Thomas H Boyd Memorial Hospital
Policy & Procedure
Revised May 2012, December 2012, June 2018,
February 2019, September 2019, May 2022
November 2022

PATIENT FINANCIAL ASSISTANCE POLICY

PURPOSE: To outline the process for Thomas H Boyd Memorial Hospital d/b/a Boyd Healthcare Services' (Boyd or the Hospital) Financial Assistance Program for hospital services and rural health clinic visits. Boyd's mission is to provide quality health care and promote wellness for the residents in our region through Health Services, information resources and education. Boyd recognizes that not all patients have the financial resources to pay their hospital or rural health clinic bills.

POLICY: This policy is intended to be compliant with the provisions under 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. Boyd has established guidelines in which a patient may apply and qualify for financial assistance versus the unwillingness of a patient to pay (bad debt). Financial assistance includes services provided to patients at a reduced charge or no charge. Discounts provided to patients that qualify under this legislation will be classified as charity adjustments.

Application Process:

1. Boyd will provide notification of the Patient Financial Assistance Program, plain language summary, and application forms at no charge. Communication of the program will include, but not limited to:
    a. Posting signs and brochures in the registration areas of the hospital and rural health clinics;
    b. On hospital bills delivered in the mail;
    c. On Boyd's website (www.boydhcs.org);
    d. Patient financial counselor on site for program information or answer questions regarding program;
    e. Upon request

2. To apply for financial assistance, completed and signed applications, including all supporting documents outlined in application and policy below, must be submitted. Applications will be accepted by mail or in person to Patient Financial Counselor or Chief Financial Officer (CFO) located at 800 School St., Carrollton, IL 62016. Applications not meeting these conditions will be returned to the applicant for clarification/completion. Failure to complete necessary documentation will result in no discounts awarded under this policy until all supporting documents have been received.

3. The Financial Assistance Program intended solely for the benefit of the patient and his or her family living within the same household as dependents. If a non-minor child lives in the same household and is claimed on their parents' tax return, the parents' income will be factored into calculation to determine eligibility.

4. Boyd will provide written notification of approval or denial of financial assistance to the patient based on completed application, including the amount of discount and any remaining account balance to be paid by the patient.

5. If application is approved, the application will be valid for 12 months upon approved date. It is the responsibility of the patient or guarantor to notify the hospital that financial assistance was previously

granted and should be applied to subsequent accounts. A new application and income verification will be required to qualify for the program subsequent to 12 months and is the responsibility of the patient or guarantor to complete a subsequent application.

Qualification and Eligibility:

1. Boyd's primary method of determining eligibility for financial assistance is through the completion of the Financial Assistance Application. A single application form is used for both uninsured and insured patients and will be utilized to examine the applicant's eligibility.

2. The process for determining eligibility includes the following criteria:
    a. Determine if the patient meets eligibility under the Illinois Uninsured Patient Discount Act;
        i. 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.
    b. Determine if the patient meets medically indigent;
        i. Per Centers for Medicare and Medicaid Services (CMS), medically indigent is defined as patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.
        ii. To be considered medically indigent, Boyd will take into consideration the patient's total resources which would include disposable assets (checking, savings, certificates of deposit, extra property not used as primary source of income, or similar assets that can be accessed or sold to help cover medical expenses), liabilities, income and expenses.
        iii. Medical expenses utilized will income patient's balances at Boyd, as well as outside healthcare providers, based on current copies of statements submitted by the patient.
        iv. To be considered medically indigent, the patient portion of medical expenses must exceed 40% of patient's annual household income (net of disposable assets), which would then cause the applicant to be less than 300% of the Federal Poverty Level.
        v. Asset information, as well as expense information, is not used for determining eligibility for financial assistance (sliding fee discount), rather only used for calculating medically indigent status, as required by CMS. Financial Assistance eligibility is determined based on income and household size only.
    c. Determine if the patient meets presumptive eligibility;
        i. Presumptive Eligibility will be used to outline the criteria Boyd will use to determine if a patient is eligible for hospital financial assistance without further scrutiny by the Hospital. 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). 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. Homelessness;
            2. Patient is deceased with no estate
            3. Mental incapacitation with no one to act on patient's behalf; or
            4. Medicaid eligible, but not on date of service or for non-covered service.
                a. Medicaid co-pays are still collectible and payable regardless of financial need qualification
                b. Medicaid spend-down amounts do not qualify under presumptive eligibility because they do have coverage on the date of service but must pay a

specified portion of the balance due. However, the patient can submit the full application and submit to determine if they qualify for assistance.

5. Enrolled in Women's Infants, and Children's Programs (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Illinois Free Lunch and Breakfast Program, Low Income Home Energy Assistance Program (LIHEAP)
6. Incarceration in a penal institution, however, only after any other third party payments.
    a. A financial assistance application will be accepted for a patient/guarantor who is deceased and there is no estate. Boyd will review the obituary section of local newspaper and note the date of patient's death in the patient's account. If a probate is filed on a patient, a lien will be filed against the estate. If no probate has been documented, the Patient Financial Counselor or designee will call the Circuit Clerk's office in the county of the patient's residence to verify that no probate has been filed. Such conversation will be noted in the patient's account(s). Financial Counselor will be utilized to complete application if family or no other representative can complete on behalf of patient. Upon confirmation from the Circuit Clerk and documentation in the account, the account will be written off to financial assistance program upon approval by CFO or CEO.

d. Determine if the patient's annual household income is less than 300% of the Federal Poverty Level
    i. 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. Such patients qualifying for the program shall be eligible for discounts according to the following scale:

< 200% of poverty level	Full financial need write-off
201% to 250% of poverty level	75% financial need write-off w/ 50% of balance due from patient
251% to 300% of poverty level	50% financial need write-off w/ 75% of balance due from patient
> 300% of poverty level	No financial need write-off w/ 100% of balance due from patient

e. Determine if the patient's income is sufficient to pay for basic living costs but not medical care because income is assigned to a licensed nursing home or an assisted/supportive living facility.

3. For hospital visits, to be considered eligible under this policy, the patient must cooperate with Boyd 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 Medicaid, All Kids, and other 3rd party liability (i.e. health marketplace plans). Insured patients must cooperate with their insurance carrier and provide any requested information (i.e. coordination of benefits information, etc.) prior to financial assistance consideration. Boyd will cease obligations toward an individual patient if the patient unreasonably fails or refuses to provide Boyd with information or documentation requested, or if the patient fails to apply for coverage under any applicable public program within 30 days of Boyd's request.
    a. If applicant is applying for only health clinic visits, eligibility for will be on the sliding scale listed above, based solely on income and family size. No other factor (e.g., assets, insurance application and/or coverage, citizenship, population type) will be used to assess eligibility. Boyd will not require Medicare, Medicaid, All Kids, etc or proof of denial before allowing a patient to apply and be eligible for the program.

4. Financial assistance may be applied to the Insured patient's copays, deductibles and/or coinsurances if the patient meets the requirements of this policy. For rural health clinic visits, patients that qualify to receive

a full discount will be assessed a $25 nominal or discount fee per visit. However, patients will not be denied services due to an ability to pay. The nominal fee is not a threshold for receiving care, thus, is not a minimum fee or co-pay.

6. The patient shall apply within 240 days (8 months) from the first post discharge billing statement. Patients not applying within 240 days may forfeit the patient discount.

Verification of Illinois residency, Income, and Assets:

1. 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 Acceptable verification/proof of Illinois residency shall include one of the following:
    a. A valid state-issued ID
    b. A recent residential utility bill
    c. Lease agreement
    d. Vehicle registration card
    e. Temporary visitor's driver's license
    f. Voter registration card
    g. Mailed addressed to the uninsured patient at an IL address from a government or other credible source
    h. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
    i. A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

2. Unless a patient is considered medically indigent or meets presumptive eligibility, eligibility is determined by income, which means the sum of a family's household annual earnings and cash benefits from all sources before taxes (ie gross income), less payments made for child support and less assigned income to a licensed nursing home or assisted living facility. Proof of income eligibility shall require ONE of the following acceptable forms of documentation for each source of household income:
    a. Copy of the most recent tax return
    b. Copies of the two most recent pay stubs, or W-2 and 1099 forms (Preferred)
    c. Written income verification from an employer if paid in cash
    d. Benefit statements for other types of income (ie Social security, alimony or child support, unemployment, pension, rental income, interest or dividend income)
    e. Other reasonable form of third party income verification as deemed acceptable by the hospital.

3. Financial assistance levels of income may be verified for either the previous 12 months or annualized if partial information is received.

Maximum Collectible Amount:

1. The maximum amount that may be collected in a 12-month period for health care services provided to an eligible patient is 20% of the patient's family income and begins on the first date a patient receives health care services that are determined eligible under the application.

2. Following a determination of eligibility, an individual may not be charged more than Amounts Generally Billed (AGB). The AGB limitation applies to all individuals eligible for assistance under the Financial Assistance Policy, without specific reference to the individual's insurance status. The Illinois Hospital Uninsured Patient Discount Act and Internal Revenue Service regulations have different determinations on calculating AGB. Therefore, Boyd will annually calculate both methods to determine which method provides a greater discount to be in compliance with state requirements and IRS section 501(r) requirements and a charity adjustment will be provided.

a. Under the Illinois Uninsured Patient Discount Act: For all health care services exceeding $300 in any one inpatient admission or outpatient encounter, a hospital shall not collect from an uninsured patient, more than its charges less the amount of the uninsured discount (hospital's charges multiplied by 1.0 less the product of a hospital's cost to charge ratio multiplied by 1.35). Actual formula for discount is [1-(Ratio of Cost to Charges x1.35) x charges].

b. For Internal Revenue Service regulations, Boyd has chosen to use the look-back method in order to determine the hospitals AGB. Boyd calculated the 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.
c. Questions regarding Boyd's AGB percentage can be directed to the Boyd's Chief Financial Officer.

Other Information:

1. The Program also does not relieve third parties of liability for payment. Any write-offs under this policy will only apply to balances after all third party responsibilities have been applied.

2. Financial assistance will be based solely on the criteria in this policy. Boyd does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin, disability, marital status, or sexual orientation, in any of its activities or operations.

3. This policy also pertains to certain professional services provided by Boyd employed or contracted physicians, and includes services provided by clinic physicians and emergency department physicians. Services not eligible for financial assistance are included in Appendix A.

4. 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.

5. The Hospital will forego extraordinary collection actions against an individual upon approval of financial assistance for care covered under the policy. All bad debt accounts within this period will be shifted from bad debt to charity care. Upon approval of program and if only a partial discount is received, patient will work with Boyd to establish a reasonable payment option for remaining balance due. If patient does not comply or is unwilling to pay remainder balance, collection action may be taken by Boyd on the balance due.

6. Emergency admission, treatment, screening and/or stabilization services will not be delated or denied due to coverage or payment ability.

7. If the patient subsequently submits a complete application and is determined to be eligible for the care, Boyd will refund any amount the individual has paid for the care that exceeds the amount determined to be personally responsible for paying as an eligible individual, unless such excess amount is less than $5.

8. Financial need applications can be re-evaluated and revoked if it is found that the recipient misrepresented their income, or other information on the financial need application.

9. The Chief Executive Officer (CEO) and/or CFO oversees all financing procedures, and directs the authorized personnel who enforce the policies. The CEO or CFO may utilize their discretion to make exceptions to the above procedures based on specific extraordinary circumstances, in order to authorize additional financial assistance or extension of qualifying period.

Reporting Requirements:

1. Boyd will submit the Medicare cost report Worksheet C, Part I with the Attorney General's Office within 30 days of filing the Medicare cost report.

Administrator: Donna Dewitt - acting Date: 11/29/22

Financial Officer: Kathryn Garner Date: 11/29/22

Implementation Date: ongoing