BLUEFIELD REGIONAL MEDICAL CENTER

POLICY NAME : Financial Assistance	POLICY # 16.0105
DEPARTMENT: Patient Access Financial Counseling	PAGE 1 of 9 EFFECTIVE: 10/1/2019
REVIEW DATE: 3/4/2020	REVISED: 3/4/2020

STATEMENT OF PURPOSE: To define and communicate the policy and protocols for providing financial relief to patients who receive non-elective care and do not qualify for State or Federal assistance.

RATIONALE: To provide financial benefit to individuals unable to pay for medical care.

Scope: All Patient Financial Service areas responsible for requesting and evaluating Financial Assistance Applications for the purpose of processing a Financial Assistance discount.

TEXT: It is the policy of Bluefield Regional Medical Center to provide medically necessary care to individuals who present themselves and are unable to pay for such care in accordance with standards and procedures developed by the Hospital. Medical care will not be withheld while eligibility for Financial Assistance is being determined.

PROCEDURE:

Notices will be posted of the availability of Financial Assistance. Applications deemed eligible will receive a 100% reduction of eligible charges.

The following classes of patients may qualify for a Financial Assistance discount based on income and net worth as well as other extenuating circumstances. Income must not exceed 200% of the Federal Income Poverty Guidelines and liquid assets in excess of indebtedness may not exceed $5,000. The number of persons considered in the home will only be the patient and/or responsible party dependents.

ELIGIBILITY CRITERIA

Classes of patients eligible for Financial Assistance consideration:

Under insured: Patients with limited third party payer coverage but such coverage is insufficient to pay the current bill and indigency is established. No Financial Assistance

discount can be applied to any account with any outstanding payer liability. We do not delay or deny emergency or medically necessary care based on inability to pay or based on any outstanding balances due the Hospital on prior accounts.

Uninsured: Patients with no third party payer coverage who have made application for Financial Assistance determination.

Agency Return: Accounts returned from the primary collection agency determined to be indigent and documented on the close and return report as willing but unable to pay.

Bankruptcy: Chapter 7 bankruptcy accounts where no assets exist and legal interpretation has been made of inability to pay and the Hospital cannot pursue collections will be classified as a Financial Assistance discount.

Presumptive Charity: Patients who do not complete a Financial Assistance Application can receive a Financial Assistance discount at the Hospital's discretion and subject to legal limitations. Prior to placement of accounts for collection with the Primary Bad Debts Collection agency and after placement with the early out vendor, the Hospital utilizes a predictive model to "score" individual ability to pay based on defined criteria which includes:

* Income and household size estimates
* A socio-economic need factor
* Information on home ownership.
* Less than 200% of poverty guidelines
* The Presumptive Charity score results can be substituted for incomplete Financial Assistance application requirements on a discretionary basis.

Forensic Medical Examinations: WV Code Section 61-8B-16, under subsection (b), restricts any and all licensed medical Facilities from "collecting costs" related to" a forensic medical examination" from a patient or the patient's insurance when the patient alleges that he or she is a victim of a violation of a sexual offense under Article 8B of Chapter 61 of the WV Code.

Required: Patients presenting to the Financial Counselor/Patient Support Services must complete a Financial Assistance Application to be considered and are referred to the appropriate vendor for a Medicaid determination. Patients who present and refuse to apply for a Medicaid determination are deemed ineligible. To the extent possible, the Hospital may waive the requirement to apply for a Medicaid determination.

The following classes of patients are considered ineligible for a Financial Assistance discount:

Criteria Classes of patients ineligible for Financial Assistance consideration:

Elective: Patients who receive elective services are required to make an advance payment. Example: Cosmetic procedures which do not impact the patients overall health.

Uncooperative: Patients will be sent a letter 2 weeks from the date of receiving the application if additional information is required. If no response is received from the applicant, the application will be denied if the required information is not provided to the Hospital within 30 days of the date of the last correspondence from the Hospital requesting information regarding the application Patients who do not provide the required documentation

will be denied Financial Assistance and normal collection procedures will proceed. A copy of the application and reason for denial will be provided to the applicant within 30 days.

Note:
Patients who present and refuse to apply for a Medicaid determination are deemed ineligible for Financial Assistance or a Financial Assistance discount.

Exceed income: Patients with income as measured in excess of 200% of the Federal Income Poverty Guideline compared to family unit size.

Net worth: Patients whose liquid assets exceed indebtedness by more than $5000 are ineligible. Patients may apply the amount in excess of $5000 to the medical expenses to become eligible.

Patients whose monthly income exceeds monthly living expenses and that excess when annualized exceeds the $5000 net worth threshold will be required to establish an appropriate payment option.

Following a determination of FAP-eligibility, a FAP-eligible may not be charged more than amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage.

Note: Patients who are ineligible for the Financial Assistance discount may be granted the uninsured discount as defined by the Uninsured/Underinsured Policy.

Extenuating circumstances where the patient/guarantor is not able to complete the Financial Assistance Application and/or provide supporting documentation and resource verification will be evaluated on a case by case basis and subject to legal limitations.

The Patient Support Service Manager can waive the documentation requirements for the following:

Undocumented Residents or homeless through:

- Medicaid Eligibility screening
- Registration process
- Discharge to a shelter
- Case Management documentation
- Attempt to run a credit report

Patient Expiration: After research through a family contact and/or courthouse records, a determination is made that an expired patient docs not have an estate and this is documented for the file.

Medically Indigent: Based upon research by Patient Support Services Manager, the patient/responsibility party meets the indigent status and no application was completed due to extenuating circumstances and/or process. Presumptive Charity qualifies under this requirement.

Services Covered/Not Covered Under Financial Assistance Policy.

The Hospital contracts with certain medical groups and third-party providers of medical care. Appendix A to this policy lists the providers who provide emergency or medically necessary care in the Hospital's facility and indicates those who are covered and those who are not covered under this Policy. If a medical provider and/or certain services supplied by a medical provider are not covered, this means that Financial Assistance is not available under this Policy for these services.

Please provide the following information in order for the Hospital to evaluate whether you are eligible for Financial Assistance-

Income Verification requirements:

- Most recent employer pay stubs - gross income 3 months
- Written documentation from income sources
- Most recent bank statements and/or tax returns
- Current credit report at BRMC discretion

Expense requirements:

- Housing, Transportation, Utilities, Living expenses (phone, cable, etc.), Medical, Taxes, Other.

Liquid Asset Verification requirements:

- Most recent checking and saving account statements.
- CD statement from Bank
- Divorce papers and-or Notarized Statement of Divorce
- Shared Custody papers
- Stocks and Bonds

Communication of Eligibility Determination:

- Upon receipt of the completed application and the necessary information to verify income, a final determination will be made and the applicant will be notified in writing within 30 days.
- Requests for additional information will be made promptly upon receipt of the application.
- If you are denied, it means that you did not meet the criteria by which to qualify for financial assistance or did not provide needed information and you are responsible for payment of the care you received. You may reapply for financial assistance by providing all of the required information at the time of filing a new application.
- If the required information is not received in thirty' days, the application will be denied and a copy of the application stating the reason for denial will be provided to the applicant.
- Support Services Manager reviews all supporting documents and makes final determination for approval. Individual cases may be referred to the Patient Financial Service Director and-or

Chief Financial Officer.

Other:

- If the Hospital has instituted collection activity on the specific account that patient is applying for Assistance, the account will be placed on hold from collection activity. If approved, collection activity will be withdrawn. If denied, collection activity will continue. The patient will be informed by written letter.
    - In determining the level and availability of charity care, the overall financial condition of the Hospital will be considered.
    - The Hospital has a separate Billing and Collection Procedures for Self-Pav Balances document which describes the actions that the Hospital takes prior to initiating collection actions on a patient account. A copy of the Billing and Collection Procedures for Self- Pay document may be obtained free of charge by contacting Patient Access Financial Counseling Services at 304-327-1632 or 304-325-1912 between 8:00 - 4:00 Monday through Friday.
    - Installment payments involving physicians and their immediate family members shall only be provided as allowed by the federal Stark physician self-referral law.

METHODS OF APPLYING FOR FINANCIAL ASSISTANCE

- Financial Counselor assists guarantor to complete Medicaid Eligibility Determination and Financial Assistance applications.
- BOLDER staff assists guarantor to complete Medicaid Eligibility Determination and Financial Assistance applications.
- DHHR assists guarantor to complete Medicaid Eligibility Determination and Financial Assistance applications. Guarantor mails completed application to Patient Support Services.
- Incomplete applications will be called or sent a letter outlining the information needed and given a date that this information must be turned in.

METHODS OF NOTIFYING GENERAL PUBLIC AND PATIENTS

- Clearly legible signage located in all registration locations.
- The Financial Assistance Criteria document, which is the plain language summary of the FAP is offered to patients upon intake or discharge.
- Uninsured Patient Information document and Notice of Availability of General Financial Assistance document is presented and explained to patient-guarantor by registration staff.

- Financial Assistance Policy is available at each registration location for patients who indicate they want to apply.
- All patient statements contain the contact number to inquire for Financial Assistance - (304-327-1632 or 304-325-1912).
- Prior to initiating extraordinary collection actions, at least three (3) statements are sent to the patient that include the 501 (r) Financial Assistance Program notification requirements which include, among other things, informing the patient of the availability of Financial Assistance with each statement and providing a plain-language summary of the Financial Assistance Policy to the patient at least once during the 120-day post-discharge period.
- All patient statements contain the facility's web-site address where the Financial Assistance Policy and contact information is located.
- Patients/Guarantors may obtain copy of the Financial Assistance Policy free of charge by calling 304-327-1632 or 304-325-1912.
- Financial Assistance contact information and FAP policy #405 is published on Facility Web-site.www.bluefieldregional.net
- BOLDER Healthcare Solutions staff are on-site to assist the patient and the guarantor.
- Patient Support Services attempts to call the patient for collection. If the patient is reached, the patient is advised of the Financial Assistance Policy and is informed about how to obtain a copy of the same free of charge.
- Guarantor receives a copy of the approval or denial by mail within 31 days of application.
- Vendors and collection agencies contracted with BRMC include on their correspondence the contact number and web site address for patients who wish to apply for Financial Assistance.

Indigent/Charity Guidelines for 2020

Family Size	Federal Poverty Level	150% Poverty Level	200% Poverty Level
1	$12,760	$19,140	$25,520
2	17,240	25,860	34,480
3	21,720	32,580	43,440
4	26,200	39,300	52,400
5	30,680	46,020	61,360
6	35,160	52,740	70,320
7	39,640	59,460	79,280
8	44,120	66,180	88,240
FOR EACH ADDITIONAL FAMILY MEMBER ADD:	$4,480	$6,720	$8,960

Examples of Eligibility Determination

Eligible

Household of 3 with monthly income of $3,181.67 x 12 = $38,180.04 yearly income. Has a Medicaid denial and limited assets which do not exceed indebtedness by $5000.
Most recent employer pay stubs-gross income last 3 months, written documentation from income sources, most recent bank statement and/or tax returns provided.
Housing, transportation, utilities, living expenses detailed / provided.
Most recent checking and saving account, CD statements, divorce papers and –or Notarized statement of divorce, shared custody papers detailed/provided as applicable.

Ineligible

Household of 1 with monthly income of $3,181.67 x 12 = $38,180.04 yearly income.
Patients whose liquid assets exceed indebtedness by more than $5,000 are ineligible.
If any of the eligibility required documentation is not provided the application will be denied.

Reference Documents available upon request free of charge:

- Uninsured Document
- Financial Assistance Document
- Billing and Collection Procedure
- Financials Assistance Instructions

Requirement:
Early out Vendor and Primary Agency must sign off on policy yearly.

APPROVED:

Vice President of Finance

03/05/2020
Date

APPENDIX A

Providers/Groups who are covered by the Financial Assistance Policy

- Providers directly employed by Bluefield Regional Medical Center (including those providing services under or through the names or programs below)
- Bluewell Family Medicine
- Family Residency Clinic
- Internal Residency Clinic
- Bluefield Cardiology Clinic
- Bluefield Family Medicine
- Bluefield Internal Medicine
- Bluefield Orthopedics
- Bluefield Surgical Services

Providers/Groups who are not covered by the Financial Assistance Policy

- Individual Providers with privileges that are not employed by Bluefield Regional Medical Center
- CCI Anesthesia Providers
- Virtual Radiology and BlueRad Radiology Imaging Providers
- Integrated Care Physicians Emergency & Hospitalist Services Providers
- Lab-Corp laboratory services
- Bluefield HBP Group Pathology Providers
- Carl Larson Cancer Center Providers
- Consultative services provided by Providers not employed by Bluefield Regional Medical Center

For further information about which individual providers are directly employed by Bluefield Regional Medical Center, you can call 304-327-1632 or 304-325-1912.