

 Saint Francis Healthcare	Organizational	
	ORG-024.00	
	Name:	Billing, Collection and Support for Patients with Payment Obligations; also known as "Financial Assistance for Patients:
	Manual:	Organizational
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POLICY:

It is the policy of the following Trinity Health Regional Health Ministries (RHMs):

Mercy Health - Muskegon;

Mercy Health - Lakeshore;

Mercy Health - Saint Mary's Health Care

Mercy Health Physician Partners (MHPP)

Saint Joseph Health System (Indiana)

Saint Francis Delaware Delaware; and

Mercy Health Shared Services (MHSS) to provide financial assistance and charity care in accordance with the Trinity Health corporate guidelines. To that effect, this Operational Policy and Procedure is a "Mirror" of Trinity Health Revenue Excellence Procedure No. RE-02-12-07.

PURPOSE

Trinity Health is a community of persons serving together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Aligned with our Core Values, in particular that of "Commitment To Those Who Are Poor," we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the health care expenses incurred. Trinity Health is committed to:

- Providing access to quality health care services with compassion, dignity and respect for those we serve, particularly the poor and the underserved in our communities;
- Caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

This Procedure, which provides guidance regarding implementing the accompanying Mirror Policy of the same name, balances financial assistance with broader fiscal responsibilities and provides Regional Health Ministries ("RHMs") with the Trinity Health requirements for financial assistance for physician, acute care and post-acute care health care services. Each of the previously listed RHMs have adopted this System Mirror Policy "Financial Assistance to Patients" and developed local operating procedures in compliance with these requirements.

PROCEDURE

The listed Trinity Health Regional Health Ministries (RHMs) hereby establish and maintain the Financial Assistance to Patients ("FAP") procedure outlined below. The FAP is designed to address patients' needs for financial assistance and support as they seek services through Trinity Health and its ministries. It applies to all eligible services as provided under applicable state or federal law. RHMs operating in states that have established additional state-specific financial assistance

requirements will incorporate such additional requirements in their local procedures. Eligibility for financial assistance and support from the RHM will be determined on an individual basis using specific criteria and evaluated on an assessment of the patient and/or Family's health care needs, financial resources and obligations.

I. Qualifying Criteria for Financial Assistance

a. Services eligible for Financial Support:

- i. All medically necessary services, including medical and support services provided by the RHM, will be eligible for Financial Support.
- ii. Emergency medical care services will be provided to all patients who present to the RHM hospital's emergency department, regardless of the patient's ability to pay. Such medical care will continue until the patient's condition has been stabilized prior to any determination of payment arrangements.

b. Services not eligible for Financial Support:

- i. Cosmetic services and other elective procedures and services that are not medically necessary.
- ii. Services not provided and billed by the RHM (*e.g.* independent physician services, private duty nursing, ambulance transport, etc.).
- iii. As provided in Section II, RHMs will proactively help patients apply for public and private programs. RHMs may deny Financial Support to those individuals who do not cooperate in applying for programs that may pay for their health care services.
- iv. RHMs may exclude services that are covered by an insurance program at another provider location but are not covered at Trinity Health RHM hospitals after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

c. Residency requirements

- i. RHMs will provide Financial Support to patients who reside within their service areas and who qualify under the RHM's FAP procedure.
- ii. RHMs may identify Service Areas in their FAP and include Service Area information in procedure design and training RHMs with a Service Area residency requirement will start with the list of zip codes provided by System Office Strategic Planning that define the RHMs service areas RHMs will verify service areas in consultation with their local Community Benefit department. Eligibility will be determined by the RHM using the patient's primary residence zip code. (*Exhibit 02 - Service Area Zip Code List*)
- iii. RHMs will provide Financial Support to patients from outside their Service Areas who qualify under the RHM FAP and who present with an Urgent, Emergent or life-threatening condition.
- iv. RHMs will provide Financial Support to patients identified as needing service by physician foreign mission programs conducted by active medical staff for which prior approval has been obtained from the RHM's President or designee.

d. Documentation for Establishing Income

- i. Information provided to the RHM by the patient and/or Family should include earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and Income from any other source; number of dependents in household; and other information requested on the FAP application. (*Exhibit 08 Financial Assistance Application Form*)
- ii. RHMs will list the supporting documentation such as payroll stubs, tax returns, and credit history required to apply for financial assistance in the FAP or FAP application. RHMs may not deny Financial Support based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.
- iii. RHMs will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. RHMs may

initiate ECAs if the patient does not submit the missing information and/or documentation within the 30 day resubmission period and it is at least 120 days from the date the RHM provided the first post-discharge billing statement for the care. RHMs must process the FAP application if the patient provides the missing information/or documentation during the 240-day application period (or, if later, within the 30-day resubmission period).

e. Consideration of Patient Assets

- i. RHMs will also establish a threshold level of assets above which the patient/family's assets will be used for payment of medical expenses and liabilities to be considered in assessing the patient's financial resources.

Protection of certain types of assets and protection of certain levels of assets must be provided in the RHM's FAP.

Protected Assets:

- Equity in primary residence up to 50% of the equity up to \$50,000;
- Business use vehicles;
- Tools or equipment used for business; reasonable equipment required to remain in business;
- Personal use property (clothing, household items, furniture);
- IRAs, 401K, cash value retirement plans;
- Financial awards received from non-medical catastrophic emergencies;
- Irrevocable trusts for burial purposes, prepaid funeral plans; and/or
- Federal/State administered college savings plans.

All other assets will be considered available for payment of medical expenses. Available assets above a certain threshold can either be used to pay for medical expenses or, alternatively, RHMs may count the excess available assets as current year Income in establishing the level of discount to be offered to the patient. The Trinity Health recommended minimum amount of \$5,000 of available assets will be protected.

f. Presumptive Support

- i. RHMs recognize that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted it is classified as "Presumptive Support".
- ii. The predictive model is one of the reasonable efforts that will be used by RHMs to identify patients who may qualify for financial assistance prior to initiating collection actions, *i.e.* write-off of a patient account to bad debt and referral to collection agency. This predictive model enables Trinity Health RHMs to systematically identify financially needy patients.
- iii. Examples of presumptive cases include:
 - Deceased patients with no known estate
 - Homeless patients
 - Unemployed patients
 - Non-covered medically necessary services provided to patients qualifying for public assistance programs
 - Patient bankruptcies
- iv. Members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.
- v. For patients who are non-responsive to the FAP application process, other sources of information, if available, should be used to make an individual assessment of financial need. This information will enable the RHM to make an informed decision on the financial need of non-responsive patients.
- vi. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record databases. These public records enable the RHM to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by

the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

- vii. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within established timelines and be considered under the traditional financial assistance application process.
- viii. Patient accounts granted presumptive support status will be adjusted using *Presumptive Financial Support* transaction codes at such time the account is deemed uncollectable and prior to referral to collection or write-off to bad debt. The discount granted will be classified as Financial Support; the patient's account will not be sent to collection and will not be included in the RHM's bad debt expense.
- i. RHMs will notify patients determined to be eligible for less than the most generous assistance available under the FAP that he or she may apply for more generous assistance available under the FAP within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, RHMs may initiate or resume ECAs if the patient does not apply for more generous assistance within 30 days of notification if it is at least 120 days from the date the RHM provided the first post-discharge billing statement for the care. RHMs will process any new FAP application that the patient submits by the end of the application period or, if later, by the end of the 30-day period given to apply for more generous assistance.

g. Timeline for Establishing Financial Eligibility

- i. Every effort should be made to determine a patient's eligibility for Financial Support prior to or at the time of admission or service. FAP Applications must be accepted during the application period. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or either: i. the end of the period of time that a patient that is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or the deadline provided in a written notice after which ECAs may be initiated.
RHMs may accept and process an individual's FAP application submitted outside of the application period on a case-by-case basis as authorized by the RHM's established approval levels.
- ii. RHMs (or other authorized party) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refunds of payments is only required for the episodes of care to which the FAP application applies.
- iii. Determinations of Financial Support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted.
- iv. RHMs will make every effort to make a Financial Support determination in a timely fashion. If other avenues of Financial Support are being pursued, the RHM will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.
- v. Once qualification for Financial Support has been determined, subsequent reviews for continued eligibility for subsequent services should be made after a reasonable time period as determined by the RHM.

h. Level of Financial Support

- i. Each RHM will follow the Income guidelines established below in evaluating a patient's eligibility for Financial Support. A percentage of the Federal Poverty Level (FPL) Guidelines (*Exhibit 04 - Federal Poverty Level*), which are updated on an annual basis, is used for determining a patient's eligibility for Financial Support. However, other factors should also be considered such as the patient's financial status and/or ability to pay as determined through the assessment process.

- ii. RHMs are expected to implement the recommended level of Financial Support set forth in this Procedure. It is recognized that local demographics and the financial assistance policies offered by other providers in the community may expose some RHMs to large financial risks and a financial burden which could threaten the RHM's long-term ability to provide high quality care. RHMs may request approval to implement thresholds that are less than or greater than the recommended amounts from Trinity Health's Chief Financial Officer.
- iii. Family Income at or below 200% of the Federal Poverty Level Guidelines: A 100% discount for all charges will be provided for Uninsured Patients whose Family's Income is at or below 200% of the most recent Federal Poverty Level Guidelines.
- iv. Family Income between 201% and 400% of the Federal Poverty Level Guidelines:
 - i. A discount off of total charges equal to the RHM's average acute care contractual adjustment for Medicare (*Exhibit 05 - Discount Rate Table*) will be provided for acute care patients whose Family Income is between 201% and 400% of the Federal Poverty Level Guidelines.
 - ii. A discount off of total charges equal to the RHM's physician contractual adjustment for Medicare will be provided for ambulatory location patients whose Family Income is between 201% and 400% of Federal Poverty Level Guidelines.
 - iii. The RHM's acute and physician contractual adjustment amounts for Medicare will be calculated utilizing the look back methodology of calculating the sum of paid claims divided by the total or "gross" charges for those claims by the System Office or RHM annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.
 - v. Patients with Family Income up to and including 200% of the Federal Poverty Level Guidelines will be eligible for Financial Support for co-pay, deductible, and co-insurance amounts provided that contractual arrangements with the patient's insurer do not prohibit providing such assistance.
 - vi. Medically Indigent Support / Catastrophic: Financial support is also provided for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their Family or household Income (for example, due to catastrophic costs or conditions), regardless of whether they have Income or assets that otherwise exceed the financial eligibility requirements for Free Care or Discounted Care under the RHM's FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence/catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's Income, expenses and assets. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of Income will qualify the insured patient's co-pays and deductibles for catastrophic charity care assistance. Discounts for medically indigent care for the uninsured will not be less than the RHM's average contractual adjustment amount for Medicare for the services provided or an amount to bring the patients catastrophic medical expense to Income ratio back to 20%. Medically indigent and catastrophic financial assistance will be approved by the RHM CFO and reported to the System Office Chief Financial Officer.
 - vii. While Financial Support should be made in accordance with the RHM's established written criteria, it is recognized that occasionally there will be a need for granting additional Financial Support to patients based upon individual considerations. Such individual considerations will be approved by the RHM CFO and reported to the System Office Chief Financial Officer.
- i. Accounting and Reporting for Financial Support
 - i. In accordance with the Generally Accepted Accounting Principles, Financial Support provided by Trinity Health is recorded systematically and accurately in the financial statements as a deduction from revenue in the category "Charity Care". For the purposes of Community

Benefit reporting, charity care is reported at estimated cost associated with the provision of "Charity Care" services in accordance with the Catholic Health Association.

- ii. The following guidelines are provided for the financial statement recording of Financial Support:

Financial Support provided to patients under the provisions of "Financial Assistance Program", including the adjustment for amounts generally accepted as payment for patients with insurance, will be recorded under "Charity Care Allowance."

Write-off of charges for patients who have not qualified for Financial Support under this Procedure and who do not pay for the services received will be recorded as "Bad Debt."

Prompt pay discounts will be recorded under "Operational Adjustments- Administrative" or "Contractual Allowance."

Accounts initially written-off to bad debt and subsequently returned from collection agencies where the patient is determined to have met the Financial Support criteria based on information obtained by the collection agency will be reclassified from "Bad Debt" to "Charity Care Allowance".

II. Assisting Patients Who May Qualify for Coverage

- a. RHMs will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Premium assistance may also be granted on a discretionary basis according to Trinity Health's "Payment of QHP Premium and Patient Payables" procedure.
- b. RHMs will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the RHM's FAP.

III. Effective Communications

- a. RHMs will provide financial counseling to patients about their health care bills related to the services they receive from the RHM and will make the availability of such counseling known.
- b. RHMs will respond promptly and courteously to patients' questions about their bills and requests for financial assistance.
- c. RHMs will utilize a billing process that is clear, concise, correct and patient friendly.
- d. RHMs will make available information about charges for services they provide in an understandable format.
- e. RHMs will post signs and display brochures that provide basic information about their FAP in public locations (at a minimum, the emergency room (if any) and admission areas) in the RHM and list those public locations in the RHM's FAP. (*Exhibit 06 - Financial Assistance Flyers and Poster (Examples)*)
- f. RHMs will make available a paper copy of the plain language summary of the FAP (*Exhibit 07 - Plain Language Summary*) to patients as part of the intake or discharge process. An RHM will not have failed to widely publicize its FAP because an individual declines a plain language summary that was offered on intake or before discharge or indicates that he or she would prefer to receive a plain language summary electronically.

- g. RHMs will make the FAP, a plain language summary of the FAP and the FAP application form available to patients upon request, in public places (at a minimum, the emergency room (if any) and admission areas) in the RHM, by mail and on the RHM website. Any individual with access to the Internet must be able to view, download and print a hard copy of these documents. The RHM must provide any individual who asks how to access a copy of the FAP, FAP application form, or plain language summary of the FAP online with the direct website address, or URL, where these documents are posted.
- h. RHMs will list the names of individual doctors, practice groups, or any other entities that are providing emergency or medically necessary care in the RHM's facility by the name used either to contract with the hospital or to bill patients for care provided. Alternately, a hospital facility may specify providers by reference to a department or a type of service if the reference makes clear which services and providers are covered under the RHM's FAP.
- i. These documents will be made available in English and in the primary language of any population with limited proficiency in English that constitutes the lesser of the 1,000 individuals or 5 percent of the community served by the RHM. (*Exhibit 11 - WM CSA Languages Spoken*)
- j. RHMs will take measures to notify members of the community served by the RHM about the FAP. Such measures may include, for example, the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low income populations.
- k. RHMs will include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the RHM's FAP and includes the telephone number of the RHM's department that can provide information about the FAP, the FAP application process and the direct Web site address (or URL) where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained.
- l. RHMs will refrain from initiating ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient. RHMs will also ensure all vendor contracts for business associates performing collection activity will contain a clause or clauses prohibiting ECA(s) until 120 days after providing patients the first post-discharge billing statement for the episode of care, including the most recent episodes of care for outstanding bills that are aggregated for billing to the patient.
- m. RHMs will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECA(s) that the RHM (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided. RHMs will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the RHMs FAP and about how the patient may obtain assistance with the FAP application process.
- n. In the case of deferring or denying, or requiring a payment for providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the RHM's FAP, the RHM may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, a RHM must satisfy several conditions. The RHM must:
 - i. Provide the patient with an FAP application form (to ensure the patient may apply immediately, if necessary) and notify the patient in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process an FAP application submitted by the

patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the patient must be afforded at least 30 days after the notice to submit an FAP application for the previously provided care.

- ii. Notify the patient about the FAP by providing a plain-language summary of the FAP and by orally notifying the patient about the hospital facility's FAP and about how the patient may obtain assistance with the FAP application process.
- iii. Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above are not needed in the following cases:

- i. If 120 days have passed since the first post-discharge bill for the previously provided care, and the RHM has already notified the patient about intended ECAs
 - ii. If a RHM had already determined whether the patient was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the patient was FAP-eligible for the previously provided care
- o. RHMs will provide written notification that nothing is owed if a patient is determined to be eligible for Free Care.
- p. RHMs will provide patients that are determined to be eligible for assistance other than Free Care, with a billing statement that indicates the amount the patient owes for care as a FAP-eligible patient. The statement will also describe how that amount was determined or how the patient can get information regarding how the amount was determined.

IV. Fair Billing and Collection Practices

- a. RHMs will implement billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations.
- b. RHMs will make available to all patients who qualify a short term interest free payment plan with defined payment time frames based on the outstanding account balance. RHMs will also offer a loan program for patients who qualify.
- c. RHMs will have written procedures outlining when and under whose authority a patient debt is advanced for external collection activities that are consistent with this Procedure.
- d. The following collection activities may be pursued by the Trinity Health RHM or by a collection agent on their behalf:
 - i. Communicate with patients (call, written correspondence, fax, text, email, etc.) and their representatives in compliance with the Fair Debt Collections Act, clearly identifying the RHM. The patient communications will also comply with HIPAA privacy regulations.
 - ii. Solicit payment of the estimated patient payment obligation portion at the time of service in compliance with EMTALA regulations and state laws.
 - iii. Provide low-interest loan program for payment of outstanding debts for patients who have the ability to pay but cannot meet the short-term payment requirements.
- iv. Report outstanding debts to Credit Bureaus only after all aspects of this Procedure have been applied and after reasonable collection efforts have been made in conformance with the RHM's FAP.
- v. Pursue legal action for individuals who have the means to pay, but do not pay, or who are unwilling to pay. Legal action also may be pursued for the portion of the unpaid amount after application of the RHM's FAP. An approval by the Trinity Health or RHM CEO/CFO, or the functional leader for Patient Financial Services for those RHMs

- utilizing the Trinity Health shared service center, must be obtained prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).
- vi. Place liens on property of individuals who have the means to pay, but do not pay, or who are unwilling to pay. Liens may be placed for the portion of the unpaid amount after application of the RHM's FAP. Placement of a lien requires approval by the Trinity Health or RHM CEO/CFO, or the functional leader for Patient Financial Services for those RHMs utilizing the Trinity Health shared service center. Liens on primary residence can only be exercised upon the sale of property and will protect certain asset value in the property as documented in each RHM's Procedure. Trinity Health recommends protecting 50% of the equity up to \$50,000.
 - e. RHMs (or a collection agent on their behalf) shall not pursue action against the debtor's person, such as arrest warrants or "body attachments." Trinity Health recognizes that a court of law may impose an arrest warrant or other similar action against a defendant for failure to comply with a court's order or for other violations of law related to a collection effort. While in extreme cases of willful avoidance and failure to pay a justly due amount when adequate resources are available to do so, a court order may be issued; in general, the RHM will first use its efforts to convince the public authorities not to take such an action and, if not successful, consider the appropriateness of ceasing the collection effort to avoid an action against the person of the debtor.
 - f. RHMs (or a collection agent on their behalf) will take all reasonably available measures to reverse ECAs related to amounts no longer owed by FAP-eligible patients.
 - g. RHMs may have a System Office approved arrangement with a collection agency, provided that such agreement meets the following criteria:
 - i. The agreement with a collection agency must be in writing;
 - ii. Neither the RHM nor the collection agency may at any time pursue action against the debtor's person, such as arrest warrants or "body attachments;"
 - iii. The agreement must define the standards and scope of practices to be used by outside collection agents acting on behalf of the RHM, all of which must be in compliance with this Procedure;
 - iv. No legal action may be undertaken by the collection agency without the prior written permission of the RHM;
 - v. Trinity Health Legal Services must approve all terms and conditions of the engagement of attorneys to represent the RHM in collection of patient accounts;
 - vi. All decisions as to the manner in which the claim is to be handled by the attorney, whether suit is to be brought, whether the claim is to be compromised or settled, whether the claim is to be returned to the RHM, and any other matters related to resolution of the claim by the attorney shall be made by the RHM in consultation with Trinity Health Legal Services;
 - vii. Any request for legal action to collect a judgment (*i.e.*, lien, garnishment, debtor's exam) must be approved in writing and in advance with respect to each account by the appropriate authorized RHM representative as detailed in section V;
 - viii. The RHM must reserve the right to discontinue collection actions at any time with respect to any specific account; and
 - ix. The collection agency must agree to indemnify the RHM for any violation of the terms of its written agreement with the RHM.

V. Implementation of Accurate and Consistent Policies

- a. Representatives of the RHM's Patient Financial Services and Patient Access departments will educate staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections, physician offices) about billing, financial assistance, collection policies and practices, and

treatment of all patients with dignity and respect regardless of their insurance status or their ability to pay for services.

- b. RHMs will honor Financial Support commitments that were approved under previous financial assistance guidelines.

VII. Other Discounts

- a. **Prompt Pay Discounts:** RHMs may develop a prompt pay discount program which will be limited to balances equal to or greater than \$200.00 and will be no more than 20% of the balance due. The prompt pay discount is to be offered at the time of service and recorded as a contractual adjustment and cannot be recorded as charity care on the financial statements.
- b. **Self-Pay Discounts:** RHMs will apply a standard self-pay discount off of charges for all registered self-pay patients that do not qualify for financial assistance (e.g., >400% of FPL) based on the highest commercial rate paid.
- c. **Additional Discounts:** Adjustments in excess of the percentage discounts described in this Procedure may be made on a case-by-case basis upon an evaluation of the collectability of the account and authorized by the RHM's established approval levels.

Should any provision of this FAP conflict with the requirement of the law of the state in which the Trinity Health RHM operates, state law shall supersede the conflicting provision and the RHM shall act in conformance with applicable state law.

SCOPE/APPLICABILITY

This procedure applies to all Trinity Health RHMs that operate licensed tax-exempt hospitals. Trinity Health organizations that do not operate tax-exempt licensed hospitals may establish their own financial assistance procedures for other health care services they provide and are encouraged to use the criteria established in this FAP procedure as guidance.

This Procedure is based on a Trinity Health "Mirror Policy." Thus, all Trinity Health RHMs and Subsidiaries that operate licensed tax-exempt hospitals are required to adopt a local Procedure that "mirrors" (*i.e.*, is identical to) the System office Procedure. Questions in this regard should be referred to the Trinity Health Office of General Counsel.

DEFINITIONS

Application Period begins the day that care is provide and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either --

- i. the end of the 30 day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.
- ii. the deadline provided in a written notice after which ECAs may be initiated.

Amounts Generally Billed ("AGB") means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, The RHM's acute and physician AGB will be calculated utilizing the look back methodology of calculating the sum of paid Medicare claims divided by the total or "gross" charges for those claims by the System Office or RHM annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

Discounted care means a partial discount off the amount owed for patients that qualify under the FAP.

Emergent medical services are those needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by Emergency Medical Treatment and Active Labor Act (EMTALA).

Executive Leadership Team ("ELT") means the group that is composed of the highest level of management at Trinity Health.

Extraordinary Collection Actions ("ECA") include the following actions taken by a RHM (or a collection agent on their behalf):

Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the

hospital facility's FAP. If a RHM requires payment before providing care to an individual with one or more outstanding bills, such a payment requirement will be presumed to be because of the individual's nonpayment of the outstanding bill(s) unless the RHM can demonstrate that it required the payment from the individual based on factors other than, and without regard to, his or her nonpayment of past bills.

Reporting outstanding debts to Credit Bureaus.

Pursuing legal action to collect a judgment (i.e. garnishment of wages, debtor's exam).

Placing liens on property of individuals.

Family (as defined by the U.S. Census Bureau) is a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility under the RHM's FAP.

Family Income - A person's Family Income includes the Income of all adult Family members in the household. For patients under 18 years of age, Family Income includes that of the parents and/or step-parents, or caretaker relatives' annual Income from the prior 12 month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Financial assistance policy (FAP) means a written policy and procedure that meets the requirements described in §1.501(r)-4(b).

Financial Assistance Policy ("FAP") application means the information and accompanying documentation that a patient submits to apply for financial assistance under a RHM's FAP. RHMs may obtain information from an individual in writing or orally (or a combination of both).

Financial Support means support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by Trinity Health who meet the eligibility criteria for such assistance.

Free Care means a full discount off the amount owed for patients that qualify under the FAP.

Income includes wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, child support, alimony, educational assistance, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity is defined as documented in each RHM's state's Medicaid Provider Manual.

Policy means a statement of high-level direction on matters of strategic importance to Trinity Health or a statement that further interprets Trinity Health's governing documents. System Policies may be either stand alone or Mirror Policies designated by the approving body.

Plain language summary of the FAP means a written statement that notifies a patient that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

A brief description of the eligibility requirements and assistance offered under the FAP.

A brief summary of how to apply for assistance under the FAP.

The direct Web site address (or URL) and physical locations where the patient can obtain copies of the FAP and FAP application form.

Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail

The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and provide assistance with the FAP application process

A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.

A statement that a FAP-eligible patient may not be charged more than AGB for emergency or other medically necessary care

Procedure means a document designed to implement a Policy or a description of specific required actions or processes.

Regional Health Ministry ("RHM") means a first tier (direct) subsidiary, affiliate or operating division of Trinity Health that maintains a governing body that has day-to-day management oversight

of a designated portion of Trinity Health System operations. RHMs may be based on a geographic market or dedication to a service line or business.

Service Area is the list of zip codes comprising a RHMs service market area constituting a "community of need" for primary health care services.

Standards or Guidelines mean additional instructions and guidance which assist in implementing Procedures, including those developed by accreditation or professional organizations.

Subsidiary means a legal entity in which a Trinity Health RHM is the sole corporate member or sole shareholder.

Uninsured Patient means an individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which Trinity Health is subrogated, but only if payment is actually made by such insurance company.

Urgent (service level) are medical services needed for a condition that is not life threatening, but requiring timely medical services.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Procedure may be obtained from the VP, Patient Financial Services, in the Revenue Excellence Department.

RELATED PROCEDURES AND OTHER MATERIALS

Trinity Health Revenue Excellence Policy No. 1: "Financial Assistance to Patients" ("FAP") [*add hyperlink*]

Trinity Health Revenue Excellence Policy No. 2: "Payment of QHP Premiums and Patient Payables" [*add hyperlink*]

Patient Protection and Affordable Care Act: Statutory Section 501(r)

Internal Revenue Service Schedule H (Form 990)

Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Final Rule: Volume 79, No. 250, Part II, 26 CFR, Part 1

Individual RHM's EMTALA Policies