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Type of Document	Policy
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Title of Owner	AVP Patient Access
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University of Vermont Health

TITLE: Financial Assistance Program – Vermont Hospitals

PURPOSE: To establish a policy and procedure for the administration of The University of Vermont Health Network Financial Assistance Program for Vermont hospitals.

POLICY STATEMENT: The University of Vermont Health ("UVMH") is a patient-centered organization committed to treating all patients equitably, with dignity and respect, regardless of the patient's health care insurance benefits or financial resources. Further, the UVMH Vermont Hospital Partners (defined below) are committed to providing financial assistance to persons who have essential health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable health care services and to fulfill our obligations as a nonprofit organization, UVMH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Financial Assistance is not considered a substitute for personal responsibility. Patients are expected to cooperate with UVMH's Vermont Hospital Partners' procedures for obtaining other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

To manage resources responsibly and to allow UVMH to provide the appropriate level of assistance to the greatest number of persons in need, the following policies and procedures have been established for the provision of patient financial assistance.

Policy applies to the Inpatient General Hospital and Outpatient Hospital Departments of the following UVMH Vermont Hospital Partners:

Central Vermont Medical Center
130 Fisher Road
Berlin, VT 05602

Porter Medical Center
115 Porter Drive
Middlebury, VT 05753

The University of Vermont Medical Center
111 Colchester Avenue
Burlington, VT 05401

PROCEDURES:

Financial Assistance

Health Care Service Eligibility:

The following services are eligible for financial assistance:

- Emergency medical services provided in an emergency room setting and
- Medically necessary health care services, such as urgent services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.

Services not eligible for financial assistance include, but are not limited to:

- Cosmetic/plastic services;

- Infertility/fertility services (e.g., IVF, vasectomies/reversals, tubal ligations/reversals);
- Non-medically necessary care, including custodial care where acute hospitalization necessity is not present;
- Services covered under a global policy (e.g., discount already applied);
- Research/experimental services;
- Care for non-US citizens who are in the US under a travel/visitor foreign visa; *unless* (i) such care is provided in an emergency room setting; or (ii) such non-US citizen is residing or working in Vermont as of the time of such care;
- Services rendered at Appletree Bay; and
- Services reimbursed directly to the patient by an insurance carrier or third party

Practitioner Coverage: All UVMH employed medical practitioners rendering care at the UVMH Vermont Hospital Partners and physician practices are covered under this policy. An up-to-date list of eligible practitioners is available on each applicable hospital website, links to which can be found under the program contact information section of this policy. To request a paper copy of the list, free of charge, please contact our Customer Service Department at 802-847-8000 or 800-639-2719.

Hospital Coverage: All eligible services provided or ordered at UVMH Vermont Hospital Partners regardless of employed or non-employed physicians status. *Note*: This provision pertains to hospital/facilities billing only; see practitioner coverage to determine whether the physician bill will be covered.

Financial Eligibility: Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, or who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of assistance shall be based on an individualized determination of financial need and shall be conditioned upon the Residency Criteria defined below, but shall not consider age, race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information.

Except in cases of Catastrophic Medical Indigence (as defined below), eligibility for financial assistance is based on an income test and asset test. A patient must pass both tests to be eligible for financial assistance.

- Income Test: A patient whose household income, determined in accordance with 18 V.S.A. § 9481(5), is at or below 400% of the Federal Poverty Level Guidelines (FPLG) may pass the income test.
    - Dependents aged 18 or older may be included within the household size when listed as a dependent on the Federal Income Tax return.
    - Migrant workers whose direct family members (spouse and biological/adoptive children) reside outside the country will be included in the household size.

- Asset Test: Each individual/household is allowed liquid assets equal to income levels at 400% of FPL, adjusted to household size. If liquid assets are below this guideline, the patient passes the assets test.
    - Liquid assets are assets that can be converted to cash without incurring significant penalties, and include but are not limited to: checking, savings, or money market accounts; nonqualified brokerage accounts;
    - Liquid assets specifically *exclude* the household's primary residence, any qualified retirement accounts (e.g., 401(k), IRA, etc.), pension plans, and 529 savings accounts, secondary properties and land. Such assets will not be considered for purposes of determining financial assistance eligibility.

- Catastrophic Medical Indigence: For patients with household income, determined in accordance with 18 V.S.A. § 9481(5), at or below 600% FPLG, and whose out-of-pocket hospital bill exceeds 20% of household income; then UVMH shall reduce the amount due from the patient to 20% of household income or $10,000, whichever is lesser.

Residency Criteria: Patients must reside within the UVMH service area unless medical services were urgent or emergent in nature. Scheduled services for patients residing outside of the UVMH service area are not eligible for financial assistance. Financial assistance for residents outside of the UVMH service area will be granted only in unique circumstances and with appropriate approval.

The UVMH service area is defined as: all Vermont Counties, select New York Counties (Clinton, Essex, Franklin, Washington, Hamilton, Warren, and St. Lawrence) and select New Hampshire Counties for reference lab (Coos, Grafton, and Sullivan Counties).

- Vermont residents live in Vermont, are employed by a Vermont employer to deliver services in Vermont or attend school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time the services are provided but who lacks stable permanent housing.
- New York residents must live in our service area greater than 6 months per annum to meet the residency requirement.

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

- Most recent federal income tax return showing a service area address;
- Service area driver's license, housing bills with service area address, lease for service area property or a service area utility bill, copy of migrant worker contract or letter of contracted employment by the employer;
- Vermont employment pay stubs, proof of school enrollment, or written documentation from the Open-Door Clinic; or
- A written, signed statement from the patient (or guardian or caregiver, as the case may be) indicating that the patient was living in Vermont but lacked stable housing at the time such services were provided.

Health Insurance and Liability Payments: Services rendered at a UVMH Vermont Hospital Partner will be billed to patient's primary coverage, a private medical insurance, an employer occupational health plan, workers' compensation, or pending by med pay/third-party liability carriers. In cases where there is a potential auto/injury liability payment pending at a future date, UVMH will file a lien to protect its financial interests, excluding Medicare/Medicaid recipients. After the lien is filed, financial assistance may be granted, if the patient otherwise qualifies. If there is a future time when liability payments are distributed, the UVMH lien will allow UVMH to recover some or all the financial assistance initially granted to the patient.

Public Health Care Program/Health Care Exchange Criterion: Patients applying for the UVMH Vermont Hospital Partner financial assistance program are reviewed for their potential eligibility for state or federal health care programs and encouraged to apply for health insurance. Excluding undocumented immigrants, patients identified as candidates for potential eligibility with Medicare or Medicaid, an application for and compliance with those program guidelines is a pre-requisite for the UVMH financial assistance program.

Exclusions:

- Patients falling under the ACT119 exclusions will not have their discount reduced on this basis
- Vermont residents who qualify for Medicaid are required to seek coverage only if their income is below Medicaid maximum guidelines.
- An undocumented immigrant's refusal to apply for public programs shall not be grounds for denying financial assistance.
- Vermont residents' refusal to purchase private or exchange plan health insurance shall not be grounds for denial of financial assistance.
- Patients' whose religious or cultural belief system prohibits seeking or receiving financial assistance from a government entity may be excluded from the public health care program criterion. The patient will, however, be required to assume a portion of financial responsibility to be assessed by the Financial Assistance Program Appeals Committee and the CFO.

Determination of Financial Need: Financial need will be determined in accordance with procedures that involve an individual assessment which will include the following:

- An application process, in which the patient or the patient's guarantor is required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
- A review of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
- Reasonable efforts by UVMH to explore appropriate alternative sources of payment and coverage from public and private payment programs, and, where applicable, to assist the patient to apply for such programs;
- Consideration the patient's available liquid assets, and all other financial resources available to the patient; and
- A review of the patient's UVMH outstanding accounts receivable for eligible prior services rendered.

In cases of Presumptive Financial Assistance, as described below, the application process may be modified at the discretion of UVMH.

It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering of services. A patient must have a current patient balance that is due to a UVMH Vermont Hospital Partner, an expectation that an account currently pending insurance will leave a balance that is due to a UVMH Vermont Hospital Partner, or a future scheduled/referred service at a UVMH Vermont Hospital Partner that is expected to leave a patient balance.

Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for assistance, however, there is no financial assistance application on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide sufficient evidence to provide the patient with financial assistance.

Presumptive eligibility may be determined based on individual life circumstances that may include:

- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid)
- Supplemental Nutrition Assistance Program (SNAP) eligibility
- Participation in Women, Infants and Children programs (WIC)
- Patient is incarcerated/inmate with balances not covered by insurance
- Patient is homeless

Presumptive eligibility will be adjusted to a specific transaction/pay code to ensure these dollars are excluded from the Medicare Cost Report.

Application Period: UVMH will process complete applications submitted by individuals at any time during the collection process.

Application Processing Timelines: Within 30 calendar days following receipt of an application for financial assistance, UVMH will notify the patient in writing as to whether the application is approved or denied or, if the application is incomplete, what information is needed to complete the application. Additional information, if requested, must be returned within 30 days of request, or the application will be closed for non-compliance. If UVMH denies the patient's application, then the written notification will include the factual grounds for denial. If UVMH approves the application for financial assistance, UVMH will provide the patient with a calculation of the financial assistance granted and a revised bill.

If UVMH denies the application for financial assistance, the patient may submit an appeal within 60 days following receipt of UVMH's decision. UVMH will notify the patient of its approval or denial of the patient's appeal within 60 days following the receipt of the appeal.

Financial Assistance Eligibility Period: The need for financial assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for assistance becomes known. Re-evaluation of patients who are disabled or whose age exceeds 64 and whose income is fixed below 400% FPLG shall occur annually. Re-evaluation of UVMH full and part time employees whose income is below 400% FPLG shall occur annually. It is the responsibility of the patient to advise UVMH of financial changes within their award period.

Financial Assistance Guidelines: The amount of assistance provided to an eligible patient will vary based upon income level. For eligible patients who are uninsured, the award shall be based on a discount from the amount generally billed ("AGB") for the services received. For eligible patients who are insured, the award shall be based on a discount on the patient's out-of-pocket costs. In no case shall an eligible patient be charged more than AGB for emergency or other medically necessary care, after all deductions, discounts (including discounts under this policy), and insurance reimbursements.

Amount generally billed, or AGB, means the amount UVMH generally bills to individuals who have insurance covering the same care, determined using the "look-back method" set forth in 26 C.F.R. § 1.501(r)-5(b)(3). You may obtain a copy of the AGB calculation and percentage, which is updated annually, in writing and free of charge by visiting our website or by calling our customer service department. Website and phone contact directions are located under the program contact information section of this policy.

Assistance Awards:

- Eligible patients shall receive free care (a 100% discount on self-pay balances) when their modified adjusted gross household income is at or below 250% of the federal poverty level (FPLG).
- Eligible uninsured patients with modified adjusted gross household income between 250% and 400% of the FPLG shall receive an additional 40% discount from the amount generally billed for the services received.
- Eligible patients with insurance or other coverage for the services delivered and with household income between 250% and 400% of the FPLG shall receive an additional 40% discount on the patient's out-of-pocket costs, after insurance payments or payments from other coverage.

Approved Application Processing: Upon application approval, the patient award is applied against all open balances (i.e., hospital and physician, gross charges for the uninsured and balance after insurance for the insured) and extends for a coverage window of six months or twelve months, as noted above, where income is fixed within the calendar year. The coverage window begins on the date of approval and extends through the last day of the month that the award expires. When the award period expires, patients will be required to re-apply for financial assistance, and based upon their financial status, may have their award category adjusted.

Refunds: If the patient submits a complete financial assistance application and is determined to be eligible for financial assistance, then UVMH will refund any excess amount the patient has paid for their care within the 240 days prior to the receipt of a complete application. Payments made outside the application 240 day window period will not be eligible for a refund.

Appeals/Individual Case Reviews: UVMH acknowledges that extenuating circumstances may exist where an individual's income may exceed program eligibility guidelines or where hardship remains with the approved award. Patients have 60 days following the receipt of a written financial assistance decision to appeal the decision. UVMH will inform the patient no later than 60 days after the receipt of the appeal as to whether the appeal was approved or denied.

A multidisciplinary appeals committee will be convened to review appeals, as well as catastrophic or unusual cases that do not meet established program guidelines but present unusual hardship. The committee will review cases and provide a recommendation to the CFO. The CFO is the final decision maker.

Where medical necessity is unclear, cases will be presented to the Chief Medical Officer or their designee for a decision regarding medical necessity of services rendered. If services are deemed medically necessary and the financial assistance eligibility guidelines are met, assistance will be awarded.

Notification Period: UVMH will make reasonable efforts to notify patients about the financial assistance program. This period begins on the date a billing statement for the patient balance of care is presented and ends 180 days later. As defined in this policy, multiple methods of notification occur beginning in advance of care, during care and throughout the 180 day billing cycle.

If at the end of the 180-day notification period an account has been referred to a collection agency and an application is received and awarded, accounts shall be recalled from the agency and processed under the financial assistance program.

Application and Award Letters: In accordance with ACT119 regulations, the following data elements will be reflected in written documentation to patients.

- For incomplete applications, letters will notify the patient of what information is needed to complete the application
- Approvals will include the amount of assistance, the basis for the calculation of the amount owed, followed by an updated bill for any balances on the next billing cycle, with reference to budget plans that do not exceed five percent of the patients' monthly gross income.
- Denials will include the reasons for denial along with information on how to appeal the decision

Reasonable Efforts: Reasonable efforts will be made to determine if a patient is eligible for financial assistance prior to balance transfer to collections. Reasonable efforts may include the use of presumptive scoring, the notification and processing of applications and notification before, during and after care.

- UVMH shall not initiate any extraordinary collection actions (ECA)

- Incomplete applications shall be processed with notification to patients providing direction on how to appropriately complete the application and/or what additional documentation is required, along with a 30-day window of time to respond to the UVMH request
- UVMH shall process completed applications within 30 days of receipt

University of Vermont Health Partners: Patients may submit a single application for assistance at any UVMH Vermont Partner referenced in this policy. Based upon variations in state law, separate applications must be generated for UVMH New York Partners. Each Partner will provide assistance at the appropriate FPLG award level set for the individual institution, based upon the unique AGB calculation set for the organization. Supporting documentation will be retained by the organization processing the application, however, it will be made available to the Partner organization as needed to facilitate audit functions.

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

- Reference to the financial assistance program printed on each patient statement.
- Posting notices in emergency rooms, admitting and registration departments, and patient financial services offices that are located on facility campuses; conspicuous displays may be found in the main registration and emergency departments.
- Providing a copy of the plain language policy summary at the point of registration on the facility campuses and making the summary available at our satellite clinics. Providing copies of the policy and application upon request.
- For inpatient, observation and short stay patients, a copy of the inpatient guide will be provided, which includes information regarding the financial assistance program.
- Information shall be available on the UVMH website, including the policy, a plain language summary, the application, FAQ, FPLG guidelines and contact information for follow-up assistance.
- Referral of patients for financial assistance may be made by any member of UVMH staff or medical staff, 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.
- Translations for individuals with limited English proficiency will be provided for populations with >1,000 individuals or 5% of the service area community. Additionally, translations for UVMH Vermont Partners shall include the top 14 languages identified by the Vermont Office of Racial Equity 2023 Language Access Report. Written translations are available on our public website or upon request at any registration location. Oral translations are available by contacting the Customer Service Department and/or meeting with a financial advocate at our main hospital campus. Contact information reflected below.
- Patients requiring a translated copy and/or assistance in completing the application will be assisted by financial advocates and/or customer service representatives, who will secure the services of an appropriate interpreter.
- Information, rack cards and flyers are available through the Community Health Improvement office, where staff routinely interact with community centers and advocates disseminating information and programs available to the public.
- Policies, applications, practitioner rosters and copies of the plain language summary are available, free of charge, online, or in person at the contact locations listed below.

How to Apply for Financial Assistance: Patients seeking financial assistance should complete and submit an application form, including all required documentation. Applications should contain the applicant's signature or a signature of a representative acting on behalf of the applicant (i.e., power of attorney). Signature indicates the accuracy of data submitted, as well as confirmation that current income remains as reflected on the federal income tax return forms. Mail your completed application, along with supporting documentation to the following:

UVMH Patient Access Department
40 IDX Drive, Bldg. 200-22052
111 Colchester Avenue, Burlington, VT 05401

Program Contact Information Summary: Policies, applications, practitioner rosters, plain language summaries and in-person assistance are offered free of charge and can be obtained through:

- The University of Vermont Medical Center

    - Website: http://UVMHealth.org/medcenter
    - Customer Service: (802) 847-8000 or (800) 639-2719
    - Financial Advocacy: (802) 847-1122 or for in-person assistance, UVMMC, 111 Colchester Avenue, Burlington, VT 05401
    - Health Assistance Program: (802) 847-6984 or toll free (888) 739-5183
    - Fax: (802) 847-9332
    - Registration desks in all locations
    - Provider roster coverage: https://www.UVMHealth.org/medcenter/patients-and-visitors/billing-insurance-and-registration/financial-assistance
- Porter Medical Center:
    - Website: http://www.portermedical.org
    - Customer Service: (802) 847-8000 or (800) 639-2719
    - Patients may call (802) 388-8808 option 5, Monday through Friday, 7:30 am – 4:00 pm
    - Financial Advocacy at 23 Pond Lane, Middlebury VT 05753
    - Registration desks in all locations
    - Provider roster coverage: http://www.portermedical.org
- Central Vermont Medical Center:
    - Customer Service: (802) 847-8000 or (800) 639-2719 or (802) 371-4600 option 1, option 1
    - Financial Advocacy: 3 Home Farm Way, Montpelier, VT 05602
    - Website: https://www.cvmc.org/patients-visitors/patient-financial-services/financial-assistance
    - Registration desks in all locations
    - Provider roster coverage: https://www.cvmc.org/patients-visitors/patient-financial-services/financial-assistance

Relationship to Collection Policies: UVMH management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from UVMH, and a patient's good faith effort to comply with their payment agreements with UVMH. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, UVMH may offer extended payment plans to eligible patients.

Note: UVMH will not engage in extraordinary collection actions (ECA). ECA is defined as selling an individual's debt to another party, reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus, deferring, denying or requiring payment before providing medically necessary care because of an individual's non-payment of one or more bills for previously provided care under the FAP, and/or certain actions requiring a legal or judicial process. A copy of the UVMH Credit and Collections policy may be obtained by contacting the Customer Service Department at (802) 847-8000 or (800) 639-2719. A copy may also be obtained at any registration location at UVMH.

Confidentiality/Document Retention: All information relating to financial assistance applications will be kept confidential. Financial assistance applications and supporting documentation will be kept for seven years from the date of approval or denial to allow for subsequent retrieval and review and audits.

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

$1 - $20,000	Financial Assistance Program Specialist
$20,001 – $50,000	Manager
$50,001 - $ 150,000	Director/AVP
>$150,001	CFO
Committee Appeals	CFO

Regulatory Requirements: In implementing this policy, UVMH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

Document Retention: Completed applications for the Financial Assistance Program will be scanned and retained in the electronic health record for a minimum period of seven years after the date the application was approved or denied.

Monitoring Plan: Compliance with this policy will be monitored through annual review of Financial Assistance Program applications and grant/deny decisions. Quarterly department spot auditing will occur, and monthly reporting of outcomes will be reviewed.

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

- **AGB**: Amount generally billed to insurance payers for services provided.
- **Bad Debt**: The charges incurred by a patient who based on available financial information, appears to have the financial resources to pay the charged health care services, but who has demonstrated by their actions an unwillingness to resolve the bill.
- **Catastrophic/Medical Indigence**: There are instances when individuals are financially unable to access adequate medical care without depriving themselves and their dependents of food, clothing, shelter, and other essentials of living. A patient will generally be considered medically indigent if the balance of a hospital bill exceeds 20% of the person's annual household modified adjusted gross income, and he or she is otherwise unable to pay all or a portion of the bill balance resulting from a catastrophic illness or injury.
- **Family**: A group of two or more people who reside together and who are related by birth, marriage, or adoption.
- **Gross Charges**: The total charges at full-established rates before deductions are applied.
- **Household Income**: Income is calculated in accordance with the financial methodologies for determining eligibility for advance premium tax credits, e.g., MAGI (modified adjusted gross income).
    - Includes earnings, unemployment compensation, social security, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, and other miscellaneous sources
    - Includes capital gains or losses
    - If a person lives with a family/domestic Partner, it includes the income of all eligible family members
    - Excludes pre-tax contributions such as those for childcare, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401K and 403b
    - Excludes workers compensation
    - Excludes SSI (supplement security income)
    - Excludes income from child support
    - Excludes cash benefits (such as Reach Up, Emergency/General Assistance
    - Excludes noncash benefits (such as SNAP benefits and housing subsidies)
- **Household Size**: Patient, spouse, children, domestic Partners, and any individual who is considered a dependent of either partner for federal income tax purposes, shall be treated as members of the same household. Domestic partners are defined as unrelated/unmarried people sharing a home who are in a committed, intimate relationship that is not legally defined as marriage.
    - Excludes married individuals who live separately while divorcing, regardless of federal income tax filing. These are separate households.
    - Both parents may claim children living under a shared custody agreement as dependents if the custody agreement indicates both parents provide equal financial support..
- **Income Verification**: **May include but is not limited to**:
    - A copy of the most recent tax return is the primary determinant for income verification
    - In lieu of the most recent federal income tax return:
        - Copies of two of the most recent pay stubs or last paystub of calendar year
        - Statement of earnings from the Social Security Office (800-772-1213)
        - Social Security/SSI benefit letter
        - Pension/Retirement Distribution
        - Self-employment profit and loss income statement
        - Copy of unemployment benefits, if applicable
        - Rental income, if property is not included in the asset's calculation
        - Written income verification from an employer (if paid in cash)
        - Documentation of public assistance
        - Contract or written confirmation of migrant worker contract
        - Written documentation from the Open Door Clinic of financial information will be accepted in lieu of the above income verification.
- **LEP/Translation**: Limited English proficiency requiring translated copies of the policies, application, plain language summary and application.

- **Medically Necessary Health Care Services**: Health care services, including diagnostic testing, preventive services, and after care, which are appropriate to the patient's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medically necessary care must: (A) be informed by generally accepted medical or scientific evidence and be consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; (B) be informed by the unique needs of each individual patient and each presenting situation; and (C) meet one or more of the following criteria: (i) help restore or maintain the patient's health; (ii) prevent deterioration of or palliate the patient's condition; or (iii) prevent the reasonably likely onset of a health problem or detect an incipient problem.
- **Modified Adjusted Gross Income**: Modified adjusted gross income (MAGI) is an individual's adjusted gross income (AGI) after considering certain allowable deductions and tax penalties
- **Patient Statement**: The monthly patient account summary mailed to a patient at their stated home address which states the amount due from the patient for patient care services rendered by UVMH.
- **Transaction/Pay Code**: The unique transaction used to record the uninsured patient discount and financial assistance adjustments
- **Uninsured**: The patient has no level of insurance or third-party assistance to assist with meeting their payment obligations.
- **Underinsured**: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities.
- **UVMH Vermont Hospital Partners**: Includes Central Vermont Medical Center, Porter Medical Center, and the University of Vermont Medical Center.
- **Vermont Residency**: An individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in Vermont, or attends school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time the services are received but who lacks stable permanent housing

RELATED POLICIES:

PAS35	Limitation on Charges (AGB)
EXEC11	Requests for Provision of Health Care Services to Foreign National Patients
RISK4	Medical Screening and Stabilization
UVMH_CUST1	Credit and Collections

REFERENCES:
IRC § 501(r)(4):
IRC § 501(r)(5):
IRC § 501(r)(6):
26 C.F.R. §1.36B-2
26 C.F.R .§ 1.501(r)-5(b)(3)
18 V.S.A. § 9481(5)
H.287 (Act 119)
VT Title 18, Chapter 221, Subchapter 10:
VT Admin. Code 12-3-213:4373
§ 9481 Definitions
§ 9482 Financial assistance policies for large health care facilities
§ 9483 Implementation of financial assistance policy
§ 9484 Public education and information
§ 9485 Prohibition on sale of medical debt
§ 9486 Prohibition of waiver of rights
§ 9487 Enforcement

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