

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
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

/bjk



SYSTEM POLICY #: 9

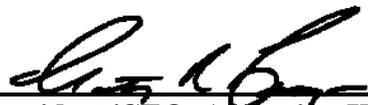
SUBJECT: Care of Persons Who Are Poor and
Community Benefit

BOARD APPROVAL DATE: 09/06/00

EFFECTIVE DATE: 09/06/00

REVISION DATE: 03/12/03

06/08/06



President/CEO, Ascension Health

POLICY

It is the policy of the System that each Health Ministry, guided by the Mission, Vision, Values, and Philosophy of the System, will plan for care of persons who are poor and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. The System desires to strengthen its commitment to this principle through a unified system of accountability.
2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their integrated and strategic and financial planning.
3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.
4. Annually Ascension Health will produce an aggregate report highlighting the best practices and innovative programs in the System.

APPLICABILITY TO AFFILIATES

It is expected that all organizations with which System member organizations are affiliated will adopt a policy that is consistent with and supportive of this System policy. Such organizations also will be expected to comply with System reporting requirements regarding care of persons who are poor and community benefits.

SYSTEM PROCEDURES

Guidelines and Procedures for planning and reporting on Care of Persons Who are Poor and Community Benefit can be found in the System Procedures binder-#M-1.



SYSTEM POLICY#: 16 **SUBJECT:** Billing and Collection for the Uninsured

BOARD APPROVAL DATE: 12/10/03

EFFECTIVE DATE: 07/01/04

REVISION DATE: 06/08/06



President/CEO, Ascension Health

POLICY

It is the policy of the System to ensure a socially just practice for billing for all patients receiving care at any of our Health Ministries (HMs). Many of the HM patients are billed according to the rates negotiated by their insurance plan. This policy is specifically designed to address the billing and collection practices for uninsured patients who receive care within the System.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- “Patient” shall mean those persons who receive care at a System hospital or medical center and the person who is financially responsible for the care of the patient.
- “Uninsured Patients” are defined as all persons who are uninsured or do not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
 - Qualify for charity care as defined in Ascension Health Policy 9 and herein. (See Ascension Health System Policy #9),
 - Do not qualify for charity care but do qualify for some discount of their charges for hospital services based on a substantive assessment of their ability to pay (“Means Test”), such as total income, total medical bill, assets, mortgage payments, utilities, number of family members, disability considerations, etc., or
 - Have some means to pay but qualify for a discount based on this policy.

PRINCIPLES

1. All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with poor and vulnerable persons, and our commitment to distributive justice and stewardship

2. This policy applies to all non-elective services provided in the inpatient or outpatient acute care setting, including behavioral health, and to non-elective procedures. This policy does not apply to payment arrangements for elective procedures as defined by each hospital.
3. The application of this policy to International patients will be defined by each hospital.
4. Each hospital must ensure that:
 - a. Its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.
 - b. Patients receive prompt access to charge information for any item or service provided.
 - c. Patients and their families are advised of the hospital's applicable policies, including charity care and the availability of need-based financial assistance in easily understood terms, as well as in any language commonly used by patients in the community.
 - d. Uninsured Patients who do not qualify for charity care, but are in need of financial assistance, are offered appropriate extended payment terms or other payment options that take into account the patient's financial status.
 - e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves.
 - f. Financial counselors are available to all Patients.
 - g. Information is posted in the admitting and registration areas, including the Emergency Room, regarding financial assistance and charity care policies.
 - h. Hospital programs that include nominal payments by Uninsured Patients designed to encourage Uninsured Patients to participate in their care are permissible.
5. Charity Care (Minimum Standards)
 - a. At a minimum, Uninsured Patients with income less than or equal to 200% of the Federal Poverty Level ("FPL"), which may be adjusted by the hospital for cost of living utilizing the local wage index compared to national wage index, will be eligible for 100% charity care write off of the charges for services that have been provided to them in accordance with Ascension Health Policy #9.
 - b. At a minimum, Uninsured Patients with incomes above 200% of the FPL but not exceeding 300% of the FPL, subject to inflationary adjustments as described in Section 5(a) will receive a discount on the services provided to them based on a sliding scale. The sliding scale will be determined by each hospital and/or Health Ministry in accordance with guidelines established in Policy #9.

- c. Eligibility for charity care may be determined at any point in the revenue cycle.
- d. Individual hospitals may employ percentages of the FPL limits that exceed these minimum standards.
- e. Eligibility for charity care write-off must be determined for any balance for which the patient is responsible.

6. Financial Assistance

- a. Uninsured Patients with income greater than 300% of the FPL, which may be adjusted by the hospital for cost of living utilizing local wage index compared to national wage index, will be eligible for consideration for some discount of their charges for hospital services based on a substantive assessment of their ability to pay.
- b. The assessment of an Uninsured Patient's ability to pay is termed a "Means Test" and will consider, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. The Means Test should include determination based on eligible assets and based on eligible income.
- c. The Means Test will be determined by each hospital and/or Health Ministry in accordance with guidelines established in System Policy # 9.
- d. Each hospital must establish a process for patients and families to appeal decisions of the hospital regarding eligibility for financial assistance.
- e. Eligibility for financial assistance may be determined at any point in the revenue cycle.
- f. Eligibility for financial assistance must be determined for any balance for which the patient is responsible.

7. Uninsured Patients with the Ability to Pay

- a. Uninsured Patients with the ability to pay will be provided a discount based on the discount provided to the highest-paying payor for that hospital.
- b. The highest paying payor must account for at least 3% of the hospital's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the hospital business for that given year.
- c. A prompt pay discount must be provided to all of these Uninsured Patients, but can be in the form of an additional discount provided over the minimum required discount.

8. Collection Practices

- a. Liens on personal residences are permitted only in the following circumstances:
 - i. The Patient does not qualify for charity or financial assistance, and the Patient is not complying with payment arrangements that have been agreed to by the hospital and the Patient.
 - ii. The lien will not result in a foreclosure on a personal residence.
 - iii. Liens pursued by a collection agency or other representative of the hospital have had prior review and approval from executive management of the hospital
- b. Garnishments of wages are permitted only if:
 - i. The Patient does not qualify for charity or financial assistance under Section 5 or 6 of this Policy, and a court determines that the Patient's wages are sufficient for garnishment.
 - ii. Garnishment pursued by a collection agency or other representative of the hospital has had prior review and approval from executive management of the hospital.
- c. No hospital will pursue an involuntary bankruptcy proceeding against a Patient as a result of its collection efforts on Uninsured Patients.
- d. No hospital, collection agency, or other representative working on behalf of the hospital may take any actions that would cause a bench warrant, an order issued by a judge or court for the arrest of a person (also called body attachments), to be issued.
- e. Interest charges on outstanding balances may only be assessed if:
 - i. The financing plan offered is one of several options offered to the patient
 - ii. The interest rate is fair (i.e., less than that charged by standard credit cards).
 - iii. The amounts financed include only those amounts due after charity or financial assistance has been given.
 - iv. The amount of interest anticipated to be charged by the financing entity must be netted against the balance the patient is deemed able to pay.
- f. All hospital collection agency agreements will be amended to incorporate the language set forth below as notice to the collection agency of Ascension Health's policies and procedures regarding billing and collection practices for Uninsured Patients including the values based manner in which all contacts with patients and families are to be conducted. The following language will be included in all collection agency service agreements:

Addendum To Collection Agency Services Agreement

_____ [Health Ministry] and _____ [Collection Agency], for mutual consideration hereby acknowledged, agree, effective this _____ day of _____, to amend the current collection services agreement between the parties to include the following:

1. The [Health Ministry] has adopted a new policy ("Policy") intended to further ensure socially just billing and collection practices for [the Health Ministry's] uninsured patients.
2. A copy of the Policy has been provided to [the Collection Agency].
3. Subject to Paragraph 4 of this Addendum, [the Collection Agency] agrees to abide by the Policy in the course of conducting its collection-related activities involving uninsured [Health Ministry] patients. Such activities include, but are not limited to, the following:
 - a. All communications with any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry]; and
 - b. All legal proceedings, of whatever kind or nature, against any uninsured [Health Ministry] patient or person financially responsible referred to [the Collection Agency] for purposes of collecting amounts owed to [the Health Ministry].
4. [The Collection Agency] agrees not to deviate from the standards and requirements set forth in the Policy without the prior written consent from [the Health Ministry].

	_____ [Health Ministry]
	_____ [Collection Agency]

System Procedures

Detailed guidance in support of this Policy is found in the Finance section of the System Procedures.

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

Annual Income Income as a % of FPL Family Size	Hospital Based Inpatient & Outpatient Services										All Uninsured Patients regardless of income (d) 38% OPI/ 44%IP Discount					
	Charity Care					Between 200 and 300% FPL= Financial Assistance (Charity)						> 300% FPL =Uninsured with the Means To Pay (d)				
	100%a	200%	225%	250%	275%	300%	325%	350%	375%	400%		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	\$47,353	\$50,995	\$54,638	\$58,280		
2	\$14,570	\$29,140	\$32,783	\$36,425	\$40,068	\$43,710	\$47,353	\$50,995	\$54,638	\$58,280	\$61,923	\$65,565	\$69,208	\$72,850		
3	\$18,310	\$36,620	\$41,198	\$45,775	\$50,353	\$54,930	\$59,508	\$64,085	\$68,663	\$73,240	\$77,818	\$82,395	\$86,973	\$91,550		
4	\$22,050	\$44,100	\$49,613	\$55,125	\$60,638	\$66,150	\$71,663	\$77,175	\$82,688	\$88,200	\$93,713	\$99,225	\$104,738	\$110,250		
5	\$25,790	\$51,580	\$58,028	\$64,475	\$70,923	\$77,370	\$83,818	\$90,265	\$96,713	\$103,160	\$109,608	\$116,055	\$122,503	\$128,950		
6	\$29,530	\$59,060	\$66,443	\$73,825	\$81,208	\$88,590	\$95,973	\$103,355	\$110,738	\$118,120	\$125,503	\$132,885	\$140,268	\$147,650		
7	\$33,270	\$66,540	\$74,858	\$83,175	\$91,493	\$99,810	\$108,128	\$116,445	\$124,763	\$133,080	\$141,398	\$149,715	\$158,033	\$166,350		
8b	\$37,010	\$74,020	\$83,273	\$92,525	\$101,778	\$111,030	\$120,283	\$129,535	\$138,788	\$148,040	\$157,293	\$166,545	\$175,798	\$185,050		
SVHS Discount	100%	100%	90%	80%	75%	70%	65%	60%	55%	50%	50%	50%	50%	50%		

a) Federal register Vol 74 January 23, 2009 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: 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 Administrative Approval:
Admission Policy (600-1)
Financial Assistance Policy (700-1)
Ascension Policy #16 (Billing and
Collecting for the uninsured)



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

/bjk