
EFFECTIVE DATE: *April 6, 2022***PROCEDURE TITLE:***Financial Assistance to Patients**To be reviewed every three years by:
Revenue Excellence Integrity Committee***REVIEW BY:** *May 1, 2025*

PROCEDURE

Trinity Health Ministries 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 Trinity Health and its Health Ministries. It applies to all eligible services as provided under applicable state or federal law. Health 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 the Health Ministry 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.

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

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

This Procedure, which provides guidance on implementing the accompanying Mirror Policy of the same name, balances financial assistance with broader fiscal responsibilities and provides Health Ministries with the Trinity Health requirements for financial assistance for physician, acute care and post-acute health care services. Each Health Ministry will adopt the System Mirror Policy

“Financial Assistance to Patients” and develop local operating procedures in compliance with these requirements.

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 Health Ministry, will be eligible for Financial Support.
- ii. Emergency medical care services will be provided to all patients who present to the Health Ministry’s hospital 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.
- iii. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs.
- iv. Charges for patients that have exceeded the length of stay for Medicaid or other indigent care programs.

b. Services Not Eligible for Financial Support:

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

c. Residency Requirements

- i. Health Ministries will provide Financial Support to patients who reside within their Service Areas and who qualify under the Health Ministries’ FAP procedure.

- ii. Health Ministries may identify Service Areas in their FAP and include Service Area information in procedure design and training Health Ministries with a Service Area residency requirement will start with the list of zip codes provided by System Office Strategic Planning that define the Health Ministry's Service Areas. Health Ministries will verify Service Areas in consultation with their local Community Benefit department. Eligibility will be determined by the Health Ministry using the patient's primary residence zip code.
 - iii. Health Ministries will provide Financial Support to patients from outside their Service Areas who qualify under the Health Ministry FAP and who present with an Urgent, Emergent or life-threatening condition.
 - iv. Health Ministries 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 Health Ministry's President or designee.
- d. Documentation for Establishing Income
 - i. Information provided to the Health Ministry 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. Health Ministries 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. Health Ministries 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. Health Ministries 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. Health Ministries may initiate Extraordinary Collection Actions (ECAs) if the patient does not submit the missing information and/or documentation within the 30-day resubmission period and it is at least 120 days from the date the Health Ministry provided the first post-discharge billing statement for the care. Health Ministries 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

Health Ministries will not utilize Patient Assets in consideration of patient Financial Assistance.

f. Presumptive Support

- i. Health Ministries 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 Health Ministries to identify patients who may qualify for financial assistance prior to initiating collection actions, i.e. write-off of a patient account to bad debt and referral to collection agency. This predictive model enables Trinity Health Ministries 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 the Health Ministry 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 the Health Ministry 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 Health Ministry's bad debt expense.
- vii. Health Ministries 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, Health Ministries may initiate or resume ECAs if the patient does not apply for more generous assistance within 30 days of notification if it is at least 120 days from the date the Health Ministry provided the first post-discharge billing statement for the care. Health Ministries will process any new FAP application that the patient submits by the end of the Application Period or, if later, by the end of the 30-day period given to apply for more generous assistance.

g. Timeline for Establishing Financial Eligibility

- i. Every effort should be made to determine a patient's eligibility for Financial Support prior to or at the time of admission or service. 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.

Health Ministries 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 Health Ministry's established approval levels.

- ii. Health Ministries (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. 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.
- 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)), the Health Ministry 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. Health Ministries will make every effort to make a Financial Support determination in a timely fashion. If other avenues of Financial Support are being pursued, the Health Ministry 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 Health Ministry.

h. Level of Financial Support

- i. Each Health Ministry 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. Health Ministries 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 Health Ministries to large

financial risks and a financial burden which could threaten the Health Ministry's long-term ability to provide high quality care. Health Ministries 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 Health Ministry'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 Health Ministry'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 Health Ministry'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 Health Ministry 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 that otherwise exceeds the financial eligibility requirements for Free Care or Discounted Care under the Health Ministry'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 and medical expenses. 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, co-insurances, and deductibles for catastrophic charity care assistance. Discounts for medically indigent care for the uninsured will not be less than the Health Ministry'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 Health Ministry CFO and reported to the System Office Chief Financial Officer.

- vii. While Financial Support should be made in accordance with the Health Ministry's established written criteria, it is recognized that occasionally there will be a need for granting additional Financial Support to patients based upon individual considerations. Such individual considerations will be approved by the Health Ministry CFO and reported to the System Office Chief Financial Officer.

- i. Accounting and Reporting for Financial Support

- i. In accordance with the Generally Accepted Accounting Principles, Financial Support provided by Trinity Health is recorded systematically and accurately in the financial statements as a deduction from revenue in the category "Charity Care." For the purposes of Community Benefit reporting, charity care is reported at estimated cost associated with the provision of "Charity Care" services in accordance with the Catholic Health Association.
- ii. The following guidelines are provided for the financial statement recording of Financial Support:
 - (a) Financial Support provided to patients under the provisions of the "Financial Assistance Program", including the adjustment correlated with amounts generally accepted as payment for patients with insurance, will be recorded under "Charity Care Allowance."
 - (b) 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."
 - (c) Pre-Pay discounts will be recorded under "Contractual Allowance".
 - (d) 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. Health Ministries 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. Health Ministries will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the Health Ministry’s FAP.

III. Effective Communications

- a. Health Ministries will provide financial counseling to patients about their health care bills related to the services they receive from the Health Ministry and will make the availability of such counseling known.
- b. Health Ministries will respond promptly and courteously to patients’ questions about their bills and requests for financial assistance.
- c. Health Ministries will utilize a billing process that is clear, concise, correct and patient friendly.
- d. Health Ministries will make available information about charges for services they provide in an understandable format.
- e. Health Ministries will post signs and display brochures that provide basic information about their FAP in public locations (at a minimum, the emergency room (if any) and admission areas) in the Health Ministry and list those public locations in the Health Ministry’s FAP. Level of communication including; size of font, language(s) of communication, exact locations, should be determined by local state Medicaid guidelines for financial assistance communication.
- f. Health Ministries 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 Health Ministry 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. Health Ministries 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 Health Ministry, by mail and on the Health Ministry website. Any individual with access

to the Internet must be able to view, download and print a hard copy of these documents. The Health Ministry 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. Health Ministries will list the names of individual doctors, practice groups, or any other entities that are providing emergency or medically necessary care in the Health Ministry'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 Health Ministry'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 Health Ministry.
- j. Health Ministries will take measures to notify members of the community served by the Health Ministry 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. Health Ministries will include a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the Health Ministry's FAP and includes the telephone number of the Health Ministry'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. Health Ministries 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. Health Ministries 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. Health Ministries will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the ECA(s) that the Health Ministry (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. Health Ministries 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 Health

Ministry'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 Health Ministry's FAP, the Health Ministry may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, a Health Ministry must satisfy several conditions. The Health Ministry must:
 - i. Provide the patient with an FAP application form (to ensure the patient may apply immediately, if necessary) and notify the patient in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital facility will no longer accept and process an FAP application submitted by the patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written (and oral) notice is provided, the patient must be afforded at least 30 days after the notice to submit an FAP application for the previously provided care.
 - ii. Notify the patient about the FAP by providing a Plain Language Summary of the FAP and by orally notifying the patient about the hospital facility's FAP and about how the patient may obtain assistance with the FAP application process.
 - iii. Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

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

- i. If 120 days have passed since the first post-discharge bill for the previously provided care and the Health Ministry has already notified the patient about intended ECAs.
 - ii. If a Health 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. Health Ministries will provide written notification that nothing is owed if a patient is determined to be eligible for Free Care.
- p. Health Ministries 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 verification 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 application on behalf of the patient.

V. Fair Billing and Collection Practices

- a. Health Ministries will implement billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations.
- b. Health Ministries 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. Health Ministries will also offer a loan program for patients who qualify.
- c. Health Ministries will have written procedures outlining when and under whose authority a patient debt is advanced for external collection activities that are consistent with this Procedure.
- d. The following collection activities may be pursued by the Trinity Health Ministry 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 Health Ministry. 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 Health Ministry'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 Health Ministry's FAP. An approval by the Trinity Health or Health Ministry CEO/CFO, or the functional leader for Patient Financial Services for those Health Ministries 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 Health Ministry's FAP. Placement of a lien requires approval by the Trinity Health or Health Ministry CEO/CFO, or the functional leader for Patient Financial Services for those Health Ministries 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 Health Ministry's Procedure. Trinity Health recommends protecting 50% of the equity up to \$50,000.
- e. Health Ministries (or a collection agent on their behalf) shall not pursue action against the debtor's person, such as arrest warrants or "body attachments." Trinity Health recognizes that a court of law may impose an arrest warrant or other similar action against a defendant for failure to comply with a court's order or for other violations of law related to a collection effort. While in extreme cases of willful avoidance and failure to pay a justly due amount when adequate resources are available to do so, a court order may be issued; in general, the Health Ministry 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. Health Ministries (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. Health Ministries may have a System Office approved arrangement with a collection agency, provided that such agreement meets the following criteria:
 - i. The agreement with a collection agency must be in writing;

- ii. Neither the Health Ministry 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 Health Ministry, 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 Health Ministry;
- v. Trinity Health Legal Services must approve all terms and conditions of the engagement of attorneys to represent the Health Ministry in collection of patient accounts;
- vi. All decisions as to the manner in which the claim is to be handled by the attorney, whether suit is to be brought, whether the claim is to be compromised or settled, whether the claim is to be returned to the Health Ministry, and any other matters related to resolution of the claim by the attorney shall be made by the Health Ministry 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 Health Ministry representative as detailed in section V;
- viii. The Health Ministry must reserve the right to discontinue collection actions at any time with respect to any specific account; and
- ix. The collection agency must agree to indemnify the Health Ministry for any violation of the terms of its written agreement with the Health Ministry.

VI. Implementation of Accurate and Consistent Policies

- a. Representatives of the Health Ministry'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. Health Ministries will honor Financial Support commitments that were approved under previous financial assistance guidelines.

VII. Other Discounts

- a. **Pre-Pay Discounts:** Health Ministries 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:** Health Ministries will apply a standard self-pay discount off of charges for all registered self-pay patients, that are uninsured and do not qualify for financial assistance, based on the highest commercial rate paid, calculated by the Health Ministry. In addition, Pre-Pay discounts can apply, if Uninsured Patient is able to pay prior to services or at time of services.
- c. **Additional Discounts:** Adjustments in excess of the percentage discounts described in this Procedure may be made on a case-by-case basis upon an evaluation of the collectability of the account and authorized by the Health Ministry's established approval levels.

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

SCOPE/APPLICABILITY

This Procedure applies to all Trinity Health Ministries 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 Ministries 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 Health Ministry'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 Health Ministry 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).

Extraordinary Collection Actions (“ECA”) include the following actions taken by a Health 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 Health 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 the Health Ministry 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 Health Ministry’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 Health Ministry’s FAP. Health Ministries 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.

Health Ministry (sometimes referred to as 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 Health Ministry may be based on a geographic market or dedication to a service line or business. Health Ministries include Mission Health Ministries, National Health Ministries, and Regional Health Ministries.

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.

Policy means a statement of high-level direction on matters of strategic importance to Trinity Health, its Health Ministries and Subsidiaries or a statement that further interprets Trinity Health's, its Health Ministries' and Subsidiaries' governing documents. System Policies may be either stand alone, Systemwide 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 Amounts Generally Billed (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.

Service Area means an aggregate list of zip codes across all Trinity Health Ministries' service market areas 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 Ministry 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 1
- Individual Health Ministry's EMTALA Policies

APPROVALS

Initial Approval: April 1, 2014

Subsequent Review/Revision(s): October 15, 2015, July 10, 2017, September 3, 2020, April 6, 2022