Administrative Policies and Procedures

FINANCIAL ASSISTANCE

POLICY

This Financial Assistance Policy is intended to ensure our patients who are at or near the federal poverty level receive appropriate hospital-based medical services and/or appropriate non-hospital-based medical services at a cost that is based on their ability to pay for services up to and including care without charge. Regardless of insurance (Medicare, Medicaid, Apple Health, Children's Health Insurance Program, etc.), Valley Medical Center does not discriminate when providing financial assistance. Financial assistance will be provided to all eligible persons regardless of age, race, color, religion, sex, sexual orientation, or national origin in accordance with Chapter 246- 453 WAC and Chapter 70.170 RCW.

POLICY AVAILABILITY

A notice advising patients that Valley Medical Center provides financial assistance is posted in key areas of the hospital, including Admitting, Financial Counseling, Emergency Department, and Outpatient Registration that will notify the public of the Financial Assistance Policy.

Eligibility for financial assistance requires that patients must fulfill all requirements and expectations as outlined in the Financial Assistance Policy. This Financial Assistance Policy, its plain language summary, application, and billing & collection policy for Financial Assistance are available in any language spoken by the lesser of five percent of the population or 1,000 individuals in the applicable hospital's service area. Additionally, interpreter services will be made available for other non-English speaking or limited-English speaking patients or patients who cannot read or understand the written application materials. Copies are available free of charge on Valley Medical Center websites and upon request.

DEFINITIONS

Financial Assistance: Medically necessary health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer based on the criteria in this policy.

Indigent Persons: Those patients or their guarantors who qualify for financial assistance under this Financial Assistance policy based on the federal poverty level, adjusted for family size, and who have exhausted any third-party coverage.

Third-Party Coverage: An obligation on the part of an insurance company, health care services contractor, health maintenance organization, group health plan, government program (Medicare, Medicaid or medical assistance programs, workers compensation, veteran benefits), or tribal health benefits to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others (for example, auto accidents or personal injuries) which have resulted in the medical condition for which the patient has received health care services. Valley Medical Center will evaluate other coverages (e.g., health care ministry) for reimbursement on a case-by-case basis.

Appropriate Hospital-Based Medical Services: Those Valley Medical Center hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. A course of treatment may include mere observation or, where appropriate, no treatment at all. Appropriate hospital-based services do not include care in Place of Service 11 freestanding clinics/physician offices even if associated with Valley Medical Center.

Appropriate Non-Hospital-Based Medical Services: Those services rendered, in Place of Service 11 freestanding clinics/physician offices by Valley Medical Center, which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. A course of treatment may include mere observation or, where appropriate, no treatment at all. For purposes of this Financial Assistance Policy, preventive care services may be considered "appropriate non-hospital-based medical services".

Emergency Medical Condition: 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:

1. Placing the health of the individual (or, with respect to a pregnant patient, the health of the patient or their unborn child) in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant patient who is having contractions the term shall mean:

1. That there is inadequate time to affect a safe transfer to another hospital before delivery; or
2. That the transfer may pose a threat to the health or safety of the patient or the unborn child.

Place of Service 11: For purposes of this policy, this term shall indicate all Valley Medical Center Primary Care locations and any other freestanding clinic or non-hospital physician office setting in which a healthcare professional renders services and bills a professional fee.

Valley Medical Center Physicians Members: For purposes of this policy, a physician or other qualified healthcare professional who has executed a practice agreement with Valley Medical Center Physicians or has otherwise reassigned their services to Valley Medical Center Physicians under a contractual arrangement and provides services at approved Valley Medical Center sites of practice.

ELIGIBILITY CRITERIA

Persons seeking Financial Assistance must meet eligibility requirements and complete an application process, as described herein.

Scope of Services

Eligibility for financial assistance requires that the medically necessary services sought are appropriate hospital-based medical services, as opposed to services which are investigational, elective, or experimental in nature. Exceptions to the scope of services requirements outlined in this paragraph may be made only in extraordinary circumstances and with the approval of the Valley Medical Center Chief Financial Officer or designee. While not required by federal or state law, eligibility for financial assistance will be extended to individuals who receive appropriate non-hospital based medical services and meet the above eligibility criteria under this policy.

Third-Party Coverage

Financial assistance is generally secondary to all other third-party coverage resources available to the patient. This includes:

1. Group or individual medical plans.
2. Workers' compensation programs.
3. Medicare, Medicaid, or other medical assistance programs.
4. Other state, federal or military programs.
5. Third-party liability situations. (e.g.: auto accidents or personal injuries).
6. Tribal health benefits.
7. Other situations in which another person or entity may have legal responsibility to pay for the costs of medical services.

Patients who do not follow through in obtaining insurance coverage potentially available to them and for which they are otherwise eligible (e.g., Medicaid, Apple Health) will be individually evaluated for financial assistance.

Before being considered for financial assistance, the patient's/guarantor's eligibility for the third-party payment coverage will be assessed, and the patient/guarantor may be required to apply for coverage under those programs for which they are eligible. Patients who fail to comply with the financial assistance application requirements may be denied financial assistance. Valley Medical Center may choose not to provide financial assistance to any patient/guarantor that is eligible for Washington state retroactive Medicaid and/or other Apple Health programs if the patient/guarantor does not make reasonable efforts to cooperate with the application process for Medicaid or other Apple Health programs. Valley Medical Center will not deny financial assistance to a patient solely based upon the patient's refusal to enroll in a plan available to the patient on the Health Benefits Exchange.

Income

In accordance with law and policy, persons whose income exists within the federal poverty level guidelines based on the date of service may be eligible to receive financial assistance. Valley Medical Center will consider all sources of income in establishing income eligibility for financial assistance. Income includes total cash receipts before taxes derived from wages and salaries; welfare payments; Social Security payments; strike benefits; unemployment or disability benefits; child support; alimony; and net earnings from business and investment activities paid to the individual patient/guarantor.

APPLICATION

When a patient wishes to apply for financial assistance, the patient shall complete a Confidential Financial Information (CFI) Form and provide necessary and reasonable supplementary financial documentation to support the entries on the CFI Form. Valley Medical Center will make an initial determination of a patient's financial assistance status at the time of admission or as soon as possible following the initiation of services to the patient. The financial assistance application procedures shall not place an unreasonable burden upon the patient, taking into account any barriers which may hinder the patient's capability of complying with the application procedures. Screening for eligibility for Washington state Medicaid or other relevant public assistance benefits will be coordinated through the Patient Access Department, Discharge Planning/Outcomes Management (if not nursing home placement) or through Patient Financial Services. Valley Medical Center can assist out of state patients and/or their guarantors in identifying where to apply for Medicaid and Exchange programs within their state.

1. Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of financial assistance eligibility:
    a. "W-2" withholding statement;
    b. Current pay stubs (3 months);
    c. Bank statements (3 months);
    d. Last year's income tax return, including schedules, if applicable;
    e. Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income;
    f. Forms approving or denying eligibility for Medicaid and/or state funded medical assistance;
    g. Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies.
2. In addition, in the event the patient is not able to provide any of the documents described above, Valley Medical Center shall rely upon written and signed statements from either the responsible party or another party describing the applicant's income. If none of the above is available, Valley Medical Center may make a determination based on knowledge of a prior Valley Medical Center grant of financial assistance or based on verbal representation.
3. All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the financial assistance application form and retained for seven years.

Valley Medical Center may waive income requirements, documentation, and verification if Financial Assistance eligibility is obvious. Valley Medical Center staff discretion will be exercised in situations where factors such as social or health issues exist. In such cases, Valley Medical Center shall rely upon written and signed statements from the responsible party for making a final determination of eligibility.

Valley Medical Center shall notify persons applying for financial assistance of its determination of eligibility within 14 days of a receiving person's completed application and supporting documentation. Approval, request for more information or a denial for financial assistance shall be in writing and shall include instructions for appeal or reconsideration. If Valley Medical Center denies financial assistance, Valley Medical Center shall notify the person applying of the basis for the denial. If denied the patient/guarantor may provide additional documentation to Valley Medical Center or request review within 30 days of receipt of the notification of denial. If this review affirms the previous denial of financial assistance, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

Valley Medical Center does not take assets into consideration for determining Financial Assistance eligibility. Valley Medical Center may consider assets and collect information related to assets for determining Hardship eligibility.

FINANCIAL CRITERIA

In the event that a responsible party pays a portion, or all of the charges related to appropriate hospital-based or appropriate non-hospital-based medical services were provided all such payments shall be refunded to the responsible party within 30 days of Valley Medical Center's determination that the patient is eligible for financial assistance. If partial Financial Assistance is approved, refunds will be issued after applying prior patient payments. Additional information can be found in the Billing and Collections policy for the applicable hospital.

Annual family income of the applicant will be determined as of the time the appropriate hospital-based medical services or appropriate non-hospital-based medical services were provided, or at the time of application for financial assistance if the application is made within two years of the time of service, the patient has been making good faith efforts towards payment for the health care services rendered, and the patient demonstrates eligibility for financial assistance. Additional information can be found in the Federal Poverty Level Guidelines: https://www.valleymed.org/patients--visitors/billing-and-insurance/financial-help--options/federal-poverty-guidelines

For facility and/or professional services at Valley Medical Center:

- 0% - 300% of the Federal Poverty Level (FPL) for a 100% financial assistance discount

For facility services only with discharge dates on or after July 1, 2022, at Valley Medical Center:

- 301% - 350% of the Federal Poverty Level (FPL) for a 75% financial assistance discount
- 351% - 400% of the Federal Poverty Level (FPL) for a 50% financial assistance discount

LIMITATION ON CHARGES

Valley Medical Center limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under this Financial Assistance policy to no more than the amounts generally billed (AGB) to individuals who have insurance covering such care and may not collect "gross charges" from such individuals. See 26 USC §501(r)(5)(A) and (B). Refer to the appendix for more information.

PROCEDURE

Responsible Parties: Financial Counseling or Patient Financial Services

A. Guidelines/Steps

Valley Medical Center provides comprehensive patient screening and financial assistance awareness. Valley Medical Center will make every reasonable effort to make the determination of any third-party coverage for medically necessary health care. Valley Medical Center will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under Chapter 74.09 RCW or the Washington Health Benefit Exchange. If information in a Financial Assistance application indicates that the patient or their guarantor is eligible for coverage, Valley Medical Center will assist the patient or their guarantor in applying. In addition, trained navigators are available to assist with:

- General questions
- Access to Interpreter Services
- Washington state Medicaid, Medicare, and Washington state Health Benefit Exchange enrollment

Patients/Guarantors are identified for Financial Assistance screening at various points such as preservice/scheduling, during their visit/registration, and post service/billing.

Financial Assistance awareness includes:

- Signage is displayed in key public areas of the hospital, emergency department and clinics in languages spoken by more than the lesser of five percent (5%) of the population or 1,000 individuals in the applicable hospital's service area. Virtual signage is provided within MyChart for patients scheduling electronically.
- Valley Medical Center offers Financial Assistance documents at: valleymed.org/financialassistance.
- Staff are trained to communicate the availability of financial assistance and refer patients for support.
- Valley Medical Center has established a standardized annual training program on its Financial Assistance Policy and the use of interpreter services to assist persons with limited English proficiency and non-English- Speaking persons in understanding information about its Financial Assistance Policy. This training is appropriate for front-line staff who work in registration, admitting, emergency department, and billing, and any other appropriate staff, to answer financial assistance questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.
- Patient billing communications offer financial assistance availability in English and Spanish (second most common language spoken).

Valley Medical Center will not initiate collection efforts until an initial determination of financial assistance eligibility status is made. Where Valley Medical Center initially determines that a patient may be eligible for financial assistance, any and all extraordinary collection actions (including civil actions, garnishments, and reports to collections or credit agencies) shall cease pending a final determination of financial assistance eligibility.

However, as set forth in WAC 246-453-020 (5), the failure of a patient or responsible party to reasonably complete Financial Assistance application procedures under this policy shall be sufficient grounds for Valley Medical Center to initiate collection efforts directed at the patient. Accordingly, for purposes of this policy, a patient or responsible party has failed to reasonably complete Financial Assistance Application procedures when the patient or responsible party does not submit application materials within 15 business days of the patient's or responsible party's receipt of the materials. Any collection efforts will be halted if the patient or responsible party reengages in the application process.

Accounts assigned to a collection agency and have judgement granted through the court system are no longer eligible for financial assistance consideration. A patient may apply for financial assistance at any time prior to the account receiving a court judgement.

REVIEW/REVISION DATES:
3/2/2015, 3/23/2016, 4/18/2016, 10/2/2017, 10/1/2018, 5/29/2019, 1/1/2020, 1/12/2022, 07/01/2022, 02/15/2024, 06/17/2024, 10/01/2024 / 04/23/2025

APPENDIX:
Amounts Generally Billed (AGB) Guidelines

Appendix
Amounts Generally Billed (AGB) Guidelines

If you receive assistance under the Valley Medical Center Financial Assistance Policy, Valley Medical Center may not charge you more than the amounts generally billed (AGB) to individuals who have insurance covering the same services. IRS Section 501(r)(5) requires 501(c)(3) hospitals to limit the amounts charged to Financial Assistance Policy eligible individuals to less than the gross charges for that care. A patient/guarantor eligible for financial assistance will be "charged" only patient responsibility portion of the bill, after all adjustments and insurance payments have been applied (if applicable).

Valley Medical Center determines AGB based on the "look-back method" by multiplying gross charges for that care by one or more percentages of gross charges, called "AGB percentage." The AGB percentage is calculated annually by dividing the full amount of all of Valley Medical Center claims that have been allowed by health insurers during the prior 12-month period by the sum of the associated gross charges for those claims. For these purposes, the full amount allowed by a health insurer includes both the amount to be reimbursed by the insurer and the amount (if any) the patient/guarantor is responsible for paying in the form of co-payments, co-insurance, or deductibles.

The AGB calculation is performed annually. Once eligibility for financial assistance is approved, Valley Medical Center will apply the applicable financial assistance adjustments based on the Federal Poverty Guidelines. If the balance due is more than the AGB allowable amount, an additional adjustment will be applied to the balance to reduce it to the AGB percentage.

Entity	Hospital & Professional Combined AGB Rate (effective7/1/2022)	Questions
Valley Medical Center	31%	425.690.3578

Consistent with the Patient Protection and Affordable Care Act, hospitals which are nonprofit and recognized as 501(c)(3) organizations (including **Valley Medical Center**) must limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under this Financial Assistance Policy to not more than the amounts generally billed to individuals who have insurance covering such care and may not collect "gross charges" from such individuals. *See* 26 USC §501(r)(5)(A) and (B).

Valley Medical Center satisfies this requirement by writing off all charges for individuals who qualify for financial assistance under this policy. Valley Medical Center provides information regarding this policy to local nonprofit and public agencies that address the health needs of their respective communities' low-income populations.

Additionally, Valley Medical Center maintains plain language summaries of this policy, available in languages spoken by more than the lesser of 5% of the population or 1,000 individuals in the applicable hospital's service area. Valley Medical Center will provide copies of this policy, its plain language summary, and application free of charge on their websites, upon request where medical services are performed and via US Mail at:
Valley Medical Center Financial Counseling, 400 South 43rd St., Renton, WA 98055-5010; (425) 690-3578; (open M to F, 8:30 a.m. to 5:00 p.m.).