Carson Valley Medical Center
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CARSON VALLEY MEDICAL CENTER	Section/Number	Reviewed/Revision Date:
Department: **CVMC Admitting**	ADT 550.01	10/03/2013, 11/11/2015, 06/21/2016, 04/18/2017, 09/8/2017, 08/28/2018
Minden Family Medicine & Complete Care		02/07/2019, 03/07/2020,7/14/2020
Topaz Ranch Medical Clinic	**New Date:**	
Title: **Financial Assistance Policy**	9/8/17	Page 1 of 14 Pages

POLICY:

Financial assistance is provided only when care is deemed medically necessary and after patients have been found to meet all financial criteria. Carson Valley Medical Center offers both free care and discounted care, depending on individuals' family size and income.

Patients seeking assistance may first be asked to apply for other external programs as appropriate before eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the financial ability to purchase health insurance may be asked to do so to help ensure healthcare accessibility and overall well-being.

PURPOSE:

Consistent with our Vision to strengthen our community by providing accessible, affordable, high quality healthcare to all, Carson Valley Medical Center is committed to providing financial assistance to uninsured or underinsured individuals who are need of emergency or medically necessary treatment.

DEFINITIONS:

1. Community Care: Medically necessary services rendered without the expectation of full payment to patients meeting the criteria established by this policy.
2. Medically Necessary: Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:
   - Provided in accordance with generally accepted standards of medical practice;
   - Clinically appropriate with regard to type, frequency, extent, location and duration;
   - Not primarily provided for the convenience of the patient, physician or other provider of health care;
   - Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
   - The most clinically appropriate level of health care that may be safely provided to the insured.
3. Emergency 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.
4. Uninsured: Patients with no insurance, third-party assistance, or other contractual arrangement to help resolve their financial liability to healthcare providers.
5. Underinsured: Patient having some insurance coverage but not enough, or when a patient is insured yet unable to afford the out-of-pocket responsibilities not covered by patient insurer.

6. Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care (determined as described in section D of the policy below).
7. Presumptive Eligibility: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

PROCEDURE:

A. Referral Process:

1. The referral process will optimally occur prior to or at the time of service, but may occur any time during the collection process, including post-assignment to an outside collection agency.
2. Uninsured patients may first be screened by an eligibility vendor or financial counselor to determine eligibility for an alternate payer source, including but not limited to federal, state, or county assistance.
3. Referrals for the Community Care Program may be made by the following areas: Patient Access, Patient Accounting, Eligibility Vendor, Collection Agency, Physician Practice, and other community organizations.
4. Community Care referrals should be made prior to any planned procedure.

B. Screening Process:

1. All patients with the inability to pay will be screened for outside financial assistance by Patient Access, Customer Service, or an eligibility vendor based on time of service. If found not to be eligible for any outside assistance, the patient is referred to the Patient Financial Counselor for Community Care screening using the most current income guidelines released by the Department of Health and Human Services. At this time the Community Care application process begins.
2. The financial screening process will be utilized to determine a patient's ability to pay. Other factors to be considered during the screening process include comparing the patient's gross income to the annually published Federal Poverty Guidelines and legal household determination.
3. Uninsured patients may be required to apply for government program assistance through the government program directly, or through Carson Valley Medical Center's eligibility vendor or Patient Financial Counselor for eligibility determination.
4. Patient may be requested to provide proof that they applied for Healthcare Insurance coverage.

C. Healthcare Services Eligible for Assistance

1. Emergency medical services provided in an Emergency Room setting.
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
4. Medically necessary services, evaluated on a case-by-case basis at Carson Valley Medical Center's discretion.

D. Eligibility Criteria:

1. Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care program, and who are unable to pay for their care based upon a determination of financial need in accordance with policy.
2. The Financial Assistance Program may only be used for medically necessary care as defined in the definitions section 2 above.
3. All applicants will be assigned a Federal Poverty Level (FPL) using the matrix found in the most current FPL table as defined by the IRS (Attachment A).
4. Household number of legal dependents may be confirmed based on the latest filed tax return. Unusual circumstances will be considered on a case-by-case basis.
5. Patients with a household FPL ≤350% will be considered for the Community Care program. Patients with an FPL >350% are not eligible and alternate payment arrangements will be pursued.
6. Patients eligible for the following programs/services are deemed medically indigent and may not require a complete Community Care application in order to be considered for the program:
    - State assistance programs (food stamps, pharmaceutical assistance programs, welfare, etc.) Patient will need to submit proof of enrollment for determination.
    - Patients currently covered for Medicaid, but not eligible on the date of service, or patients eligible for Medicaid emergency or pregnancy services only.
7. For underinsured patients, a payment, denial, or benefit summary from primary insurance must be secured prior to consideration for Community Care program.
8. Patient cost share amounts, if any, will be determined utilizing the matrix shown in Attachment A.

E. Determining Discount Amount

1. Once eligibility for financial assistance has been established, Carson Valley Medical Center will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) to insured patients for emergency or medically necessary care.
2. To calculate the AGB, Carson Valley Medical Center uses the "look-back" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. Carson Valley Medical Center uses data based on claims processed by Medicare fee for-service and all private commercial insurers for all medical care over the past fiscal year to determine the percentage of gross charges that is typically allowed by these insurers.
3. The AGB percentage is then multiplied by gross charges for emergency and medically necessary care to determine the AGB. Carson Valley Medical Center re-calculates the percentage each year.
4. The discount will be applied to gross charges or balance after insurance once a complete Community Care application has been received and a determination has been made by the committee. (Gross Charges X AGB percentage = Amount adjusted to Community Care or Balance after insurance X AGB percentage = Amount adjusted to Community Care)

F. Application Process

1. Community Care applications (Attachment B) can be distributed by the Patient Access and Business Office departments. Patients can also retrieve a Community Care application from the CVMC website, or online at: [http://www.cvmchospital.org/patients_visitors/financial_assistance.aspx].
2. When requested, supporting financial documentation must be submitted with a completed Community Care application and will include:
    - Prior year filed tax forms
    - At least past 90 days of pay stubs or other sources of income (i.e. social security, unemployment, etc.)
    - Last three months of bank statements, or three months bank summary (all accounts)used to confirm income

3. Completed applications must be returned along with all supporting documentation within 60 days of issuance. Follow up will be made with the patient every two weeks to ensure timely receipt of completed application. Non-cooperation from the patient to follow-up with Patient Financial Counselor requests will result in a denial after 30 days of no response. If no information is received, the account will be placed back in the regular collection flow.
4. Patients will be notified of incomplete information for applications submitted missing any of the supporting documents. Patients will be given an additional 30 days to comply with required documentation requests. Additional time to submit requested documentation or documentation request waivers may be provided on a case-by-case basis. Failure to comply with additional requests will result in a denial of Community Care application.

G. Application Review

1. Completed Community Care applications with required supporting documentation will be forwarded to the appropriate staff member, who will be responsible for assembling the complete Community Care application packet.
2. Patients may be contacted at any time during the application review process and asked to submit additional documentation necessary to make a determination. Non-cooperation of such requests can result in a denial.
3. All Community Care documentation will be scanned into the patient account and/or retained for a minimum of seven years.
4. Completed Community Care application packets will be routed to the appropriate staff member for approval (including applications for pre-approval) on a monthly or as needed basis.

H. Approval

1. Adjustments made for Community Care approvals are completed within the month of approval and requested by the Patient Financial Counselor routed to Manager through appropriate WQ for final adjustment.
2. Community Care approvals are good for a six month period based on approval date. A new application must be completed every six months. Patient will need to re-apply for Community Care with any updated information if financial assistance is needed beyond the approval period.

3. Community Care approvals will include balances up to 6 months prior to the determination.
4. Approval notification (Attachment C1) is sent to the patient within 10 days of decision and financial arrangements are made for any patient balance remaining.
5. It is expected that physicians making Community Care referrals will provide free or partial pay care in proportion to that provided by Carson Valley Medical Center.
6. Accounts eligible for the Financial Assistance will be addressed by the patient financial counselor or customer service within 240 days of first post-discharge statement.

I. Denials

1. Denial notification (Attachment C2) is sent to the patient within 10 days of decision and efforts are made to collect on remaining account balances.
2. Accounts denied for Community Care Assistance will be sent back through the collection process, including re-placement to collection agency.
3. Reconsiderations can be made for patients who submit new or revised information within 30 days of the denial decision notification.
4. Application denial disputes made by the patient/guarantor must be made in writing and forwarded to the Patient Financial Counselor at Carson Valley Medical Center for review and response.

J. Actions in the Event of Non-Payment

The collection actions Carson Valley Medical Center may take if a financial assistance application and/or payment is not received are described in a separate policy.

In brief, Carson Valley Medical Center will make certain efforts to provide patients with information about our financial assistance policy before we or our agency representatives take certain actions to collect your bill (these actions may include civil actions, debt sales, or reporting negative information to credit bureaus).

For more information on the steps Carson Valley Medical Center will take to inform uninsured patients of our financial assistance policy and the collection activities we may pursue, please see Carson Valley Medical Center's Billing and Collections Policy.

You can request a free copy of this summary in person at our facility at 1107 Hwy 395, Gardnerville, NV 89410, by mail, at PO Box 790, Gardnerville, NV 89410, by calling us at 775-783-3080, or online at: [http://www.cvmchospital.org].

K. Eligible Providers

a. Any services billed by Carson Valley Medical Center are eligible for Community Care coverage.

ATTACHMENT "A"

FEDERAL POVERTY INCOME GUIDELINES

CARSON VALLEY MEDICAL CENTER'S ELIGIBILITY DETERMINATION FOR COMMUNITY CARE ASSISTANCE.

Eligibility Guide for 2020: Using household income and size as calculated in the financial screening process identify eligibility for financial discount. Family Size Period Federal Poverty Guidelines (100%): If income is below 250% (shown below) of FPIG eligible for *Full write-off.* If income is above 250% but below 400% (shown below) of FPG, eligible for *Partial write-off.*

Household Size	2020 Yearly Income	0-200%	201% - 225%	226% - 250%	251% - 275%	276% - 300%	301% - 350%
1	$ 12,760	$ 25,520	$ 28,710	$ 31,900	$ 35,090	$ 38,280	$ 44,660
2	$ 17,240	$ 34,480	$ 38,790	$ 43,100	$ 47,410	$ 51,720	$ 60,340
3	$ 21,720	$ 43,440	$ 48,870	$ 54,300	$ 59,730	$ 65,160	$ 76,020
4	$ 26,200	$ 52,400	$ 58,950	$ 65,500	$ 72,050	$ 78,600	$ 91,700
5	$ 30,680	$ 61,360	$ 69,030	$ 76,700	$ 84,370	$ 92,040	$ 107,380
6	$ 35,160	$ 70,320	$ 79,110	$ 87,900	$ 96,690	$ 105,480	$ 123,060
7	$ 39,640	$ 79,280	$ 89,190	$ 99,100	$ 109,010	$ 118,920	$ 138,740
8	$ 44,120	$ 88,240	$ 99,270	$ 110,300	$ 121,330	$ 132,360	$ 154,420
Add for each additional person	$ 4,480	$ 8,960	$ 10,080	$ 11,200	$ 12,320	$ 13,440	$ 15,680

For each additional person add $4,480 for annual income and $ 360 monthly. Carson Valley Medical Center Inpatient Outpatient

Financial Assistance Policy – Plain Language Summary

The Carson Valley Medical Center (CVMC) Financial Assistance Policy (FAP) exists to provide eligible patients partially or fully discounted emergent or medically-necessary hospital care. Patients seeking Financial Assistance must apply for the program, which is summarized below.

Eligible Services – Emergent and/or medically-necessary healthcare services billed by Carson Valley Medical Center.

How to Apply – Financial Assistance Applications may be obtained/completed/submitted as follows:

- Obtain an application in person at Carson Valley Medical Center located at 1107 Hwy 395 Gardnerville, NV. 89410.
- Request to have an application mailed to you by calling (775)782-1625.
- Request an application by mail at Carson Valley Medical Center, Attn: Patient Financial Counselor P.O. BOX 790, Gardnerville, NV 89410.
- Download an application through the Carson Valley Medical Center website: http://www.cvmchospital.org/patients_visitors/financial_assistance.aspx

Determination of Financial Assistance Eligibility – Generally, patients are eligible for financial assistance based on their income level and assets as determined by Federal Poverty Guidelines (FPG) and the patient's ability to pay. Eligible patients will not be charged more for emergency or other medically-necessary care than patients who have insurance. CVMC determines amounts generally billed based on all CVMC claims processed by Medicare and private health insurers over the past fiscal year. Patients have 240 days after the first bill to submit an Application for Financial Assistance. If collections are already underway when the application is received, we will stop collection efforts while a patient's application is processed. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. Please refer to the full policy for a complete explanation and details.

This summary, the Financial Assistance Policy, and Financial Assistance application are available in Spanish by request.