SUBJECT: **FINANCIAL ASSISTANCE PROGRAM**		
PREPARED BY: **DIRECTOR OF PFS**		**RESPONSIBLE DEPARTMENT:** Patient Financial Services
CONTRIBUTING DEPARTMENT(S): PATIENT FINANCIAL SERVICES		
ADMINISTRATIVE APPROVAL: **SCOTT COMEAU, CHIEF FINANCIAL OFFICER**		**POLICY CREATION DATE:** JANUARY 29, 2024
NEW:	**SUPERSEDES POLICY:** Financial Assistance Policy **DATED:** MARCH 10, 2020	**REVISED DATE:** JANUARY 29, 2024
REVIEW DATES & INITIALS OF REVIEWER:		
OTHER RELATED POLICIES: (LIST POLICY TITLE & DEPT. IF NOT ADMIN.) - Credit & Collections		

I. PURPOSE:

To establish a policy and procedure for the administration of the University of Vermont Health Network Elizabethtown Community Hospital's (ECH) Financial Assistance Program.

II. POLICY STATEMENT:

ECH 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, ECH 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, ECH 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 ECH'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 ECH 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.

III. 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.
- Non-Emergent foreign national and foreign national obstetrics and labor and delivery
- Services deemed not medically necessary.
- Services reimbursed directly to the patient by an insurance carrier or third party.

Provider Coverage: All ECH employed medical providers rendering care at ECH are covered under this policy. For a listing of providers rendering care at the ECH and an indication as to whether their services are covered under this policy see our website at www.ech.org > Patients & Visitors > Billing & Financial Assistance > Medical Group Participation Grid

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, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, religion, marital status, immigrant status, language, socioeconomic status, physical or mental disability, protected veteran status or obligation for service in the armed forces.
NY Hospitals have the option, with the DOH's prior approval, of taking assets into account when determining income eligibility, but only as follows:

- The use of an asset test must be set forth and described in writing in the hospital's financial assistance policies and procedures and in the summary, information given to potential financial aid applicants.
- Asset tests cannot be used to deny financial assistance, but only to upgrade a patient's level of payment obligation, up to the legal maximum permitted.
- Assets can only be used to upgrade the payment obligations of patients with incomes up to 150% of the Federal Poverty Level (FPL).

Eligibility for financial assistance is based on either an income test or may be based on both an income test and asset test if permitted by DOH.

- Income Test: Patients whose household income is at or below 400% of the Federal Poverty Level Guidelines (FPLG), as adjusted for household size, pass the income test and are considered for charity care assistance if they also pass the asset test, if the asset test is used.

    - 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.
    - Students between the ages of 18 – 21 may be included within the household when more than 50% of the support is provided by the parent. To qualify for this household extension, the student must be listed as a dependent on the Federal Income Tax return.
    - 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.

Other Exclusions:

- 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.

Residency Criteria: Patients must reside within the service area, unless medical services were urgent or emergent in nature. Eligibility for patients residing outside of the service area will be determined on a case-by-case basis. Financial assistance for residents outside of the service area may be granted only in unique circumstances and with appropriate approval.

Residents of the service area, including college students who reside in the service area part-time, must live in our service area greater than 6 months per annum to meet the residency requirement.

Proof of residency may be established by one of the following:

- Service area driver's license, tax bill with service area address, lease for service area property or a service area utility bill.
- Potential exceptions may be considered on an individual case-by-case.

Health Insurance and Liability Payments: Services rendered at ECH will be billed to patient's primary coverage, a private medical insurance, an employer occupational health plan, workers' compensation, or pending by medical pay/third-party liability carriers. In cases where there is a potential auto/injury liability payment pending at a future date, ECH may 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, the ECH lien will allow ECH to recover some or all of the financial assistance initially granted to the patient.

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

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

- 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 the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay. ECH reserves the right to obtain a credit report, when approval from the patient is granted, to verify financial stability before financial assistance is authorized.
- Include reasonable efforts by ECH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs.
- Include a review of the patient's ECH outstanding accounts receivable for prior services rendered and the patient's payment history.

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 ECH, an expectation that an account currently pending insurance will leave a balance that is due to ECH, or a future scheduled service at ECH that is expected to leave a patient balance. However, the determination may be done at any point in the billing cycle.

ECH'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 ECH 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, The University of Vermont Health Network - ECH 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)
- Transient (homeless)
- Patient is deceased with no known estate (documented by probate court)
- 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 will 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.

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 (AGB) to an insured patient and the Maximum Amount Paid (MAP) by the Highest Volume Payor (HVP) (see definitions for AGB, MAP, HVP).
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 amounts generally billed (AGB) to patients is calculated by ECH using the "Look-Back method" of; actual 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. Additionally, as provided for in NYS PHL 2807, eligible patients cannot be charged more for emergency or other medically necessary care than the Maximum Amount Paid (MAP) by the Highest Volume Payor (HVP). This forms the minimum grant percentage awarded to patients who qualify for assistance. Calculation: Allowed claims/ charges for prior fiscal year.

These calculations for the previous fiscal year shall determine the grant percentage to 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: ECH 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: ECH has 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 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 400% FPLG grant percentage 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: ECH acknowledges that extenuating circumstances may exist where an individual's income or assets exceed program eligibility guidelines. The program administrator, on an as-needed basis, will 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 Patient Assistance Program (PAP) administrator, 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 PAP Administrator in preparation for the Director of Patient Financial Services to review. The patient will be notified of the final grant/deny decision.

Notification Period: ECH 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: ECH 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.

- ECH 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 ECH request.
- ECH shall process completed applications within 30 days of receipt.

University of Vermont Health Network Partners: As stated previously the average generally billed and the federal poverty level coverage for each network affiliate varies; UVMHN partners have agreed to

share FPL information to help expedite the financial review for our shared patients. For patients who receive care at a network affiliate a single application with supporting documentation may be submitted for financial assistance. This does not guarantee a grant at each organization nor does it guarantee the grant awarded at one organization will be awarded at a network affiliate. If an application is approved and the patient indicates balances at another network hospital exist, the patients FPL will be shared with the affiliate. The affiliate will then determine whether the patient qualifies for assistance at their facility and if so, what if any grant will be awarded. Applications will be shared with partner affiliates for asset review upon request; applications and supporting documentation will be made available to partner organizations as needed to facilitate audit functions

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

- Reference to the charity program is 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 ECH 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 the ECH 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.
- Information, rack cards and flyers are available through the Community Health Planning Committee where staff routinely interact with community centers and advocates disseminating information and programs available to the public.

Application Assistance Contact Information: Assistance in completing the application may be obtained through the Patient Financial Advocates located in the billing, financial services, and medical records offices at 8 Williams Street in Elizabethtown, New York. Information regarding our policy and/or application may be obtained by contacting the Patient Financial Advocates at 1-518-873-3150 or in person 8 Williams Street in Elizabethtown, New York.

Relationship to Collection Policies: The ECH 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 the ECH, and a patient's good faith effort to comply with his or her payment agreements with ECH. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, The ECH may offer extended payment plans to eligible patients.

Note: The ECH 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 the ECH Credit and Collections policy may be obtained by contacting the Financial Advocates at 1-518-873-3150. A copy may also be obtained at any registration location at ECH.

FAP Adjustment Authority Levels: The following approval levels will be followed before charges may be adjusted off an individual patient's account under the Financial Assistance Program:

$1 - $20,000	PFA Specialist
$20,001 – $50,000	Manager, Patient Accounting
$50,001 to $ 100,000	Director/AVP Patient Financial Svcs
Appeals with balance > $100,000	CFO/VP Finance/Financial Officer

Regulatory Requirements: In implementing this policy, The ECH 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 ten years after the date the application was approved or denied.

Monitoring Plan: Compliance with this policy will be monitored through annual review of the Financial Assistance Program applications and grant/deny decisions.

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 or owed by the beneficiaries.
- **HVP:** Per NYS PHL 2807, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.
- **MAP:** Maximum Amount Paid per NYS PHL 2807 is the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, or for services provided pursuant to title XVIII of the federal social security act (Medicare), or for services provided pursuant to title XIX of the federal social security act (Medicaid), and provided further that such amounts shall be adjusted according to income level.
- **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).
- **Foreign National:** Non US citizens who are in the United States under a travel/visitor visa.
- **The ECH Service Area**: New York (Clinton, Essex, Franklin, Washington, Hamilton, Warren and St. Lawrence)
- **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 ECH.
- **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, exchange plans, etc.) during the dates of service provided by ECH.
- **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, Porter Medical Center, Home Health and Hospice, Elizabethtown Community Hospital and Alice Hyde Medical Center.

REFERENCES:
IRC § 501®(4):
IRC § 501®(5):
IRC § 501®(6):
NYS PHL 2807- k (9-a)- financial aid
NYS DOH HFAL

IV. DISTRIBUTION

This policy is available in Medical Policy for all employees on an as needed basis.

All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to their immediate supervisor. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

All questions regarding this policy or its implementation must be referred to your immediate administrative supervisor.