Patient Financial Assistance

Applicability: Organizational	**Date Effective:** 10/2007
Department: Patient Financial Services	**Date Reviewed:** 10/2017
Supersedes: "Charity Free Care", "Eligibility Guidelines for Uncompensated Care"	**Date Last Revised:** 10/2017
Administration Approval: Stephanie Breault, Director of Finance Chris Hickey, Senior Vice President, Chief Financial Officer	

Purpose: To establish guidelines and the process for providing financial assistance to patients.

Policy Statement: At each patient registration/admission interaction, and in all oral communications regarding the amount due that occur during the Notification Period (defined below), NMC shall advise the patient of the availability of NMC's financial assistance program and where to obtain additional information about eligibility and how to apply. In addition, all points of check-in/registration areas for the hospital and physician practices shall have written materials regarding the financial assistance program and applications located in a conspicuous place easily viewable and accessible by patients, and such information shall be included in every patient admission packet. Relevant information about the hospital's financial assistance program shall also be available on the hospital's website and patient portal with an ability to download and print the financial assistance application without any special hardware or software.

Notice of financial assistance availability shall be noted on every patient billing statement sent out through NMC's contracted billing service. The billing service will direct individuals requesting financial assistance information to the hospital's website, or, at the patient's option, the billing service will mail a copy of the financial assistance application to the patient.
The Notification Period is defined as the period during which the hospital must notify an individual about its financial assistance policy in order to have been deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Notification Period begins the first date that an episode of care is provided and ends the 120th day after NMC provides the first billing statement to the patient for the care. NMC must provide patients with written notice within 30 days of the end of the Notification period that the Notification Period is ending. Efforts are deemed reasonable if NMC notifies the patient about its financial assistance program as described above, and follows the requirements for incomplete and complete financial assistance applications described in the Review and Approval section below.

NMC's financial assistance program shall be widely publicized within the community in a manner that will reasonably reach those who are most likely to require financial assistance. This shall generally be accomplished by information about the program being included in the local St. Albans Messenger newspaper and certain free publications in the greater Franklin and Grand-Isle counties periodically throughout the year. In addition, information about NMC's financial assistance program shall be displayed in a conspicuous public display at the Franklin-Grand Isle United Way office and the Vermont Department of Health St. Albans District office.

Background: The Patient Protection and Affordable Care Act of 2010 contains provisions that require 501(c)3 hospitals to comply with various patient billing and collection guidelines, including rules for offering financial assistance to patients. This policy shall become effective no more than 45 days after approved by the Board of Directors and shall not be retroactive.

Definitions: N/A

Procedure:

A. Eligibility Requirements

Financial assistance is provided on a sliding scale basis, based on the following eligibility criteria:

- Individual or family income – up to 300% of the federal poverty level. Employment status shall be considered when determining income levels. Prior income levels may not meet the established poverty level guidelines; however, recent unemployment should be considered as the current source of income.

- Individual or family net worth – up to $250,000, except for amounts owing NMC in excess of $100,000. When reviewing net worth, other financial obligations, such as high medical bills, should be considered. Patients with high net worth that would otherwise disqualify them for financial assistance may be considered for eligibility if they have, for example, uninsured catastrophic health care costs that would significantly reduce their net worth.

Financial assistance is available to all individuals for emergent care, and to individuals with a primary residence (live in for over 6 months a year) in Franklin or Grand Isle Counties for all services provided by the Hospital and Hospital owned physician practices, except elective services such as teeth extractions, voluntary sterilizations, cosmetic surgery and routine eye exams. Financial assistance is also available under the same guidelines as described within this paragraph for individuals obtaining services from NMC that are offered at NMC locations outside of Franklin or Grand Isle Counties.

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, Patient Financial Services and its

Certified Financial Counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages and available tax credits offered through Vermont Health Connect.

The Request for Financial Assistance Form (Free Care Application) shall be completed for all requests for financial assistance, and be submitted to Patient Financial Services. All requests for financial assistance must be signed by either the patient or authorized patient representative attesting that the information provided on the application is true and accurate.

1. **Verification of Information Provided**

Data used to determine eligibility for financial assistance should be verified to the extent practical in relation to the amount of financial assistance involved and the significance of an element of information in the overall determination. In all cases, the minimum verification shall include:

- Income, by reviewing sources such as a W-2, recent pay stub showing year-to-date totals, tax returns, unemployment statements, notices of social security and retirement benefits.

- An individual's net worth (excluding their primary household), by reviewing applicable supporting documentation (bank statements, investment statements, loan documents). It should be specified to the patient that assets could be considered as a possible source of payment.

Financial assistance of $5,000 or more may include documentation supporting other financial obligations, such as living expenses, child support, and other health care bills.

If a financial assistance application is received during the Application Period (as defined below) and deemed incomplete, a written notice to the patient/guarantor will be sent within 15 days of receipt of the incomplete application requesting the missing information be returned within 30 days of the date of the notice. Any extraordinary collection efforts, i.e., collection efforts by a collection agency, in progress at the time an incomplete application is received must be suspended. Such collections may be initiated or resumed if a completed application is not received after request for additional information is not received after 30 days of notification.

The required supporting documentation described above may be waived in lieu of information NMC obtains through use of technology tools as predictive measures of a patient's ability to pay and financial status.

2. Review and Approval

Financial assistance must be documented on the Request for Request for Financial Assistance Form and approved by the Patient Financial Services Representative for amounts up to $999, the Manager of Patient Financial Services for amounts of $1,000 to $9,999 and by either the Chief Executive Officer or Chief Financial Officer for any higher amounts. Documentation of receipt, review and approval of the Request for Financial Assistance shall be made on the Patient Request for Financial Assistance Processing Form – see attached. At the time a decision is made for the approval or denial of an account for financial assistance, a letter shall be sent to the patient or responsible party as notification of the decision made. The letter, which shall be sent within 15 days of receiving the Request for Financial Assistance Form, should be typewritten and should include the following information:

- Patient name
- Account number(s) for both hospital and physician accounts
- Current outstanding balance of the account(s)
- Dollar amount or number of days stay granted for financial assistance
- Any balance which will be due on the account (if only a portion of the account is covered by financial assistance)
- Detail of arrangements to pay for any remaining balance on the account after financial assistance is provided
- Appeal process if request for financial assistance was denied

Upon approval of a financial assistance request, NMC shall:

- If any amount is due from patient, provide a billing statement to the patient showing the amount due, how the AGB (see definition in the Charge Limitation section below) was determined, and how the amount due was arrived at;
- Refund any payments made by the patient in excess of amounts approved for financial assistance; and

Approval of financial assistance will be denied if Medicaid or other health and welfare eligibility application is refused by patient if NMC reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with NMC in reviewing affordable insurance coverage options offered through Vermont Health Connect. If the patient chooses not to purchase insurance coverage through the Vermont Health Connect and does not quality for VT Medicaid, then the patient will be required to submit a Financial Assistance application, along with a letter explaining why they have chosen not to purchase insurance coverage. The information contained in the letter will be used in the process of evaluating the patient for NMC financial assistance. Financial assistance will also be denied if the patient does not

provide additional information (if required). Assignment to Hospital of all insurance payments, including liability settlements, is required, up to the amount of gross charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting reevaluation (Free Care Appeal Form). The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred to and reviewed by the Manager of Patient Financial Services within thirty (30) days of being received. If the Manager of Patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer will be asked to review and assist with the determination.

If subsequent to review and determination of financial assistance it is found that the information relied on was in error, the following shall occur:

- If the corrected information in a prior denial of financial assistance now qualifies the patient for financial assistance, the patient will be notified that they are now eligible for financial assistance and the account(s) will be processed as described above.

- If the corrected information in a prior granting of financial assistance now disqualifies the patient for financial assistance, the patient will be notified that they are not eligible for financial assistance and payment is expected on their account(s).

The completed Financial Assistance Processing Form and Request for Financial Assistance will be scanned into the patient's accounts in Meditech or Medent as appropriate.

Notwithstanding the above, NMC must accept and process a financial assistance application for a period up to 240 days after NMC provides the first billing statement to the patient. (defined as the Application Period). NMC may initiate or resume extraordinary collection actions, i.e., transfer account to a collection agency, against an individual who has submitted an incomplete financial assistance application and who has not provided the missing information necessary to complete the application any earlier than the later of:

- 30 days after NMC provides written notice that the additional information is required, or
- The last day of the Application Period

Key timeframes required to be provided under this policy are flowcharted in Attachment A to this policy.

3. Accounting for and Tracking Financial Assistance Data

Approved financial assistance shall be classified and recorded as charity care, because, by definition, charity care is "demonstrated inability to pay". The amount of charity care provided will be reported separately in the monthly financial statements.

Finance shall calculate the cost associated with the services approved for financial assistance for disclosure in the annual financial statements.

4. <u>Frequency of Re-Evaluation of Eligibility</u>

Once a patient has been approved for financial assistance, as well as a discount based on poverty level and net assets as described in a separate Discounts for Medical Services policy, the patient will be deemed to have approval for services rendered by the hospital for one year subsequent to approval, except as follows:

- There is a change in financial status as described below. After one year, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.

- In NMC's reasonable estimation, patient can afford to purchase insurance coverage through Vermont Health Connect and the period for which such coverage can be obtained is in less than six months from the time financial assistance is granted by NMC.

If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, NMC will not reverse the amount of financial assistance granted.

5. Changes in Patient Financial Status

Patients may have unexpected changes to their ability to pay that occur after the time service is rendered and after either a payment plan or financial assistance has been granted. If a patient agreed to a payment plan (see separate Patient Payment Plans policy) that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job or had some other financial hardship occur and became unable to pay under the plan, the patient may apply for financial assistance under the guidelines of this policy.

Alternatively, if a patient who was granted financial assistance but subsequently experiences a positive change to his or her ability to pay for the services rendered, the hospital may bill the patient for the services rendered and advise the patient of their change in status.

6. Charge Limitation

Individuals who qualify for financial assistance will not be charged more than the Average Generally Billed (AGB) amount (effectively the amounts NMC collects from insurance companies and Medicare). This amount will be determined by doing a yearly look-back of payment percentages from commercial payers and Medicare (including copayments and deductibles paid by patients). Separate payment percentages will be calculated to develop separate AGB amounts for inpatient, outpatient, and physician practice/clinic services. AGB amounts shall be calculated by the 45th day after September 30th each year for the 12-month period ended September 30th. The billing statement to a patient may state the standard hospital gross charge, but must show a write-off to get to the AGB. The difference between the hospital's standard gross charge and the AGB amounts will be accounted for as a charity care write-off.

This policy is not required to be approved by the Board each year for updates to the AGB.

7. Discounts

Patients who do not qualify for financial assistance as provided in this policy may receive a discount as described in the Discounts for Medical Services policy.

8. Medicaid Coverage

Medicaid copays not paid at the time of service will be billed to the patient. If unable to collect the copays by the end of the Application Period, the copays will be written off as a charity write-off.

Patients who have Medicaid coverage and have balances due for service dates up to twelve months prior to the effective date of their coverage, will be granted 100% financial assistance on such balances without further review or documentation from the patient.

9. NOTCH Collaboration

NMC is working in collaboration with Northern Tier Center for Health (NOTCH), our local FQHC, in qualifying their patients for financial assistance for services performed at NMC. NOTCH patients approved for discounted or uncompensated services through NOTCH are also eligible for the same at NMC because Notch's guidelines are stricter than NMC's. NOTCH will forward the patient's applications with supporting documentation to NMC. If upon review, it appears that the patient would be eligible for Medicaid coverage, the patient will be required to apply for Medicaid before any financial assistance will be applied to uninsured balances.

10. Other

Generally the determination that a patient stay qualifies for financial assistance will be made upon pre-admission, admission or as soon as possible thereafter. A Patient Financial Counselor is available near the front entrance of the hospital to assist patients with settlement of their accounts including applications for financial assistance, government sponsored programs and referral to outside resources. However, in some cases qualification for financial assistance may be made after rendering services and in some circumstances even after rendering of the bill. Collection efforts, including the use of a collection agency, are part of the information collection process and can appropriately result in identification of eligibility for financial assistance.

Services rendered at NMC by radiologists and anesthesiologists (including certified nurse anesthetists) are from separate entities that are not affiliated with NMC and therefore are not subject to NMC's financial assistance policies.

For questions related to this policy and all forms please contact our Financial Counselor, Bryan Kiernan at address below

Northwestern Medical Center
133 Fairfield Street
St. Albans, VT 05478
802-524-1006
bkiernan@nmcinc.org

Note Well: N/A

Monitoring Plan: N/A

Related Policies:
Patient Payment Plans
Guidelines for Patient Discounts
Discount for Medical Services

Northwestern Medical Center List of Providers

References: Health Care Financial Management Association Principles and Practices Board Statement 15, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts.

American Hospital Association Hospital Billing and Collection Practices Statement of Principles and Guidelines May 5, 2012

Patient Protection and Affordable Care Act

IRS Notice 2014-2 issued on December 30, 2013

IRS CFR Parts 1, 53, and 602 (issued December 29, 2014)

Also refer to the policy entitled "Billing and Collection Practices"

Reviewers:

A. **Key Stakeholders:** Fred O'Neil – Manager, Patient Access
B. **Committees:** None
C. **Key Process Owner:** Megan Branon Smith- Manager, Patient Financial Services

---

Keywords - Not Part of Policy: Patient Assistance, Financial Assistance, Charity Care, Free Care