SSMHealth
Rehabilitation Network

Financial Assistance Policy

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Financial Assistance Policy

SSM Rehabilitation Network's Financial Assistance Policy identifies opportunities for financial assistance to patients who are financially or medically indigent and demonstrate an inability to pay for the services provided to them or their dependents. The Financial Assistance Policy (FAP) provides and establishes guidelines for financial assistance that ensures compliance with all state, federal and regulatory guidelines.

SSM Rehabilitation Network is committed to providing financial assistance to persons who have healthcare needs and are uninsured or underinsured. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, SSM Rehabilitation Network strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

Accordingly, this policy:

- Includes eligibility criteria for financial assistance
- Describes the basis for calculating Amounts Generally Billed (AGB) to patients eligible for financial assistance under the policy
- Describes the method by which patients may apply for financial assistance
- Limits the amounts that the hospital will charge for medically necessary care provided to individuals eligible for financial assistance to the AGB.
- Lists Financial Assistance and Other Discounts that may be provided to patients

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with SSM Rehabilitation Network's procedures for obtaining insurance available or other forms of payment, and to contribute to the cost of their care based on their individual 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. SSM Rehabilitation Network may at any time define and revise the criteria determining eligibility for financial assistance.

SCOPE:

This policy is applicable to SSM Bridgeton Rehabilitation Hospital, SSM Richmond Heights Rehabilitation Hospital and SSM Lake St. Louis Rehabilitation Hospital.

DEFINITIONS:

I. **Application Period**: Defined as the time provided to patients by the hospital to complete the Financial Assistance application. It begins on the first day care is provided and ends on the 240th day after the hospital provides the individual with the first post-discharge billing statement for the care provided.

II. **Eligible Service Area**: The principal beneficiaries of the Financial Assistance Policy are intended to be patients who reside within 50 miles of any hospital within the SSM Rehabilitation Network.

III. **Family Size**: Family size is defined by the Internal Revenue Service and is equal to the number of individuals for whom the taxpayer is allowed a deduction on their federal tax return. If IRS tax documentation is not available, family size will be determined by the number of family members documented and verified on the financial assistance application.

IV. **Family Income**: Family Income is determined using the Census Bureau definition, which uses the following income when computing Federal Poverty Level (FPL):

A. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, assistance from outside the household, and other miscellaneous sources;

B. Noncash benefits (such as food stamps and housing subsidies) do not count;

C. Determined on a before-tax basis;

D. Excludes capital gains or losses; and

E. Includes the income of all family members who are included in the family size. (Non-relatives, such as housemates, do not count).

V. **Federal Poverty Level (FPL)**: The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. It is determined by the Department of Health and Human Services and is adjusted for inflation and reported annually in the form of poverty guidelines.

VI. **Financial Assistance**: Defined as free or discounted health care services provided to persons who cannot afford to pay all or a portion of their financial liability for services and who meet SSM Rehabilitation Network's financial assistance policy criteria.

VII. **Financial Indigence**: Financially indigent persons include uninsured and underinsured persons who meet an institution's eligibility for discounted care up to and including a 100% discount.

VIII. **Medical Indigence**: Medically indigent patients include persons with catastrophic medical costs for whom payment of medical bills would threaten the household financial viability. Qualifying as a medically indigent patient does not require qualification as financially indigent. Generally, medically indigent persons qualify for reductions in their obligations to pay for medical services rendered. The Medical Indigence program considers the patient's ability to pay without liquidating assets critical to living or earning a living, such as home, car, personal belongings, etc. All patients are eligible to be considered for medically indigent status with the exception of patients with income below 200% of the FPL, as these patients are considered eligible for 100% financial assistance under the financially indigent definition.

IX. **Medically Necessary Services**: Defined by Medicare as services or items reasonable and necessary for the diagnosis, prevention or treatment of an illness, injury or disease.

X. **Patient Liability**: The amount a patient is personally responsible for paying after all available discounts, including uninsured discount, financial assistance discount and discount due to limitation on charges to patients per 501 (r) regulations.

XI. **Plain Community**: A faith based group connected by business, shared culture, and simple living (e.g. Amish, Mennonite)

XII. **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.

XIII. **Uninsured**: The patient has no insurance coverage for the Medically Necessary care provided.

PROCESS:

I. **Services Eligible**: For purposes of this policy, all Medically Necessary services provided by the hospital are eligible.

II. **Eligibility for Financial Assistance**: Eligibility for financial assistance will be considered for those individuals who:

A. Have limited or no health insurance;

B. Cooperate with SSM Rehabilitation Network's policies and procedures;

C. Demonstrate financial need;

D. Supply all required information to process the application; and

E. Reimburses the Hospital for any monies paid directly to patient by insurance.

The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account race, color national origin, religion, sex, gender identity, sexual orientation, disability, age, marital status, socioeconomic status, or source of payment. A determination of financial assistance will be effective for a period of up to 60 days. This eligibility starts at the approval date and will encompass all outstanding receivables including those at bad debt agencies.

III. **Financial need and eligibility will be determined in accordance with the following procedures:**

A. **Application** - In order to be eligible for financial assistance consideration, the patient or guarantor must complete the Patient Financial Assistance Application form and submit the documentation requested to support reported income and expenses. Applications for financial assistance should be complete and accurate and include verifiable proof of income and/or assets as well as unusual expenses.

Patients can also submit an application verbally, either over the phone or face to face. The Admissions Office Representative will document the patient responses onto the application form and the patient will verify and attest to all the information. All supporting documentation must be supplied for the application to be considered complete.

SSM Rehabilitation Network's values of respect and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly and SSM Rehabilitation Network shall notify the patient, or applicant, within a reasonable time limit of receipt of a completed application. Each patient has the opportunity to apply for financial assistance prior to treatment, and throughout the Application Period.

Applications for Financial Assistance require the following documents (Please note that the documents will not be accepted if they are altered):

1. Completed written/verbal application

2. Bank/Savings Statements for most recent three months

    a) An explanation of any unusual deposits/expenses on the bank/savings statements

    b) Documents must reflect all deposits.

3. Income verification for applicant.

    a) Verification of income can include (not an inclusive listing): pay stubs, unemployment checks, social security award letters/checks, disability award letters, child support documentation, and pension verification.

    b) If guarantor filed married, filing joint on most recent taxes, the guarantor must send income verification for spouse as well.

4. Tax Return Documentation

    a) Most recently filed tax return or Non-Filing Letter from the IRS. Taxes must be accompanied by all supporting schedules (A-F) and documents (W2s, 1099s) to be considered complete.

5. Medicaid Approval/Denial Letter

    a) This is only a requirement if the hospital has pre-screened the patient for Medicaid eligibility.

    b) If patient is pre-screened as potentially eligible, they must cooperate with Medicaid application process to be eligible for financial assistance with SSM Rehabilitation Network.

6. Additional documents that may be requested (to qualify patient for medical indigence) include:

    a) Verification of monthly expenses

    b) All medical bills, housing bill, and any other bill essential to the basic needs of living.

    c) A declaration of income/supporter statement

B. **Consideration for Patient Assets**: Available assets in excess of $5,000, with the exception of Protected Assets listed below, will be added to current year's income in establishing the level of financial assistance to be offered to the patient.

Protected Assets include:

1. 50% of the equity in primary residence up to $50,000;

2. Business use vehicles;

3. Tools or equipment used for business; reasonable equipment required to remain in business;

4. Personal use property (clothing, household items, furniture);
5. IRAs, 401K, cash value retirement plans;
6. Financial awards received from non-medical catastrophic emergencies;
7. Irrevocable trusts for burial purposes, prepaid funeral plans; and/or;
8. Federal/State administered college savings plans.

C. **Incomplete Applications**: All incomplete applications will receive a letter of notification that will detail the information that is needed to satisfy the documentation requirements for eligibility. If the applicant sends in incomplete documentation a second time, the applicant will receive a letter and a phone call attempt to notify the patient that their application is not complete.

Applications for financial assistance can be returned to the admissions office at the hospital in which care was provided.

Questions about the Financial Assistance Policy may be directed to the admissions office at the hospital where care was provided or to the Central Billing Office at 888-868-1103.

IV. **Eligible Service Areas**: Eligibility for financial assistance may be restricted to residents within 50 miles of any facility within the SSM Rehabilitation Network's Operating Entities.

V. **Cooperation to Establish Coverage**: SSM Rehabilitation Network, will proactively help patients apply for public and private programs to establish coverage for health care services. SSM Rehabilitation Network may deny financial support to those individuals who do not cooperate in applying for those programs (e.g. Medicaid, COBRA, Ticket to Work) that may pay for their health care services.

VI. **Out-of-Network Services**: SSM Rehabilitation Network hospitals are not in-network for certain insurance plans. As an out-of- network provider, SSM Rehabilitation Network may not receive any reimbursement from the insurance carrier. Patients that seek services at SSM Rehabilitation Network hospitals, out of network of their insurance plan, are not eligible for financial assistance.

VII. **International/Traveling Patients**: The Financial Assistance will not be available to International/Travelling patients.

VIII. **Plain Community Patients**: Due to these patient's inability to cooperate with applying for insurance coverage and ability to provide necessary supporting documentation, these patients will not be eligible for Financial Assistance. A discount will be provided to the Plain Community patients.

IX. **Discounts to Patients**:

A. **Charity Discounts**: SSM Rehabilitation Network provides a charity discount for eligible patients based on Federal Poverty Level Guidelines. The charity care discount is applied to the patient's remaining liability after insurance for insured patients. Below are the discounts that will be applied:

Sliding Eligibility Scale based on Federal Poverty Level

Federal Poverty Level	Financial Assistance Discount
0% – 200%	100%
201% - 250%	80%
251% - 300%	60%
301% - 350%	50% of amount over $2,000
351% - 400%	20% of amount over $2,000
Over 400%	0%

B. **Plain Community Discounts**: Members of an established Plain Community will receive a discount in the range of average of Medicare Fee-for-service and private health insurance to 10 percentage point below the average.

C. **Catastrophic Discounts**: Patients may be eligible to receive a discount on a case-by-case basis based on their specific circumstances, such as catastrophic illness or Medical Indigence, at the discretion of SSM Rehabilitation Network. Additional financial information may be requested.

X. **Amount Generally Billed (AGB)/Limitation of Charges**: SSM Rehabilitation Network limits the amount charged for medically necessary care provided to patients who are eligible for financial assistance under this policy to not more than gross charges for the care multiplied by the AGB percentage. The AGB percentage is determined using the look-back method. (See Appendix A).

XI. **Relationship to Collection Policies**: Patients/guarantors are expected to pay the amount of their account that is not eligible for assistance under this policy. Patients/guarantors who fail to pay their balance after the associated discounts have been applied will be subject to normal collection procedures.

A. **Determination of Eligibility**: SSM Rehabilitation Network seeks to determine whether a patient is eligible for assistance under this Policy prior to or at the time of admission or service. If a patient has not been determined eligible for financial assistance prior to discharge or service, SSM Rehabilitation Network will bill for care. If the patient is insured, SSM Rehabilitation Network will bill the patient's insurer on record for the charges incurred. Upon adjudication from the patient's insurer, any remaining patient liability will be billed directly to the patient. If the patient is uninsured, SSM Rehabilitation Network will bill the patient directly for the charges incurred. Patients will receive a series of up to four billing statements over a 120 day period beginning after the patient has been discharged, delivered to the address on

record for the patient. Only patients with an unpaid balance will receive a billing statement. Billing statements include a plain language summary of this Policy and how to apply for financial assistance. Reasonable efforts to determine eligibility include: notification to the patient of the Policy upon admission and in written and oral communications with the patient regarding the patient's bill, an effort to notify the individual by telephone about the Policy and the process for applying for assistance at least 30 days before taking action to initiate any lawsuit, and a written response to any financial assistance application for assistance under this Policy submitted within 240 days of the first billing statement with respect to the unpaid balance or, if later, the date on which a collection agency working on behalf of SSM Rehabilitation Network returns the unpaid balance to the Hospital.

B. **Collection Actions for Unpaid Balances:** If a patient has an outstanding balance after up to four billing statements have been sent during a 120 day period, the patient's balance will be referred to a collection agency representing SSM Rehabilitation Network which will pursue payment. Collection agencies representing SSM Rehabilitation Network have the ability to pursue collection for up to 18 months from the point when the balance was sent to the collection agency. A patient may apply for financial assistance under this Policy even after the patient's unpaid balance has been referred to a collection agency. After at least 120 days have passed from the first post-discharge billing statement showing charges that remain unpaid, and on a case-by-case basis, SSM Rehabilitation Network may pursue collection through a lawsuit when a patient has an unpaid balance and will not cooperate with requests for information or payment from SSM Rehabilitation Network or a collection agency working on its behalf.

In no case will Medically Necessary Care be delayed or denied to a patient before reasonable efforts have been made to determine whether the patient may qualify for financial assistance. At SSM Rehabilitation Network, an uninsured patient who seeks to schedule new services and has not been presumed eligible for financial assistance will be contacted by a representative who will notify the patient of the Policy and help the patient initiate an Application for financial assistance if requested.

C. Review and Approval

SSM Rehabilitation Network's representative has the authority to review and determine whether reasonable efforts have been made to evaluate whether a Patient is eligible for assistance under the Policy such that extraordinary collection actions may begin for an unpaid balance.

XII. **Providers Covered**: Certain services are performed by physicians who are not covered by the SSM Rehabilitation Network financial assistance policy. These services may be covered by the SSM Rehabilitation Network System financial assistance policy available online at www.ssmhealth.com. Physicians working at SSM Rehabilitation Network who are ***not*** covered under this Policy are identified in the

Appendix B, Provider List, by name. The list is updated quarterly and is also available online at www.ssm-rehab.com, in our admissions areas, and upon request by asking an SSM Rehabilitation Network representative.

XIII. **Regulatory Requirements**: In implementing this policy, SSM Rehabilitation Network 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.

XIV. **Documentation**: Patient Business Services will maintain records of its financial assistance applications, determinations of financial assistance and notices to patients to adequately document its fair and consistent application of this policy in accordance with our policy on record retention and destruction

XV. **Annual Reporting**: Each hospital will be required to report information related to financial assistance and non-covered services for Medicaid and other public aid programs for the indigent in the annual disclosure packet and in the Community Benefit Inventory for Social Accountability (CBISA) software program.

Information to be collected shall include:

1. Total number of persons served;
2. Total charges forgiven;
3. Total cost of financial assistance as defined in this policy and;
4. Expenses incurred by the provision of financial assistance

Provider taxes, assessments or fees or Medicaid DSH funds in the appropriate state, are used in whole or in part to offset the cost of financial assistance.

XVI. **Policy Questions**: If operational questions arise as to the application of certain guidelines contained within this policy, they should be referred to the Admissions Office at the Hospital where services were provided or to the Central Billing Office at 888-868-1103.