THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

SUBJECT:

Patient Financial Assistance Program

PURPOSE:

To establish a policy and procedure for the administration of Central Vermont Medical Center's Patient Financial Assistance Program.

POLICY STATEMENT:

Central Vermont Medical Center (CVMC) is a patient-centered organization committed to treating all patients equitably, with dignity and respect regardless of the patient's health care insurance benefits or financial resources. Further, CVMC is committed to providing financial assistance to persons who have essential healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to fulfill our obligation as a non-profit organization, CVMC strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with CVMC's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow CVMC to provide the appropriate level of assistance to the greatest number of persons in need, the following policies and procedures have been established for the provision of patient financial assistance.

PROCEDURES:

Patient Financial Assistance

Healthcare Service Eligibility:

The following services are eligible for financial assistance

- Emergency medical services provided in an emergency room setting;
- Urgent services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
- Elective medically necessary services for patients who meet established program guidelines

Services not eligible for financial assistance:

- Cosmetic services unless medically necessary based upon physician review
- Infertility/fertility services, e.g. birth control, vasectomies/reversals, tubal ligations/reversals, unless medical necessity documentation from physician is provided
- General Dentistry unless medically necessary extenuating circumstances are presented by the dental program
- International/Foreign national patient care unless service is provided in an emergency room setting; note: obstetrics and labor/delivery are not emergent or provided in an emergency room setting.
- Services deemed not medically necessary
- Services reimbursed directly to the patient by an insurance carrier or third party

Provider Coverage: All CVMC employed medical providers rendering care at Central Vermont Hospital (CVH) and physician practices are covered under this policy.

Patient Eligibility: Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, 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 charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation, gender identity or expression, or religious affiliation.

Eligibility for financial assistance is based on an income and asset test.

- Income Test: This program is limited to patients with demonstrated financial need either due to limited income or if their medical bills are an excessive portion of their income. The most recently published Federal Provider Guidelines will be used as the primary determinant. A patient whose household income is at or below 400% of the Federal Poverty Level Guidelines (FPLG), as adjusted for household size, may pass the income test and are considered for charity care assistance if they also pass the asset test.

    - Non-custodial parents may have their income adjusted for child support when supporting documentation of payment is provided.
    - Patients may have their income adjusted for alimony when supporting documentation of payment is provided.
    - Dependents may be included within the household when more than 50% of the support is provided by the guarantor. To qualify for this household extension, the dependent must be listed as a dependent on the Federal Income Tax return.

- Asset Test: Each individual/household residing in Vermont or applicable counties in New York and New Hampshire are allowed liquid assets equal to $50,000. If assets are below this guideline, the patient passes the assets test.

    - Included in the asset test:
        - Cash, savings account balances, checking account balances, money markets, CD's, term certificates, annuities, stocks, bonds, mutual funds and other "liquid" assets.
        - Homes (excluding the primary residence), rental properties, and fair market value for recreational vehicles. Depending upon the value, rental properties may be excluded from the calculation provided rental income is included in the monthly household calculation.

Exclusions:

- Primary residence, assets held in a tax deferred comparable retirement savings account and college savings accounts held by the patient for the patient are excluded from the assets review.

- Accounts already referred to a collection agency greater than 120 days from placement to agency, unless referred in error;
- Services reimbursed directly to the patient(s) by an insurance carrier or already covered by another third party.
- Tuition stipends and/or grants for education are not considered a liquid asset and shall not be factored into the assets test.

Health Insurance and Liability Payments: Services rendered at CVMC will be billed to patient's primary coverage, a private medical insurance, an employer occupational health plan, workers' compensation, or pending by med pay/third-party liability carriers. In cases where there is a potential auto/injury liability payment pending at a future date, CVMC will file a lien to protect its financial interests, excluding Medicare/Medicaid recipients. After the lien is filed, financial assistance may be granted assuming that the patient otherwise qualifies. If there is a future time when liability payments are distributed, CVMC's lien will allow CVMC to recover some or all of the financial assistance initially granted to the patient.

Public Health Care Program/Healthcare Exchange Criterion: Patients applying for CVMC financial assistance are reviewed for their potential eligibility for state or federal healthcare program benefits and/or benefits offered through the Vermont or NY healthcare exchange programs. Any patient identified with potential to be granted such assistance will be instructed to apply. For those patients identified as candidates for eligibility for either the NY or VT or NH Healthcare Exchange Program; application for and compliance with those program guidelines is a pre-requisite for CVMC patient financial assistance.

Exclusions: A patient whose religious or cultural belief system prohibits seeking or receiving financial assistance from a government entity may be excluded from the public health care program criterion. The patient will, however, be required to assume a portion of financial responsibility to be assessed by the Patient Assistance Program Appeals Committee.

Determination of Financial Need: Financial need will be determined in accordance with procedures that involve an individual assessment of financial need which will include the following: Note, in the case of presumptive charity, the application process may be excluded.

- Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
- Include reasonable efforts by CVMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
- Take into account the patient's available assets, and all other financial resources available to the patient

It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. A patient must have a current patient balance that is due to CVMC, an expectation that an account currently pending insurance will leave a balance that is due to CVMC, or a future scheduled/referred service at CVMC that is expected to leave a patient balance. However, the determination may be done at any point in the billing cycle.

Central Vermont Medical Center's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for charity shall be processed promptly and CVMC shall notify the patient / applicant of decision in writing within 30 days of receipt of a completed application.

Financial Assistance Eligibility Period: The need for charity assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known. Re-evaluation of patients whose age exceeds 65 and whose income is fixed below 400% FPLG shall occur annually. Note: It is permissible for patients to submit new supporting financial documentation provided the application on file is less than one year old.

Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance application on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide sufficient evidence to provide the patient with financial care assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, CVMC could use outside agencies in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
- Food Stamp Eligibility
- Participation in Women, Infants and Children programs (WIC)
- Patient is incarcerated with no health care coverage

Presumptive eligibility may additionally be determined through an automated predictive assessment. Demographic, payment history, and third-party information may be used to determine household income levels. This may be done at any time during an account life cycle. Vendor model results can be correlated to the FPLG, allowing charity to be granted even if all documentation is not available. When an automated predictive tool is used, accounts scoring <200% of FPLG may be provided a 100% write-off for the services provided at the time of scoring. A complete application is expected from patients for ongoing approval. For accounts scoring >200% of FPLG, a formal application will be required to fully identify the poverty level and appropriate discount to be provided.

Presumptive eligibility will be adjusted to a specific transaction/pay code to ensure these dollars are excluded from the Medicare Cost Report.

Patient Financial Assistance Guidelines: In accordance with financial need, eligible services under this policy will receive financial assistance based upon the federal poverty guidelines. The amount of assistance provided to a patient will vary based upon their income level and the grant awarded shall ensure the patient is not responsible for more than the amount generally billed to an insured patient.

As defined by the IRS, eligible patients cannot be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. The average generally billed (AGB) to patients is calculated using the "Look-Back method"; actual claims paid to the organization by Medicare only or claims paid to the organization by Medicare together with all private health insurers, including any associated portions of these claims paid or owed by beneficiaries.

CVMC uses the combined Medicare and private health insurer look-back method calculation. This forms the minimum grant percentage awarded to patients who qualify for assistance. Calculation: Allowed claims/ charges for prior fiscal year.

The amount generally billed for the previous fiscal year shall be applied to the 351 – 400% FPLG level. Additional discounts shall apply to each FPLG category up to a maximum assistance grant of 100% for <200% FPLG.

FPLG	<= 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%
Grant	100%	85%	75%	65%	55%

The patient grant is applied against all current balances (i.e. hospital and medical group) and extends for a coverage window of 6 months, 12 months for aged >65 years on a fixed income. When the grant period has closed, patients will be required to re-apply for financial assistance and based upon their financial status, may have their grant category adjusted.

Safe Harbor: CVMC shall limit all charges for financial assistance qualified individuals to the amounts generally billed to insured patients. The hospital will refund any amount paid in excess of the amount he or she is personally responsible for paying under the financial assistance policy within the application period or 240 days prior to the receipt of a complete application. Payments made outside the application period will not be eligible for a refund.

Catastrophic Medical Indigence: CVMC determined that catastrophic assistance beyond 400% of the FPLG will be reviewed for an appropriate level of financial assistance. Medically Indigent in most cases will be a patient for whom the balance of a hospital bill exceeds 30% of the person's annual household gross income and who is unable to pay all or a portion of the bill balance resulting from a catastrophic illness or injury. Cases that are deemed Medically Indigent will be processed at the 55% grant level of assistance and will be applied against all current balances (i.e. hospital and medical group). Patients who qualify for catastrophic medical indigence will have their out-of-pocket liabilities capped at no more than $10,000.

Individual Case Reviews and Appeals Process: CVMC acknowledges that extenuating circumstances may exist where an individual's income may exceed program eligibility guidelines. An appeals committee will be convened on an as-needed basis to review unusual or catastrophic cases that do not meet established program guidelines but present unusual hardship.

Other cases involving services that require review for medical necessity will be presented to the Chief Medical Officer or his/her designee for a decision regarding medical necessity of services rendered. If services are deemed medically necessary and the charity eligibility guidelines are met, assistance will be granted.

Patients whose applications for charity are denied may appeal the denial decision. Requests for appeal should be sent to the financial assistance program specialist, in writing, within 30 days of receipt of the denial decision and must clearly indicate the reason for the appeal. All cases will be reviewed by Specialist in preparation for the Appeals Committee to review. The patient will be notified of the final grant/deny decision.

Notification Period: CVMC will make reasonable efforts to notify patients about the financial assistance program. This period begins on the date a billing statement for the patient balance of care is presented and ends 120 days later. As defined in this policy multiple methods of notification occur beginning in advance of care, during care and throughout the 120 day billing cycle.

Application Period: CVMC will process applications submitted by individuals during the application period which begins on the date a billing statement for the patient balance of care is presented and ends 240 days later. If at the end of the 120 day notification period an account has been referred to a collection agency and an

application is received and granted within the 240 day application period, accounts shall be recalled from the agency and processed under the financial assistance program.

Reasonable Efforts: Reasonable efforts will be made to determine if a patient is eligible for financial assistance prior to balance transfer to collections. Reasonable efforts may include the use of presumptive scoring, the notification and processing of applications and notification before, during and after care.

- CVMC shall not initiate any ECA (extraordinary collection actions)
- Incomplete applications shall be processed with notification to patients providing direction on how to appropriately complete the application and/or what additional documentation is required along with a 30 day window of time to respond to the CVMC request.
- CVMC shall process completed applications within 30 days of receipt.

University of Vermont Health Network Partners: Patients who have qualified at one of the partner organizations across the Health Network may be granted across all partner facilities, based upon the eligibility criteria and the patients FPLG scale which is specific to each organization. Upon assistance approval, applications will be shared with partner facilities with supporting documentation remaining at the local organization. Each partner facility will provide assistance at the appropriate grant level set for the individual institution, based upon the unique AGB calculation set for the organization. Supporting documentation will be made available to the partner organization as needed to facilitate audit functions.

Communication of the Charity Program to Patients and the Public: Notification about patient assistance charity care available from CVMC, which shall include a contact number, shall be disseminated by CVMC by various means, which may include, but are not limited to:

- Reference to the charity program printed on each patient statement
- By posting notices in emergency rooms, admitting and registration departments, and patient financial services offices that are located on facility campuses; conspicuous displays may be found in the main Registration and Emergency Departments'.
- By providing a copy of the plain language policy summary at the point of Registration on the facility campuses and making available the summary at our satellite clinics. Providing copies of the policy and application upon request
- For inpatient, observation and short stay patients, a copy of the inpatient guide will be provided which includes information regarding the financial assistance program.
- Information shall be available on the CVMC website, including the policy, a plain language summary, the application, FAQ, FPLG guidelines and contact information for follow-up assistance
- Referral of patients for charity assistance may be made by any member of CVMC staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
- Translations for individuals with limited English proficiency will be provided for populations with >1,000 individuals or 5% of the service area community based upon US census bureau statistics.
- Patients requiring a translated copy and/or assistance in completing the application will be assisted by financial advocates and/or customer service representatives who will secure the services of an appropriate interpreter.

Application Assistance Contact Information: Assistance in completing the application may be obtained through the Financial Counseling Office located on the main campus, basement. Information regarding our policy and/or application may be obtained by contacting our office at 802-371-4600 option 1, option 1 or in person at Central Vermont Medical Center, Financial Counseling Office, 130 Fisher Road, Berlin VT 05641 or 3 Home Farm Way, Montpelier VT 05602.

Relationship to Collection Policies: CVMC management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from CVMC, and a patient's good faith effort to comply with his or her payment agreements with CVMC. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, CVMC may offer extended payment plans to eligible patients.

Note: CVMC will not engage in extraordinary collection actions (ECA). ECA is defined as selling an individual's debt to another party, reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus, deferring, denying or requiring payment before providing medically necessary care because of an individual's non-payment of one or more bills for previously provided care under the FAP and/or actions requiring a legal or judicial process. A copy of CVMC'S Credit and Collections policy may be obtained by contacting the us directly at 802-371-4600 option 1 option 1 or from our website at www.cvmc.org.

Regulatory Requirements: In implementing this policy, CVMC 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.

Document Retention: Completed applications for the Patient Assistance Program will be maintained for a period of seven years after the date the application was approved or denied.

Monitoring Plan: Compliance with this policy will be monitored through annual review of Patient Assistance Program applications and grant/deny decisions. Quarterly department spot auditing will occur and monthly reporting of outcomes will be reviewed.

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

- **AGB:** Amount generally billed to insurance payers for services provided. The look-back method is used to calculate the AGB, reflecting a combination of fully adjudicated claims for Medicare fee for service and all private health care plans, including the portions paid by the beneficiaries.
- **Charity:** Refers to healthcare services provided without charge or at a sliding scale discount to qualifying patients.
- **Family:** Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption.
- **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;
  - Excludes capital gains or losses; and
  - If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count).
- **International/Foreign National:** Non US citizens who are in the United States under a travel/visitor visa.
- **FSC**: Financial Status Class of a patient account, indicates the primary payer responsible for payment.
- **LEP/Translation**: Limited English Proficiency requiring translated copies of the policies, application, plain language summary and application.

- **Medical Indigence:** There are instances when individuals are financially unable to access adequate medical care without depriving themselves and their dependents of food, clothing, shelter and other essentials of living. A patient will generally be considered Medically Indigent if the balance of a hospital bill exceeds 30% of the person's annual household gross income and he or she is otherwise unable to pay all or a portion of the bill balance resulting from a catastrophic illness or injury.
- **Medical Necessity:** Services or items that are: (1) appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease or injury; (2) provided for the diagnosis or the direct care of the condition, illness, disease or injury; (3) in accordance with current standards of good medical practice; (4) not primarily for the convenience of the patient or provider; and (5) the most appropriate supply or level of service that can be safely provided to the patient.
- **Patient Statement**: The monthly patient account summary mailed to a patient at their stated home address which states the amount due from the patient for patient care services rendered by CVMC.
- **Primary Homestead:** The primary residence of the patient, whether solely or jointly owned.
- **Transaction/Paycode**: The unique transaction used to record the uninsured patient discount.
- **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. An uninsured patient is ineligible for any government healthcare entitlement program (Medicare, Medicaid, Vermont Health Connect exchange plans, etc.) during the dates of service provided by CVMC.
- **Underinsured:** The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.
- **Uninsured Self-Pay FSC**: The financial status class (FSC) for those patients who have no third party health care insurance benefits, and are directly responsible for payment of their health care services.
- **University of Vermont Health Network**: Includes the University of Vermont Medical Center, Central Vermont Medical Center, Champlain Valley Physicians Hospital, Elizabethtown Community Hospital and Alice Hyde Medical Center.

REFERENCES:
IRC § 501®(4):
IRC § 501®(5):
IRC § 501®(6):

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