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Financial Assistance

Policy Statement:

This policy sets forth guidelines used by Blessing Health System (BHS) entities to evaluate whether patients need financial assistance, while ensuring that BHS adheres to its mission and values in providing sound stewardship of its financial resources.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with BHS procedures for obtaining financial assistance or other forms of payment, and to contribute to the cost of their care based on their ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow BHS entities to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Trustees establishes the following guidelines for the provision of patient charity.

Blessing Health System (BHS) will work to identify patients in need of financial assistance and determine availability of financial assistance to patients on an individual basis, according to the following:

1. Provision of partially discounted services and full financial assistance will be based solely on a patient's ability to pay and not on the basis of race, color, national origin, age, disability, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, or because all or part of an individual's income is derived from any public assistance program.
2. Emergency admission, treatment, screening and/or stabilization services provided in an emergency room setting will not be delayed or denied due to lack of insurance or other third-party coverage or a patient's financial ability to pay.
3. The necessity for and availability of financial assistance may be determined at any time with all reasonable efforts being made first to determine whether other financial resources are

available to the patient.

4. Financial assistance will not be provided by any BHS entity for non-medically necessary services such as, but not limited to:
    a. Chiropractic Services performed in a Chiropractors Office
    b. Cosmetic surgery
    c. Services provided for patient convenience, or for social, educational, custodial and related purposes
    d. Services considered not medically necessary under Title XVIII of the Federal Social Security Act
    e. Services that could have been safely performed in another facility free of charge, but were knowingly refused by the patient
    f. Any procedure not covered by third-party insurance, despite being medically necessary, due to patient's failure to follow insurance payer guidelines and procedures. Patient will not be charged more for emergency or other medically necessary care than the amounts generally billed to the individuals who have insurance covering such care

Blessing Health System's Financial Assistance Policy does not apply to the portion of services that have been, or may be, paid for by a first or third party such as an automobile insurance company. As allowed by the State of Illinois, when a patient presents for services following an accident or injury, Blessing Health System may place a hospital lien against the third party settlement.

Scope:

X	Blessing Corporate Services ("BCS")		Current Health Solutions ("CHS")
	Blessing Foundation		Denman Services ("Denman")
X	Blessing Hospital ("BH")		Hannibal Clinic ("HC")
X	Blessing Physician Services ("BPS")	X	Illini Community Hospital ("Illini")
	Crossriver Quality Health Partners ("CQHP")		Rivercross Diagnostics

Definitions:

Adjusted Gross Income: gross income minus adjustments to income per IRS guidelines. Line 8b if filing Form 1040 and 1040SR.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. Under Illinois law, a civil union is a legal relationship between two persons of the same or opposite sex. Parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded to spouses by the law in Illinois. The Act recognizes civil unions or marriages legally entered into other jurisdictions. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance. A civil union can file joint Illinois returns, but not Federal returns.

In cases of newborn, adoption or foster care, documentation including birth certificate and/or court order will meet criteria of dependent.

In cases of separation of marriage, legal documentation will meet criteria of separation.

Bad Debt: An account that is uncollectible from a patient, although the patient has or may have the ability to pay, resulting in a credit loss for the hospital, clinic, or other healthcare facility.

Federal Poverty Income Guidelines (FPIG): Guidelines developed and published annually by the Department of Health and Human Services, which account for the previous calendar year's inflation increase in prices as measured by the Consumer Price Index.

Catastrophic Medical Indigence: This occurs when an uninsured or underinsured patient incurs BHS medical bills exceeding 20% of the patient's total reported family income as defined below. Patients experiencing Catastrophic Medical Indigence are eligible for an 85% one time discount and ongoing full financial assistance for following 12 months.

Collection Action: Any referral of a bill to a collection agency or law firm to collect payment for services rendered by a BHS entity from a patient or a patient's guarantor for healthcare services.

Copayment "Coinsurance": The portion of the cost of an item or service which the beneficiary must pay.

Deductible: The amount that must be paid by a beneficiary before Medicare will pay for any items or services for that individual.

Financial Assistance: Healthcare services that have or will be provided but are never expected to result in cash inflows. Medical services provided at no charge or for a reduced charge to patients who do not have or cannot obtain adequate financial resources or other legal means to pay for their care and meet established criteria.

Financial Indigence: An uninsured or underinsured patient is financially indigent when the patient's total reported adjusted gross income is between 0% to 275% of the FPIG. Patients who are financially indigent are eligible for a 100% discount unless they qualify for catastrophic financial assistance then the discounted rate is due from the patient.

Healthcare Plan: A Healthcare Plan includes a health insurance company, health maintenance organization, preferred provider arrangement, or third party administrator authorized in the State of Illinois to issue policies or subscriber contracts or to administer those policies and contracts that reimburse for inpatient and outpatient healthcare services. A Healthcare Plan, however, does not include any government-funded program such as Medicare or Medicaid, workers' compensation or accident liability insurers.

Family Income: Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Adjusted gross income
- Social security
- Supplemental security income

- Unemployment compensation
- Worker's compensation
- Public assistance
- Alimony, child support, and military family allotments or other regular support received from an absent family member or someone not living in the household
- Private and government employee pensions
- Regular insurance or annuities Dividends and interest
- Net rental income

National Health Services Corps (NHSC): The NHSC builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care. Participating providers are required to provide care to patients regardless of their ability to pay for services and requires financial assistance eligiblity to solely be based on income and family size.

Out-of-Pocket Expense: The amount of medical expenses a patient must pay from his or her own income sources not paid or covered by an insurance plan.

Reasonable Installment Plan: A plan to pay outstanding medical bills offered to the patient or the patient's legal representative that takes into account the patient's available income, the amount owed, and any prior payments made.

Self-Pay: Self Pay individuals assume responsibility for payment of all medical bills that otherwise might be covered by an insurance policy.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third party assistance but still has out of pocket expenses that exceed his/her financial abilities.

Procedure:

BHS will communicate this policy to all patients using methods including, but not limited to:

1. Placing signs, applications, brochures, and other similar written materials in prominent patient locations throughout the facility, such as the Emergency Department (ED), Patient Financial Services (PFS), Patient Access (PA) and on the Blessing Website in English and any language that is the primary language of at least 5% of the total patients served annually by BHS entities.
2. Providing a Financial Assistance Plain Language Summary with all hospital patient final pre-collection notices. (See forms)
3. Designating staff members or a department to explain the policy to patients and/or account guarantors.
4. Providing the patient with financial assistance contact information, including application information, coverage issues and other third-party governmental programs.
5. Making available to the public upon request a copy of this policy, the application form and eligibility criteria.

BHS will provide an itemized bill at the patient's request.

BHS staff in PFS and PA, and those who regularly interact with patients, will be familiar with this policy and be able to direct questions regarding the policy to the proper BHS representative/department.

Types of Financial Assistance

BHS offers four types of financial assistance: assistance to patients who qualify for fully discounted services under BHS Guidelines for Financial Indigence and assistance to patients who are eligible to receive partial discounts under BHS Guidelines for Catastrophic Medical Indigence. The amount of assistance for which the patient qualifies is based on information provided by the patient as outlined below. BHS income guidelines are based on the U.S. Department of Health and Human Services (DHHS) FPIG (Attachment A), updated annually. In addition, BHS offers assistance to determine whether patients are eligible for government sponsored programs or other insurance coverage. BHS will also assist patients in setting up alternative payment arrangements if necessary and appropriate.

1. **Full Financial Assistance**
    a. Patient has reported income below 275% of the Federal Poverty Income Guidelines at Blessing Hospital, Blessing Physician Services, Blessing Health Hannibal, Blessing Health Keokuk Clinic or Illini Community Hospital.
    b. Patients will receive medications ordered by a Blessing Hospital, Blessing Health Hannibal or Illini Community Hospital provider at no cost at owned retail facilities.
        a. Pharmacy assistance exemptions:
            i. Medicaid and Medicare
2. **Catastrophic**
    a. Patient is eligible for catastrophic financial assistance if their income is greater than 275% of the Federal Poverty Guidelines and their medical bills exceed 20% of their total reported family income. See also, the definition of Catastrophic Medical Indigence above for more details.
    b. Uninsured patients are responsible for the remaining balance following the one time 85% discount of total charges. Patient will receive full financial assistance for following 6 months.
    c. Underinsured patients are responsible for the remaining balance following the health insurance remittance and 85% discount.
    d. Patients will receive medications ordered by a Blessing Hospital, Blessing Health Hannibal or Illini Community Hospital provider at no cost at owned retail facilities.
        a. Pharmacy assistance exemptions:
            i. Medicaid and Medicare
3. **Restricted Financial Assistance**
    a. Patient has reported income below 275% of the Federal Poverty Guidelines at Blessing Hospital, Blessing Physician Services, Blessing Health Hannibal, Blessing Health Keokuk Clinic or Illini Community Hospital.

b. Financial Assistance coverage is restricted to the State in which their insurance provides coverage.

c. All other requirements apply as listed under Full Financial Assistance section.

Patient Qualification and Eligibility

Eligibility for financial assistance is based upon an individual's or family's total income and family size. All sources of income will be defined by the census bureau definition of family income. Self-employment income shall equal adjusted gross income as reported on the individual's last Federal Tax return. Income will be compared to the BHS Schedule of Discounts based on the FPIG for the current year to determine if the patient is experiencing Catastrophic Medical Indigence or Financial Indigence.

External Assistance

Patients may qualify for one or more of the following types of assistance to pay their BHS account. The PFS department of the BHS entity to which the patient is indebted will assist the patient by providing applications and information, and making referrals for the following programs as applicable:

- Illinois Healthcare and Family Services
- Social Security Disability
- Rape/Crime Victims
- Crippled Children – The Illinois Division of Services
- Veterans Administration

Financial Assistance Application

General Application Guidelines

- No application for financial assistance will be required in advance for emergency medical treatment. Application to cover emergency treatment may be made after the service is provided. The application should be completed as soon as possible, keeping the patient's medical needs as the primary focus.
- It is crucial that financial assistance applicants cooperate with BHS by providing accurate and detailed information within a reasonable time. If necessary information is not legible, if the application is incomplete, or if false information is provided, financial assistance may be denied or the application may be returned to the applicant for additional information, at the sole discretion of BHS. Applications should contain the applicant's signature, but where that is not possible, the party making application must provide documentation demonstrating the applicant's intent to apply for financial assistance.
- An approved application for financial assistance may be used for previous active and eligible collection balances on accounts and any eligible accounts for the next (12) months unless legal action has been pursued.
- An approved application for financial assistance may be used to re-evaluate a patient's need for financial assistance for up to twelve (12) months following the original application approval date. Pertinent information shall be supplemented as needed.

- Patient Financial Services Representatives are available to assist in completion of the application.
    - Blessing Health Center (927 Broadway, Quincy, Illinois): Monday - Friday, 8:00am to 5:00pm
    - Blessing Health Hannibal (100 Medical Drive, Hannibal, Missouri): Monday - Friday, 8:00am to 5:00pm

Application Process

Verification of income and medical expenses may be requested to accompany the application.

Upon receipt of a completed application and necessary documentation, the PFS representatives will evaluate the financial assistance application and submit it for appropriate approval.

The financial assistance worksheet will be used to determine the percentage of financial assistance for which the applicant is eligible. The BHS schedule of discounts is used as a tool to aid in determining the percentage of financial assistance applicable. The Patient Financial Service verify that all figures used to calculate eligibility are correct, and if necessary may seek additional verification before submitting the application for approval.

The application will be evaluated by the appropriate person(s) who will approve, deny, or forward the application, as necessary in accordance with each BHS entity's approval process. A letter will be sent to the patient if the application is approved or denied within 30 days of receipt of a completed application. Should a patient make a payment on a visit after the approval date but within the approval period, the monies should be refunded to the patient.

Verification of Income

To enable BHS to determine the patient's eligibility for financial assistance, the patient may be required to provide certain information, including, but not limited to, the following:

- Copy of your most recent filed Federal 1040 Income Tax Return including all schedules, W-2 Statements, and 1099 forms. If you did not file a Return for the most recent filing period, your application must include an explanation of the reason why no Return was filed.
- Forms advising status of unemployment, worker's compensation, or Medicaid
- Copy of most recent paycheck stubs from all jobs held in the current year showing year to date earnings in the absence of income, a letter of support and/or a declaration of no income from the patient and/or responsible party detailing how the individual's current living needs are being met
- Proof of all income such as Social Security, unemployment, disability, pensions, child support, alimony or foster care.
- Evidence that all active possible third party payers have been exhausted and the balance is due directly from the patient/responsible party
- Other information that BHS may deem relevant in assisting BHS entities in making the most appropriate financial determination

Failure to provide information necessary to verify income or providing false information may result in

denial of the application and/or denial of financial assistance. Income may be verified for the previous twelve (12) months or based on information from a partial year, as BHS deems appropriate. The future earning capacity and ability to meet future obligations within a reasonable time may also be considered. All such financial information is considered confidential and will be used only to evaluate or assist in enrollment for financial assistance.

Presumptive Financial Assistance Eligibility

Patient may appear eligible for financial assistance, but no completed financial assistance form is on file. In the event there is no evidence to support a patient's eligibility for financial assistance, BHS may use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility. Compliance with government program eligibility guidelines, such as Medicaid, is encouraged for financial assistance approval for patients but patient will not be denied financial assistance for non compliance with government programs. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include, but not limited to:

1. Full Medicaid benefits (non premium or spenddown programs or programs that exceed BHS full financial assistance income guidelines)
2. Homeless or received care from a homeless clinic
3. Participation in Women, Infant and Children programs (WIC)
4. Full food stamps eligibility
5. Subsidized school lunch program eligibility
6. Approved for low income/subsidized housing and/or State energy assistance program
7. Patient is deceased with no known estate and no living spouse
8. Patients with a shortened length of stay due to end of life care.

Exceptions to this Policy

In the event of a catastrophic illness where proper documentation has been submitted but the patient still has a responsible balance resulting from BHS medical bills, or if other unforeseen events transpire that cause an undue hardship upon the household, a member of BHS senior management will determine if an additional financial discount is merited.

When the patient has been approved under this financial assistance policy for a partial discount, BHS will work with the patient or the responsible party to establish a reasonable payment plan. (See BHS Patient Accounting policy)

In implementing this policy, BHS management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

Routine Waivers of Deductibles and Copayments

Routine waiver of deductibles and copayments are not offered by the Blessing Health System. One

important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners, or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made.

Communication of Financial Assistance Policy

The Financial Assistance policy is published on the Blessing Health System website. Financial Account Specialists and all points of access can provide the policy and application per request. Charity guidelines are posted in the Emergency Department.

Billing and Collection Policy

1. **Amounts Generally Billed**
    a. The hospital uses the look-back method to determine the amounts generally billed to individuals who have insurance covering emergency or other medically necessary care (AGB). The AGB percentage is calculated annually based upon fiscal year activity. The hospital's fiscal year begins October 1 and ends September 30. The updated percentage is put into effect for services on or after January 1 of the following year. The AGB may be obtained from Patient Financial Services.

2. **Internal Collection Policy**
    a. Collection activities could involve internal or external efforts such as phone call follow-up and mail follow-up as well as pre-collect letter service on select accounts. Failure to collect the account from these efforts where the patient has indicated that he/she will not pay in accordance with the financial expectation guidelines and policies may result in the account being referred to a collection agency and/or legal firm. BCS will continue to collect from a patient even when the account is involved in litigation or dispute. BCS is not bound by third party proceedings.
    Accounts will be considered delinquent if:
        i. The patient's responsibility is not received within 30 days UNLESS:
            1. a ten (10) month payment arrangement has been approved, or
            2. bank loan financing has been obtained, or
            3. extended payment arrangements have been approved.
        ii. Monthly payment arrangements have not been approved.
        iii. The patient or family fails to cooperate in meeting prerequisites for determination of financial assistance.
        iv. The patient has indicated that they will not pay.
        v. There is a default of payment arrangements previously established. (Payment terms are outlined in the specific contracts.)
    b. Accounts may be considered eligible for external collection when an account has

not been paid in full within thirty (30) days of determining the patient's responsibility and when no alternate arrangements have been made.

3. **External Collection Practices**
   All letters will conform to the Fair Debt Collection Practices Act.
   a. Validation of Debt
      After an account has been placed with an external collection agency and/or law firm, the collection/law entity will send notification to the debtor in compliance with § 809 Validation of debts [15 USC 1692g] of the Fair Debt Collection Practices Act.
   b. Full Collection Action
      Accounts listed with a collection agency or law firm will be written off as Bad Debt. The guarantor for the account will be responsible for payment of any attorney fees and court costs that may be incurred in attempts to collect the debt. The collection agency or law firm will initiate full collection efforts, which may include letters, phone calls and recommending litigation.

      BH, BHH, Illini, and BPS: Checks that are returned and declared non-sufficient funds will be handled internally.
   c. Litigation Authorization
      If a debtor fails to respond to the collection agency's or law firm's request for payment, litigation may be pursued. More specifically, litigation may be pursued when:
      i. The debtor has failed to respond to collection efforts with a reasonable payment offer, and
      ii. The debtor has verified income or attachable assets.

      Accounts authorized for litigation will receive a letter notifying the debtor of a pending suit. If there is no positive response from the debtor, the account is referred for litigation. If the attorney's attempts to arrange suitable payment arrangements are not successful, the attorney will file suit and secure a court date.
   d. Court Judgments Entered
      At a court appearance, judgment can be obtained by confession of the debtor or by default if the debtor fails to appear. If a judgment is obtained by default, the debtor has thirty (30) days to ask the court to vacate the judgment if he can demonstrate to the court "good cause" for not appearing at the scheduled first appearance.

      Once a judgment has been obtained, one of the following tools may be used by the attorney to demand payment from the debtor:
      i. Wage Deduction Order
      ii. Asset Lien
      iii. Court Ordered Payment Agreement

4. **Refunds for Financial Assistance Eligible Patients on hospital balances**
   a. Blessing Hospital and Illini Community Hospital shall refund any patient payments

made within 240 days of the first patient billing statement, in excess of $5, for all active and eligible and/or collection accounts less than or equal to the approved application date if the completed financial assistance application was submitted within 240 days of the first patient billing statement.

Patients approved for partial/catastrophic assistance will have all patient payments received within 240 days of the first patient billing statement applied to the balance remaining after discount. Patient payments as described above are defined as payments received by the patient with 240 days of the first statement for all eligible and/or collection accounts less than or equal to the completed application received date.

Reference(s):

Fair Debt Collection Practices Act
Illinois Fair Patient Billing Act

Form(s):

Financial Assistance Brochure / Application

Financial Assistance Plain Language Summary