

## PATIENT DISCOUNTS POLICY

### PURPOSE:

To document discounts provided by Vanderbilt University Medical Center (VUMC) to uninsured and insured patients.

### SCOPE:

This policy adheres to the common element Scope statement presented in the Finance & Revenue Cycle Policy on Policies.

### DEFINITIONS:

**Amounts Generally Billed (AGB):** IRS Section 501(r) requires hospitals to limit the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to no more than the amounts generally billed (AGB) to insured individuals. The AGB calculation is updated annually.

**Appropriate VUMC Representative:** Those individuals serving in those positions identified in the Approval Requirements section below and relating to the corresponding Discount set forth below.

**Contracted Payer:** Third party payers, including health plans, self-insured employers, and indemnity plans, which have entered into a written managed care or pricing agreement with VUMC with respect to the health care services in question. Contracted Payers include managed care agreements with Medicare Advantage Plans and/or contracts with any other Governmental Payers.

**Eligible Health Care Services:** Services which are emergent and other medically necessary care. Eligible Health Care Services exclude:

- Non-Covered Services;
- Any contractual allowances;
- Cosmetic services or elective services that are not medically necessary;
- Vanderbilt Health On-Call services;
- Market Sensitive services where Alternative Pricing has been developed and deployed;
- Write-offs of amount due from third party payers;
- Shortfall between reimbursement from government programs and the cost of services provided;
- Write-offs of patients' balances when there is not an indication that the patient is unable to pay;
- Experimental Services;
- Transplant Services;
- CAR-T Therapy and related services;
- Retail Health Clinic Services; and
- Retail and Specialty Pharmacy items

**Financial Assistance or Financial Assistance Discounts:** Discounts or elimination of payment for health care services provided to eligible patients with documented and verified financial need.

- **Financial Assistance:** Discounts provided to patients for medical bills based on income guidelines; and
- **Catastrophic Financial Assistance:** Discounts or write offs of medical bills based on family medical debt; patients are often referred to as medically indigent

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**Financial Counseling:** Information and assistance provided to patients regarding their out-of-pocket liability including those patients without sufficient insurance coverage, or who are unable to pay their estimated/actual liability prior to the treatment, or who have large past due balances.

**International Individual:** International Individual: Any person receiving medical services who meets one of the following criteria:

- A non-U.S. citizen with non-U.S. insurance not living in the U.S. or U.S. territory for less than a continuous 12-month period
- A non-U.S. citizen with U.S. insurance not living in the U.S. or U.S. territory
- A non-U.S. citizen with no insurance not living in the U.S. or U.S. territory
- A U.S. citizen with non-U.S. insurance living in the U.S. or U.S. territory for a period greater than 12 months
- A U.S. citizen with U.S. insurance not living in the U.S. or U.S. territory for a 12-month period
- Embassy sponsored patients

**Letter of Agreement (LOA):** The written agreement stipulating the financial terms and conditions for providing healthcare services to a patient.

**Look-Back Method:** The methodology specified by IRS Code Section 501(r) and selected by VUMC to determine AGB. A hospital facility determining AGB under the Look-Back method may use claims for all medical care allowed during a prior 12-month period for the calculation of AGB.

**Non-Contracted Payer:** Third party payers, including health plans, self-insured employers, plans, which have not entered into a formal managed care or pricing agreement with VUMC.

**Non-Covered Services:** Service not covered by insurance provided to individuals with contracted payer coverage.

**Private Pay:** Patient identified as having no insurance coverage, including disease specific or defined benefit plans which are not considered health insurance benefit plans or who elects to opt out of their insurance coverage for specific services/events.

**Transplant Services:** Medical services provided to patients for either solid organ or stem cell transplantation.

**Underinsured:** Insured patients who receive Eligible Health Care Services that are determined to be noncovered services or have limited benefit coverage by the insurance provider. This includes patients with health care sharing ministries as defined in the Affordable Care Act. This does not apply to disease specific or defined benefit plans as these are not considered health care insurance coverage plans.

**Uninsured:** Patients identified as having no insurance coverage. This does not include those patients with faith-based plans as identified by the Affordable Care Act

**Uninsured Discount:** A discount on charges for medical services for patients identified as uninsured. The Uninsured Discount is determined annually based upon the Look-Back Method by determining the average discount provided by VUMC hospitals to Medicare fee-for-service and private health insurers.

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**U.S. Insurance Plan:** Insurance plan underwritten by a U.S. based insurance company and liable for the payment of the health care service provided to a patient. Registered and in good standing with the Insurance Commissioner's office of the state in which they are based.

**Vanderbilt University Medical Center (VUMC) or Vanderbilt Health:** Vanderbilt University Hospital, Monroe Carell Jr. Children's Hospital at Vanderbilt, Vanderbilt Psychiatric Hospital, Vanderbilt Medical Group, Vanderbilt Academic and Research Enterprise, Medical Center Administration, Vanderbilt Wilson County Hospital, or other similar consolidated health care entity.

### **POLICY:**

VUMC is committed to providing a discount in accordance with applicable laws and regulations to individuals who are uninsured, or, in some cases, insured but without insurance coverage for services offered by VUMC, but who may not be eligible for Financial Assistance set forth in the VUMC Financial Assistance Policy.

Discount requests are determined based upon the specific scenario and category, as described below. Consideration will be given to factors including but not limited to, patient insurance status, cost of health care services requested, payer relationships with VUMC, patient liability amount, and/or the time in which the Payer or individual can adjudicate and/or pay claims.

### **Discounts for Services Provided to Uninsured Individuals**

All Uninsured Patients will be provided an Uninsured Discount prior to the first billing statement. This Uninsured Discount is given without consideration of patient financial status. This Uninsured Discount may be ultimately classified as a Financial Assistance Discount if the patient meets the additional income-based screening criteria described in the VUMC Financial Assistance Policy. In accordance with the Tennessee regulations, uninsured patients are not to pay for services in an amount that exceeds one hundred seventy-five percent (175%) of the cost for the services provided (calculated using the cost to charge ratio in the most recent joint annual report). VUMC has chosen to use the discount calculated from the IRS 501(r) regulatory guidance pertaining to AGB as the discount to be applied to uninsured and underinsured patients who have received eligible healthcare services.

In accordance with Internal Revenue Code Section 501(r) requirements, VUMC calculates two AGB percentages: one AGB percentage for services provided at VUMC, except Vanderbilt Wilson County Hospital (VWCH); and a separate AGB percentage for services provided at VWCH. For both AGB percentages, VUMC utilizes the "Look Back Method" to determine the AGB percentage based on claims from the prior 12-month period. The AGB percentages are determined by using the calculated expected reimbursement from all claims allowed by Medicare fee-for-service and all private health insurers and dividing that total reimbursement by total charges for the same claims. The resulting percentages represent the AGB for Medicare and private insurers. VUMC includes hospital and VUMC-owned physician claims which occur in both the hospital and hospital-based clinic settings in the AGB calculation. VUMC removes from the calculation all claims which are 100% denied by the applicable insurer and claims which are in credit balance status. The AGB percentages are then updated annually based on the analysis described above.

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Therefore, patients who are eligible for an Uninsured Discount are not expected to pay more than the AGB. Please see Appendix B for the current AGB percentages. Transplant Services are excluded from the Uninsured or Underinsured Discount provisions of this policy.

### **Discounts for Non-Covered Services**

A discount from billed charges may be offered to patients, when requested by the patient, with Contracted Payer coverage for all services which are adjudicated by the payer in a fashion that does not allow the patient to benefit from a contractual adjustment based on the contract with the payer. Specifically, this includes services denied for maximum benefits, medically necessary non-covered or non-reimbursed services, and non-authorized services that can be billed to the patient. This discount does not apply to Transplant Services.

### **Discounts for Services Provided to Non-Contracted Payers**

Discounts provided to Non-Contracted Payers will be negotiated by the Associate Vice President for VUMC Managed Care or their designee on a case-by-case basis prior to services being rendered to the patient. The office of the Associate Vice President for VUMC Managed Care will coordinate any necessary LOA. The Discount amount will only be offered to Non-Contracted Payers who will honor the patient's in-network level of benefits. It is expected that the Non-Contracted Payers Discounts will be documented with LOAs prior to medical services being provided.

### **Discounts for Services Provided to International Individuals**

International Individuals enrolled in non-U.S. Insurance Plans (regardless of whether or not they are accessing a Contracted Payer or Non-Contracted Payers network) and/or have no insurance are expected to pay 100% of gross estimated charges for services provided by VUMC prior to services being scheduled or rendered. A patient may owe more if actual charges exceed the estimate. Any agreed upon discount will be negotiated on a case by case basis by the Associate Vice President of VUMC Managed Care or their designee, including Patient Financial Services up to the discount amount reflected in this policy, and documented with a LOA for estimated balances in excess of \$5,000 and will be applied within 90 days from date of service or date of discharge.

International Individuals enrolled in U.S. Insurance Plans which are Contracted Payers of VUMC will be required to follow the terms and conditions for those agreements including any discount amount.

International Individuals enrolled in U.S. Insurance Plans which are Non-Contracted Payers of VUMC will be negotiated on a case-by-case basis by the Associate Vice President for VUMC Managed Care or their designee, including Patient Financial Services up to the discount amount reflected in this policy **prior** to services being rendered to the patient. Discounts will only be offered to Non-Contracted Payers which

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honor the patient's in-network level of benefits. The Non-Contracted Payers Discount will be documented with a LOA (See Appendix A).

International Individuals who are embassy sponsored patients will be negotiated on a case-by-case basis by the Associate Vice President for VUMC Managed Care or their designee prior to services being rendered. The Discount will be documented with a LOA and applied within 90 days from the date of service or date of discharge. The Managed Care Office will coordinate with the embassy to obtain appropriate signatures on the LOA and to receive a letter of guarantee from the embassy. An embassy will NOT be required to make a deposit for an embassy sponsored patient UNLESS the embassy has previously failed to comply with a LOA. Such embassies will be required to pay any balances from previous embassy sponsored International Individuals AND pay 100% of gross estimated charges in advance for any future embassy sponsored International Individuals prior to the first patient visit.

Any exceptions to this policy require the approval of the Deputy Chief Executive Officer, VUMC and VUMC Chief Financial Officer.

### **Discounts for Services Provided to Out-of-state Medicaid Individuals**

Discounts provided to out-of-state Medicaid Individuals will only be negotiated **prior** to the rendering of authorized Eligible Health Care Services. For **Transplant Services**, discounts can be explicitly negotiated for out-of-state Medicaid Individuals only by the Associate Vice President for VUMC Managed Care or their designee. The office of the Associate Vice President for VUMC Managed Care will coordinate any necessary enrollment with the Vice President of Revenue Cycle or designee. Out-of-state Medicaid Individuals' negotiated discounts for Eligible Health Care Services or Transplant Services will be documented with a LOA.

All Out-of-state Medicaid services planned or unplanned, for **Covered Eligible Health Care Services**, should have a Single Case Agreement (SCA) or LOA, negotiated by the Managed Care Office.

All Out-of-state planned services for **Non-covered Services**, including cosmetic, experimental or services deemed not medically necessary according to the Out-of-State Medicaid plan, require formal approved of discounts by the appropriate representatives and a documented LOA prepared by the Vice President of Revenue Cycle or Associate Vice President of Revenue Cycle or their designee.

In some instances, out-of-state Medicaid regulatory statutes dictate what the respective state will pay to out of network providers. If VUMC agrees to the specific state's statute on reimbursement, a LOA will be drafted by the Associate Vice President for VUMC Managed Care or their designee, citing the applicable statute(s) and including the VUMC payment stipulation for all Covered Services, including **transplant and non-transplant services**. The office of the Associate Vice President for VUMC Managed Care will coordinate any necessary LOA with the Vice President of Revenue Cycle or their designee. For planned **non-transplant, experimental, cosmetic services**, or other non-transplant services not covered by Out-

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of-state Medicaid, a LOA will be prepared by the Vice President of Revenue Cycle, Associate Vice President of Revenue Cycle, or their designee, and formal approval of the appropriate representative will be obtained. If VUMC does not agree to the respective state's statute, VUMC will not proceed with rendering the requested service.

### **Small Balance Discounts**

No formal approval is needed for small balance discounts for accounts with outstanding patient balances up to \$24.99 for technical hospital services and \$15 for physicians' services.

### **Letter of Agreement (LOA) Stipulations**

The following language shall be incorporated into the LOA:

- List of Vanderbilt entities included
- Limitation of the payer's ability to audit
- The payment timeframe and denial of discount if payment is not made within stated timeframe
- Payer's claims address, claims contact person, and claims contact person's phone number
- VUMC payment address
- Stipulation that the discounts proposed by VUMC do not represent any future financial commitment with the Payer
- Condition that the patient must be eligible for benefits, plan coverage must be in force, and the Payer must be the primary Payer for the duration of the LOA
- Confidentiality language
- Arrangements for embassy sponsored patients to be interim billed every thirty (30) days and payment received within 15 days of the Payer's receipt of the interim bill or the Discount is forfeited (any agreed upon discount reverts to full (100%) billed charges).

### **Summary of Discount Approval Levels**

Please see Appendix C: Summary of Discount Approval Levels for an explanation of the approval levels required for discounts.

### **Contact Information**

Questions regarding the interpretation of this policy should be directed to:

Email: [financepolicy@vumc.org](mailto:financepolicy@vumc.org)

### **Exhibits**

Appendix A: Letter of Agreement for International Patients

Appendix B: Amounts Generally Billed (AGB)

Appendix C: Summary of Discount Approval Levels

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APPENDIX A: LETTER OF AGREEMENT FOR INTERNATIONAL PATIENTS

Date

VUMC Patient Financial Services  
3841 Green Hills Drive, Suite 200  
Nashville, TN 37215

Name  
Address

Dear Name:

I am writing in reference to the care to be rendered to \_\_\_\_\_ (“Patient”) by \_\_\_\_\_, MD, related to \_\_[procedure]\_\_\_\_\_. The purpose of this Letter of Agreement (“LOA”) is to outline the deposit requirements between you, \_\_\_\_\_ (“Guarantor”), and Vanderbilt University Medical Center (referred to as “Provider”) for the health care services that will be rendered to the Patient.

The Provider requires funds to be on deposit before scheduling the first patient visit. The funds required for deposit are based on an estimate of charges and includes only services provided by the Provider. The stated amount is an **estimate only** and may be more or less depending on the scope of services needed during the course of treatment. This deposit does not include meals, lodging, travel, or other expenses not expressly stated in this LOA. A breakdown of this estimate is as follows:

Services Included: \_\_\_\_\_ Coverage: Self-Pay  
International

- Services Included: \_\_\_\_\_
  - VUMC Facility Services \$xx
  - Professional Services \$xx

**Funds Required in Advance: \$xx**

Please wire required funds of \$xx (US Dollars) to:

Bank Name: The Bank of NY Mellon  
Address: 500 Ross Street  
Pittsburgh, PA 15262

Phone: 412-234-0003  
Bank Account Name: Vanderbilt University Medical Center

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ABA Routing #: XXXXXXXXX  
Bank Account Number: XXXXXXXX  
Swift Code: XXXXXXXXX  
Fed Tax ID: XXXXXXXXX

In exchange for agreement to provide prompt payment, Provider will grant a thirty percent (30%) discount off of Total Facility and Professional Charges for the services provided. This discount will apply after all hospital and professional services are provided by Provider. The discounts do not apply to any pharmacy services provided by a Vanderbilt retail pharmacy.

This discount proposal is contingent upon you, the Guarantor, accepting the following conditions:

1. No audit of the services provided to Patient will be conducted, however, Guarantor reserves the right to review all VUMC billings to (a) determine accuracy, (b) ensure compliance with standard medical coding practices.
2. If the deposit is greater than the amount due by the Guarantor, Provider will refund that amount to the Guarantor within ninety (90) days from the final service date and will send a check to the Guarantor at the address indicated above.
3. If the deposit is exhausted and service is ongoing an additional deposit will be paid to the Provider upon request.
4. If amount due is greater than the deposit, the Guarantor will pay Provider (net of any deposit) for services provided to the Patient within thirty (30) business days of receipt of a claim. All payments due Provider will be wired to the address above.
5. This proposed pricing applies only to the identified services in this letter and does not apply to any negotiations between Provider and Guarantor, with respect to other medical services.
6. Guarantor agrees that the contents of this LOA will be maintained in the strictest confidence and not disclosed to third parties without the written approval of the Provider.

If you find this letter acceptable, please sign below and fax to Vanderbilt Office of Patient Financial Services at (615) 875-2607. Receipt of the signed, faxed document at that number will establish the agreement of Provider and you to the terms set forth herein; however, we request that you also forward a signed, original version of this letter to the following address: VUMC Patient Financial Services, 3841 Green Hills Village Dr, Suite 200, Nashville, TN 37215. Please contact VUMC Patient Financial Services at (615) 936-8829 if you need additional clarification.

Sincerely,

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Tony Slack  
Patient Financial Services  
Vanderbilt University Medical Center



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**AGREED:**

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Guarantor

cc: Cecelia Moore

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**APPENDIX B: AMOUNTS GENERALLY BILLED (AGB)**

IRS Section 501(r) requires hospitals to limit the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to no more than the amounts generally billed (AGB) to insured individuals. VUMC calculates AGB using the “Look-Back” method and including Medicare fee-for-service and all private health insurers that pay claims to VUMC.

**VUMC, except Vanderbilt Wilson County Hospital, AGB:**

As of April 29, 2020, the AGB percentage for patients who receive services at VUMC, except Vanderbilt Wilson County Hospital, based on the period ending December 31, is 31% of total billed charges for Eligible Health Care Services, resulting in an Uninsured Discount of 69%.

**Vanderbilt Wilson County Hospital AGB:**

As of April 29, 2020, the AGB percentage for patients who receive services at Vanderbilt Wilson County Hospital, based on period ending January 31, is 15% of total billed facility charges for Eligible Health Care Services, resulting in an Uninsured Discount of 85%.

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**APPENDIX C: SUMMARY OF DISCOUNT APPROVAL LEVELS**

Type	Services Deemed Medically Necessary	Discount Amount	Approval Required
Uninsured Individuals who receive technical services at VUMC, except Vanderbilt Wilson County Hospital	Yes	69%	
Uninsured individuals who receive VMG professional services	Yes	69%	
Uninsured Individuals who receive technical services at Vanderbilt Wilson County Hospital	Yes	85%	
Uninsured individuals	No	0%	
Services at VUMC, not covered by Insurance provided to Individuals with Contracted Payer Coverage	Yes	58% unless patient is deemed FAP qualified	Account Reimbursement Specialist (ARS) – Lead ARS, Patient Financial Services
Technical services at Vanderbilt Wilson County Hospital not covered by Insurance provided to Individuals with Contracted Payer Coverage	Yes	80% unless patient is deemed FAP qualified	Account Reimbursement Specialist (ARS) – Lead ARS, Patient Financial Services
Services not covered by Insurance provided to Individuals with Contracted Payer Coverage	No	0%	
Non-Contracted Payers	Yes	Not to exceed 40%	AVP Managed Care
Non-Contracted Payers	No	0%	
International Individuals (includes Embassy Sponsored)	Yes	<30%	Assistant Director, PFS
International Individuals (includes Embassy Sponsored)	No	30% – 40%	AVP Managed Care
International Individuals (includes Embassy Sponsored)	No	0%	
Patient requests to restrict the use and disclosure of information; Patient requests that VUMC not bill insurance for services	N/A	0%	

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Type	Services Deemed Medically Necessary	Discount Amount	Approval Required
Market sensitive services where Alternative Pricing has been deployed	N/A	Follows the established alternative pricing; no additional discounts available	
All Other Discounts Categories Not Specifically Addressed Above Including Discounts > 40%		>40%	Chief Financial Officer and Deputy Chief Executive Officer