospital (Pathology Services)
(406) 543-7271

IRhythm (Cardiopulmonary)
(888) 693-2401

Dr. Brian Schenavar, DPM (Podiatrist)
(406) 543-5333

Dr. Laura A Salyers, MD (Psychiatry)
(406) 327-3362

Pacific Medical (Durable Medical Equipment)
(406) 327-9200

Aegis Labs (Toxicology)
(800) 553-7052

Afirma (Thyroid Analysis)
(888) 923-4762