Anderson Healthcare

Title: Financial Assistance Policy

Responsible Department: Revenue Cycle, Revenue Systems	Date Created: 12/01/2015
Approver(s): Keith Page (President)	Date Approved: 12/29/2021

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

This policy applies to Anderson Hospital, Anderson Medical Group, Community Hospital of Staunton and Community Clinic of Staunton (together "Anderson Healthcare").

Policy Statement:

Anderson Healthcare is an independent not for profit hospital system dedicated to creating a health care setting in which quality of life and service excellence are experienced by our patients, their families and the community. Anderson Healthcare provides emergency and other medically necessary care to patients that are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situations. This policy identifies those circumstances when Anderson Healthcare may provide free or discounted care based on the financial needs of the patient without discrimination regardless of their inability to pay. All patients eligible for financial assistance will not be charged more than amounts generally billed to patients with Medicare or private health insurance in accordance with 501(r) regulations.

This financial assistance policy also pertains to certain Anderson Medical Group providers that bill for professional services to patients receiving care at Anderson Hospital including, but not limited to, such specialties as Surgery, Cardiology, and Orthopedics. This policy also pertains to Anderson Medical Group providers that bill for professional services to patients receiving care at Community Hospital of Staunton.

Services not eligible for Financial Assistance include: professional services which are related to the hospital visit and billed by non-Anderson Medical Group providers, professional services provided by Anderson Medical Group providers that are not applicable to services at Anderson Hospital and Community Hospital of Staunton, Maryville Imaging Services, private contract procedures (primarily Cosmetic), Phase 3 Cardiac Rehab, Hearing Aids and other Medicare non-covered services.

Professional services for certain Anderson Medical Group providers, and other providers that perform professional services at Anderson Healthcare not covered under this policy are listed in the appendix of this Financial Assistance Policy.

Anderson Healthcare will comply with the Patient Protection and Affordable Care Act of 2010 under Section 501(r), the Illinois Hospital Uninsured Patient Discount Act, and the Illinois Financial Assistance under the Fair Billing Act. This policy has been adopted by the governing body of Anderson Healthcare in accordance with the regulations under Section 501(r). Throughout the language of this policy, the term "patient" refers to the patient and/or their guarantor.

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Guidelines/Procedures:

Definitions:

A. **Amounts Generally Billed (AGB)** – calculation of the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This calculation will be performed annually.

B. **AGB Percentage** – a percentage of gross charges that Anderson Healthcare uses to determine the AGB write off for any emergency or other medically necessary care it provides to an individual who is eligible for assistance under its financial assistance policy (FAP)

C. **Application Period** – the period during which Anderson Healthcare must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. Anderson Healthcare management may accept and process an individual's FAP application submitted outside of the application period for extenuating circumstances. With respect to any care provided by Anderson Healthcare to an individual, the application period begins on the date the care is provided and ends on the 240th day after the date that the first post-discharge billing statement for the care is provided.

D. **Bad Debt** – means the current period charge for actual or expected doubtful accounting resulting from the extension of credit.

E. **Charity Care** – means care provided by a health care provider for which the provider does not expect to receive payment from the patient or a third party payer. Charity care includes the actual cost of services provided based upon the total cost to charge ratio derived from a nonprofit hospital's most recently filed Medicare cost report Worksheet C and not based upon the charges for the services. Charity care does not include bad debt.

F. **Eligibility** for Anderson Healthcare financial assistance is defined by the patient/guarantor's income based on a sliding scale relative to Federal Poverty Guidelines (Refer to Guidelines/Procedures in this policy) or other criteria as follows:
    1. Patients must be Illinois residents to request an uninsured discount and verify Illinois residency. Acceptable verification of Illinois residency shall include one of the following:
        a. Copy of the most recent tax return, W-2, pay stubs
        b. Valid state-issued identification card
        c. Recent residential utility bill

d. Lease agreement
e. Vehicle registration card
f. Voter registration card
g. Mail address to the uninsured patient at an Illinois address from a government or other credible source
h. Statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
i. Letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility
j. Temporary visitor's driver's license

2. Patients with yearly income that falls below current federal and state poverty guidelines and are not eligible for any state or federal assistance programs which provide healthcare coverage.
3. Uninsured patients or Underinsured patients that do not qualify for local, state or federal programs, and based on their analysis of their financial situation; it is determined that full payment of the hospital bill would cause financial hardship. This determination may require partial payment by the patient.
4. Patients who apply for Medicaid and meet income eligibility requirements but are subsequently denied for reasons other than financial hardship. Lack of cooperation in complying with an insurance company does not result in a valid denial reason to be eligible for financial assistance.
5. To be considered under this policy, a person must cooperate with the hospital to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his/her health care, such as Medicare, Medicaid, AllKids, and other 3rd party liability (i.e. health marketplace plans).
6. Insured patients must cooperate with their insurance carrier and provide any requested information (i.e. coordination of benefits information, student verification, etc.) prior to financial assistance consideration. Anderson Healthcare will cease obligations toward an individual patient if the patient unreasonably fails or refuses to provide Anderson Healthcare with information or documentation requested, or if the patient fails to apply for coverage under any applicable public program within 30 days of Anderson Healthcare's request.
7. Insured patients that have a healthcare marketplace plan and discontinue paying their healthcare premiums without documentation of financial hardship will not be considered for financial assistance under this policy.
8. Uninsured patients may be eligible for a maximum collectable amount of 20% of the patients family income, if they are found to be eligible for financial assistance and if they do not own assets having a value in excess of 600% of the FPL. The 20% maximum is for a 12-month period beginning with the date the patient becomes eligible under the hospital's charity care

policy. Excluded from the excess assets are the patient's primary residence; personal property exempt from collections under Section 5/12-1001 of the Illinois Code of Civil Procedure; or any amounts held in pension or retirement plan. (Distributions from a retirement plan are considered income and are not exempt).

9. An uninsured patient must inform the hospital, in writing, before or after each subsequent visit in the 12-month period that they are eligible for the maximum collectible cap. The maximum collectable amount may be granted to patients with insurance on a case-by-case basis.
10. Patients whose family or friends have provided information establishing the patient's inability to pay.
11. Patient is deceased without an estate or other financially responsible party.
12. Patients who are screened and/or identified for financial assistance by a Patient Access Financial Counselor or Associate, Patient Financial Services employees, or a hospital contracted agency.
13. Patients will not be discriminated against in regards to race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability.
14. Other circumstances may apply at the discretion of the Director of Revenue Systems, Patient Financial Services Director or Vice President /CFO.

G. **Extraordinary Collection Action (ECA)** – actions taken by Anderson Healthcare against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require legal or judicial process, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus.

H. **FAP Application (FAP)** – information and accompanying documentation that an individual submits to apply for financial assistance under the Anderson Healthcare financial assistance policy. An individual is considered to have submitted a complete FAP application if he or she provides information and documentation sufficient for Anderson Healthcare to determine whether the individual is FAP-eligible. An incomplete FAP application is considered if he or she provides some, but not sufficient, information and documentation to determine FAP-eligibility. The term "FAP application" does not refer only to written submissions. Anderson Healthcare may obtain information from an individual in writing or orally (or a combination of both).

I. **FAP- Eligible** – individuals eligible for financial assistance under Anderson Healthcare's FAP for care covered by the FAP, without regard to whether an individual has applied for assistance under the FAP.

J. **Federal Poverty Guidelines (FPG)** – The federal government establishes and publishes annual poverty guidelines in the Federal Registry. The guidelines compare the family's yearly/monthly income with the size of the family/dependents.

K. **Family/Dependents** – The family unit is a group of individuals related by blood, marriage, adoption or residence, whose income can be applied to the patient's medical expenses. Children over eighteen years of age that are not a student, emancipated minors and children living under the care of individuals, not legally responsible for their support will not be considered part of the family/dependents unless those individuals are claimed as dependents on the responsible parties income tax.

L. **Financial Assistance** – means a discount provided to a patient under the terms and conditions the hospital offers to qualified patients or as required by law.

M. **Financial Assistance Policy (FAP)** –written policy that specifies all of the eligibility criteria that an individual must satisfy to receive a financial assistance discount, free care, or other level of assistance.

N. **Family Income** – means the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support.

O. **Federal Poverty Income Guidelines** – means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

P. **Government-Sponsored Healthcare** – means the unreimbursed cost to a hospital or health system of Medicare, providing health care services to recipients of Medicaid, and other federal, State or local healthcare programs, eligibility for which is based on financial need.

Q. **Gross Charges** – Anderson Healthcare's full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts or deductions.

R. **Healthcare Services** – means any medically necessary inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient.

S. **Healthcare Scoring** is a method to define and demonstrate community needs and recognizing that some patients will be unresponsive to the charity care application process. In the absence of information provided by the patient or in cases where the information provided by the patient is

incomplete, or to evaluate for comparison, an assessment process utilizing a predictive model will be deployed to screen and qualify patients (pre or post service) for financial assistance. The predictive model incorporates income and household size estimates, a socio-economic need factor as well as information on homeownership. This data will be calibrated to emulate the hospital's Financial Assistance policy and local economic factors (i.e. Federal Poverty level percentage).

T. **Illinois Discount –** Illinois state requirements related to Uninsured patients is defined as charges discounted to 135% of cost (70% of charges at Anderson Hospital and 65% at Community Hospital of Staunton) determined by applying ratio of cost to charges (RCC) from the most recently filed Medicare cost report to an Uninsured patient's bill. Actual formula for discount is [1-(RCCx1.35) x charges], applicable only to charges exceeding $150 in any one inpatient admission or outpatient encounter.

U. **Illinois Resident** – means any person who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement.

V. **Insured Patients** have medical coverage for hospital services with designated copayments, co-insurance, deductibles and/or out-of-pocket patient financial responsibilities. A patient who is represented by an attorney seeking third-party liability coverage for services rendered will be considered an Insured patient until the pending litigation is finalized, and therefore is not eligible for Financial Assistance.

W. **Medically Necessary –** means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:

   a. Non-Medical services such as social and vocational services.
   b. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.
   c. Services not eligible for Financial Assistance includes Private Contract procedures (primarily Cosmetic), Phase 3 Cardiac Rehab, and Hearing Aids.

X. **Net Patient Revenue** – means gross service revenue less provisions for contractual adjustments with third-party payors, courtesy and policy discounts, or other adjustments and deductions, excluding charity care.

Y. **Substantial Assets** related to Illinois state requirements regarding discounts for Uninsured patients is defined as a value in excess of 600% FPL in urban areas, and 300% in rural areas. Assets excluded for consideration are patient's primary residence, personal property exempt from collections under Section 5/12-1001 of the Illinois Code of Civil Procedure and any amounts held in a pension or retirement plan.

Z. **Plain Language Summary of the FAP** – a written statement that notifies an individual that Anderson Healthcare offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand. It includes:

1. A brief description of the eligibility requirements and assistance offered under the FAP
2. A brief summary of how to apply for assistance under the FAP
3. The direct Website address (or URL) and physical locations where the individual can obtain copies of the FAP and FAP application form
4. Instructions on how the individual can obtain a free copy of the FAP and FAP application by mail
5. The contact information, including telephone number and location where an individual can go for assistance
6. 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
7. A statement that a FAP-eligible individual may not be charged more than AGB for emergency or other medically necessary care

AA. **Presumptive FAP-eligibility determination** – determination that an individual is FAP-eligible based on information other than that provided by the individual or based on a prior FAP-eligibility determination.

BB. **Presumptive Eligibility (Illinois only)** is defined as those uninsured patients presumed to be eligible for charity care discounts on the basis of individual life circumstances (Presumptive Eligibility). Illinois uninsured patients are screened for Presumptive Eligibility prior to the issuance of any bill for those health care services provided by the hospital. Such patients may be presumed eligible for 100% charity without the completion of a financial assistance application, when at least one of the following circumstances applies for the patient:

1. Medicaid eligible but not eligible on the date of service or for non-covered services;
2. Homelessness;
3. Deceased with no estate;
4. Mental incapacitation with no one to act on patient's behalf;
5. Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

a. Women, Infants and Children Nutrition Program (WIC)
b. Supplemental Nutrition Assistance Program (SNAP)
c. Illinois Free Lunch and Breakfast Program;
d. Low Income Home Energy Assistance Program (LIHEAP);
e. Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership;
f. Receipt of grant assistance for medical services
g. Temporary Assistance for Needy Families
h. Healthcare Score indicates presumptive eligibility has been met.

CC. **Underinsured Patients**– individual that has medical insurance but has inadequate financial coverage to address their medical needs. This includes high deductible health plans, coinsurance, non-covered services, etc. Patients who refuse or otherwise fail to provide information regarding other coverage may not be eligible for financial assistance.

DD. Uninsured Discount – means a hospital's charges multiplied by the uninsured discount factor.

EE. Uninsured Discount Factor – means 1.0 less the product of a hospital's cost to charge ratio multiplied by 1.35.

FF. **Uninsured Discount Eligibility Criteria** regarding Illinois state requirements related to Uninsured patients is defined as having family income that is no more than 600% of the Federal Poverty Level (FPL) in urban areas, and 300% in rural areas. (Family income in this context is defined as a family's annual earnings and cash benefits from all sources before taxes [including distributions and payments from pensions or retirement plans] less payments made for child support.). Discounts available under Illinois law is only required for "residents", i.e. a person who lives in Illinois and who intends to remain living in Illinois indefinitely. Anderson Healthcare will annually calculate 135% of the hospitals cost to provide services, compared to the amounts generally billed (AGB) to determine which method provides a greater discount to be in compliance with Illinois state requirements and section 501(r) requirements.

GG. Uninsured Patient – means an Illinois resident who is a patient of a hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

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Notification

A. All patients registered for Anderson Healthcare hospital services will be offered a plain language summary as part of the intake process. The plain language summary will be a written statement that notifies an individual that Anderson Healthcare offers financial assistance under its financial assistance policy.

B. Financial assistance policies are transparent and will be readily available to the community including eligibility criteria, and how to apply for financial assistance. Free paper copies of financial assistance policies will be available in all admission areas, as well as, posted on the Anderson Hospital and Community Hospital of Staunton websites.

C. Anderson Healthcare will prominently and conspicuously post complete and current versions of financial assistance documents and other application information on the Anderson Hospital and Community Hospital of Staunton website in English and in Spanish in compliance with the Patient Protection and Affordable Care Act of 2010 under Section 501(r). The following will be posted:
   1. Financial Assistance Policy (FAP)
   2. Financial Assistance Application Form (FAA)
   3. Plain Language Summary (PLS)
   4. Information regarding how to visit a Financial Counselor in the Patient Access department during the hours of 8am – 4:30pm
   5. How to obtain an application from any hospital registration desk including the Emergency department
   6. How to apply for financial assistance after hospital services have been performed and a patient billing statement has been received by calling 1-877-444-6382
   7. How to apply for financial assistance if services were provided by an Anderson Medical Group provider by calling 1-866-724-6658

D. Anderson Healthcare will provide a conspicuous notice on each patient billing statement regarding availability of financial assistance. The notice will also reference the uninsured patient discount for Illinois resident's legislation.

E. Emergency Medical Care – Anderson Healthcare will prohibit debt collection activities, such as copays, that interfere with the provision, without discrimination, of emergency medical care regardless where such activities occur. Anderson Healthcare Patient Access Registrars are trained that collection activities during the registration process that can delay the provision of screening and treatment for an emergency medical condition are prohibited. The actions of requesting

immediate payment before or while providing screening or stabilizing treatment for emergency medical conditions is prohibited under this policy.

Anderson Healthcare Methods of Calculating the Financial Assistance Discount

A. Anderson Healthcare has established a financial assistance policy that provides financial assistance to uninsured and underinsured individuals. The discounts are as follows:

Anderson Hospital:

Family Income as percentage of FPL	Discount Percentage Off Charges
Up to 200% of the Federal Poverty Guidelines	100% (free care)
201% - 300%	90%
301% - 400%	80%
401% - 600%	72%

Community Hospital of Staunton:

Family Income as percentage of FPL	Discount Percentage Off Charges
Up to 125% of the Federal Poverty Guidelines	100% (free care)
126%-200%	75%
201%-300%	50%

Anderson Healthcare will comply with the Illinois Hospital Uninsured Patient Discount Act, the Illinois Financial Assistance Under the Fair Billing Act, and the Patient Protection and Affordable Care Act of 2010, 501(r)(3) -(6). Discounts provided to Anderson Healthcare patients that qualify under this legislation will be classified as charity adjustments.

The minimum financial discount percentage (charity adjustment) is calculated in accordance with section 501(r) – 5(b) regulations. Anderson Healthcare has chosen to use the look-back method in order to determine the hospitals Amounts Generally Billed (AGB). Anderson Healthcare calculated the amounts generally billed (AGB) based on all claims allowed by Medicare and private health insurers over a specified 12-month period, divided by the associated gross charges for those claims. This calculation is performed annually and any changes that are made to the AGB percentage will go into effect within 120 days after the end of the 12-month period used in calculating the AGB percentage. Questions regarding Anderson Healthcare's AGB percentage can be directed to the Anderson Healthcare Financial Counselor.

B. The maximum amount that may be collected in a 12-month period for health care services provided by the hospital from a patient determined by that hospital to be eligible under subsection (a) is 20%

of the patient's family income and is subject to the patient's continued eligibility. The 12-month period to which the maximum cap applies shall begin on the first date an uninsured patient receives services that are determined to be eligible for the uninsured discount at that hospital. To be eligible to have the maximum amount applied to subsequent charges, the uninsured patient shall inform the hospital of subsequent inpatient admissions or outpatient encounters that the patient has previously received health care services from that hospital and was determined to be entitled to the uninsured discount.

C. For purposes of the section 501(r) limitation on charges, a financial assistance eligible individual is considered to be "charged" (patient liability) only the amount he or she is personally responsible for paying after all deductions and discounts have been applied and less any amounts reimbursed by insurers (i.e. deductibles, coinsurance, copays). Upon determination of financial assistance eligibility, an individual will not be charged more than amounts generally billed for emergency or other medically necessary care.

D. Uninsured patients are excluded from financial assistance when the patient owns assets having a value in excess of 600% of the federal poverty level, or 300% in rural areas, not counting the following assets: the uninsured patient's primary residence; personal property except from judgement under Section 12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan, provided, however that distributions and payments from pension or retirement plans may be included as income for the purposes of the law.

Screening and Application Process

A. Anderson Healthcare will screen uninsured patients for presumptive eligibility as soon as possible (before or after receipt of healthcare services) and prior to the issuance of any bill for those health care services without further scrutiny by the hospital. Patient Access staff will utilize a registration questionnaire and healthcare scoring as a means of screening when a patient is uninsured. For patients meeting presumptive eligibility criteria, Patient Financial services will discount the patients financial liability 100% if any of the below conditions are met:
    1. No third-party coverage is available
    2. Patient is already eligible for assistance (i.e. Medicaid), but the services are not covered
    3. Medicare or Medicaid benefits have been exhausted and the patient has no further ability to pay
    4. Patient meets Illinois state charity care requirements

B. In order to assess individual needs, Anderson Healthcare Patient Access Financial Counselors and Associates, (or contracted agents) may provide the patient with a Financial Assistance application and review with the patient the information needed and the documentation required to complete the eligibility process.

C. Patients are notified of the hospitals financial assistance programs throughout the billing cycle. The billing statements sent to the patient give a brief description on how to apply for financial assistance.

D. Patients are sent billing statements each month for a period of 120 days before the account may be referred to an outside agency for further collection efforts.

E. In the event a patient inquiries about financial assistance, they are sent a plain language summary which includes a listing of required supporting documentation.

F. The financial assistance application contains a notation that if a patient meets the presumptive eligibility criteria, or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the financial assistance application addressing the monthly expense information and estimated expense figures.

G. Once a financial assistance application is received, all collection activities are placed on hold pending the outcome of the application determination. In the event that an application is received and the account has already been referred to an outside agency for further collections activities, the agency is notified and the account is placed on hold pending the determination of the application.

H. The application is then evaluated to determine if all necessary documents for making a determination are included. If all documents are present, then the information from the patient's application is processed and a determination is made.

I. A determination letter is provided to every patient that applies for financial assistance within 21 days of the completed application. The determination letter specifically documents the outcome of the application submitted.

J. When an application is approved and the patient is determined to qualify for either full or partial assistance, the discount will be applied retroactively to all qualifying accounts that are within 365 days from the first post-discharge billing statement. The patient account(s) are documented and the appropriate adjustment is added to the account(s). The applicable outside agency is notified to cease collection activities and the account(s) are processed for the appropriate discount.

K. In the event the patient does not qualify for financial assistance, and the application is denied, a determination letter reflecting the reason for the denial is submitted to the patient. The account is then taken off hold and collection activities will resume.

L. In the event that a patient has not submitted all of the documents necessary for completing their application, a determination letter is submitted to the patient along with a listing of the documents necessary to complete the application.

M. The patient is instructed to return any outstanding items within 10 days from the date of the request. However, an application will remain valid for up to 30 days in the event that a patient does return documents after the recommended 10 day period.

N. Anderson Healthcare will give individuals eight months (240 days) after the first post-discharge bill to apply for financial assistance to be considered to have made reasonable efforts to determine whether the patient is FAP eligible.

O. Anderson Healthcare will provide a patient who has been determined to be eligible for free care with written documentation of that eligibility determination. A zero balance billing statement indicating that nothing is owed for the care is not required.

P. If a patient submits a completed financial assistance application and is determined to be eligible, Anderson Healthcare must refund any amounts the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as an eligible individual. There is an exception to this general requirement to refund, under which Anderson Healthcare is not required to refund excess payments of less than $5.

Q. Applications for account balances or estimated services exceeding $5,000 in account balance(s) must be approved by the Director of Patient Financial Services or the Director of Revenue Systems.

R. Applications for account balances or estimated services exceeding $25,000 in account balance(s) must be approved by the Vice President /CFO.

Supporting Documentation

Unless an IL uninsured patient has demonstrated 100% presumptive eligibility for financial assistance in accordance with this policy, the following documents are requested to determine financial assistance eligibility:

a. Listing of patient's available financial resources (net worth).
b. Last two (2) statements for checking, savings, stocks, bonds, annuities, etc.
c. Last three (3) paycheck stubs or earnings statements as proof of household income.
d. Previous year's Federal Income Tax Return and W-2's.
e. If an applicant does not have any of the listed documents to prove household income, he or she may call Anderson Hospital's Financial Counselor to discuss other reliable evidence that may be provided to demonstrate eligibility. Additional information may be provided via written submission, orally, or a combination of both.
f. Other information requested by Anderson Healthcare (i.e. Medicaid denial letter, Support or Public Assistance or Food Stamp Benefit Award letter, or documentation to prove Illinois residency).
g. Internal Revenue Service Form 4506-T if applicable.

Eligibility Determination

A. Each application will be reviewed independently and allowances will be made for extenuating circumstances based on good faith effort and mitigating factors. Anderson Healthcare reserves the right to review credit reports or any other method to validate the information submitted on the financial assistance application.

B. The portion of the patient's unpaid and outstanding medical bills in excess of what the patient is able to pay in installments over (5) years is considered catastrophic medical costs and will be eligible for financial assistance. Any payment arrangements as a result of the catastrophic process must be made through the bank loan program.

C. The availability of a financial assistance discount and the maximum collectible amount is contingent upon the uninsured patient first applying for coverage under public health insurance programs, such as Medicare, Medicaid, AllKids, the State Children's Health Insurance Program, or any other program, if there is a reasonable basis to believe that the uninsured patient may be eligible for such program.

D. In the event that the patient does not cooperate (or is unable) with the financial assistance determination process, Anderson Healthcare staff, or their agent, has the right to determine financial assistance eligibility based on the information the hospital has obtained and/or by the use of healthcare scoring and credit reporting.

E. Uninsured or underinsured patients who qualify for financial assistance are expected to honor the payment plans for their discounted hospital bill and are expected to honor the provisions of

their payment plan or to communicate to the hospital any change in their financial situation that may impact their ability to pay their discounted hospital bill.

F. Anderson Healthcare staff will ensure that the guidelines outlined in this policy are followed by any contracted agent engaged to assist in obtaining payment on outstanding bills from patients who have received financial assistance.

G. Financial assistance may be applied to the Insured patient's copays, deductibles and/or coinsurances if the patient meets the requirements of this policy.

H. Financial assistance approved applications can be applied to eligible accounts for six (6) months from the date of the initial application without requiring the patient to complete a new application. At the end of six (6) months, the patient is responsible for reapplying for financial assistance.

I. Once a financial assistance eligibility determination has been made, the applicable discount may be applied to patient balances associated with prior dates of service at Anderson Healthcare for a period of one (1) year.

J. Financial assistance under this policy will be provided to Illinois residents and out of state patients (non-residents). International patients are not eligible to apply for financial assistance.

K. Anderson Healthcare does not accept appeals on financial assistance applications unless there has been a significant change in guarantor's income since the application was reviewed (such as a lay-off, patient has exhausted all their resources or a disability).

L. If a patient would like to appeal the financial assistance application determination (i.e. the application was not approved or only partial assistance was awarded), the appeal must be sent in writing to the Financial Counselor or contracted agent who processed the application. The patient must provide documentation of change in income/circumstances along with the appeal letter. The patient has 30 days from the date of the award letter to appeal the decision.

Extraordinary Collection Actions (ECA's)

A. Anderson Healthcare or authorized party may not initiate ECA's against an individual whose financial assistance eligibility has not been determined before 120 days after the first post-discharge billing statement, provided the required notifications and reasonable efforts have

been made prior to the initiation of ECA's.

B. Written patient notices (and an accompanying plain language summary of the FAP) regarding ECAs will be mailed and state the ECAs that Anderson Healthcare or other authorized party actually "intends to take". This notice does not need to be provided unless, and until one or more ECAs are initiated against an individual. The written notice will state the deadline after which the identified ECAs may be initiated, that is no earlier than 30 days after the date that the written notice is provided. Written notices or communications that are mailed will be considered "provided" on the date of mailing. A communication may also be considered provided on the date it is sent electronically or delivered by hand.

C. Anderson Healthcare or authorized party may provide any of the written notices or communications electronically (i.e. email) to any individual who indicates he or she prefers to receive the written notice or communications electronically.

D. Oral notification about the FAP is also considered as a reasonable effort to determine FAP eligibility for those patients that Anderson Healthcare or other authorized party intends to engage in ECAs. Anderson Healthcare or authorized party is to make a reasonable effort to orally notify an individual about the hospital's FAP and about how the individual may obtain assistance with the FAP application process at least 30 days before the initiation of the ECAs against the individual.

E. Anderson Healthcare or authorized party will need to document whether and how reasonable efforts were made to determine an individual's FAP-eligibility before engaging in ECAs.

F. If Anderson Healthcare or authorized party receives a completed financial application during the application period from an individual after initiating an ECA against the individual, the application must be processed. If the individual is determined to be eligible for financial assistance, the ECA should be reversed and the collection process should be stopped (if the patient is eligible for free care), or continues anew based on the adjusted amount.

G. If an individual is determined to be ineligible for financial assistance, no reversal of ECA's will be necessary (suspension will be necessary only for the period of time the application is being processed).

H. If Anderson Healthcare or authorized party receives an incomplete financial assistance application, ECAs must be suspended against an individual until, either the individual completes the FAP application, or until the individual has failed to respond to requests for additional

information and/or documentation within a reasonable period of time.

I. The reasonableness of the period of time individuals are given to complete a FAP application before ECAs may resume will depend on the particular facts and circumstances including the amount of additional information and/or documentation that is being requested. Anderson Healthcare or authorized party will inform the individual who has submitted an incomplete FAP application of the potential ECAs (and an accompanying plain language summary of the FAP) to ensure the individual knows who to contact for assistance in completing the application.

J. The application period for the care of an individual will be longer than 240 days if the hospital facility provides the individual with notice about available financial assistance that is after the 240th day from the first post-discharge bill.

K. Anderson Healthcare or authorized party is permitted to initiate or resume ECAs before the end of the application period against an individual who has failed to respond to requests for additional information and/or documentation. If the individual subsequently completes the FAP application during the application period, Anderson Healthcare or authorized party will again suspend any ECAs taken against the individual until the hospital determines whether the individual is FAP-eligible.

L. If Anderson Healthcare or authorized party aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs, the ECAs may not be initiated until 120 days after the post discharge bill was provided for the most recent episode of care.

M. Anderson Healthcare or authorized party will only suspend ECAs taken against the individual "to obtain payment for the care" at issue, not ECAs relating to past care for which Anderson Healthcare has already satisfied the reasonable efforts requirements.

N. In cases where Anderson Healthcare staff or authorized party believes an individual who has submitted a completed FAP application may qualify for Medicaid, the determination for FA eligibility may be postponed until after the individuals Medicaid application has been completed and submitted, and a determination as to Medicaid eligibility has been made. However, when an individual has submitted a complete FAP application, Anderson Healthcare or authorized party may not initiate or resume any ECAs to obtain payment for the care at issue until a FAP-eligibility determination has been made.

O. Anderson Healthcare or authorized party is required to report whether and how reasonable efforts were made to determine an individual's FAP eligibility before engaging in ECA's, and as a general matter,

Anderson Healthcare will maintain records to substantiate any information requested.

CHARITY CARE DISCOUNT QUALIFICATIONS UNDER ILLINOIS HOSPITAL UNINSURED PATIENT DISCOUNT ACT (Public Act 95-0965):

A. Illinois residents applying for financial assistance should be evaluated as outlined herein. If the policy does not provide for a financial charity adjustment of at least 50%, the patient should be considered for charity discount as required by the Illinois Public Act 95-0965.

B. Uninsured Patients are those patients who have no form of insurance or are not insured for any of the services provided. The term uninsured patients excludes patients who are covered for the services provided by Medicare, Medicaid or another public aid program.

C. Uninsured patients charges will be discounted 50% (so that billed amount does not exceed 135% of cost) of medically necessary services.

D. Patients are to provide third-party verification of income, information regarding assets and documentation of residency within thirty (30) days of request.

E. The maximum amount collectible for medically necessary services from uninsured patients is 20% of annual family income for those Illinois resident patients who meet eligibility criteria and do not have substantial assets. For any subsequent services to be included in the maximum, the patient must inform the hospital that he/she had received prior services from that hospital which were determined to be eligible for discount.

References:

A. Patient Protection and Affordable Care Act of 2010, 501(r)(3) -(6) effective December 29, 2015
B. Illinois Register Hospital Financial Assistance Under the Fair Patient Billing Act (January 1, 2014)
C. Illinois Hospital Uninsured Patient Discount Act (Public Act 95-0965)
D. Anderson Hospital Out of Market Policy for Elective Services
E. Federal Poverty Guidelines / Federal Poverty Level
F. Section 5/12-1001 Illinois Code of Civil Procedure (Appendix A)
G. Medicare Guidelines / Medical Necessity
H. Anderson Healthcare Billing and Collection Policy

Responsible Department: Revenue Cycle, Revenue Systems	Date Created: 12/01/2015
Approver(s): Keith Page (President)	Date Approved: 12/29/2021

Appendix A

Anderson Medical Group and Community Clinic of Staunton Providers
Eligible for Financial Assistance under this Policy

Cardiology of Maryville
Distinctive Care for Women
Endocrinology of Maryville
Gastroenterology of Maryville
General & Laparoscopic Surgical Associates
Greenleaf Orthopaedics
Illinois Ear, Nose and Throat Associates
MidAmerica Plastic Surgery
Neurology of Maryville
Precision Orthopaedics
Pulmonary and Sleep Medicine of Maryville
R. Craig McKee, MD, LLC
Rheumatology of Maryville
The Center for Advanced Orthopedics
The Community Clinic of Staunton

Responsible Department: Revenue Cycle, Revenue Systems	Date Created: 12/01/2015
Approver(s): Keith Page (President)	Date Approved: 12/29/2021

Appendix B

Providers Not Eligible for Financial Assistance Under This Policy

A to Z Pediatrics
Ahmad & Rana Pediatrics
Allergy & Asthma Care Ltd.
Associated Foot Surgeons of Southwest Illinois
Bard & Didriksen Pediatrics
BJCMG Cardiology of Belleville
BJCMG Cardiology of Maryville
Cardinal Glennon Pediatrics - Pediatric Emergency Medicine
Cardinal Glennon Specialty Clinic
Casandra Roy, Nurse Practitioner Wound Care
Center for Interventional Pain Management
Chestnut Family Health Center
Christina Midkiff, MD SC
Collinsville Pediatrics
Dalla Riva & Hulsen OB/GYN
DB Orthopedic Institute
ENT & Sleep Associates
Family Health Care Medical Center
Family Medicine Associates, PC
Foot Health Center
Gateway Surgical & Vein Care
GC Physician Corp.
Greenville Family Medicine
Highland Pediatrics & Adolescent Med.
Illinois SW Orthopedics (ILSWO)
Infectious Disease Consultants
Interventional Pain Consultants
Interventional Pain Management Services
Lee Vascular Specialty Services
Lopatin & Associates
Mary Mioux-Berry, DO
Maryville Pediatrics
Maryville Radiology
Maryville Women's Center
Mercy Clinic Neurosurgery
Meridian OB/GYN
Metro East Gastroenterology Ltd.
Metro East Healthcare

Metro Hypertension and Kidney Center
Metro OMS
Midwest Bone & Joint Surgery, PC
Midwest Emergency Department Services (MEDS)
Midwest Gastroenterology Consultants
Midwest NHA
Millennium Anesthesiology Consultants
Prairie Psychiatry
Prairie Spine & Pain Institute
Premier Foot and Ankle
Sawar's Neurological Institute
Schumacher Clinical Partners (SCP): 1/1/22 – 1/31/22 at Community Hospital of Staunton, and 1/1/22 – 2/14/22 at Anderson Hospital
Serene Women's Wellness
SIHF
SLU Pathology
SLUCare OB/GYN - MFM
Southern IL Family Medicine
Southern OB/GYN Associates
Southwestern IL Internal Medicine, LLC
St. Louis Nephrology & Hypertension, Inc
St. Louis Pain Consultants, LLC
Steven Hyten, DMD
Urology of St. Louis
Vitas Healthcare
Young Pediatrics