RESPONSE TO #18

Dartmouth Health

Policy Title	Financial Assistance for Healthcare Services Policy	Policy ID	179
Keywords	patient, financial, assistance, charity, care, needed, services, NSA, Excluded, Financial Assistance Exclusions, FAA		

I. Purpose of Policy

To establish a policy for the administration of Dartmouth Health (DH) financial assistance for healthcare services program. This policy outlines the following with respect to all emergency or other medically necessary care provided by all DH facilities:

- eligibility criteria for financial assistance.
- method by which patients may apply for financial assistance.
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care.
- DH's measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be updated periodically to the extent required by applicable law.

II. Policy Scope

This policy applies to any DH provider working in any DH facility responsible for providing emergency and any other medically necessary care and billed by a DH provider.

For purposes of this policy, "financial assistance" requests pertain to the provision of emergency and other medically necessary care provided in any DH facility by any provider employed by DH.

III. Definitions

Financial Assistance (also known as "charity care"): The provision of healthcare services free or at a discounted rate to individuals who meet the criteria established pursuant to this policy.

Family is defined by the U.S. Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption.

- The state law regarding marriage or civil union and the federal guidelines are used to determine who is included in a family.
- In the case of applicants who earn income by caring for disabled adults in their homes, the disabled adult will be counted as a family member and their income included in the determination.

- The Internal Revenue Service rules that define who may be claimed as a dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

Presumptive Financial Assistance: The provision of financial assistance for medically necessary services to patients for whom there is not a completed DH Financial Assistance Form due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), and parents claimed on adult child's claim on a tax return.

Family Income: As defined under the federal poverty level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services based on:

- 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
- pre-tax income
- the income of all family members (non-relatives, such as housemates, do **not** count).

Uninsured Patient: A patient with no insurance or other third-party source of payment for his/her medical care.

Underinsured Patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay in as determined according to this policy.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Emergency Medical Conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

- with respect to a pregnant woman:
  - inadequate time to effect a safe transfer to another hospital before delivery.
  - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Medically Necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Elective: Healthcare items or services which are not considered medically necessary.

Financial Assistance Exclusions: Services, which are not considered medically necessary or are considered elective. This policy applies to care provided by Dartmouth Health. These service are not covered by the DH Financial Assistance policy.

Dartmouth-Health: For purposes of this policy Dartmouth Health System Members (DH) are Alice Peck Day Memorial Hospital, Cheshire Medical Center, Dartmouth Hitchcock Clinic, Mt. Ascutney Hospital and Health Center, New London Hospital, Mary Hitchcock Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH). All other hospitals in New Hampshire and Vermont are considered Non-Member facilities.

This policy applies to those DH member facilities using the Epic system.

IV. Policy Statement

Dartmouth Health (DH), is committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay for services or balances that are their responsibility.

DH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided, including after an account has been referred to an outside collection agency.

DH will provide care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay or eligibility for financial or government assistance, and regardless of age, gender, race, social or immigrant status, sexual orientation or religious affiliation. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), no patient shall be screened for financial assistance or payment information prior to the rendering of services for emergency medical conditions.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with DH procedures for obtaining financial assistance or other forms of payment, 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 are required to do so, as a means of ensuring access to health care services, for their overall personal health, and for the protection of their individual assets.

DH will not impose extraordinary collections actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Chief Financial Officer.

For information on actions DH may take in the event of nonpayment, please refer to our credit and collections policy. A copy of the Credit and Collection Policy is available online, can be requested at the Patient Financial Services Offices, or can be mailed to you by calling 844-808-0730.

A. Method by Which Patients May Apply for Financial Assistance

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this policy, such patients may nevertheless be considered for eligibility for presumptive financial assistance.

1. DH will explore alternative sources of coverage and/or payment from federal, state, or other programs and assist patients in applying for such programs. With respect to any balances remaining after such other sources have been exhausted, DH will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:

    - A patient or guarantor is required to submit an application on a form approved by DH management, and provide such personal, financial, and other information and documentation as required for DH to determine whether such individual qualifies for assistance, including, but not limited to, documentation to verify Family Income and available assets or other resources. If DH is unable to obtain an application or any required supporting documentation from the patient or the patient's guarantor, DH may consider whether the patient is eligible for presumptive financial assistance.
    - In lieu of an application and supporting documentation from the patient, staff may use any of the following to support a recommendation for approval of a financial assistance application:
    - DH may utilize one or more vendors to screen individuals for eligibility using publicly available data sources that provide information on a patient's or guarantor's capacity and propensity to pay.
    - Current eligibility for Medicaid.
    - Current statement from a federal or state housing authority.
    - Verification from a homeless shelter or a Federal Qualified Health Center.
    - Verification of incarceration with no source of payment from the correctional facility.
    - For an individual patient, a patient's verbal attestation of income and assets, in lieu of a written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than $1,000.

2. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies to all balances for which the patient has applied for charity, in addition to emergency and other medically necessary care provided for a period of time, dates of service prior to receipt of the financial assistance application, including balances placed at a collection agency, and any services provided before or on the expiration date listed on the acknowledgement letter as long as the service is not listed below. After that time, or at any time additional information relevant to the eligibility of the patient for

financial assistance becomes known, DH will re-evaluate the individual's financial need in accordance with this Policy.

DH recognizes decisions made by the following assistance programs without requesting copies of applications. DH reserves the right to accept or deny decisions made outside DH guidelines made by the organizations listed below. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

- NH Health Access Network Card for insured patients only
- Good Neighbor Health Clinics
- Manchester Community Health Center
- Nashua Area Health Clinic
- Mobile Community Health
- Teen Health Clinic
- Current Medicaid eligibility if not retroactive to cover past services
- Deceased patient with no estate (as confirmed by executor or state)

3. It is the goal of DH to process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application.

4. **Appeals Process**: If DH denies partial or total financial assistance, then the patient (or his/her agent) can appeal the decision within 30 days. The patient must write a letter to the Director of Eligibility and Enrollment to explain why the decision made by DH was inappropriate. The appeal letter will be reviewed by DH and a final decision will be sent to the patient within 30 days of the receipt of the request for appeal.

B. Eligibility Criteria for Financial Assistance – Non HIV Patients In order to qualify for financial assistance under this Policy, a patient must meet the following criteria:

- Be a resident of NH or VT, or a non-resident who receives emergency treatment at a DH facility.
- Be uninsured or underinsured, ineligible for any government health care benefit program, and unable to pay for their care as outlined in the Credit and Collections Policy, based upon a determination of financial need under this Policy.
- Have Gross Family Income, inclusive of all members of the patient's household, during the past 12 months of less than 300% of FPL.
- Have Gross Family Income exceeding 300% of FPL and aggregate balances owed for services performed at DH in excess of 10% of 2 years Family Income, plus 10% of the value of household assets in excess of sheltered amounts (as described below).
- For purposes of determining value of assets, assets include, but are not limited to: savings, alimony, certificates of deposit, IRAs, stocks, bonds, 401Ks, and mutual funds. In calculating the amount of assets for purposes of qualifying a patient for charity above:
    - Savings (which includes savings accounts, alimony, or certificate(s) of deposit) are sheltered up to 100% of FPL.

- Retirement accounts (which includes IRAs, stocks, bonds, 401Ks and mutual funds) are sheltered up to $100,000, equity in a primary residence is sheltered up to $200,000 for applicants up to age 54, and equity in a primary residence is sheltered up to $250,000 for applicants age 55 or older.
- When dividends are noted on a tax return, the source of the dividends will be requested along with a recent market value statement.
- Documentation of all trust fund payments and ability to access funds is required.

- Demonstrate compliance with the requirements to apply for qualified health plan coverage the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs. Exceptions to this requirement may be approved by senior leadership for good cause on a case-by-case basis. "Good cause" will depend on facts and circumstances, and may include:
  - Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
  - Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

C. Determination of Amount of Financial Assistance

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied. See DH Uninsured Patient Discount Policy: Revenue Management Division (linked below).

If an individual is approved for financial assistance, the amount of such assistance to be provided for applicable care will be as follows:

- Family income at or below 225% of FPL will receive 100% financial assistance
- Family income between 226% - 250% of FPL will receive a 75% discount
- Family income between 251% - 275% of FPL will receive a 50% discount
- Family income between 276% - 300% of FPL will receive a 25% discount.
- As discussed above, patients whose family income exceeds 300% of FPL may be eligible to receive a discount based on the self-pay balance. Discounts will be granted such that the total self-pay bill does not exceed 10% of 2 years' gross income, plus 10% of assets in excess of the sheltered asset calculation described earlier in the Policy. Any discounts other than those described above must be approved by the Financial Assistance Appeals Committee based on a written appeal from the patient or responsible party.
- Patients meeting criteria for Presumptive Financial Assistance, will receive 100% financial assistance.
- Financial Assistance is effective for the following timeframes, based on the date of the application signature:
  - Working Family – Six (6) Months
  - Fixed Income Family – Twelve (12) Months
  - Unemployed Family – Three (3) Months
  - Out of State Residents – One (1) Month

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Dartmouth Health applies a discount against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay.

The discount is based on the "look-back Medicare fee for service plus private payors" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn't apply to any copayments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

For fiscal year FY23 -7/1/2022 to 6/30/2023, the following discount rates apply:

	FY22	FY 23
Dartmouth-Hitchcock Clinic	61.6%	62%
Mary Hitchcock Memorial Hospital	61.6%	62%
Alice Peck Day Memorial Hospital	30.8%	36.7%
Cheshire Medical Center	64.3%	68.7%
New London Hospital	51.7%	45.2%
Visiting Nurse and Hospice of VT and NH		0%

D. Communication Regarding the DH Financial Assistance Policy to Patients and Within the Community

- Referral of patients for financial assistance may be made by any DH staff member or agent, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

- Information regarding financial assistance from DH, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning DH's patient collection policies and procedures, will be available to the public and to DH patients through at least the mechanisms described below:
  - On the DH websites
  - Posted in patient care areas
  - Available on Information Cards in the registration and admitting departments
  - Available in other public spaces as determined by DH
  - Provided in the primary languages spoken by the population serviced by DH/CMC; translation services are utilized as needed
- If the balance is approved, the patient is sent a letter indicating approval.

E. Eligibility Criteria for Financial Assistance - HIV Patients. In order to qualify for financial assistance under this policy, a patient must meet the following criteria:

- NH Cares HIV program for Part C and Part D. To qualify for the NH State (NH Cares funding), the patient must first apply for NH Medicaid and be denied. If denied, and income is below 500% of FPL, and if the patient is eligible and provides required documents, the grant will cover outpatient services for HIV care only. Inpatient services are not covered under this grant, however, these charges count toward the out-of-pocket charges. The grant provision requires a limit or cap of charges based on a percentage of patient income. Charges toward the cap include all medical care, home care, prescriptions, even if not provided by DH providers. The DH financial assistance is always applied before a cap on charges. Assets are not calculated for Part C and Part D cap on charges.

  Requirements for the program:

  - Diagnosis of HIV (Part C)
  - Diagnosis of HIV or family member of woman/child with HIV

  Requirements for the NH State HAB (NH CARES) program:

  - Resident of NH
  - Diagnosis of HIV
  - Income at or below 300% FPL
  - Must apply for Medicaid at least once a year

  The chart below describes what percent of income a patient is expected to pay out-of-pocket before DH will stop charging the patient anything (co-pays, co-insurance, deductibles, or visit fees) for any further encounters.

Individual Income	**Maximum Charge**
At or below 100% of current Federal Poverty Guideline	$0
101% to 200% of current Federal Poverty Guideline	No more than 5% of gross annual income (example: $18,000 income; $500 cap on charges)
201% to 300% of current Federal Poverty Guideline	No more than 7% of gross annual income (example: $33,000 income; $2,310)
Over 300% of current Federal Poverty Guideline	No more than 10% of gross annual income (example: $49,000 income; $4,900)

  - Income documents must be obtained from every patient under Part C or Part D grants at least once every year, and income verified every 6 months if DH FAA decision extends longer than 6 months. Supporting information includes one of the following:
    - Most recent tax return
    - Recent pay stub
    - Unemployment verification notice

- Food stamps allocation
- Social security income

- It is preferred the patient complete either the special HIV financial application, but the DH application will also be accepted. Additional information, such as housing accommodations must be obtained and tracked.

F. Assistance in Completing the Applications

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756 (603) 650-8051	**Dartmouth-Hitchcock Clinic Concord** 253 Pleasant Street Concord, NH 03301 (603) 229-5080	**Dartmouth-Hitchcock Clinic Manchester** 100 Hitchcock Way Manchester, NH 03104 (603) 695-2692
Dartmouth-Hitchcock Nashua 2300 Southwood Drive Nashua, NH 03063 (603) 577-4055	**Dartmouth-Hitchcock Keene** 580-590 Court Street Keene, NH 03431 (603) 354-5454 ext:4444	**Cheshire Medical Center** 580 Court Street Keene, NH 03431 (603) 354-5430
Alice Peck Day Memorial Hospital 10 Alice Peck Day Drive Lebanon, NH 03766 (603) 443-9579	**New London Hospital** 273 County Road New London, NH 03257 (603)526-2911	**Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)** 88 Prospect St. White River Junction, VT 05001 (888) 300-8853

You will continue to be financially responsible for any services you receive until your completed application is received.

Additional options can be obtained through New Hampshire Health Access Network (https://www.healthynh.com/nh-health-access-network.html)

G. Financial Assistance Appeals Process

- If the balance is not approved, the patient will be sent a denial letter or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction.
- A committee of three DH Leaders not involved in the original process will review the appeal and make recommendations on all denial appeals monthly.

H. Presumptive Eligibility for Financial Assistance

DH may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socioeconomic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Dartmouth Health system.

Information from the predictive model may be used by DH to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Presumptive financial assistance is not available for balances after Medicare.

Presumptive screening is used, without respect to outstanding balance, on eligible accounts greater than 120 days after statements, after notices to collect the debt and prior to referral of the account to an outside collection agency to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application. Probate accounts that have exceeded time limits are eligible for presumptive screening.

Presumptive Charity does not replace traditional FAP processes; it is used to supplement these efforts, and meant for those patients who are otherwise unresponsive to the tradition FAP process. In an effort to remove barriers for these patients, and improve our benefit to the patient, the hospital uses an electronic screening process prior to bad debt placement. Patients found eligible for presumptive charity will not be placed with a bad debt collection agency.

Inclusion in this program is based on a scoring algorithm using public record information and does not typically use a sliding fee scale. Partial discounts are not allowed with Presumptive Charity. Specific demographic populations are intended to include:

- Deceased with no estate or known family
- Transient, homeless person
- Persons estranged from family with no support group
- Patients unresponsive or incapable of completing the traditional process

Presumptive charity scoring incorporates a socio-economic factor and non-credit based data. The screening process leverages public databases that contain the following information:

- Consumer transactions
- Court records
- Asset ownership
- Home ownership vs. renter
- Demographics, economics of the region
- Employment status
- Utility files
- Governmental
- Files (Bankruptcy, SSN, deceased individuals)

Presumptive charity does not rely on credit bureau reporting data and leaves no soft hits on credit reporting. The information obtained incorporates a Presumptive Charity score of 0 (most needy) to 1000 (least needy). The information predicts the need of the guarantor based on the known factors including but not limited to Income, Assets and Liquidity.

Refunds:

If a patient has paid an outstanding balance and subsequently submits a competed Financial Assistance Application which is approved for financial assistance through the application process, the hospital will refund any amount the individual has paid for the care.

I. Charity Determination Levels

- Approval levels are as follows:

Position	Dartmouth-Hitchcock	Member Hospitals
Vice President/ CFO/President	>$350,000	>$100,000
Director Revenue Management	>$50,0000	>$50,0000
Director – Conifer	Up to $50,000	Up to $50,000
Manager – Conifer	Up to $10,000	Up to $10,000
Supervisor – Conifer	Up to $1000	Up to $1000
Account Rep – Conifer	Up to $500	Up to $500

J. Financial Assistance Exclusions – Services

a. Special Considerations

- The below medical procedures are not meant to be all inclusive.
- Non-medically necessary services, as deemed by the Provider could be excluded.
- All best efforts will be made to inform the patient prior to service of any new treatments not covered under the Financial Assistance Program.

b. Elective Cosmetic Procedures (not covered)

- Breast Capsulectomy w/implants
- Mastpexy (Breast lift)
- Gynecomastiz (Male Breast Removal)
- Mastectomy (Cosmetic)
- Ryhtidectomy (Face Lift)
- Blepharoplasty (Eyelids)
- Brow Lift (fat/wrinkles on forehead)
- Augmentation Mammaplasty (breast implants)
- Reduction mammaplasty (breast reduction if not covered by insurance)
- Rhinoplasty (nose)
- Dermatology Procedures
- Abdominoplasty (tummy tuck)
- Lipectomy of any kind (liposuction) – can also be listed as removal of excess skin or fat which is not deemed a medical necessity

  Note: Above procedures are usually screened and identified by the Financial Information Coordinators

c. Artificial Insemination

- Microreanastomosis (tubal reversal)
- Vasovasostomy (vasectomy reversal)
- Laparoscopy for treatment of infertility (IUI - IVF - GIFT Programs)
- Infertility treatment

d. Other

- Acupuncture
- Chiropractic Services
- Hearing aids and repairs
- Eye glasses
- Massage therapy
- Pharmaceuticals – prescription and over-the-counter medication
- Travel Clinic
- Blood Cord Study
- Retail Sales
- Services provided by Renaissance Psychiatry of New England, LLC

e. Financial Assistance ONLY after Medical Necessity has been approved

- Bariatric Surgery

f. Manchester and Nashua Divisions Only

- **Routine Eye Exams**
  - Only covered if determined to be medically necessary and/or there is an underlying medical condition.
  - In cases where these conditions do NOT exist, the scheduler will inform the patient that financial assistance will not apply.
  - Keene and Lebanon Ophthalmology write these off.

g. Exemptions

- Some services fall under the elective and not medically necessary category, may be covered under the DH Financial Assistance Policy for all or some services related to the episode of care.
- Policies and procedures will be outlined for known services and maintained by the Patient Access Resource Team.
- These will be reviewed annually for needed revisions.
- Individual cases will be reviewed by Patient Access leadership and the Vice President of Revenue Management for approval of the exception.

h. Financial Assistance Exclusions – Non DH Providers

- Cheshire – Radiology Associates of Keene
- Cheshire – Surgicare Medical Equipment
- Cheshire – Monadnock Family Services
- Manchester – Foundation Medical Partners
- Manchester – Amoskeag Anesthesia
- Manchester – Dietician Services
- Manchester – Alliance Health Services/Catholic Medical Center
- Bedford – Alliance Health Services/Catholic Medical Center
- Nashua – Greater Nashua Mental Health Center (Social Worker)
- Nashua – Nashua Anesthesiologist Group
- Nashua – St. Joseph's Hospital (PT/Rehab Services)
- Concord – Riverbend Community Mental Health

- Concord – Services provided by Concord Hospital
- Lebanon – Orthocare medical equipment
- Alice Peck Day – Medstream Anesthesia
- Alice Peck Day – Upper Valley Neurology and Neurosurgery (UVNN)
- Alice Peck Day – Envision (ED & Hospitalist)*
- New London Hospital – Counseling Associates (professional)
- New London Hospital – Dr. Richard Rosato– Oral and Maxillofacial Surgery (professional)

*Contract Terminated

V. References N/A

Responsible Owner:	Finance Division Corporate	**Contact(s):**	Kimberly Mender
Approved By:	Chief Officer - Finance; Office of Policy Support - Organizational Policies Only; Cohen, Lisa; Fielding, Wendy; Gross, Daniel; Naimie, Tina; Roberts, Todd	**Version #**	12
Current Approval Date:	06/14/2022	**Old Document ID:**	RMD.0031
Date Policy to go into Effect:	06/14/2022 Approved by MHMH/DHC Finance Committee 6/23/2016; MHMH/DHC Boards of Trustees 6/24/16		
Related Polices & Procedures:	Uninsured Patient Discount Policy - Revenue Management Division Credit and Collection Policy Budget Payment Policy - Revenue Management Division		
Related Job Aids:			

Receive in-person assistance by going to one of the following locations:

Dartmouth Hitchcock Medical Center
Patient Financial Services/Main Mall
One Medical Center Drive
Lebanon, NH 03756

Dartmouth Hitchcock Clinics Concord
Financial Counselor
253 Pleasant Street
Concord, NH 03301

Dartmouth Hitchcock Clinics Manchester
Financial Counselor
100 Hitchcock Way
Manchester, NH 03104

Dartmouth Hitchcock Clinics Nashua
Financial Counselor
2300 Southwood Drive
Nashua, NH 03063

Alice Peck Day Memorial Hospital
Registration/Financial Counselor
10 Alice Peck Day Drive
Lebanon, NH 03766

Cheshire Medical Center
Registration/Cashiers Main Lobby
580 Court Street
Keene, NH 03431

New London Hospital
Financial Counselor/Reception
273 County Road
New London, NH 03257

VRH000289

Call one of our patient advocates at:

(844) 647-6436

Please send completed applications to:

Dartmouth Hitchcock Medical Center
Attn: PFS - Level 3 – FAA
One Medical Center Drive
Lebanon, NH 03756-0001

Cheshire Medical Center
Attn: PFS – FAA
580 Court Street
Keene, NH 03431

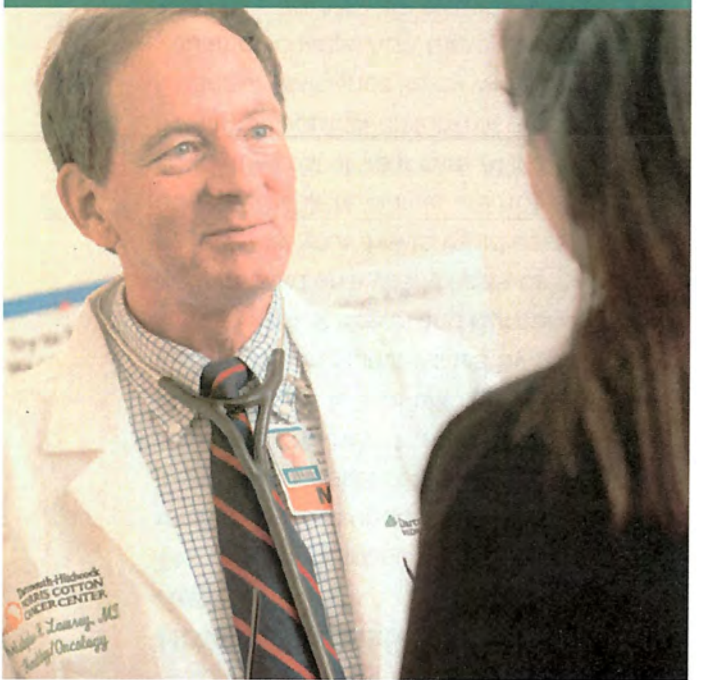
New London Hospital
Attn: Financial Counselor
273 County Road
New London, NH 03257

Dartmouth Health

dartmouth-hitchcock.org/patients-visitors/financial-assistance

Dartmouth Health

Financial Assistance Policy



Do you need assistance to pay your bill for emergency or medically necessary care at a Dartmouth Health facility?

You may be eligible for financial assistance.

Dartmouth Health offers free or discounted charity care for emergency or other medically necessary services provided to patients who qualify. Patients who are determined eligible for financial assistance may not be charged more for emergency or other medically necessary care than amounts generally billed to patients covered by insurance for the same care.

Financial Policy

Dartmouth Health provides care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay, eligibility for financial or government assistance, age, gender, race, immigration status, sexual orientation or religious affiliation. We provide financial assistance to persons who (i) are residents of New Hampshire or Vermont, or non-residents who experience a medical emergency while in the area; do not have insurance or who have health insurance but need financial assistance to help cover out-of-pocket medical expenses such as deductibles, co-pays and co-insurance; are ineligible for any government healthcare benefit program; and meet financial eligibility criteria as described in our Financial Assistance Policy. Local conditions or exclusions may apply as further described in our Financial Assistance Policy. Patients are expected to cooperate with the procedures for obtaining financial assistance or accessing other sources of payment, and to contribute to the cost of their care based on their ability to pay. Individuals who can purchase health insurance are expected to do so, to ensure access to healthcare services that benefit their overall health as well as provide protection for their personal assets.

VRH000290

How and when to apply for financial assistance?

You can apply at any point during your care or the subsequent collections cycle. However, we strongly encourage applications to be completed prior to appointments. Patient advocates can assist you in identifying and applying for insurance coverage or other resources and with completing an application for financial assistance. If you have a remaining balance after exhausting all other coverage options, you may be eligible for financial assistance. An application can be requested in person, over the telephone: **dartmouth-hitchcock.org/patients-visitors/financial-assistance**.

Discounted rate

If you do not qualify for financial assistance, you may still be eligible for the uninsured discount or other discounts according to our policy. This uninsured discount is applied prior to billing the patient and applying any financial assistance adjustments. The discount is based on the "prospective Medicare" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. Discount rates may vary by facility.

How is financial assistance determined?

The amount of financial assistance you receive is based upon your total gross income and assets compared to the federal poverty guidelines. You may qualify: If your family income is at or below 300% of the Federal Poverty Limit; issued by the U.S. Department of Health and Human Services and updated on a yearly basis; or If you believe that your assets, liquid assets and other available resources are not enough to cover the cost of your care. At your request, a financial application form or a copy of the Financial Assistance Policy will be mailed to you at no charge. Also, these documents and this summary are available on our website, at **dartmouth-hitchcock.org/patients-visitors/financial-assistance**.

These documents are also available in the following languages: *Spanish, French, Portuguese, Chinese, Greek, Vietnamese, Nepalese, Arabic, Russian, Bosnian, Korean, Lao, Somali, Swahili, and Thai.*

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Policy:	**Financial Assistance For Healthcare Services Policy (FAP)**	**Policy ID:**	**Reference #**
Policy Level	Finance		
Keywords	Financial Assistance, Affordable Care		

I. Purpose of Policy

To establish a policy for the administration of Mt. Ascutney Hospital and Health Center's (MAH) financial assistance for healthcare services program. This policy outlines the following with respect to all emergency or other medically necessary care provided by all MAH facilities:

- eligibility criteria for financial assistance
- method by which patients may apply for financial assistance
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care
- MAH measures to publicize the policy within the community served

This policy is intended to comply with the requirements of the Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be changed from time to time the extent required by applicable law.

II. Policy Scope

For purposes of this policy, "financial assistance" requests pertain to the provision of emergency and other medically necessary care provided in any MAH facility by MAH or any provider employed by MAH.

III. Definitions

Financial Assistance (also known as "affordable care"): The provision of healthcare services free or at a discounted rate to individuals who meet the criteria established pursuant to this Policy.

Presumptive Financial Assistance: The provision of financial assistance for medically necessary services to patients for whom there is not a completed MAH Financial Assistance Form due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption.

- The state law regarding marriage or civil union and the federal guidelines are used to determine who is included in a family.
- In the case of applicants who earn income by caring for disabled adults in their homes, the disabled adult will be counted as a family member and their income included in determination.
- The Internal Revenue Service rules that define who may be claimed as a dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

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Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adopt ion), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child/children, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), and parents claimed on adult child's claim on a tax return.

Family Income: As defined under the federal poverty guidelines as published annually by the U.S. Department of Health and Human Services ("FPL"), based on:

- 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)
- pre-tax income,
- the income of all family members (non-relatives, such as housemates, do **not** count)

Uninsured Patient: A patient with no insurance or other third party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay in as determined according to this Policy.

Underinsured Patient: A patient with some insurance or other third party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay as determined according to this policy.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Emergency Medical Conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part

Medically Necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. See Attachment A.

Prompt Pay Discount: Discount offered for prompt payment.

IV. Policy Statement

MAH is committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay for services or balances that are their responsibility. MAH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided, including after an account has been referred to an outside collection agency.

MAH will provide care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay or eligibility for financial or government assistance, and regardless of age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with MAH procedures for obtaining financial assistance or other forms of payment, 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 are required 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.

MAH will not impose extraordinary collections actions, such as sending to collections or other legal actions, for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Chief Financial Officer. For information on actions MAH may take in the event of nonpayment, including extraordinary collection actions and reasonable efforts to determine eligibility for assistance, please refer to our Credit and Collections Policy. Copies of the Credit and Collection Policy are available online or can be requested at Customer Services or can be mailed to you by calling 802-674-7471.

A. Qualifications for Financial Assistance

- Reside in our service area; see attachment B. or a non-resident who receives emergency treatment at MAH or receives services at MAH that are unavailable in their service area.
- Be uninsured, underinsured, or ineligible for any government health care benefit program, and unable to pay for their care as outlined in the Credit and Collections Policy, based upon a determination of financial need under this Policy.
- Have gross family income, inclusive of all members of the patient's household, during the past 12 months of less than 300% of FPL. These guidelines will be updated annually. The guidelines are set up with a prorated scale of assistance based on income.
- Ownership, Liquid Assets and Assets with limited liquidity will be considered for each application for assistance totaling over $10,000. Ability to satisfy the obligation through these assets will be determined. Assets such as retirement accounts, real estate, and others will be considered to be available resources.
- For purposes of determining value of assets, assets include, but are not limited to: savings, alimony, certificates of deposit, IRA's, stocks, bonds, 401Ks, and mutual funds. In calculating the amount of assets for purposes of qualifying a patient for the charity above, (i) savings (which includes savings accounts, alimony, or certificate of deposit) are sheltered up to 100% of FPL, (ii) retirement accounts (which includes IRA's, stocks, bonds, 401Ks and mutual funds) are sheltered up to $100,000, equity in a primary residence is sheltered up to $200,000 for applicants up to age 54, and (iv) equity in a primary residence is sheltered up to $250,000 for applicants age 55 or older. When dividends are noted on a tax return, the source of the dividends will be requested along with a recent market value statement. Documentation of all trust fund payments and ability to access funds is required.
- Demonstrate compliance with the requirements to apply for qualified health plan coverage from the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs.
- Demonstrate that services received are not the result of an accident or torte case for which there may be settlement proceeds. Balances owed that exceed proceeds from such a settlement, can be considered for financial assistance.

Exceptions to this requirement may be approved by senior leadership for good cause on a case by case basis. "Good cause" will depend on facts and circumstances, and may include:

- Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
- Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this Policy, such patients may nevertheless be considered for eligibility for presumptive financial assistance.

B. Method by Which Patients May Apply for Financial Assistance

1. MAH will explore alternative sources of payment from federal, state or other programs and assist patients in applying for such programs. With respect to any balances remaining after such other sources have been exhausted, MAH will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:

   - A patient or guarantor is required to submit an application on a form approved by MAH management, and provide such personal, financial and other information and documentation as required for MAH to determine whether such individual qualifies for assistance, including, but not limited to, documentation to verify Family Income and available assets or other resources. If MAH is unable to obtain an application or any required supporting documentation from the patient or the patient's guarantor, MAH may consider whether the patient is eligible for presumptive financial assistance;
   - In lieu of an application and supporting documentation from the patient, staff may use any of the following to support a recommendation for approval of a financial assistance application:

     - o MAH may utilize one or more vendors to screen individuals for eligibility using publicly available data sources that provide information on a patient's or guarantor's capacity and propensity to pay;
     - o Current eligibility for Medicaid;
     - o Current statement from a Federal or State housing authority;
     - o Verification from a homeless shelter or a Federal Qualified Health Center;
     - o Verification of incarceration with no source of payment from the correction facility; or
     - o For an individual patient, a patient's verbal attestation of income and assets, in lieu of written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than $1,000.

2. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies to all balances for which the patient has applied for charity, in addition to emergency and other medically necessary care provided for a period of time, dates of service prior to receipt of the financial assistance application, including balances placed at a collection agency, and any services provided before or on the expiration date listed on the acknowledgement letter as long as the service is not listed on the Attachment A. After that time, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known, MAH will re-evaluate the individual's financial need in accordance with this Policy.

   - Current Medicaid eligibility if not retroactive to cover past services

3. It is the goal of MAH to process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application.

4. Appeals Process: If MAH denies partial or total financial assistance then the patient (or his/her agent) can appeal the decision within 30 days. The patient must write a letter to the Revenue Cycle Director to explain why the decision made by MAH was inappropriate. The appeal letter

will be reviewed by MAH and a final decision will be sent to the patient within 30 days of the receipt of the request for appeal.

C. Determination of Amount of Financial Assistance

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied. If an individual is approved for financial assistance, the amount of such assistance to be provided for applicable care will be as follows:

- Family income at or below 225% of FPL will receive 100% financial assistance,
- Family income between 226% - 250% of FPL will receive a 75% discount,
- Family income between 251% - 275% of FPL will receive a 50% discount,
- Family income between 276% - 300% of FPL will receive a 25% discount.
- As discussed above, patients whose family income exceeds 300% of FPL may be eligible to receive a discount based on the self-pay balance. Discounts will be granted such that the total self-pay bill does not exceed 10% of 2 year's gross income, plus 10% of assets in excess of the sheltered asset calculation described earlier in the Policy. Any discounts other than those described above must be approved by the Financial Assistance Appeals Committee based on a written appeal from the patient or responsible party.
- Patients meeting criteria for Presumptive Financial Assistance will receive 100% financial assistance.

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. MAH applies a discount to FAP eligible patients against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay. The discount is based on the "lookback Medicare" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn't apply to any copayments, coinsurance, deductible amounts, pre- payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

D. Communication Regarding the MAH Financial Assistance Policy to Patients and Within the Community

Referral of patients for financial assistance may be made by any MAH staff member or agent, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient. Free copies of financial assistance documents (policy, application, summary) can be obtained within the facility, mail and by email. You can receive in person assistance completing this application at the following locations: Mt. Ascutney Hospital and Health Center, 289 County Road, Windsor, VT, Ottauquechee Health Center, 32 Pleasant Street, Woodstock, VT, and Mt. Ascutney Hospital Ophthalmology, 80 S. Main Street, Hanover, NH.

Information regarding financial assistance from MAH, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning MAH's patient collection policies and procedures, will be available to the public and to MAH patients through at least the mechanisms described below:

- On the MAH website, www.mtascutneyhospital.org
- Posted in patient care areas
- Available on Posters and Brochures in the registration and admitting departments
- Available in other public spaces as determined by MAH
- Provided in the primary languages spoken by the population serviced by MAH; translation services are utilized as needed
- If the balance is approved, thepatient is sent a letter indicating approval

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- Providing information about the policy and how to apply during verbal communication about the patient's bill (e.g. phone call)
- Uninsured and underinsured patients are educated and assisted with the process through the Windsor Community Health Clinic
- Brochure that summarizes the FAP (which is given to patients by hospital team members)
- Information provided on reverse side of patient billing statement

E. Financial Assistance Appeals Process

- If the balance is not approved, the patient will be sent a denial letter or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction.
- A committee of three MAH Leaders not involved in the original process will review the appeal and make recommendations on all denial appeals.

F. Charity Determination Levels

Approval levels are as follows:

- Over $10,000 - CFO
- Less than $10,000-Revenue Cycle Director

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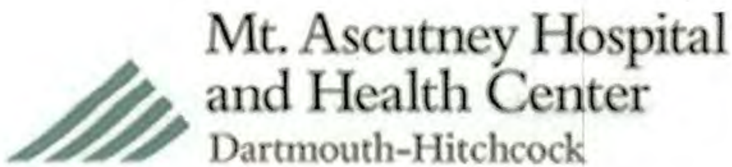

Services at Mt. Ascutney Hospital that ARE covered by the MAHHC Financial Assistance Policy:

Cardiology	Cardiac Rehabilitation	Diabetes and Nutrition
EEG/EMG	Emergency Medicine	Gastroenterology
General Surgery	Hospice Care	Hospitalist Program
Laboratory	Neurology	Oncology
Ophthalmology	Pain Management	Palliative Care
Pediatrics	Physiatry	Physical Medicine & Rehabilitation
Podiatry	Primary Care	Radiology – Facility Charges
Rheumatology	Surgical Services	Therapy - Inpatient
Therapy - Outpatient	Urology	

Services, providers, and venders that are NOT covered by the MAHHC Financial Assistance Policy:

D-HH Cardiology Echocardiogram and Holter Monitor	D-HH Laboratory & Pathology	D-HH Radiology Diagnostic Imaging (Interpretation)
HCRS	Keene Medical	Dr. Knott, DMD
The Medical Store	MedStream Anesthesia	Orthocare
Peraza Dermatology Group	Dr. Sverrisson	Tactile Medical
	Willowbrook Prosthetics	

Attachment B

MAHHC Service Area

Place of Service

Residence	Windsor	Woodstock	Hanover
VT			
Barnard	X	X	
Bridgewater	X	X	
Brownsville	X	X	
Cavendish	X	X	
Hartford	X	X	X
Hartland	X	X	X
Ludlow	X	X	
Norwich			X
Pomfret	X	X	
Quechee	X	X	X
Reading	X	X	
Sharon			X
Taftsville	X	X	X
Thetford			X
Weathersfield	X	X	
White River Junction	X	X	X
Wilder	X	X	X
Windsor	X	X	X
NH			
Canaan			X
Claremont	X		X
Cornish	X		X
Enfield			X
Etna			X
Hanover			X
Lebanon	X		X
Lyme			X
Plainfield	X		X

Note:

- Inpatient Rehabilitation Unit has no service area restrictions
- Emergency Care has no service area restrictions
- Patients receiving services not available in their service area are eligible for those services
- Only larger towns have been listed as a general guide. Small towns and villages normally

associated with these larger towns should be considered as well.

Education

Staff Education

- Staff education.

Patient Education

- Educate and involve the patient, family and/or significant other.
- Patient and family education shall be documented in the designated patient/family interdisciplinary teaching document.

Communication/Reporting

- This policy will be implemented and disseminated through the organization and will be published in the organizations Policy Library. Access to this document is open to all.
- It is the responsibility of the departmental managers to ensure all staff working in financial assistance area is aware of this policy.
- Departmental managers are responsible for ensuring staff receives training to support the implementation of this policy.
- Monitoring of staff competence will form part of the individual's annual performance review and where necessary, additional training will be provided.

V. References N/A

Responsible Owner (role):	Bonnie Paquette	Contact(s): email	Bonnie.paquette@mahhc.org
Approved by (committee):	Board	To be reviewed/renewed annually	
Approved By (Sr. Leader):	CFO	David Sanville	
Policy Type/Level:	Administrative	Finance	
Current Approval Date:	8/3/2021	Intentionally left blank	
Date Policy to go into Effect:	1/1/2005	Intentionally left blank	
Related Policies & Procedures:	n/a		
Related Job Aids:	n/a		

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Do you need assistance completing an application?

You can get help in the following ways:

Receive in-person assistance by going to the following locations

Mt. Ascutney Hospital and Health Center
289 County Road
Windsor, VT 05089

Ottauquechee Health Center
32 Pleasant Street
Woodstock, VT 05091

Mt. Ascutney Hospital Ophthalmology
80 S. Main Street
Hanover, NH 03755

Call one of our Financial Counselors at

(802) 674-7471 or Windsor Community Health Clinic at (802) 674-7213

Please send completed applications to:

ATTN: Customer Service Department
Mt. Ascutney Hospital and Health Center
289 County Road
Windsor, VT 05089

FINANCIAL ASSISTANCE POLICY

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Latest Revision: **May 2017**

VRH000300

Do you need assistance to pay your bill for emergency or medically necessary care at Mt. Ascutney Hospital and Health Center?

You may be eligible for financial assistance. MAHHC offers free or discounted care for emergency or medically necessary services provided to patients within our service area who qualify and are residents or to non-residents who experience a medical emergency while in our service area.

Generally, financial assistance will be available to help with balances you owe if:

- You have no insurance or you are under-insured.
- You are not eligible for insurance coverage or other governmental assistance, and either of the following is true:
  - Your family income is at or below 300% of the Federal Poverty Limit; issued by the Department of Health and Human Services (HHS), updated on a yearly basis, or;
  - If you believe that your assets, liquid assets, or other available resources are not enough to cover the cost of your care.

In addition to your completed application, we may require documents verifying your income, assets and medical expenses to determine whether you qualify for assistance. If you do not qualify for financial assistance, you may still be eligible for the prompt pay discount. You can find information below about how to get a copy of the full MAHHC Financial Assistance Policy which describes these potential discounts in more detail.

MAHHC Financial Policy

Patients without insurance cannot be charged any more than amounts generally billed to patients who have insurance covering the same care. MAHHC applies a discount to the FAP eligible patient's gross charges to all balances where there is no insurance, or to medically necessary services processed by insurance carriers resulting in a balance, which the patient is expected to pay. This discount doesn't apply to any co-payments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discounts or any non-covered services per our policy.

How do I apply for financial assistance?

Windsor Community Health Clinic Patient Advocates and our Financial Counselors can assist you in identifying and applying for insurance coverage or other resources and with completing an application for financial assistance. If you have a remaining balance after exhausting all other coverage options, you may be eligible for financial assistance. An application can be requested in person, over the telephone or obtained via the web link below.

At your request, a financial application form or copy of the Financial Assistance Policy will be mailed to you at no charge. Also, these documents and this brochure summary of the policy are available on our website at MtAscutneyHospital.org/FAP and can be printed in alternative languages by contacting the public relations office at (802) 674-7327. Translation and sign language services can also be arranged by request through any MAHHC clinical or clerical staff.

Valley Regional Hospital

Compassion | Accountability | Respect | Excellence | Service

Policy Title: Financial Assistance

Policy Manual Name: Patient Accounting

Last Revised: 10/21

Policy Statement/Purpose: The Financial Assistance Program has been established to provide financial assistance relief to those who are unable to meet their financial obligation to Valley Regional Hospital. This policy outlines the following with respect to all emergency or other medically necessary care provided by Valley Regional Hospital and Valley Regional owned physician clinics:

- eligibility criteria for financial assistance;
- method by which patients may apply for financial assistance;
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care; and
- measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be changed from time to the extent required by applicable law.

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

Charity Care: Healthcare services that have or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: A group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), parents claimed on adult child's claim on a tax return.

Family Income: Family Income is determined by using the following income sources:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, rents, royalties, income from estates, trusts, alimony, child support, food stamps, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as fuel assistance 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 and is claimed as a dependant on the head of household's tax return, it includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

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.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Emergency medical conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part, or
- with respect to a pregnant woman:
  - inadequate time to effect a safe transfer to another hospital before delivery, or
  - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Medically necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Procedure:

A. Services Eligible Under this Policy. The following healthcare services are eligible for charity:

1. Medically necessary services.
2. Preventative care services
3. Some elective services, evaluated on a case-by-case basis at the hospital's discretion. Please see Exhibit A of excluded services, located at the end of this policy.

B. Eligibility for Charity. Eligibility for charity 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 or religious affiliation.

Eligibility – Patient eligibility will be based on the following information:

a. Patient must be a resident of New Hampshire or Vermont, except instances where presumptive charity guidelines are used.

b. All inpatient and outpatient accounts are eligible for charity with the exception of Priority Care services.

c. Crisis stabilization services rendered in the Emergency Room which are considered non-covered by VT Medicaid, when performed by a LCSW, will be considered eligible for charity assistance.

d. If a patient has exceeded their maximum number of allowed Emergency Visits under Medicaid, Medicaid eligibility is verified and the balance can then be adjusted to Financial Assistance at 100%.

e. The application includes:

1) Income disclosure from all sources (see above).

2) Number of dependents.

3) A copy of the most recent federal income tax forms, employment pay stubs for the last 2-3 pay periods, a copy of social security disclosure/check (or bank statement showing deposit of funds from US Treasury), statement of pension balance (if available), federal w-2 form.

4) 2-3 most recent bank statements from all accounts.

F. Deductible and co-insurance amounts are eligible for charity benefits if financial circumstances warrant.

Note that individuals with the financial capacity to purchase health insurance are required 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. Likewise, applicants must demonstrate compliance with the requirements to apply for qualified health plan coverage through the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs. Exceptions to this requirement must be approved by the Revenue Cycle Director and/or Chief Financial Officer and may include:

- Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
- Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

C. Determination of Financial Need:

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

- 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 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; and
- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
- Due to Regulation 501(r)(6) limitation on the use of liens, applicants who own their own home will not be required to apply for Medicaid prior to approval of financial assistance.

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle.

3. Eligibility may be determined in one of three ways:

1. Standard Application Process
2. Presumptive Eligibility

3. ED Quick Application: A one-time approval for patients who complete the pre-qualification application and are determined to meet the financial criteria as stated in this policy

   a. Patients who reside outside of Valley Regional's catchment area (more than 30 miles away)

   b. Have not been seen at Valley Regional or a VRH owned practice

   c. Sign an attestation that the information that they have provided in the pre-qualification application is true and accurate to the best of their ability.

D. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for charity care, the hospital can use outside agencies in determining estimate 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:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down, QMB);
7. Participation in other state Medicaid programs for which the hospital is not considered a participating provider;
8. Dates of service rendered prior to any Medicaid coverage period, or if timely filing requirements were not met due to non-disclosure by the patient;
9. Low income/subsidized housing is provided as a valid address; and
10. Patient is deceased with no known estate.

E. Program Administration: The Financial Assistance Program will be administered according to the following guidelines:

1. The application information, along with the federal income tax forms, will be reviewed and verified by patient accounts personnel. The applicant must return applications to Valley Regional Hospital within ten-(10) days of receipt. Failure to comply may result in denial.
2. If the patient/guarantor qualifies for 100 percent (100%) charity, he/she will be notified within thirty-(30) days of receipt of the application, and the account will be written off per procedures.
3. If the patient/guarantor qualifies for a reduction in liability, he/she will be notified of payment arrangements made for the non-write-off amount.
4. Falsification of application or refusal to cooperate will result in denial of charity benefits.
5. Valley Regional Hospital will maintain complete confidentiality of all information received.
6. Financial Assistance will be extended past the expiration date to include hospital stays that begin while covered under the Financial Assistance Program.
7. Patient's receiving financial assistance must reapply at 6-month intervals.

Patients living on fixed incomes such as social security will need to reapply each year. The patient or family member must complete the financial assistance application *except* if a NH Health Access Network (NH HAN) approval has been given by another hospital; however, we reserve the right to request a copy of the full application from the partner hospital in the event of an audit.

Valley Regional Hospital will not impose extraordinary collections actions, such as engaging legal action, for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Revenue Cycle Director and/or the Chief Financial Officer. **Exhibit B** (Credit and Collection Policy) defines the actions Valley Regional Hospital may take in the event of nonpayment, including extraordinary collection actions and reasonable efforts to determine eligibility for assistance. A copy of the Credit and Collection Policy is available at the end of this document, or can be requested at the Patient Accounting Offices, or can be mailed to you by calling (603) 543-5693.

F. Program Guidelines:

Valley Regional Hospital determines eligibility using the national Federal Poverty Income Guidelines, which are published on a yearly basis.

You may be granted Financial Assistance for any date of service before your effective date with Vermont or New Hampshire Medicaid. The hospital will apply current Medicaid guidelines to show proof of household income.

To be eligible for 100% approval for the Valley Regional Hospital Financial Assistance Program, family income must be less than or equal to 200% of the Federal Poverty Income Guidelines.

To be eligible for 75% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 201%-225% of the Federal Poverty Income Guidelines.

To be eligible for 50% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 226%-250% of the Federal Poverty Income Guidelines.

To be eligible for 25% approval for the Valley Regional Hospital Financial Assistance Program, family income must be between 251%-275% of the Federal Poverty Income Guidelines.

If your family exceeds 275% of the Federal Poverty Income Guidelines, you are not eligible for assistance through the Valley Regional Hospital Financial assistance Program.

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied.

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Valley Regional Hospital applies a discount against gross charges to all balances for patients who have no

insurance, resulting in a discounted balance which the patient is expected to pay. The discount is based on the "Look Back" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn't apply to any copayments, coinsurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

Communication Regarding the Financial Assistance Policy to Patients and Within the Community:

Information regarding financial assistance from Valley Reginal Hospital includes this policy, a plain language summary of this policy, an application form and information concerning Valley Regional's credit and collection policies and procedures, will be available to the public and to VRH patients through at least the mechanisms described below:

- On the Valley Regional Hospital website at www.vrh.org
- Posted in patient care areas,
- Available in other public spaces as determined by VRH,
- Included on the back of each patient statement, and
- Provided in the primary languages spoken by the population serviced by VRH

Providers Accepting VRH Financial Assistance:

Please see **Exhibit C** for a listing of both providers who accept financial assistance and those that do not.

Valley Regional Hospital
Financial Assistance Program
2021-2022 Guidelines

It is the policy of Valley Regional Hospital to provide financial assistance to those patients who are unable to pay for all or part of the cost of their care that is not covered by other sources of funding. Valley Regional Hospital's Financial Assistance Program is a program that assists uninsured and under-insured patients who meet specific income, geographical and Valley Regional Hospital Guidelines.

Valley Regional Hospital's Financial Assistance Income Guidelines Per Year

Household Size	100% Federal level	VRH 100% = 200% FPL	VRH 75% = 225% FPL	VRH 50% = 250% FPL	VRH 25% = 275% FPL
1	$ 12,880.00	$ 25,760.00	$ 28,980.00	$ 32,200.00	$ 35,420.00
2	$ 17,420.00	$ 34,840.00	$ 39,195.00	$ 43,550.00	$ 47,905.00
3	$ 21,960.00	$ 43,920.00	$ 49,410.00	$ 54,900.00	$ 60,390.00
4	$ 26,500.00	$ 53,000.00	$ 59,625.00	$ 66,250.00	$ 72,875.00
5	$ 31,040.00	$ 62,080.00	$ 69,840.00	$ 77,600.00	$ 85,360.00
6	$ 35,580.00	$ 71,160.00	$ 80,055.00	$ 88,950.00	$ 97,845.00
7	$ 40,120.00	$ 80,240.00	$ 90,270.00	$ 100,300.00	$ 110,330.00
8	$ 44,660.00	$ 89,320.00	$ 100,485.00	$ 111,650.00	$ 122,815.00

ea add'l person
$4,540.00

In addition to having it's own Financial Assistance Program, Valley Regional Hospital is a participating provider with the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to health care for uninsured and under-insured children and adult residents of the State of New Hampshire only.

NH Health Access Network Income Guidelines Per Year (Please note this program has been suspended in light of coverage through the Exchange & NH Health Protection Program – aka expanded Medicaid)

Household Size	100% Federal level	NHHAN 100% = 125% FPL	NHHAN 75% = 150% FPL	NHHAN 50% = 175% FPL	NHHAN 25% = 200% FPL
1	$ 12,880.00	$ 16,100.00	$ 19,320.00	$ 22,540.00	$ 25,760.00
2	$ 17,420.00	$ 21,775.00	$ 26,130.00	$ 30,485.00	$ 34,840.00
3	$ 21,960.00	$ 27,450.00	$ 32,940.00	$ 38,430.00	$ 43,920.00
4	$ 26,500.00	$ 33,125.00	$ 39,750.00	$ 46,375.00	$ 53,000.00
5	$ 31,040.00	$ 38,800.00	$ 46,560.00	$ 54,320.00	$ 62,080.00
6	$ 35,580.00	$ 44,475.00	$ 53,370.00	$ 62,265.00	$ 71,160.00
7	$ 40,120.00	$ 50,150.00	$ 60,180.00	$ 70,210.00	$ 80,240.00
8	$ 44,660.00	$ 55,825.00	$ 66,990.00	$ 78,155.00	$ 89,320.00

ea add'l person
$4,540.00

Effective 4/1/21-3/31/22

Exhibit A - Excluded services – The following services are excluded from coverage of financial assistance:

Elective cosmetic procedures

Hearing Aids and repairs

DOT Examinations

Sports Physicals

Gait Analysis

Dry Needling

Exhibit B – Credit and Collections Policy

Exhibit C – Providers accepting or not accepting VRH Financial Assistance:

Providers accepting: All employed providers of VRH including all VRH owned physician clinics, including:

Asscociates in Medicine

Valley Family Physicians

Valley Primary Care

Valley Regional Orthopedics

Valley Regional Surgical Associates

Valley Regional Urology

Valley Regional Womens' Health

The following independent providers also accept VRH Financial Assistance:

Dartmouth Hitchcock – VRH will share an applicant's application and supporting documentation upon request.

Providers Not accepting: Any area independent provider group.

Keady Family Practice

Charlestown Family Medicine

Please note that Valley Regional Hospital will, ***upon applicant's request***, share their application and supporting documentation with any hospital that the applicant requests.

Reference(s): (APA/ AMA format)
1.

Cross Reference(s): (List title of relevant policies within the organization)
1.

Valley Regional Hospital

Compassion | Accountability | Respect | Excellence | Service

Policy Title: Financial Counseling

Policy Manual Name: Patient Accounting

Last Revised: 10/2021

Purpose: The purpose of this policy is to ensure that patients who may have difficulty meeting or understanding their financial obligations receive appropriate financial counseling from VRH staff.

Policy Scope:

Definitions:

Procedure:

It is the policy of VRH that patients receive financial counseling when it has been determined that they may be unaware of or unable to pay their financial obligations. This identification of patients will occur as early in the revenue cycle as possible. Financial counseling includes:

- Apprising the patient of estimated "out-of-pocket" expenses
- Arranging for payment of outstanding balances, co-pays, or deductibles prior to or at the time of service
- Securing payment for all non-covered services or patient convenience items.
- Assisting patients with making alternative payment arrangements (i.e. budget plans)
- Referring patients to the Financial Assistance program if applicable
- Providing access to state Medicaid applications

Reference(s): (APA/ AMA format)

1.

Cross Reference(s): (List title of relevant policies within the organization)

1.

Printed copies are for reference only. Please refer to electronic copy for the latest version.