IDENT	PAS35
Type of Document	Policy
Applicability Type	Network CVMC/PMC/UVMMC
Title of Owner	Dir Patient Access
Title of Approving Official	VP Network Revenue Cycle
Date Effective	7/1/2024
Date of Next Review	10/1/2024

TITLE: Limitation on Charges (AGB)

PURPOSE: To establish a policy and procedure for the amount charged to patients who qualify for financial assistance.

POLICY STATEMENT: In accordance with the IRS 501r regulations, The University of Vermont Health Network – VT Partners will limit charges to patients qualified under our Financial Assistance Program to the Amounts Generally Billed (AGB) to insured patients for emergency or other medically necessary care. In accordance with State of Vermont, statute H.287, further limitations shall be applied to the uninsured patient

Policy Applies to the following UVMHN Partners:

Central Vermont Medical Center
130 Fisher Road
Berlin, VT 05602

Porter Medical Center
115 Porter Drive
Middlebury, VT 05753

The University of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

PROCEDURE:

1. The University of Vermont Medical Health Network, VT Partners shall calculate the amount generally billed to insured patients annually and limit by the same, the amounts billed to patients for services that qualify for financial assistance. AGB will be calculated in October and will apply to all services delivered in the new fiscal year.

2. UVMHN VT Partners shall use the look-back method to calculate the AGB and will include government and commercial payers; specifically, Medicare, Medicare ACO, Medicare Advantage, Medicaid and commercial/private insurance payers.

3. In accordance with IRS regulations, UVMHN VT Partners shall include all allowed claims for the prior fiscal year, including patient responsibility charges. The claims reviewed are those that have been paid within that 12 month period, not services that were provided in that timeframe. If a claim has not been finalized by the last day of the 12 month period, it will not be included in this fiscal year's calculation.

4. When calculating the amount generally billed, we include the full amount allowed by an insurance company plus the amount the patient will pay. This would include copayments, coinsurance and deductibles.

5. To ensure we include only those charges/services which have an allowed adjustment, UVMHN VT Partners will reduce the allowed total by adjustments made for lack of authorization. These charges are not allowed by the payer and are adjusted at the gross charge level.

6. The calculation will include the full amount allowed by the insurance payer, minus the lack of authorization administrative adjustments applied; this amount is then divided by the gross charges billed for those claims.

7. The calculation for Fiscal Year 2024 (October 1, 2023 – September 30, 2024):

    a. Central Vermont Medical Center: 57%
    b. Porter Medical Center: 53%
    c. The University of Vermont Medical Center: 57%

8. In accordance with Vermont State Law, uninsured patients will receive an additional 40% discount after the AGB is applied. The UVMHN VT Partners have calculated a blended rate for this adjustment. While not required by statute, our policy will apply the best blended rate adjustment to both the uninsured and underinsured patient across the Vermont hospitals.

9. The blended rate calculation for Fiscal Year 2024 (July 1, 2024 – September 30, 2024):

    a. Central Vermont Medical Center: 75%
    b. Porter Medical Center: 75%
    c. The University of Vermont Medical Center: 75%

10. For late discovery of eligibility and in compliance with safe harbor rules, UVMMC shall refund any patient payments in excess of the AGB for care that would have qualified for assistance with a 240 day window from application approval. Note, overpayments may be applied to other open balances prior to processing a refund to the patient.

MONITORING PLAN:

Annual audits
EHR Automation review

DEFINITIONS:

Administrative Adjustment: An adjustment or write-off of charges on an account, e.g., lack of authorization, etc.

Allowed Amount: The maximum payment a plan will pay for a covered health care service

Gross Charges: The full amount charged for the service provided prior to adjustments or discounts

Limitation on Charges: Each tax-exempt hospital must limit the amount generally billed for emergency or other medically necessary care provided to patients eligible for financial assistance to the amounts generally billed to insured patients, and cannot use gross charges.

Look-back Method: Retrospective review of all claims paid by insurers in the prior fiscal year.

RELATED POLICIES:

PAS1 Financial Assistance Program

REFERENCES:

IRC § 501®(4):
IRC § 501®(5):
IRC § 501®(6):
H.287 (Act 119)
26 C.F.R.§1.36B-2
VT Title 18, Chapter 221, Subchapter 10:
§ 9481 Definitions
§ 9482 Financial assistance policies for large health care facilities
§ 9483 Implementation of financial assistance policy
§ 9484 Public education and information
§ 9485 Prohibition on sale of medical debt
§ 9486 Prohibition of waiver of rights
§ 9487 Enforcement

REVIEWERS:

Amy Vaughan, Network VP Revenue Finance & Reimbursement
Craig Bennett, Network Chief Compliance & Privacy Officer
Melissa Laurie, Network VP/Corporate Controller
Gina Slobodzian, Network Director Customer Service
Chris Cook, Director Patient Financial Services PMC
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