PURPOSE
St. Mary Medical Center (SMMC) 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. SMMC 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.

In addition, this policy provides administrative and accounting guidelines for the identification, classification and reporting of patients as Financial Assistance as distinguished from Bad Debts.

PROCEDURE
SMMC will 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. It applies to all eligible services as provided under applicable state or federal law. Eligibility for financial assistance and support 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 SMMC, will be eligible for Financial Support.
   ii. Emergency medical care services will be provided to all patients who present to SMMC’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 which are not medically necessary.
   ii. Services not provided and billed by SMMC (e.g. independent physician services, private duty nursing, ambulance transport, etc.).
   iii. As provided in Section II, SMMC will proactively help patients apply for public and private programs. SMMC may deny Financial Support to those individuals who do not cooperate in applying for programs that may pay for their health care services.
   iv. SMMC may exclude services that are covered by an insurance program at another provider location but are not covered at SMMC 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. SMMC will provide Financial Support to patients who reside within their service areas and who qualify under the SMMC FAP procedure.
   ii. SMMC will utilize the service area list provided by System Office Strategic Planning Department and coordinate with their local Community Benefit department. Eligibility will be determined using the patient’s primary residence zip code.
   iii. SMMC will provide Financial Support to patients from outside their Service Areas who qualify under the SMMC FAP and who present with an Urgent, Emergent or life-threatening condition.
   iv. SMMC 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 SMMC’s President or designee.
   v. Exceptions to residency requirements will be reviewed at the Financial Assistance Steering Committee.

d. Documentation for Establishing Income
   i. Information provided to SMMC 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 SMMC application.
   ii. SMMC will list the supporting documentation such as payroll stubs, tax returns, and credit history required to apply for financial assistance in the FAP application. SMMC 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. SMMC 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. SMMC 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 SMMC provided the first post-discharge billing statement for the care. SMMC 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. SMMC will not utilize Patient Assets in consideration of patient Financial Assistance.
f. Presumptive Support
   i. SMMC 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 SMMC 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 SMMC 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
       - Members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order
   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 SMMC to make an informed decision on the financial need of non-responsive patients.
   iv. 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 SMMC 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.
   v. 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.
   vi. 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 SMMC’s bad debt expense.
   vii. SMMC 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, SMMC 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 SMMC provided the first post-discharge billing statement for the care. SMMC will process any new FAP application that the patient submits by the end of the 240 day 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. Internal St. Mary Medical Center staff such as Financial Counselors/
Benefit Advisors and contracted vendors, such as Medicaid enrollment and financial counselors, should administer the assessment process of financial support. FAP Applications must be accepted any time 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:

1. 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

2. the deadline provided in a written notice after which ECAs may be initiated.

SMMC 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 SMMC’s established approval levels.

ii. SMMC (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. If a patient is exploring third party financial assistance, such as Medicaid, or if the patient has a legal settlement pending, final 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. If a patient is deemed eligible for government assistance, but the coverage does not satisfy all the patient’s financial obligations (i.e., Medicaid, Spend Down, Medicaid Emergency Services Only (ESO)), SMMC may assume that since Medicaid requires the patient Federal Poverty Limit (FPL) to be at 138% and the Financial Assistance Policy goes up to 250% of the FPL, the patient would meet Presumptive Eligibility Requirements. Therefore, no additional documentation or verification are required by the patient.

v. SMMC will make every effort to make a Financial Support determination in a timely fashion. If other avenues of Financial Support are being pursued, SMMC 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.

vi. 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 SMMC no greater than a one (1) year.

h. Level of Financial Support

i. SMMC 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, which are updated on an annual basis, are 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. Family Income at or below 250% of the Federal Poverty Level Guidelines:

1. A 100% discount for all charges will be provided for Uninsured Patients whose Family’s Income is at or below 250% of the most recent Federal Poverty Level Guidelines.

iv. Family Income between 251% and 400% of the Federal Poverty Level Guidelines:

1. A discount off of total charges equal to SMMC average acute care contractual adjustment for Medicare will be provided for uninsured acute care patients whose Family Income is between 251% and 400% of the Federal Poverty Level Guidelines. Patients will receive a sliding scale discount of 25%, 50% or 75% of the average acute care Medicare contractual adjustment.
2. A discount off of total charges equal to the RHM’s physician contractual adjustment for Medicare will be provided for uninsured ambulatory location patients whose Family Income is between 251% and 400% of Federal Poverty Level Guidelines. Patients will receive a sliding scale discount of 25%, 50% or 75% of the average acute care Medicare contractual adjustment.

3. SMMC’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 SMMC annually using twelve months of paid claims with a 30 day lag from report date to the most recent discharge date.

v. Insured patients with Family Income up to and including 250% 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.

1. An insured patient whose Family Income is between 251% and 400% of Federal Poverty Level Guidelines, will receive a sliding scale discount of 25%, 50% or 75% off of the 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 SMMC’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 claim 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 SMMC average contractual adjustment amount for Medicare for the services provided or an amount to bring the patient’s catastrophic medical expense to Income ratio back to 20%. Medically indigent and catastrophic financial assistance will be approved by the SMMC CFO and reported to the System Office Chief Financial Officer.

vii. While Financial Support should be made in accordance with the SMMC 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 CFO and reported to the System Office Chief Financial Officer.

i. SMMC Special Circumstances

i. Patients in need of take-home prescriptions and or supplies upon discharge who verbalize an inability to pay will be supplied with medication and supplies for up to 30 days as ordered with self-disclosure of income meeting the financial assistance guidelines. Upon discharge the patient would be instructed by social worker to apply through regular channels for our FA program should they need additional assistance in paying for their medications. The Patient would be eligible for medication support for one year from the date of Financial Assistance approval.
ii. A partnership between SMMC and BCHIP allows for this entity to screen patients for financial assistance in accordance with SMMC policies prior to receiving healthcare services from SMMC. A referred patient from BCHIP is considered to be financially cleared. The SMMC financial assistance committee will perform a yearly audit of these entities for completeness and accuracy of the financial assistance documents. If the entity is found to be noncompliant, a report that outlines the deficiencies along with an action plan will be developed and sent to the Director/VP over the entity. A follow-up audit will be performed 3-months after the action plan is developed to ensure the entity is in compliance with the SMMC financial assistance policy.

j. 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 the “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 “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. SMMC 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. SMMC will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the SMMC FAP.

III. Effective Communications

a. SMMC will provide financial counseling to patients about their health care bills related to the services they receive from SMMC and will make the availability of such counseling known.

b. SMMC will respond promptly and courteously to patients’ questions about their bills and requests for financial assistance.

c. SMMC will utilize a billing process that is clear, concise, correct and patient friendly.

d. SMMC will make available information about charges for services they provide in an understandable format.

e. SMMC 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) at SMMC and list those public locations in the SMMC’s FAP.
f. SMMC will make available a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process. SMMC 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. SMMC 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 hospital, by mail and on the SMMC website. Any individual with access to the Internet must be able to view, download and print a hard copy of these documents. SMMC will 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. SMMC will list the names of individual doctors, practice groups, or any other entities that are providing emergency or medically necessary care in the 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 SMMC’s FAP. (Attachment A)

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 SMMC.

j. SMMC will take measures to notify members of the community served by SMMC 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. SMMC will include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the FAP and includes the telephone number of the 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. SMMC 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. SMMC 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. SMMC will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECA(s) that SMMC (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. SMMC 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 SMMC’s 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 SMMC’s FAP, SMMC may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, SMMC must satisfy several conditions. SMMC 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 SMMC
has already notified the patient about intended ECAs.

ii. If SMMC 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. SMMC will provide written notification that nothing is owed if a patient is determined to be eligible
for Free Care.

p. SMMC 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. SMMC will implement billing and collection practices for patient payment obligations that are fair,
consistent and compliant with state and federal regulations.

b. SMMC 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. SMMC will also offer a loan program for
patients who qualify.

c. SMMC 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 SMMC 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 SMMC. 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 SMMC’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
SMMC’s FAP. An approval by the Trinity Health or SMMC 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 FAP. Placement of a lien requires approval by the Trinity Health or SMMC 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 SMMC’s Procedure. Trinity Health recommends protecting 50% of the equity up to $50,000.

e. SMMC (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, SMMC 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. SMMC (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. SMMC 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 SMMC 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 SMMC, 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 SMMC;

v. Trinity Health Legal Services must approve all terms and conditions of the engagement of attorneys to represent SMMC 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 SMMC, and any other matters related to resolution of the claim by the attorney shall be made by SMMC 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 SMMC representative as detailed in section (IV)(d)(v);

viii. SMMC reserves the right to discontinue collection actions at any time with respect to any specific account; and

ix. The collection agency must agree to indemnify SMMC for any violation of the terms of its written agreement with SMMC.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.
V. Implementation of Accurate and Consistent Policies
   a. Representatives of SMMC’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. SMMC will honor Financial Support commitments that were approved under previous financial assistance guidelines.

VI. Other Discounts
   a. Pre-Pay Discounts: SMMC will utilize a pre-pay discount program, for uninsured patients only, which will be limited to balances equal to or greater than $200.00 and will be 10% of the balance due. The pre-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. Prompt pay discounts apply to self-pay population. Additional accounts may qualify for approval by exception.
   b. Self-Pay Discounts: SMMC 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 largest commercial carrier.
   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 SMMC’s established approval levels.
   d. Self-Pay Discount Emergency Room Prompt Pay: SMMC will apply a standard self-pay rate for emergency Room visits paid at time of service or within three (3) days. Refer to Emergency Department Procedure.

Should any provision of this FAP conflict with the requirement of the law of the State of Pennsylvania, state law shall supersede the conflicting provision and SMMC 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 provided 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 SMMC 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 SMMC (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. SMMC 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 SMMC 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 SMMC’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 the FAP. SMMC 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, alimony, 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 the Pennsylvania 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 SMMC’s 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.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.
**Subsidiary** means a legal entity in which a Trinity Health RHM (SMMC) 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 Patient Accounting Department.

**RELATED POLICIES, PROCEDURES, AND OTHER MATERIALS**
- Trinity Health Revenue Excellence Policy No. 1: “Financial Assistance to Patients” (“FAP”)
  intranet.trinity-health.org/web/policies-procedures/table-of-contents#finance
- Trinity Health Revenue Excellence Policy No. 2: “Payment of QHP Premiums and Patient Payables”
  intranet.trinity-health.org/web/policies-procedures/table-of-contents#finance
- 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