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Owner:	*Richard Felbinger: Senior VP/ CFO*
Policy Area:	*Leadership - Finance*
Applicability:	*Borgess Health* *Borgess Ambulatory Services* *Borgess Medical Center* *Borgess Pipp Hospital* *Borgess-Lee Memorial Hospital*

Patient Financial Assistance

SCOPE:

Borgess Health and its related corporations, including Borgess Medical Center, Borgess Pipp Hospital, Borgess-Lee Memorial Hospital and Borgess Medical Group (collectively referred to as "Borgess").

PURPOSE:

To set forth the policy and procedure for providing patient financial assistance to eligible patients.

POLICY:

It is the policy of Borgess (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.
2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.
3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the Financial Assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "501(r)" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- **"Amount Generally Billed"** or **"AGB"** means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.

- **"Community"** means Kalamazoo and Cass Counties.
- **"Emergency Care"** means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    1. placing the health of the individual or unborn child in serious jeopardy,
    2. serious impairment to bodily functions,
    3. serious dysfunction of any bodily organ or part
- **"Medically Necessary Care"** means care that is determined to be medically necessary following a determination of clinical merit by a licensed provider. In the event that care requested by a Patient covered by this policy is determined not be be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- **"Organization"** means Borgess Health.
- **"Patient"** means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. At a minimum, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Household Size	Charity Care		Financial Assistance Program				Uninsured - Means to Pay
FPL	100%	200%	250%	300%	350%	400%	> 400%
% Assistance	100%	100%	90%	85%	80%	75%	71%

   An uninsured Patient eligible for the sliding scale discount will also receive a prompt pay discount of 10% if the balance due is fully paid prior to 30 days after the date of the first billing statement. An insured Patient eligible for the sliding scale discount will also receive a prompt pay discount of 10% on non-covered services only if such balance due is fully paid prior to 30 days after the date of the first billing statement, but an insured Patient is not eligible for a prompt pay discount on balances related to copay, deductible, or coinsurance amounts.
3. Patients with demonstrated financial needs with income greater than 400% of the FPL may be eligible for consideration under a "Means Test" for some discount of their charges for services from the Organization based on a substantive assessment of their ability to pay. This Means Test considers the patient's expenses, household income, and medical bill balances when considering assistance.
4. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and

circumstances.

5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application ("FAP Application").
    a. Presumptive financial assistance may also be provided at the 100% charity care level in the following situations:
        i. Deceased patients where the Health Ministry has verified there is no estate and no surviving spouse.
        ii. Patients who are eligible for Medicaid from another state in which the Health Ministry is not a participating provider and does not intend to become a participating provider.
        iii. Patients who qualify for other government assistance programs, such as food stamps, subsidized housing, and Women's Infants and Children's Program (WIC).
6. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
7. Completed applications are valid for 12 months from the date of the signed application, unless significant changes have occurred in the financial status of the patient. A new application will be filled out with updated information.
8. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:
    A. A decision letter is sent to patients applying for charity assistance, and will contain a designated Financial Counselor that reviewed their case. All appeal requests should be submitted in writing within 14 calendar days of receipt of the outcome letter, and directed to the specified Financial Counselor listed on the Decision letter.
    B. All appeals will be considered by Borgess Health's Financial Assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by Borgess Health.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured Patients who are not eligible for financial assistance will receive a prompt pay discount of 10% if the balance due is fully paid prior to 30 days after the date of the first billing statement. Insured Patients who are not eligible for financial assistance will receive a prompt pay discount of 10% on non-covered services if such balance due is fully paid prior to 30 days after the date of the first billing statement, but

insured Patients are not eligible for a prompt pay discount on balances related to copay, deductible, or coinsurance amounts.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization will calculate two AGB percentages – one for inpatient services and one for outpatient services – both using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation and percentage may be obtained by submitting a request in writing to the Finance department or calling (269) 226-8301.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process. The FAP Application and FAP Application Instructions are available online at www.borgess.com or can be requested via phone at (269) 553-3915 or (877) 563-9518.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by submitting a request in writing to the Revenue Cycle Director.

Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

Providers

See www.borgess.com for a list of providers delivering care within the Organization's facilities that specifies which are covered by the Financial Assistance policy and which are not.

RELATED POLICIES:

None

REFERENCES:

1. Section 501(r) of the Internal Revenue Code

ATTACHMENTS:

None

This policy is effective for 48 hours only

All revision dates: 8/15/2017, 2/24/2015

Attachments:

 Image 01

Approval Signatures

Approver	Date
Kathy Young: CEO/President Borgess Health	8/15/2017
Susan McDonald: Corporate Responsibility Officer	8/15/2017
Richard Felbinger: Senior VP/CFO	8/14/2017
Karri Fuller: Executive Secretary	8/14/2017
Susan McDonald: Corporate Responsibility Officer	8/14/2017