

POLICY TITLE: RHS - RC - Financial Assistance Policy			
RIVERSIDE FACILITY:			
Riverside Health System (to include HRSH, RBHC, RDHW, RRI, RPMC, RSMH, RTH, RWRH)			
CATEGORY:		DISTRIBUTION GROUP:	
Revenue Cycle, Patient Access, Customer Service Center		RHS	
EFFECTIVE DATE: 6/4/2017			
AUTHORIZED BY: Director, Patient Accounting			
DATE OF ORIGIN: 10/1/2002	LAST DATE OF REVIEW: May 2017	LAST REVISION DATE: 5/22/2017	Page 1 of 6

Revision Date	Revision Description (Most Recent)
5/31/2017	Added Sliding Scale

POLICY STATEMENT: Riverside Health System understands that health care expenses are often unexpected and the costs may be more than patients can afford. Riverside Health System is a not-for-profit organization with a mission for providing excellent care to all patients without regard for ability to pay for clinically urgent care.

POLICY:

Riverside Health System will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance. Accordingly, this written policy:

- Includes eligibility criteria for financial assistance
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients are considered eligible for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to less than the amount generally billed (received by) the hospital for Medicare patients.

Prior to seeking financial assistance, the patient and Riverside will pursue reasonable forms of third party payment to include all benefits from any third party insurance source, benefits from State or Federal assistance programs, pending litigation and all benefits from any charitable organization.

RIVERSIDE SCOPE:

Riverside Health System financial assistance policies cover the following: Riverside Regional Medical Center, Riverside Tappahannock, Riverside Walter Reed, Riverside Shore Memorial, Doctors Hospital of Williamsburg, Riverside Rehabilitation Institute, Riverside Behavioral Health Center, Hampton Roads

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Specialty Hospital and all locations which operate as a “department of” one of the above listed acute care facilities. There are no providers, other than those listed in Appendix A, who are covered under this policy. The provider listing is updated quarterly. For further clarification, MD Express, Skilled Nursing Facilities, Wellness Centers, Home Health, Hospice, and Retirement Communities are not included in this policy.

ELIGIBILITY FOR FINANCIAL ASSISTANCE:

Eligibility for Financial Assistance for emergency and medically necessary conditions will be considered for those individuals who are ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social status, sexual orientation, or religious affiliation.

To qualify for a patient discount, patients must meet the following guidelines:

1. Scheduled for or have received services at a Riverside Acute facility.
2. Meet at least one of the criteria below:
 - a. Are a U.S. citizen; or
 - b. Carry a United States Permanent Resident Card (USCIS Form I-551); or
 - c. Live in Riverside’s service area (defined by a 50 mile radius around those facilities defined under the *Riverside Scope* section of this policy)
3. Meet one of the criteria below:
 - a. Be uninsured and have household income at or below 200% of the Federal Poverty Level to receive a 100% write off; or
 - b. Be insured and have household income at or below 200% of the Federal Poverty Level to receive a 100% write off of patient liability after insurance has been finalized; or
 - c. Be uninsured with a household income between 201% and 400% of the Federal Poverty Level to receive a 75% write off of eligible billed charges.

Uninsured patients that do not qualify for financial assistance will receive a 50% administrative adjustment off of eligible billed charges.

Federal Poverty Guidelines can be found at the following link: <https://aspe.hhs.gov/poverty-guidelines>

Uninsured patients can be qualified for financial assistance through presumptive charity using third party scoring software when available. Otherwise patients must submit a complete financial assistance application.

The financial assistance application must be completed and submitted within 180 days after the first post discharge bill. A call center representative can assist patients by providing someone to help fill out the form. They can be reached at (757) 989-8830; option #3

If the individual subsequently submits a complete financial assistance application and/or is determined to be eligible for financial assistance, a refund will be provided if the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying, unless such amount is less than \$5.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

- **Financial Assistance:** Healthcare services that have been or will be provided but are never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.
- **Charity Care:** Services provided to a patient who does not have the financial ability to pay for medical care. Charity Care services is applicable only to emergent and medically necessary services.
- **Medical Indigence:** The condition in which individuals are financially unable to access adequate medical care without depriving themselves and their dependents of food, clothing, shelter, and other essentials of living.
- **Family:** Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
- **Family Income:** Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
 - Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources; Noncash benefits (such as food stamps and housing subsidies) do not count;
 - Determined on a before-tax basis;
 - If a person lives with their immediate family, includes the income of all family members
- **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.
- **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.
- **Emergency medical conditions:** Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.
- **Medically necessary:** Defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

SERVICES ELIGIBLE UNDER THIS POLICY:

The following healthcare services are eligible for financial assistance, when eligibility criteria have been met:

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 nonemergency room setting; and
4. Medically necessary services as defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).
5. Patients referred from a Free Health Clinic to the hospital for diagnostics are automatically deemed eligible for charity if not covered by Medicare, Medicaid, or other payment source.

SERVICES INELIGIBLE UNDER THIS POLICY:

The following healthcare services are ineligible for financial assistance:

1. Elective Procedures including Cosmetic and Retail Procedures
2. Retail Services or items
3. Gastric Bypass
4. Services that require the issuance of a Medicare Advance Beneficiary Notification (ABN)
5. Medicare outpatient statutorily excluded services that are non-covered and do not require an ABN (i.e. pharmaceuticals, dental, etc.)

CATASTROPHIC

If a patient's aggregate medical bills within a twelve month period total more than 100% of annual income, the patient will be declared medically indigent and is eligible for 100% charity of patient liable amount, regardless of income.

POLICY EXCEPTIONS:

The Chief Financial Officer, Vice President of Revenue Cycle, System Director of Patient Accounting, System Director of Patient Access, and Director of Patient Accounting 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 they meet the eligibility and determination requirements set forth in this policy.

AMOUNTS GENERALLY BILLED (Allowed):

This policy limits the amounts that Riverside will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to the amount generally billed (allowed) by the hospital for Medicare patients. This is calculated using the prospective method to set amounts generally billed at the amount Riverside determines Medicare would allow/pay. You can call our Customer Service department for a quote of amount generally billed to Medicare for your service at (757) 989-8830; option #3. This percentage determination can be obtained in writing and by mail, free of charge, in any of the following languages English and Spanish.

PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY:

Riverside Health System may use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility. If current presumptive eligibility is unavailable, Riverside may use a prior determination of eligibility of up to 180 days prior to service date.

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COMMUNICATION OF THE FINANCIAL ASSISTANCE PROGRAM TO PATIENTS AND OUR COMMUNITY:

Notification about the financial assistance program is available from Riverside Health System, which shall include a contact number, shall be disseminated by Riverside Health System by various means, which may include, but are not limited to, the publication of notices in patient bills, providing Financial Assistance Brochures in emergency rooms, admitting and registration departments, hospital business offices, patient financial services offices, and at other public places as Riverside Health System may elect. Riverside Health System also shall publish and widely publicize this financial assistance policy on facility websites. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Riverside Health System.

The following documents are available in English and Spanish at no charge. Patients may obtain additional information and / or paper copies of the following documents in person by visiting any Riverside Hospital Admissions Department, by mail, via our website or by calling our Customer Service Center:

Financial Assistance Policy #7.30

Collections Process policy #7.37

Patient Liability Assistance policy #7.31

Riverside Health System – 1-800-621-7677

Riverside Health System
608 Denbigh Blvd. Ste. 500A
Newport News, VA 23608

RELATIONSHIP TO COLLECTION POLICIES:

Riverside Health System management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collection action and reporting to credit agencies) that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance. Riverside Health System will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance under this policy.

Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the hospital;
2. Documentation that Riverside Health System has or has attempted to qualify the patient for financial assistance pursuant to this policy;

Accounts that have not qualified for financial assistance may be placed with a third party collection agency 120 days after the first billing statement. Patients are able to request reconsideration under this financial assistance policy for an additional 60 days after being placed with a third party collection agency. Reasonable efforts will be made to determine whether a patient is eligible for financial assistance prior to any extraordinary collection action requiring court proceedings.

The System Director of Patient Accounting has final authority to determine when reasonable efforts have been made to determine if a patient is eligible for financial assistance. Once determination is made then extraordinary collection efforts can begin against the individual as necessary.

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REGULATORY REQUIREMENTS:

In implementing this Policy, Riverside Health System management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

APPLYING FOR 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 https://www.riversideonline.com/patients_guests/financial-assistance.cfm. The Application for Financial Assistance may also be mailed free-of-charge to patients upon request by calling 757-989-8830; option #3, or by sending a written request to the following address:

Riverside Health System
 608 Denbigh Blvd. Ste. 500A
 Newport News, VA 23608

Completed Applications for Financial Assistance, along with proof of Household Income, should be mailed to the address above. 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 the number above Monday through Friday during normal business hours to speak with a customer service representative.

MONITORING:

Outcomes Monitoring – The Patient Accounting System Director shall be responsible for confirming that the policy is being carried out appropriately.

Document Management – The Patient Accounting System Director shall be responsible for developing, communicating and maintaining this policy and related procedures and job aids necessary for the implementation and continuance of the policy. This policy shall be reviewed at least every 3 years for repeal or amendments appropriate.

Revision Date	Revision Description

Related Documents:

<i>Policies</i>	
<i>Procedures</i>	
<i>Job Aids</i>	
<i>References</i>	