SENTARA®

Policy:	Financial Assistance Policy		
Entity:	Princess Anne Ambulatory Surgery Management, LLC	**Original Date:**	
Department:	Administration	**Review/Revision Effective Date:**	January 2016
Category:	Compliance	**Adopted September 2015 By:**	The Board of Managers of Princess Anne Ambulatory Surgery Management, LLC
Location(s):	See below	**Owner:**	

Previous Review/Revision Dates:

Purpose:

This Financial Assistance Policy ("Policy") establishes the policy to be followed by Princess Anne Ambulatory Surgery Management, LLC in: (1) determining the eligibility for Financial Assistance for those patients receiving Medically Necessary Services; (2) calculating amounts charged to a patient eligible for Financial Assistance; and (3) facilitating the patient application process for Financial Assistance. In addition, this Policy outlines Princess Anne Ambulatory Surgery Management, LLC's billing and collections practices for medical care services provided at its Facility, including the efforts that Princess Anne Ambulatory Surgery Management, LLC will make to determine a patient's eligibility for Financial Assistance prior to engaging in Extraordinary Collection Actions in the event of non-payment.

Definitions:

Amounts Generally Billed or AGB – Amounts generally billed by the Facility for Medically Necessary Services to individuals who have insurance covering such care, determined in accordance with Treas. Reg. Sec. 1.501(r)-5(b).

Application Period – Period of time commencing at the beginning of a patient's continuum of care through 240 days after the provision of the patient's first post-discharge billing statement.

Covered Services - Medically Necessary Services provided by the Facility.

Emergency Services – Care or treatment provided by the Facility for an "emergency medical condition," as such term is defined in EMTALA.

EMTALA – Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd; 42 C.F.R. § 489.24).

Extraordinary Collection Actions or ECAs – Extraordinary collection actions as defined in Treas. Reg. Sec. 1.501(r)-6(b).

Federal Poverty Guidelines - Federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. *See* http://aspe.hhs.gov/poverty/index.cfm for the current guidelines

Financial Assistance – A reduction in the amount of Facility Gross Charges for those patients who are eligible for financial relief under this Policy.

Gross Charges – A Facility's full, established price for medical care services that the Hospital Facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Facility– An outpatient surgical facility requiring hospital licensure under Title 32.1, Chapter 5 of the Code of Virginia.

Household Income – The annualized gross income for a patient and all members of his/her household being claimed on the same federal tax return.

Insured Patients – Individuals with any governmental, commercial, managed care, or private health insurance.

Medically Necessary Services– Reasonable and necessary services required for the diagnosis or treatment of an illness or injury that are performed in accordance with recognized standards of care at the time of service and that are not primarily for the convenience of the patient or the patient's physician or other health care provider.

Third-Party Liability Claims – Any claim a patient may have against another individual, insurer, or entity responsible for covering the patient's cost of medical services.

Uninsured Patients – Individuals who do not have governmental, commercial, managed care, or private health insurance or whose insurance benefits have been exhausted.

Covered Services:

The Facility does not employ its own physicians. Each physician bills separately for his/her services and follows his/her own billing and collections procedures. **There are no providers, other than the Facility itself, delivering Medically Necessary Services in the Facility who are covered under this Policy. This statement applies to all surgical services provided in the Facility.**

ONLY COVERED SERVICES PROVIDED IN THE FACILITY BY THE FACILITY ITSELF ARE CONSIDERED ELIGIBLE PATIENT CARE UNDER THIS POLICY. The Facility does not have the authority to offer Financial Assistance with respect to charges from physicians or other healthcare professionals who are not employed by the Facility.

The Facility is licensed as an outpatient surgical hospital under Title 32.1 Chapter 5 of the Code of Virginia and does not provide Emergency Services.

Financial Assistance Disqualification:

Financial Assistance is not available for patients who fail to reasonably comply with applicable payor requirements, including, but not limited to, obtaining authorizations, referrals, or other requirements for claim adjudication.

Financial Assistance is not available when a related Third Party Liability Claim is available to the patient. Exceptions are determined on a case-by-case basis, based upon the particular facts and circumstances.

Financial Assistance will be denied if a patient or patient's responsible party/guarantor provides false information regarding his/her income, household size, assets, liabilities, expenses, or other resources available that might indicate a financial means to pay for Covered Services.

Eligibility Criteria and Determination of Financial Assistance Amount:

Patients are eligible to apply for Financial Assistance for Covered Services under this Policy at any time during the Application Period. Each patient's Household Income is evaluated in light of relevant facts and circumstances, such as reported income, assets, liabilities, expenses, and other resources available to the patient or patient's responsible party, when determining the level of Financial Assistance that an applicant qualifies for under this Policy.

Taking all of these other factors into account, the following Household Income criteria is used to determine what amount, if any, of the outstanding patient account balance related to Covered Services for patients will be written off as Financial Assistance:

- Uninsured Patients with Household Income at or below 200% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of Hospital Facility Gross Charges related to Covered Services under this Policy.

- Insured Patients with Household Income at or below 200% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of any remaining patient responsibility balance after insurance has paid on Covered Services under this Policy.

- Uninsured Patients with a Household Income **above** 200% of the then-current Federal Poverty Guidelines are not eligible for Financial Assistance under this Policy. However, they should contact the Facility as described in this Policy to determine if they may qualify for discounts offered outside of this Policy.

Applicants for Financial Assistance under this Policy may be required to submit any of the following documents to verify Household Income during the Application Period: three most recent pay stubs at time of application; most recent annual Federal tax return or W-2 at time of application; employer verification; governmental assistance documents; social security, workers compensation, or unemployment compensation determination letters; bank statements; or such other documents that provide proof of Household Income. The Facility may also utilize the income, asset, liability, expense, and other resource data from third-party credit inquiries and publicly available data sources as evidence in determining and validating an applicant's Household Income for Financial Assistance eligibility under this Policy.

A patient's prior eligibility determinations with respect to Financial Assistance are not presumed to apply to new episodes of care for that patient. A new application for Financial Assistance must be completed.

Pursuant to this Policy, once a patient is determined to be eligible for Financial Assistance under this Policy, s/he will not be charged for any AGB for Covered Services under this Policy and, therefore, AGB calculations are not applicable.

Methods for Applying for or Obtaining Financial Assistance:

The Application for Financial Assistance is available at the patient registration area of the Facility and may also be downloaded from the internet free of charge at www.sentara.com/financialassistance. The Application for Financial Assistance may also be mailed free-of-charge to patients upon request by phoning 757-507-0188, or by sending a written request to the following address:

Princess Anne Ambulatory Surgery Management, LLC
ATTN: Business Office Manager
1975 Glenn Mitchell Drive, Suite 300
Virginia Beach, Virginia 23456
Telephone: 757-507-0188

Completed Applications for Financial Assistance, along with proof of Household Income, should be mailed to the address set forth in this Policy. Alternatively, a patient may return a completed application, along with proof of Household Income, to the patient registration area of the Facility.

Patients who need additional information about this Policy, or who need assistance with the Financial Assistance application process, may call or visit the above location Monday through Friday during normal business hours to speak with the Business Office Manager.

Length of Eligibility:

Eligibility determinations under this Policy are effective for Covered Services rendered up to 240 days prior to the application for Financial Assistance final approval date, and do not apply to dates of service after this Financial Assistance final approval date.

Actions Taken in the Event of Non-Payment (Collections):

Reasonable efforts are taken to determine a patient's eligibility for Financial Assistance under this Policy with respect to Covered Services prior to engaging in collection efforts with respect to such patient. Such efforts include notifying a patient about this Policy, helping a patient remedy an incomplete Application for Financial Assistance, and informing an applicant for Financial Assistance regarding his/her eligibility determination once a completed application has been received.

If, after reasonable efforts are taken, a patient is found to either not qualify for Financial Assistance under this Policy or is unresponsive to the Facility's efforts to obtain the information necessary to determine eligibility for Financial Assistance, the patient's account may be moved to bad debt and the delinquent account turned over to a third-party collections agency. ECAs may be taken by the Facility once an account has been turned over to the collections agency. ECAs may include the reporting of the delinquent account to one or more consumer reporting agencies (credit bureaus) as well as deferring or denying Covered Services, or requiring a payment before providing Covered Services, due to nonpayment for previously provided Covered Services. In addition, the Facility may file lawsuits, take judgments, record judgments or deeds of trust, place liens on realty, and garnish wages and other assets.

Prior to categorizing patient accounts as bad debt, the Facility, as part of its routine collections process, mails a series of three patient statements, and may also make attempts by phone to contact patients. The Facility also enlists the services of eligibility vendors to assist Uninsured Patients in applying for government programs, such as Medicaid. The Facility utilizes technology and other vendor services to help identify a patient's payor information when such information is not communicated to the Facility during the patient's registration process.

In the event of non-payment or the absence of any mutually agreed-upon payment arrangement, the Facility will consider an account to be bad debt and may undertake ECAs after 120 days from the provision of a patient's first post-discharge billing statement. A patient will be mailed an additional series of three patient statements when the account is considered to be bad debt. Any unpaid account(s) remaining at the end of this second series of statements to the patient will be reviewed for legal consideration or possible placement with an outside collections agency.

Patient balances are eligible for Financial Assistance evaluation during the Application Period. Upon receipt of an Application for Financial Assistance during the Application Period, any ECAs are suspended until a final eligibility determination is made by the Facility. An applicant for Financial Assistance who provides incomplete information during the Application Period is given a reasonable period of time, as determined by the Facility and based upon the particular facts and circumstances, to respond to the Facility's written notice describing the additional information and/or documentation required to complete the application. If the applicant does not respond to the request for additional information from the Facility within a reasonable period of time, as determined by the Facility and based upon the particular facts and circumstances, then ECAs may resume.

At least 30 days before any ECAs are initiated by the Facility, a patient is notified, in writing, regarding any ECAs the Facility intends to initiate to obtain payment, as well as the availability of Financial Assistance for eligible individuals. Along with this notice, the patient is provided a plain language summary of this Policy. The Facility will also make a reasonable effort to orally notify its patients about this Policy and how they may obtain assistance with the financial assistance application process during the period between mailing the ECA-initiation notice and resuming or initiating ECAs. ECA(s) may occur no earlier than 120 days from the provision of a patient's first post-discharge billing statement, as outlined in Treas. Reg. Sec. 1.501(r)-6(c)(3)(i).

The Facility's Business Office Manager is responsible for determining that the Facility has made reasonable efforts to determine a patient's eligibility for Financial Assistance under this Policy before engaging in any ECAs.

Exceptions to this Policy

The Facility's Business Office Manager is 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 s/he meets the stated eligibility and determination requirements for Covered Services set forth in this Policy.