

ST. VINCENT'S MEDICAL CENTER PATIENT FINANCIAL SERVICES

Subject: Collection & Bad Debt Referral

Effective Date: 10/1/06

Category: Financial

Policy: All patients receiving services are given the opportunity to take advantage of policies developed to assist them financially. These policies include Charity Care, Free Bed Funds, financial counseling as well as State & Federal programs. In addition, patients are given the opportunity to make payment within a reasonable amount of time. The Medical Center reserves the right to refer patients who choose not to pay an amount determined to be their responsibility to a licensed collection agency.

Purpose: To collect outstanding balances from patient's as a result of deductibles, co-payments or services rendered within a reasonable time-frame. If amount due is determined to be uncollectable, the balances are adjusted and referred to a licensed collection agency.

1. A determination is made that a balance is the responsibility of the patient based as a result of carrier payments or a review of the account by a representative of Patient Financial Services. At that point the account is changed, manually or by system functions, to Phase 7.
2. The changing of the account to Phase 7 triggers a referral to FITNESS FINANCIAL SERVICE for follow-up and processing. The account retains an active Accounts Receivable status.
3. All self pay balances (either true self pay or balance after insurance), regardless of payor type, placed with FITNESS FINANCIAL SERVICE (FFS) shall receive the minimum of an initial statement to be sent upon receipt of the account, as well as a final notice sent 30 days prior to referral to bad debt. Referral to bad debt, total number of calls and total number of letters sent will be at the discretion of FFS who agrees to initiate every reasonable effort to collect the amount placed with them. FITNESS is required to initiate collection activity for a period of no less than 120 days before referral for bad debt with the exception of skips, bankruptcies, and deceased patients.
4. Accounts will be followed up for a minimum of 120 days with the following exceptions:
 - DECEASED PATIENTS with a balance under \$1000.00 in these categories will be placed on a Bad Debt Report and placed with our licensed collection agency as referenced in Step #5. Accounts over \$1000 will remain with the billing vendor

with collection activity focused on determining there is an estate and probate.
When determined a claim is filed and pursued.

- SKIPS with a balance under \$1000.00 will be placed on a Bad Debt Report and placed with our licensed collection agency as referenced in Step #5. Accounts over \$1000 will remain with the billing vendor and a skip tracing process/mechanism is utilized to determine the correct address and/or phone number.
 - BANKRUPTCY ACCOUNTS will be closed regardless of the balance and placed on a Bad Debt Report and placed with our licensed collection agency.
 - Based on their review of the account at the conclusion of this activity, a recommendation is made by FITNESS FINANCIAL SERVICE to adjust the account to a Bad Debt status and refer the account to an outside collection agency.
5. Based on this recommendation, the account is adjusted to reflect a \$0.00 balance utilizing a Bad Debt Allowance Code. The account is also manually changed to reflect Phase 8, which allows the account to be referred to a collection agency.
 6. The account remains with the agency until requested or returned. Accounts returned from our agency are deemed uncollectible and no further activity takes place.

St Vincent's Medical Center
Financial Assistance Eligibility Matrix
Based on Federal Poverty Guidelines (FPL)

Monthly Income	Hospital Based Inpatient & Outpatient Services										All Uninsured Patients regardless of Income (d)
	> 300% FPL =Uninsured with the Means To Pay (d)										
	100%a	200%	225%	250%	275%	300%	325%	350%	375%	400%	
Family Size	Charity Care	200%	Between 200 and 300% FPL=	250%	275%	300%	325%	350%	375%	400%	
1	903	1,805	1,806	2,266	2,482	2,708	\$2,933	3,159	3,384	3,610	
2	1,214	2,428	2,429	3,035	3,339	3,643	\$3,946	4,250	4,553	4,857	
3	1,526	3,052	3,053	3,815	4,196	4,578	\$4,959	5,340	5,722	6,103	
4	0	0	1	0	0	0	\$0	0	0	0	
5	2,149	4,298	4,299	5,373	5,910	6,448	\$6,985	7,522	8,059	8,597	
6	2,461	4,922	4,923	6,152	6,767	7,383	\$7,998	8,613	9,228	9,843	
7	2,773	5,545	5,546	6,931	7,624	8,318	\$9,011	9,704	10,397	11,090	
8	3,084	6,168	6,169	7,710	8,481	9,253	\$10,024	10,795	11,566	12,337	
Annual Income	(C)										
Income as a % of FPL	100%a	200%	225%	250%	275%	300%	325%	350%	375%	400%	
1	\$10,830	\$21,660	\$24,368	\$27,075	\$29,783	\$32,490	\$35,198	\$37,905	\$40,613	\$43,320	
2	\$14,570	\$29,140	\$32,783	\$36,425	\$40,068	\$43,710	\$47,353	\$50,995	\$54,638	\$58,280	
3	\$18,310	\$36,620	\$41,198	\$45,775	\$50,353	\$54,930	\$59,508	\$64,085	\$68,663	\$73,240	
4	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
5	\$25,790	\$51,580	\$58,028	\$64,475	\$70,923	\$77,370	\$83,818	\$90,265	\$96,713	\$103,160	
6	\$29,530	\$59,060	\$66,443	\$73,825	\$81,208	\$88,590	\$95,973	\$103,355	\$110,738	\$118,120	
7	\$33,270	\$66,540	\$74,858	\$83,175	\$91,493	\$99,810	\$108,128	\$116,445	\$124,763	\$133,080	
8b	\$37,010	\$74,020	\$83,273	\$92,525	\$101,778	\$111,030	\$120,283	\$129,535	\$138,788	\$148,040	
SVHS Discount	100%	100%	90%	80%	75%	70%	65%	60%	55%	50%	

a) Federal register Vol 75 August 3, 2010 Federal Poverty Guidelines.

b) For each additional person after 8 add \$3,740

c) St Vincent's Charity Care % exceeds OHCA's requirement that care be provided at cost for income between 200% and 250% of FPL. Also CT Public Act #03-266 defines uninsured patients as patients whose income is at or below 250% of FPL.

(d) Note: All uninsured patients with the means to pay are eligible for an additional prompt pay discount per Ascension. We have determined a 2% prompt pay discount.

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

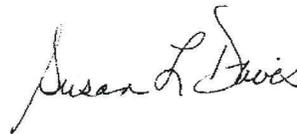
Subject: Financial Assistance (Charity Care) Classification: 700-1

Effective Date: February 3, 1992 Category: Financial
January 1, 1998

Revision Date: August 22, 1994, April 16, 1996
March 9, 1998, May 20, 2002
August 2, 2004, June 5, 2006

Reference Material: Patient Access Department
Manuals
Ascension Health System Policy #16

Administrative Approval:



Policy: St. Vincent's Medical Center has established the provision of health care to all members of the Community as an integral part of its Mission. In an effort to ensure that care is available to all segments of the community, St. Vincent's Medical Center has established a Financial Assistance Policy whereby uninsured and underinsured are provided with an opportunity to apply and be considered for financial assistance based on their ability to pay.

No person is turned away for their inability to pay; it is expected that each patient will contribute to the cost of their health care in a manner befitting their individual financial circumstances.

Purpose: To provide guidelines for decision making regarding the provision of health care based on the patient's ability to pay for care. These will be developed and updated periodically for all Services at the Medical Center.

Special Instructions, Information, Implementation Procedures:

At the time of their initial interview, patients are to be informed that the Medical Center does have a policy entitling them to a possible reduction in their liability for services rendered by the Medical Center. The Medical Center will determine income standards based on fixed percentages of those prescribed within the Federal Register as the "Federal Poverty Guidelines".

The financial counselor will do the following in accordance with the hospital procedures:

- Access the patient's income and assets
- Determine whether the patient is eligible for Federal, State or City health funds
- Determine if patient is eligible for Financial Assistance

- Determine if eligible for Free Bed Funds
- Screen for care to be provided at hospital cost as established by the Office of Health Care Access (OHCA) Public Act No. 03-266 (Section 19a-509(b) of the Connecticut General Statutes).
- In the event a financial source cannot be established or if applicant fails to cooperate, patient will be expected to pay their bill.
- Emergent or urgent service will never be refused to a patient due to inability to pay.

Eligibility Criteria

1. Applicants with income equal to or below State and City welfare standards shall complete the agency's application.
2. The applicant's income renders him/her eligible based on the income levels in relationship to the family size according to the Federal Poverty Guidelines.
3. After all applicable third party benefits have paid for their portion of the cost of the service.
4. Patient's income is above the DSS income standard, but insufficient to pay for medical bills.
5. The applicant cooperates by providing and verifying all information necessary to establish their eligibility. Applicants who fail to cooperate shall not be granted Financial Assistance and will be expected to pay their bill.
6. Account balances for patients who receive services prior to the effective date of Medicaid coverage will be written off as Charity Care.

Income/Asset Parameters

1. Patients found to have income equal to or below State and City Welfare standards shall be referred to that agency by following the application process for said program.
2. Patients will be screened for suitability for all Special Hospital Programs, such as free bed funds and all available city or state programs, before being considered for Financial Assistance.
3. Earned and unearned income shall be applied against medical needs when determining eligibility. (Earned income is income from employment; unearned income is income from other sources).
4. The income of all family members shall be applied against medical needs.
5. Income shall not be counted unless it is actually available to the applicant.
6. Earned income shall be counted for a four-week period preceding the financial assistance application date; unearned income shall be determined based on the interview.
7. The Medical Center will compare the patient's total family income to the income limits established for Financial Assistance.

Reviewed: March 28, 1994, June 10, 1996, January 24, 2000, March 3, 2004

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ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject: Patients With No Medical Insurance Classification: 700-12

Effective Date: May 18, 1977 Category: Fiscal

Revision Date: May 26, 1987, October 30, 1989
October 29, 1990, March 16, 1992
December 18, 1995, August 9, 1999
December 11, 2000, June 17, 2002
June 7, 2004, June 5, 2006

Reference Material: Patient Access Services Manuals
Admission Policy (600-1)
Financial Assistance Policy (700-1)
Ascension Policy #16 (Billing and
Collecting for the uninsured)

Administrative Approval:


Policy: Outpatients and Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their bill. Uninsured patients with the ability to pay will be provided a discount per Ascension Policy #16. This discount will be adjusted annually.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implementation Procedures:

I. Elective Patients

- A. The physicians' offices shall schedule patients in accordance with St. Vincent's Medical Center policies and procedures. (600-1 and 600-18)
- B. When a physician schedules a self pay patient, the arrival date is to be held in a pending status until the Patient Access Services Financial Counselor is able to establish a financial source.
- C. Prior to the pending arrival date, the Financial Counselor will do the following in accordance with hospital procedures to establish a payment plan:
 - Assess the patient's income and assets with the patient.
 - Determine whether the patient is eligible for Federal, State or City health insurance.
 - Determine whether or not the Financial Assistance Policy (700-1) is applicable.
 - Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.

- D. Once a financial source is determined the pending date will be finalized and detailed information provided to the physician's office.
- E. If a financial source cannot be determined, the physician's office will be notified of this and the patient will be held in pending status until a financial source has been determined.
- F. In the event a financial source cannot be established, the decision to treat the patient will be made by Senior Management of the Medical Center.

II. Urgent or Emergent Patients

- A. Emergent or urgent services will never be refused to a patient due to the inability to pay the Medical Center.
- B. The Financial Counselor will interview the patient or appropriate family member either after initial screening and stabilization or by the next business day in accordance with hospital procedures to establish a payment plan:
 - Assess the patient's income and assets with the patient.
 - Determine whether the patient is eligible for Federal, State or City health insurance.
 - Determine whether or not the Financial Assistance Policy (700-1) is applicable.
 - Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.
- C. If a financial source cannot be established, the Director of Patient Financial Services and Patient Access will refer the account over to the Collection agency utilized by the Medical Center.

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

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