PROCEDURE TITLE:

Financial Assistance to Patients

☒ The Mercy Hospital, Inc.

EFFECTIVE DATE: September 3, 2020

To be reviewed every three years by:
Revenue Excellence Integrity Committee

REVIEW BY: October 1, 2023

PROCEDURE

Sisters of Providence Health System, Inc. (SPHS) 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 through Sisters of Providence Health System, Inc and its ministries. It applies to all eligible services as provided under applicable state or federal law. Ministries 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 SPHS 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.

Sisters of Providence Health System, Inc. (SPHS) 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. Sisters of Providence Health System, Inc. 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 on implementing the accompanying Mirror Policy of the same name, balances financial assistance with broader fiscal responsibilities and provides SPHS with the Trinity Health requirements for financial assistance for physician, acute care and post-acute health care services.
Each Ministry will adopt the System Mirror Policy “Financial Assistance to Patients” and develop local operating procedures in compliance with these requirements.

SPHS is committed to providing high-quality care and services. As part of this commitment SPHS works with individuals with limited incomes and resources to find coverage for their care. Our financial assistance program helps low-income, uninsured, and underinsured individuals determine if they are eligible for public assistance or any other sources of financial assistance. SPHS understands that each individual has a unique financial situation and encourage our patients to contact our Certified Application Counselors for more information at 413-748-9357, between 8AM and 4PM, Monday through Friday. Each request for assistance is handled confidentially and requires the cooperation of the applicant. More information on applying for this program can also be found on our website at: https://www.trinityhealthofne.org/location/mercy-medical-center

This Financial Assistance procedure applies to SPHS and all affiliated entities.
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 SPHS, will be eligible for Financial Support.
   
ii. Emergency medical care services will be provided to all patients who present to SPHS 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 SPHS (e.g. independent physician services, private duty nursing, ambulance transport, etc.).
   
iii. As provided in Section II, SPHS will proactively help patients apply for public and private programs. SPHS may deny Financial Support to those individuals who do not cooperate in applying for programs that may pay for their health care services.
   
iv. SPHS may exclude services that are covered by an insurance program at another provider location but are not covered at SPHS 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. SPHS may decline to provide a patient with non-emergent, non-urgent services in those cases when SPHS is unable to identify a payment source or eligibility in a financial assistance program. Such programs include MassHealth, ConnectoCare Children’s Medical Security Plan, Health Safety Net, and others. Choices related to the delivery and access to care is often defined in either the insurance carrier’s or the financial assistance program’s coverage manual.
   

c. Residency Requirements
   
i. SPHS will provide Financial Support to patients who reside within their service areas and who qualify under the SPHS’ FAP procedure.
   
ii. SPHS may identify Service Areas in their FAP and include Service Area information in procedure design and training SPHS with a Service Area residency requirement will start with the list of zip codes provided by System Office Strategic Planning that define the SPHS’s service areas. SPHS will verify service areas in consultation with their local Community Benefit department. Eligibility will be determined by SPHS using the patient’s primary residence zip code.
iii. SPHS will provide Financial Support to patients from outside their Service Areas who qualify under the SPHS’s FAP and who present with an Urgent, Emergent or life-threatening condition.

iv. SPHS 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 SPHS’s President or designee.

d. Documentation for Establishing Income

i. Information provided to SPHS 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.

ii. SPHS 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. SPHS 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. SPHS 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. SPHS 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 SPHS provided the first post-discharge billing statement for the care. SPHS must process the FAP application if the patient provides the missing information/documentation during the 240-day application period (or, if later, within the 30-day resubmission period).

e. Consideration of Patient Assets

i. SPHS 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 SPHS’s FAP.
Protected Assets:

- Equity in primary residence up to an amount determined by the SPHS. Trinity Health recommends protecting 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, SPHS may count the excess available assets as current year Income in establishing the level of discount to be offered to the patient. A minimum amount of available assets should be protected. The minimum amount is determined by the SPHS. Trinity Health recommends the minimum amount be set at $5,000.

f. Presumptive Support

i. SPHS 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 SPHS 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 to systematically identify financially SPHS 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 SPHS to make an informed decision on the financial need of non-responsive patients.

iv. For the purpose of helping financially disadvantaged 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 SPHS 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 disadvantaged 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 the SPHS’s bad debt expense.

vii. SPHS 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, SPHS 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 SPHS provided the first post-discharge billing statement for the care. SPHS
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 Trinity Health staff, such as financial counselors and contracted vendors, such as Medicaid enrollment and financial counselors, should administer the assessment process of Financial Support. 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:

(a) 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

(b) the deadline provided in a written notice after which ECAs may be initiated.

SPHS 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 SPHS’s established approval levels.

ii. SPHS (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 determination of Financial Support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted. Determinations of Financial Support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted. SPHS provides patients with information about the availability of financial assistance programs that are available through the Commonwealth of Massachusetts, which may cover all or some of their unpaid hospital bill. For those patients that request such assistance, SPHS assists patients, by screening them for eligibility, as well as helping them apply for the program. SPHS has no role in specifically determining the eligibility for enrollment within a public assistance program. In Massachusetts, individuals apply for coverage in MassHealth, the premium assistance payment program offered through the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical
Security Program, or Medical Hardship must do so through a single uniform application that is submitted through the state’s new enrollment system called the Health Insurance Exchange (HIX). Through this process, the individual can submit an application through an online website (which is centrally located on the state’s Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from the hospital’s certified application counselor with submitting the application either on the website or through a paper application. In order to apply for coverage, the following process occurs:

1. An individual is requested to develop an online account for use by the state to conduct an identity verification of the individual. Once this is completed, the individual is then able to submit a completed application through the hCentive system on the Connector Website. If the individual does not want to go through the online identity verification system, they can submit a paper application. Other verification may still be needed, including proof of income, residency and citizenship.

2. Once the application is received, the state will verify the eligibility by comparing the individuals financial and other demographic information to a federal data site as well as conducting an income review using a modified adjusted gross income review. If necessary, the individual will also submit additional verification as requested by the system. Once this occurs, the individual is deemed:
   a. Eligible for MassHealth coverage, upon which the individual is notified by mail from MassHealth, which includes eligibility information including start date and other pertinent information; or
   b. If the individual is eligible for a qualified health plan through the Health Connector Program, they are notified of their eligibility and directed to take additional steps. This includes: (1) choosing a plan, (2) paying their monthly premium, (3) enrolling and receiving their proof of coverage.

More information regarding the MassHealth and Connector program benefits and application process can be found at www.mass.gov/masshealth and www.mahealthconnector.org.

Assisting Individuals seeking coverage through a Massachusetts public assistance program:

For those individuals who are uninsured or underinsured, SPHS will work with them to assist with applying for available financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate financial assistance programs, the hospital will provide all individuals with a general notice of the availability of programs in both the bills that are sent to individuals as well as in general notices that are posted throughout the hospital. The goal of these notices is to assist individuals in applying for coverage within a public assistance program, including MassHealth, premium assistance payment program offered through the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship.

Role of Hospital Certified Application Counselor
SPHS provides individuals with information about financial assistance programs that are available through the Commonwealth of Massachusetts. By contracting with the Executive Office of Health and Human Services (MassHealth) and the Commonwealth Health Insurance Connector Authority (Connector) SPHS has been deemed a Certified Application Counselor Organization. Through this authority, SPHS works with its staff, contractors and volunteers to be trained in the eligibility and benefit rules and regulations and be certified as a Certified Application Counselor (CAC) to assist individual with enrollment in MassHealth, premium assistance payment program offered by the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship.

As a Certified Application Counselor (CAC), the hospital staff will inform the individual of the functions and responsibility of a CAC, seek that the individual sign a Certified Application Counselor Designation Form, and assist the individual find applicable public assistance by:

a) providing information about the full range of programs, including MassHealth, premium assistance payment program offered by the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship;

b) helping individuals complete an application or renewal;

c) working with the individual to provide required documentation;

d) submitting applications and renewals to the specific programs;

e) interacting, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;

f) helping to facilitate enrollment of applicants or beneficiaries in Insurance Programs; and

g) offer and provide voter registration assistance.

It is the individual’s obligation to provide SPHS with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current insurance coverage options (including motor vehicle liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual.

If there is no specific coverage for the services provided, SPHS will work with the patient to determine if a different state program option, such as applying for Medical Hardship through the Health Safety Net, would be available following the Health Safety Net regulations. It is the patient’s obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. SPHS will endeavor to submit the total and completed application within five (5) business days of receiving all necessary information from the patient. If the total and completed application is not submitted within five business days of receiving all necessary information in the timeframe requested by the hospital, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

If the individual or guarantor is unable to provide the necessary information, SPHS may (at the individual’s request) make reasonable efforts to obtain any additional information from other sources. Such efforts also include working with individuals, when requested by the individual, to determine if a bill for services should be sent to the individual to assist with meeting the One-time Deductible. This will occur when the individual is scheduling their
services, during pre-registration, while the individual is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the hospital obtains will be maintained in accordance with applicable federal and state privacy and security laws.

SPHS will also conduct reasonable efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner’s liability policy, (2) general accident or personal injury protection policies, (3) worker’s compensation programs, (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where the hospital's reasonable efforts resulted in a payment from such sources listed above, the hospital works with each individual to notify them of their responsibility to report the payment and offset it against any claim made to MassHealth, the Health Safety Net, or other applicable programs.

iv. If a patient is deemed eligible for governmental assistance, but the coverage does not satisfy all the patient’s financial obligations (i.e., Medicaid Spend down, Medicaid Emergency Services Only (ESO)), SPHS may assume if the state Medicaid covers patients whose Income is at or less than 200% of the Federal Poverty Level (FPL) then the patient would meet Presumptive Eligibility requirements. Therefore, no additional documentation or verifications are required by the patient.

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

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, 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. SPHS 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 SPHS to large financial risks and a financial burden which could threaten the SPHS’s long-term ability to provide high quality care. SPHS 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:

(a) A discount off of total charges equal to the SPHS’s average acute care contractual adjustment for Medicare will be provided for uninsured acute care patients whose Family Income is between 201% and 400% of the Federal Poverty Level Guidelines.

(b) A discount off of total charges equal to the SPHS’s physician contractual adjustment for Medicare will be provided for uninsured ambulatory location patients whose Family Income is between 201% and 400% of Federal Poverty Level Guidelines.

(c) The SPHS’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 SPHS 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 SPHS’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 SPHS’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 SPHS’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 SPHSCFO and reported to the System Office.
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 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 “Operational Adjustments – Administrative”.

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

b. SPHS will respond promptly and courteously to patients’ questions about their bills and requests for financial assistance.
c. SPHS will utilize a billing process that is clear, concise, correct and patient friendly.

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

e. SPHS 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 SPHS and list those public locations in the SPHS’s FAP. SPHS will post a notice (signs) of availability of financial assistance as outlined in this credit and collection policy in the following locations:

- All Service Delivery Areas (Inpatient, Clinic, Emergency, Admission and/or Outpatient areas).
- All Financial Counseling Offices located throughout the Clinical Campuses
- All Certified Application Counselor offices
- Affiliated Physician Practices

Posted 8 1/2x11 signs will be clearly visible and legible to patients visiting these areas. SPHS will also include a notice about the availability of financial assistance in all initial bills.

When an individual contacts SPHS, the CACs will attempt to identify if an individual qualifies for a public assistance program or any other financial assistance. An individual who is enrolled in a public assistance program may qualify for certain benefits. Individuals may also qualify for additional assistance based on the hospital’s own internal criteria for financial assistance.

All signs and notices shall be translated into languages other than English if such language is primarily spoken by 5% or more of the residents in the hospital service area, which is based on the hospital admissions and/or discharge information.

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

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

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

p. SPHS 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. Presumptive Eligibility

a. If a patient is deemed eligible for Medicaid, that will qualify as varication of eligibility for Financial Assistance

b. Financial Assistance eligibility will be applied toward all months, current and retrospective, that a patient is deemed eligible for Medicaid

c. In the event that a patient is deemed eligible for a state specific Medicaid program that’s income eligibility guidelines are greater than this policy, then Medicaid will be deemed an acceptable form of income verification

d. Although Medicaid eligibility can be applied as a presumptive for Financial
Assistance, every effort should be made to secure a signed Financial Assistance policy on behalf of the patient.

V. **Fair Billing and Collection Practices**

a. SPHS will implement billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations. It is ultimately the patient’s obligation to keep track of and pay timely their unpaid hospital bill, including any existing co-payments, co-insurances, and deductibles. The patient is further required to inform either their current health insurer (if they have one) or the agency that determined the patient’s eligibility status a public program of any changes in family income or insurance status. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in Family Income or insurance status, but only if the hospital is made aware by the patient of facts that may indicate a change in the patient's eligibility status.

Patients are required to notify the applicable public program in which they are enrolled (e.g. Office of Medicaid and the Health Safety Net) of any information related to a change in family income. Patients are also required to notify the applicable public program in which they are enrolled (e.g. Office of Medicaid and the Health Safety Net) of any lawsuit or insurance claim that may cover the cost of the services provided by the hospital, within 10 days of filing the claim. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the applicable public program, such as the Office of Medicaid or the Health Safety Net.

SPHS will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner’s liability policy, (2) general accident or personal injury protection policies, (3) worker’s compensation programs, (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where the hospital's reasonable and diligent efforts resulted in a payment from a private insurer or public program, SPHS will report the payment and offset it against any claim that may have been paid by the private insurer or public program. For state public assistance programs, the hospital is not required to secure assignment on a patient's right to a third party coverage on services provided due to an accident. In these cases the State of Massachusetts will attempt to seek assignment on the costs of the services provided to the patient and which was paid for by either the Office of Medicaid or the Health Safety Net.

SPHS further maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

SPHS makes the same reasonable effort and follows the same reasonable process for collecting on bills owed by an uninsured patient as it does for all other patients. SPHS will first show that it has a current unpaid patient balance that is related to services provided to the patient and not covered by an insurer or a financial assistance program. SPHS follows reasonable collection/billing procedures, which include:
1. An initial bill sent to the patient or the party responsible (guarantor) for the patient’s personal financial obligations. The initial bill will include information regarding the availability of a financial assistance program that might be able to cover the cost of the hospital bill and payment plans for the uninsured;
2. Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance;
3. If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as “incorrect address” or “undeliverable;”
4. Sending a final notice by certified mail for uninsured patients (those who are not enrolled in a public program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over $1,000 on Emergency Level Services only, where notices have not been returned as “incorrect address” or “undeliverable”, and also notifying the patients of the availability of financial assistance in the communication;
5. Documentation of continuous billing or collection action undertaken on a regular, frequent basis is maintained. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported. The federal Medicare program and the state Division of Healthcare Finance and Policy, for purposes of the Health Safety Net program, deems 120 days as appropriate for period of time representing continuous billing or collection actions.
6. Checking the Medicaid Management Information System (MMIS) to ensure that the patient is not a Low Income Patient as determined by the Office of Medicaid, and has not submitted an application through the Health Insurance Exchange (HIX) for coverage of the service under a public program, prior to submitting claims to the Health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.

Patients who are eligible for enrollment in a state public assistance program, like the Massachusetts MassHealth or Health Safety Net programs, are deemed enrolled in a financial assistance program. For all patients who are enrolled in these state public assistance programs, SPHS may only bill those patients for the specific co-payment, coinsurance, or deductible that is outlined in the applicable state regulations and which may further be indicated on the state Medicaid Management Information System.

SPHS will seek a specified payment for those patients who do not qualify for enrollment in a public assistance program, such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program. For these patients, the payment amount will be reduced by the percentage designated within our internal financial assistance program.

Populations Exempt from Collection Activities

The following individuals and patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:

a. Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children, Children’s
Medical Security Plan, “Low Income Patients” as determined by the Office of Medicaid-subject to the following exceptions:

1. SPHS may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program;

2. SPHS may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) SPHS shall cease its billing or collection activities;

3. SPHS may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated, expired, or not otherwise identified on the state Medicaid Management Information System (MMIS). However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain ConnectorCare programs, SPHS will cease collection activity for services provided prior to the beginning of their eligibility.

4. SPHS may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the hospital obtained the patient’s prior written consent to be billed for the service.

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

c. SPHS 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. SPHS 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. SPHS will not undertake any “extraordinary collection activities” until such time as SPHS has made a reasonable effort and followed a reasonable review of the patient’s financial status, which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. SPHS will keep any and all documentation that was used in this determination pursuant to the hospital’s applicable record retention policy.

SPHS will not undertake collection action against an individual who has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution. The hospital will further cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program. SPHS will also cease any collection efforts when the provider fails to timely submit a Medical Hardship application.
SPHS will not garnish a Low Income Patient’s (as determined by the Office of Medicaid) or their guarantor’s wages or execute a lien on the Low Income Patient’s or their guarantor’s personal residence or motor vehicle unless: (1) the hospital can show that the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, or (3) for purposes of the lien, it was approved by the Hospital’s Board of Trustees on an individual case by case basis.

SPHS and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order, provided that the state of Massachusetts will file its own recovery action for those patients enrolled in MassHealth or the Health Safety Net. SPHS and its agents will also not charge interest on an overdue balance for any patients including Low Income Patients.

SPHS maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that SPHS determines was the result of a Serious Reportable Event (SRE). SREs that do not occur at SPHS are excluded from this determination of non-payment. SPHS does not seek payment from a low income patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the hospital.

d. The following collection activities may be pursued by SPHS 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 SPHS. 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 SPHS’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 SPHS’s FAP. An approval by the Trinity Health or Sister’s of Providence Health System, Inc. CEO/CFO, or the functional leader for Patient Financial Services for those SPHS 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 SPHS’s FAP. Placement of a lien requires approval by the Trinity Health or Sister’s of Providence Health System, Inc. CEO/CFO, or the functional leader for Patient Financial Services for those SPHS 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 Ministry’s Procedure. Trinity Health recommends protecting 50% of the equity up to $50,000.

f. SPHS (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, SPHS 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.

g. SPHS (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.

h. SPHS requires that any outside collection agency that it uses is licensed by the state of Massachusetts and that the outside collection agency also is in compliance with the Massachusetts Attorney General’s Debt Collection Regulations at 940 C.M.R. 7.00.

i. SPHS and the outside collection agencies it contracts with do not report unpaid patient debt to credit reporting agencies. Additionally, SPHS does not sell patients’ debt.

j. SPHS 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 SPHS 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 SPHS, 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 SPHS;

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

viii. SPHS 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 SPHS for any violation of the terms of its written agreement with the SPHS.
VI. Implementation of Accurate and Consistent Policies

a. Representatives of SPHS’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. SPHS will honor Financial Support commitments that were approved under previous financial assistance guidelines.

V. Deposits and Installment Plans

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either (1) determined to be a “Low Income Patient” or (2) qualify for Medical Hardship, SPHS will provide the patient with information on deposits and payment plans based on the patient’s documented financial situation. Any other plan will be based on the hospital’s own internal financial assistance program, and will not apply to patients who have the ability to pay.

Emergency Services
SPHS will not require pre-admission and/or pre-treatment deposits from individuals who require Emergency Level Services or who are determined to be Low Income Patients.

Low Income Patient Deposits
SPHS may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the Deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 13.08.

Deposits for Medical Hardship Patients
SPHS may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 13.08.

VI. Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program

An individual with a balance of $1,000 or less, after initial deposit, will be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than $25. A patient, who has a balance of more than $1,000, after initial deposit, will be offered at least a two-year interest free payment plan.

VII. Deposits for Other Patient Types:

SPHS reserves the right to request advance deposits in the following instances:

☐ Patients who receive elective cosmetic or non-medically necessary services may be required to pay an amount equal to 100% of expected charge prior to service.
Patients traveling from foreign countries to SPHS for treatment may be required to pay the full estimated bill in advance.
Insured patients (non-emergent) with co-insurance and deductible responsibilities may be required to pay such amount, or secure them via a credit card, prior to, or at the time of service.

VII. Other Discounts

a. Pre-Pay Discounts: SPHS 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.

b. Self-Pay Discounts: SPHS will apply a standard 45% self-pay discount off of charges for all registered self-pay patients, that are uninsured based on the highest commercial rate paid, calculated by RHM. In addition, a 10 % Prompt-Pay discount can apply, if uninsured patient is able to pay prior to services, or three (3) days after emergency visit determined by RHM.

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 SPHS’s established approval levels.

Should any provision of this FAP conflict with the requirement of the law of the state in which Sister’s of Providence Health System, Inc. operates, state law shall supersede the conflicting provision and SPHS shall act in conformance with applicable state law.

SCOPE/APPLICABILITY

This Procedure applies to all Sister’s of Providence Health System, Inc. affiliated entities 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 Of New England 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.

SPHS upon request will provide by appendix a list of the names of providers by reference to the practice group that provides emergency and/or medically necessary care within SPHS. This list is available upon request through the Financial Counseling Department.

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, SPHS’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). Emergency services are medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd) qualifies as an Emergency Level Service.

**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 Ministry (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 Ministry 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 SPHS 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 SPHS’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 Ministry’s FAP. SPHS 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 Ministry’s state’s Medicaid Provider Manual.

Ministry 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. A ministry may be based on a geographic market or dedication to a service line or business. SPHS include Mission Health Ministries, National Health Ministries, and Regional Health Ministries.

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 Sisters of Providence Health System, Inc. that maintains a governing body that has day-to-day management oversight of a designated portion of Sisters of Providence Health System, Inc. System operations. SPHS 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 Ministry’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.

**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

- Finance Policy No. 1: Financial Assistance to Patients (“FAP”)
• Finance Policy No. 7: Payment of QHP Premiums and Patient Payables
• 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 I
• Individual Ministry’s EMTALA Policies

APPROVALS

Initial Approval: April 1, 2014

Subsequent Review/Revision(s): October 15, 2015, July 10, 2017, September 3, 2020