A. SCOPE: Rutland Regional Medical Center

B. PURPOSE:

This policy and the Financial Assistance Program (FAP) outlined herein are intended to address the interests of providing access to care to those without the ability to pay and to offer a discount from billed gross charges for those who are able to pay a portion of the costs of their care. This policy sets forth the process for determining patient eligibility for financial assistance (a/k/a charity care, free care or discounted care) for the population of our community and to ensure that Rutland Regional will not discriminate in the determination of eligibility on the basis of race, color, creed, sex, sexual orientation, religion, age, or handicap. Applications will be processed and approval will be determined based on specified criteria. If approved, patient's obligation to Rutland Regional may be reduced or eliminated for a period of time as specified.

C. POLICY:

It is the policy of Rutland Regional to follow federal poverty household guidelines in making reasonable efforts to determine eligibility for patient financial assistance before pursuing collection actions.

For services provided by a professional not employed by Rutland Regional (oncologist, pathologist, radiologist, and/or anesthesiologist), these services will be billed to you separately from the hospital and are excluded from Rutland Regional's Financial Assistance Program. A list of providers covered under FAP can be provided upon request.

Eligibility is provided to patients where the following applies:

- You must be uninsured, underinsured, ineligible for any government healthcare insurance programs, or under financial hardship.
    - For Vermont residents whose household income is lower than 133% of the Federal Poverty Level, the patient must apply for Vermont Medicaid.
- The services provided to you must be medically necessary.
    - Examples of non-medical necessary exclusions in our financial assistance program includes: pharmacy, cosmetic surgery, vision enhancing intraocular lenses, life line, hearing aids and associated products, investigational services or where an Advanced Beneficiary Notice (ABN) was signed.

- All insurances to include workers compensation and auto insurances must have been billed and benefits paid to Rutland Regional Medical Center, as well as, all insurance guidelines/plan provisions must have been followed such as obtaining a preauthorization.
- Proof of household income and family size is required along with a completed application. Your eligibility must meet the financial assistance criteria based on household income and asset calculations as compared to the Federal Poverty Level.
    - Examples of required documentation include Social Security or Disability benefit statement, Unemployment or Pension/Annuity benefits, food stamps, housing subsidy, ANFC, SSI, Federal Income Taxes, Business Taxes Returns, bank statements showing liquid assets and any other extenuating information to show special circumstances.
    - Individuals included in household size need to be a dependent on the federal tax return provided.
    - Examples of liquid assets include cash, savings, checking, and CD's.
    - Assets such as primary residence, rental property, and personal property such as vehicles, furniture, or livestock are not considered in determining eligibility.
- Catastrophic assistance is applicable when expenses exceed 20% of the household income.

The income guidelines will be reviewed on an annual basis based on the changes in the Federal Poverty Guidelines.

This policy and the FAP set forth herein constitute the official financial assistance policy within the meaning of section 501(r) of the Internal Revenue Code for Rutland Regional as approved by Rutland Regional's System Finance Committee and Board of Directors.

No FAP eligible individual will be charged more for emergency or other medically necessary care than the amounts generally billed. Rutland Regional is required to provide individuals who come to Rutland Regional's emergency department care any treatment for emergency medical conditions without discrimination as may be required to stabilize the medical condition pursuant to Rutland Regional's EMTALA-Medical Screening and Stabilizing Treatment Policy Care must be provided regardless of the individual's ability to pay or FAP eligibility.

D. DEFINITIONS:

- Advanced Beneficiary Notice (ABN): also called a "waiver of liability" – is a notice that Medicare providers and suppliers are obligated to give to an Original Medicare

enrollee when they find that Medicare does not cover the services the enrollee requests.

- Alcohol and Drug Abuse Program (ADAP): A program administered by the VT Dept. of Health to help Vermonters prevent and eliminate the problems caused by alcohol and other drug use. This program is limited to those individuals that are uninsured (they are not covered by insurance).
- Amounts Generally Billed (AGB): AGB is the average amount paid by all private health insurers, Medicare, and Medicaid for emergency or other medically necessary patient services. Rutland Regional uses the "look back method" as defined in section 501 (r) (5) (b) (1) of the Internal Revenue Code. Rutland Regional will limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under this policy to not more than AGB. Rutland Regional will update the AGB annually. For FY2017 the AGB discount is 54.0%. The AGB will be updated annually within 120 days of Rutland Regional's fiscal year end.
- Annual Out of Pocket Maximum: The maximum amount a patient is responsible to pay for services received at Rutland Regional each year. If patient is FAP-eligible, this amount will not exceed 20% of the household income which is consistent with the definition of catastrophic encounters.
- Application Period: the period during which the hospital accepts and processes FAP applications. This period begins with the date of the first post-discharge billing statement and ends 240 days after Rutland Regional provides the individual with their first post-discharge billing statement.
- Authorized Representative: you can give a trusted person permission to talk about the Vermont Health Connect application, your information, and act for you on matters related to the Vermont Health Connect application.
- Bad debt means a debt that is not collected and is worthless to the creditor.
- Catastrophic Encounter: A balance owed by a patient that exceeds 20% of the patient's household income.
- Charged: only the amount the FAP-eligible individual is personally responsible for paying, after all deductions, discounts (including discounts available under the FAP), and insurance reimbursements have been applied.
- Co-insurance means the percentage of total charges that a person is required by their insurance to pay out-of-pocket.
- Commercial Payer: any insurance payer other than a State or Federal Insurer such as Medicare or Medicaid. Examples: BCBS or MVP.
- Contractual Adjustment means a discount as a result of the contractual arrangement with an insurance carrier. Rutland Regional will bill most insurances (exception: Killington Medical Clinic and their out-of-country patients) and does not have a contract with all insurances.
- Copay means a set fee for services that a person must pay at each visit. The amount of the copayment is determined by the person's health insurance carrier;

- Creditor: Is a person or organization to which money is owed by a debtor (Rutland Regional is a Creditor).
- Debtor: Is a person who owes a creditor; someone who has the obligation of paying a debt (Rutland Regional's customers are debtors).
- Extraordinary collection actions (ECA): ECAs are actions taken against the patient related to obtaining payment of a bill for care covered under Rutland Regional's FAP that require a legal or judicial process or involve selling an individuals' debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. Examples of ECAs include, but are not limited to: place a lien on an individual's property; foreclose on an individual's real property; attach or seize an individual's bank account or any other personal property; commence a civil action against an individual; cause an individual's arrest; cause an individual to be subject to a writ of body attachment; and garnish an individual's wages.
- Financial Assistance Program (FAP): A charity care program providing access to those without the ability to pay and to offer a discount from billed gross charges for those who are able to pay a portion of the costs of their care.
- Federal Poverty Guidelines (FPG): a simplified calculation of the official poverty population statistics used for administrative purposes, such as, determining financial eligibility for programs.
- Guarantor means an adult receiving medical services, or the parent of a minor child (under age 18) receiving services who signs the consent for medical treatment on their behalf (not the subscriber of insurance).
- Household: all family members or cohabitants residing in the same home.
- Income: Gross earnings, unemployment compensation, workers compensation, social security benefits, supplemental security income, public assistance, veteran's benefits, survivor benefits, pension or retirement, interest, dividends, rents, royalties, estate income, trusts, educational assistance, alimony, annuities, and child support for a household.
- Income-eligible means a person who meets the financial criteria according to Federal Poverty Guidelines and who qualifies for particular Medicaid programs (as outlined below).
- Indigent means poor or destitute.
- Insurance Deductible means an amount a person must pay for healthcare expenses before insurance covers the cost; often based on a yearly amount.
- Liquid Assets: any asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, and CD's.
- Look Back Method: a calculation used to average the amount billed over the prior 12 months to Medicare patients for a given service or the average amount billed over the same period to Medicare patients and all private health insurers.
- Medically Indigent: Health insurance coverage does not provide full coverage for all of the medical expenses and the self-pay unreimbursed medical expenses, in

relationship to family income, would make the patient indigent if the patient were required to pay full charges for the medical expenses.

- Medically Necessary: health services and supplies that under the applicable standard of care are appropriate: (a) to improve or preserve health, life, or function; or (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury."
- Medicare Low Income Beneficiaries Limitation: recipients with liquid assets limited to $7,160 for a single person and $10,750 for married couples.
- Notification Period: the period during which Rutland Regional must notify an individual about the FAP. The period begins with the date of the first post-discharge billing statement and ends 120 days later.
- Outside Collection Agency (OCA)**:** a company hired by Rutland Regional to collect a debt that is owed.
- Prompt Pay Discount: a discount of 20% can be offered to uninsured patients if the visit is paid within 30 days of the first billing statement.
- Reasonable Collection Efforts: Notification to an individual about our FAP; in the case of an individual who submits an incomplete FAP application, we will provide the individual with information relevant to completing the FAP application; and in the case of an individual who submits a complete FAP application, we will make and document the determination as to whether the individual is FAP eligible.
- Underinsured patient: a patient that is exposed to significant financial losses due to inadequate health insurance coverage.
- Uninsured patient: a patient who is not covered under a medical insurance plan.

E. PROCEDURE:

Rutland Regional will:

1. Post information on Rutland Regional's website, http://www.rrmc.org/patient-visitors/billing-insurance/financial-assistance/ regarding Government Assistance Programs and the Rutland Regional FAP, including copies of the FAP, FAP plain language summary, guidelines for qualification, contact information and application forms;
2. Notify patients of the FAP at the time of registration, check-in or prior to discharge. A FAP plain language summary will be provided.
3. Post "Need Help Paying Your Bill" signs in all public areas which include Financial Counselors contact information;
4. Include FAP plain language summary, guidelines for qualification, and contact information on the back of all patient billing statements.
5. Mention FAP to the individual when discussing the bill over the phone or in e-mail. FAP plain language summary brochure and application will be mailed when:

a. Financial Counselor is calling the patient to ask them to develop a payment plan,
b. The patient calls to request it.

The Financial Counselor contact information is 802.747.1648 or PatientAccounts@rrmc.org to access help with FAP applications for uninsured or underinsured patients.

To pay your bill on line, please visit us at http://www.rrmc.org/patient-visitors/paying-your-bill/.

6. Make the FAP plain language summary brochure available and without charge;
7. Publicize the FAP plain language summary brochure at Community Health Centers of the Rutland Region and at social service agencies: Council of Aging, Park Street Health Share and Department of Children and Families, Invest EAP, and Bennington Rutland Opportunity Council Inc.;
8. Include FAP information in Rutland Regional's newsletter to staff and physicians, as well as, in annual Rutland Regional mandatory training;
9. Include FAP information in appropriate reports filed with state governments;
10. Publicize the FAP through local news media and/or social service agencies.
11. If FAP needs to be translated into another language, Financial Counselors in Patient Financial Services should be contacted at 802.747.1648 and they will arrange for it to be done.
12. The FAP application will be used to determine if patient is eligible for ADAP. Patients that qualify for ADAP must have a household income of 250% FPL or less and they do not have any insurance coverage.

Rutland Regional Registration and all Rutland Regional clinics will:

1. Offer all patients a plain language summary brochure of the Rutland Regional FAP. PreRegistration will mail plain language summary brochure and application to patient.
2. Refer patient to a Financial Counselor for assistance in completing applications for Government Assistance Programs and the Rutland Regional FAP.
3. Note on the patient's registration that this information was provided.

RRMC Financial Counselors will:

1. Attempt to contact all inpatients who are uninsured, underinsured, or have no health insurance secondary to Medicare to provide information regarding Government Assistance Programs and the Rutland Regional FAP while still receiving inpatient care.
2. Verify insurance coverage and benefits for all patients scheduled for services, and contact those who are uninsured, underinsured, or have no health

insurance secondary to Medicare, to provide information regarding Government Assistance Programs and the Rutland Regional FAP.

3. Take appointments with patients to review guidelines for qualification and/or help complete Government Assistance Programs and the Rutland Regional FAP applications.
4. Document in Rutland Regional's Health Information System anything pertinent to the financial assistance process.
5. If FAP needs to be translated for those with Limited English Proficiency, Financial Counselors will contact the Vermont Interpreting and Translating Services at 802.654.1706 or 802.655.1963. If no qualified interpreter is readily available, staff will encourage the patient to use interpreter services via phone.
6. To access interpreter services for patients who have Limited English Proficiency and/or have indicated their preference to discuss health care issues in a language other than English, staff will identify which language the patient speaks and contact Deaf Talk's telephonic interpreting services to access an appropriate interpreter. Staff will contact Security to borrow the dual handset that allows both Rutland Regional staff and the patient to communicate with the interpreter.
7. Attempt to contact by phone all uninsured and underinsured patients to discuss the Rutland Regional FAP.
8. The Cerner Action codes for FAP will be used in the Revenue Cycle system to identify FAP potential patients. These are the action codes to be used: applying for FAP, FAP application received, FAP Follow-up done, FAP denied and Medicaid Application Assistance done.
9. FAP Application Hold must be applied to the encounter while application is being reviewed.
10. Provide each uninsured and underinsured patient an application offering financial assistance through the Rutland Regional FAP and respond to any and all requests for information and assistance while applying for financial assistance.
11. Telephone applications will not be accepted, as supporting documentation is required.
12. When mail is returned due to an incorrect address, demonstrate that due diligence was exercised in attempting to obtain correct contact information for the patient before referring the account to an outside agency for collection due to a bad address.
13. Review financial assistance application to include:
    a. A completed FAP application showing required full names, demographic information, household income, and signatures.
    b. Review proof of income based on the application. This could include:
        - Copy of current Federal Income Tax Return (FITR) with all corresponding schedules January through June

- Copy of current paystubs for four pay periods July through December
- Copy Social Security statement of income
- Copy of unemployment document
- Copy of State Aid income statement (food stamps, fuel assistance, etc.)
- Copies of business ledgers, if self-employed
- For Medicare patients, copies of bank statements both checking and savings for the prior 3 months
- Proof of incarceration
- Other information as needed

14. Screen for Medicaid eligibility.
    a. If Medicaid was active for the patient (during the period of time the date of service was provided), the Financial Counselor will update the insurance information so that billing can be done within the Medicaid 6 month timely filing period.
    b. If Medicaid was not active for the patient during this period of time and
        i. if patients household income are within the required FPL
        ii. the amount owed is greater than $300
        iii. the date of service is within 3 months of the retroactive Medicaid activation period
        iv. the date of service is within the Medicaid timely filing period of 6 months

    The Financial Counselor will attempt to complete the retroactive Medicaid form with the patient. If approved, change insurance and bill Medicaid.
    c. Lastly, if the date of eligibility is
        i. past the 3 month retroactive period,
        ii. past the 6 months timely filing period,
        iii. within 240 days (from 1st billing statement) of services,
        iv. and out of pocket expenses are due

    The patient will automatically qualify for financial assistance and therefore adjustments can be done without completing a FAP application. A copy of the Medicaid website showing this proof will be used in lieu of the actual FAP application.

    Note: An authorized representative form can be completed if patient isn't able to help with retroactive eligibility. An example of this would be a deceased patient

15. The patient must apply for Vermont Medicaid when:

a. Patient is a self-pay Vermont resident whose household income is lower than 133% of the Federal Poverty Level.
b. Patient is a Medicare Vermont residents whose household income is lower than 100% of the Federal Poverty Level
c. Any exceptions to this must be approved by the Director or Manager of Patient Financial Services.

16. For any Medicare Vermont residents whose household income is lower than 90% of the Federal Poverty Level, Financial Counselor should coordinate an appointment for patient to meet with the Social Security department to apply for Supplemental Security Income (SSI).
17. Determine eligibility based on household gross income (less insurance benefits paid out) for non-Medicare patients and on household gross income (less insurance benefits paid out) and liquid assets for Medicare patients per the Medicare Low Income Beneficiaries Limitation.
18. In the case of self-employed applicants or S Corporations the following will be considered:
    - Cost of goods sold
    - Employee wages
    - Officer income
    - Employee benefits
    - Pension and profit sharing plans
    - Contract labor
19. In the case of a farming applicant, the following will be considered:
    - Custom hire
    - Feed
    - Seeds/plants
    - Hired labor
    - Pension or profit sharing plans
    - Vet
    - Supplies
20. Any patient that is deceased and has no estate (as verified in writing by Probate Court) will have their balances adjusted off in full.
21. Any self-pay patient of the West Ridge Center for Addiction Recovery can apply for ADAP and/or FAP assistance. If patients household income is less than 250% of FPL, amounts owed can be written off to ADAP. Otherwise, 251%-500% would fall under the Rutland Regional FAP.
22. Patients will not be eligible for financial assistance when:
    - There is an insurance carrier or other party responsible for payment.
    - The insurance carrier determined services provided were not medically necessary.
    - Any portion of the service was denied by the insurance carrier due to non-compliance of the plan provisions or was deemed not medically necessary.

- The Medicare patient does not provide bank statements, when applicable.
- The Medicare patient has liquid assets equal to or greater than $7,160 for a single person and $10,750 for married couples per Medicare Low Income Beneficiaries Limitation.
- The amount owed is for a service of medical benefit, but not medically necessary. Examples include: pharmacy, durable medical equipment (DME), DME service such as hearing aids or for elective services such as cosmetic surgery or intraocular lens.

23. The Financial Counselor will complete the Financial Assistance checklist and submit to the Director or Manager of Patient Financial Services for final review and approval.
    - Approval/Denial of financial assistance will be at the discretion of the Director or Manger of Patient Financial Services following the guidelines outlined.
    - Unique situations may arise and financial assistance may be jointly approved by the Director or Manager of Patient Financial Services or the Chief Financial Officer based on circumstances relative to the patient's or guarantor's ability to make payments.
    - Rutland Regional may utilize external publicly available data sources which provide information on the ability to pay.
24. In the event the application is not returned, Rutland Regional must provide each patient at least three billing statements showing balance owed for services received, as well as, one final billing statement and notification (120 days after discharge) before transferring an encounter to an outside collection agency.
25. If the individual submits an incomplete application, the Financial Counselor will send the patient a written notification indicating what is still required within 30 days and include a plain language summary of the FAP. If ECA's began, they will be suspended until determination of FAP eligibility is completed.
    - If notification of required documentation is mailed to patient at the end of the application period (prior to 240 days from first post-discharge billing statement sent to patient), Rutland Regional will not begin ECA's until day 270 days from first billing statement.
    - If FAP application is <u>denied</u> because patient does not meet the eligibility guidelines or the patient did not send Rutland Regional the required additional documentation to complete the application within the 30 day notification, a letter will be sent to the patient notifying the patient that they were denied and ECA's will resume if payment is not made.
    - Denied applications due to household income, the patient can reapply after one year.

- If complete FAP application is received and approved, all ECA's will be suspended and any ECA actions taken will be reversed.
    - Financial Counselor will document determination in the health information system and make adjustments to any open accounts prior to the date of FAP approval for services provided 240 days (from 1st post-discharge billing statement) and for services 1 year after the approval date, at which time new proof of income will be required.
    - The total balance will be reduced by the AGB discount first if the patient is uninsured. FAP eligible underinsured patients will not be billed more than AGB.
    - The remaining balance after AGB discount has been applied to uninsured accounts or any balances for underinsured accounts will be adjusted as appropriate using the Federal Poverty Levels.
    - If a patient's income falls at 300% of Federal Poverty Guidelines or below, they will not be responsible for any portion of their hospital bill, and Financial Assistance will be provided at 100%;
    - If a patient's income is between 301% and 500% of Federal Poverty Guidelines, the amount owed will be reduced by a certain percent as shown below.

26. Any FAP eligible encounter payments made by the patient within the application period (prior to the application approval date) will be refunded.
27. A written notification will be sent to the patient notifying them of FAP eligibility decision, FAP eligibility timeframe, and their financial responsibility.
28. Monthly billing statements will be sent to the patient if there are remaining balances owed along with contacts to obtain information on AGB and how the amount owed was determined.

2018 Federal Poverty Guidelines

Persons in Family or Household	90% FPL for SSI	100% FPL	Medicaid 133% FPL	Up to 300% FPL	301-400% FPL	401-500% FPL
1		$12,060	$16,040	$36,180	$48,240	$60,300
2		$16,240	$21,599	$48,720	$64,960	$81,200
3		$20,420	$27,159	$61,260	$81,680	$102,100
4		$24,600	$32,718	$73,800	$98,400	$123,000
5		$28,780	$38,277	$86,340	$115,120	$143,900
6		$32,960	$43,837	$98,880	$131,840	$164,800
7		$37,140	$49,396	$111,420	$148,560	$185,700
8		$41,320	$54,956	$123,960	$165,280	$206,600
Allowed Discount		100%	100%	100%	75%	50%
Amount Owed		0%	0%	0%	25%	50%

Medicare applicants will be denied when liquid assets are more than the Medicare Low Income Beneficiary Limitation:

Single	$7,390
Couple	$11,090
Each Addtl	add $3700

29. All insured accounts that were approved for financial assistance will be adjusted as appropriate using the Federal Poverty Guidelines matrix shown above.
30. In addition to Rutland Regional's FAP, Rutland Regional will automatically consider those individuals that were approved for the following when funds are available:
    - Agan Fund – Ludlow residents
    - Goodrich Fund – Maternity only
    - Fox Fund – Rutland City residents
        - As requested, PFS will provide Finance Department with a list of applicants that are eligible for the funding listed above.

RRMC Finance Department will:

1. Inform PFS when Agan, Goodrich, or Fox funding is available.
2. Apply payments to those applicants provided by PFS for the Agan, Fox, and Goodrich funds.

F. EDUCATION

All Patient Financial Service Financial Counselors are required to read and sign that they have read and understand the policy.

G. MONITORING

These accounts will be monitored on a daily basis to adjust off approved balances as indicated for the period of time financial assistance is applicable.

H. CROSS REFERENCE

Account Adjustment Policy
Billing and Collection Policy
Notify Patients Regarding the Financial Assistance Program Policy
Probate Filing Policy

I. REFERENCES

1. 42 CFR 413.89 Bad Debts, Charity and Courtesy Allowances, Medicare Provider Reimbursement Manual, CMS Pub 15 Part 1, Ch 14, 304-326
2. Patient Protection & Affordable Care Act, Internal Revenue Code Section 9007(a) Pub. L No. 111-148
3. Healthcare Education Affordability Reconciliation Act, 2010, (H.R. 4872) Pub. L No. 111-152, Amendment to Pub. L No. 111-148, Section 501(r) (5)
4. Federal Poverty Guidelines
5. Federal Register, Vol. 77 No. 123
6. Internal Revenue Code Section 501 (r) and Treasury Regulation 1.501(r) et seq.
7. Translating Service website: http://www.refugees.org/about-us/where-we-work/vrrp/our-services/interpretation-services.html
8. RRMC Procedure for Hearing Impaired Patients
9. RRMC EMTALA-Medical Screening and Stabilizing Treatment Policy