

System – Administrative

TITLE:

Operations – Financial Assistance Policy (Charity Care)

OUTCOME STATEMENT:

In accord with the mission of SSM Health Care Corporation and its affiliated hospital entities (“SSM Health”) and the Ethical and Religious Directives for Catholic Health Care Services, as amended from time to time by the United States Conference of Catholic Bishops, care for those who lack financial resources is central to the identity of SSM Health. SSM Health’s Financial Assistance Policy (“FAP”) 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 FAP provides and establishes system-wide guidelines for financial assistance that ensures compliance with all state and federal rules and regulations.

SSM Health 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 Health strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. SSM Health will provide, without discrimination, emergency care for medical conditions to individuals regardless of their eligibility for financial or governmental assistance programs or a history of non-payment for prior services. Delivery of emergent services shall not be hindered through activities intended to collect payment for current or previous services.

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 emergency or other 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 Health’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. A social security number is not required to qualify for financial assistance; however, a social security number is required for some public programs, including Medicaid. Providing a social security number will assist the hospital in determining eligibility for public programs. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of facilitating access to health care services, for their overall personal health, and for the protection of their individual assets. SSM Health may at any time define and revise the criteria determining eligibility for financial assistance.

In order to manage its resources responsibly and to allow SSM Health to provide the appropriate level of assistance to the greatest number of persons in need, the SSM Health Board of Directors has established the following guidelines for the provision of patient Financial Assistance.

SCOPE:

This policy is applicable to all SSM Health hospitals.¹

FILE MAINTENANCE INFORMATION:

Original Effective Date: 10/31/2012
Revision Dates: 10/7/2013, 06/15/2015, 08/01/2016, 1/10/2017, 12/04/2019, 12/04/2020, 06/10/2025
Review Dates: 07/01/2023, 11/09/2023, 7/31/2024
Author(s): Director, Patient Services Center
Body or Person Last Approved: System Vice President, Patient Financial Experience
Chief Revenue Officer
Chief Financial Officer
SSM Boards of Directors

¹ As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals are included as SSM Health entities:
Missouri: (1) SSM Health St. Mary’s Hospital – St. Louis and SSM Health Cardinal Glennon Children’s Hospital, (2) SSM Health DePaul Hospital – St. Louis, (3) SSM Health St. Clare Hospital – Fenton, (4) SSM Health St. Joseph Hospital – Lake St. Louis, (5) SSM Health St. Joseph Hospital – St. Charles and SSM Health St. Joseph Hospital – Wentzville, (6) SSM Health Saint Louis University Hospital, (7) SSM Health St. Mary’s Hospital – Jefferson City,
Oklahoma: (1) SSM Health St. Anthony Hospital and Bone & Joint Hospital at St. Anthony, (2)SSM Health St. Anthony Shawnee Hospital, (3) SSM Health St. Anthony Midwest (4/1/2021)
Wisconsin: (1) SSM Health St. Mary’s Hospital - Madison, (2) SSM Health St. Clare Hospital - Baraboo, (3) SSM Health St. Mary’s Hospital - Janesville, (4) SSM Health St. Agnes Hospital, (5) SSM Health Ripon Community Hospital, (6) SSM Health Waupun Memorial Hospital
Illinois: (1) SSM Health St. Mary’s Hospital – Centralia and (2) SSM Health Good Samaritan Hospital – Mt. Vernon

DEFINITIONS:

- I. **Amounts Generally Billed (AGB):** The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. The “AGB percentage” is the percentage of gross charges that equates to the AGB for a hospital subject to this FAP, as listed in Exhibit C.
- II. **Application Period:** The time provided to patients by the hospital to complete the Financial Assistance Application. It begins on or before 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.
- III. **Eligible Service Area:** The geographic area, identified as a cluster of ZIP codes, from which 75% of a hospital’s discharges originate for all hospitals.
- IV. **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.
- V. **Family Income:** Family Income is determined using the Census Bureau definition, which consists of the following:
 - 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. Excludes capital gains or losses and noncash benefits (such as food stamps and housing subsidies);
 - C. Determined on a before-tax basis; and
 - D. Includes the income of all family members who are included in the family size (Non-relatives, such as housemates, do not count).
- VI. **Federal Poverty Guidelines (FPG):** 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, which are available here: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.
- VII. **Financial Assistance:** The 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 meet SSM Health’s FAP criteria.
- VIII. **Financial Assistance Application:** The application through which a patient may apply for financial assistance under this FAP.
- IX. **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.

- X. **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.
- XI. **Medically Necessary Services:** Pursuant to Medicare, those health care services or items needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine in the local area and are not mainly for the convenience of the patient or patient's doctor.
- XII. **Patient Liability:** The amount a patient is personally responsible for paying after the applicable of all available insurance payments and/or adjustments and after all applicable patient discounts, including: uninsured discount and Financial Assistance.
- XIII. **Plain Community:** A faith-based group connected by business, shared culture and simple living (e.g., Amish, Mennonite).
- XIV. **Presumptive Financial Assistance:** SSM Health may utilize predictive analytical software or other criteria to assist in determining financial assistance eligibility prior to or after services are rendered when no Financial Assistance Application has been submitted. Alternative forms of documentation for indigency needed to validate eligibility may be used in cases such as when a patient is: homeless, deceased with no known estate, or seeking/granted relief by the courts for bankruptcy. Patient financial services may forgo the formal application and process an approval when utilizing presumptive financial assistance eligibility determinations, as explained in Process Section III.C.
- XV. **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 for the emergency or other medically necessary care provided.
- XVI. **Uninsured:** The patient has no insurance coverage for the emergency or other medically necessary care provided.

PROCESS:

- I. **Services Eligible:** For purposes of this FAP, all emergency and medically necessary services provided by the hospital are eligible for Financial Assistance, except as provided herein.

The following health care services are not considered emergency or medically necessary and are not eligible under this FAP:

1. Cosmetic treatment and/or procedures unrelated to severe congenital malformations or physical disfigurements caused by injury or illness determined not medically necessary by a licensed physician.
2. Bariatric procedures determined not medically necessary by a licensed physician.
3. Any other service or procedure determined by a licensed physician to be not medically necessary.

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

1. Are Uninsured or Underinsured;
2. Cooperate with SSM Health's policies and procedures;
3. Demonstrate financial need;
4. Supply all required information to process the application; and
5. Reimburses SSM Health for any monies paid directly to the patient by insurance.

Eligibility for 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, immigration status, or source of payment. An eligibility determination will be effective for a period of six (6) months after the approval date. This eligibility starts on the date the Financial Assistance Application is approved and will encompass all outstanding receivables within the Application Period, including those at bad debt collections agencies.

III. **Financial Need and Eligibility Determinations:**

- A. **Application** – Unless otherwise approved through the presumptive eligibility process, in order to be eligible for Financial Assistance, the patient or guarantor must complete the Financial Assistance Application and submit the documentation requested to support reported income and expenses. One application will cover the unpaid patient liabilities for all open accounts for the same guarantor and family members included on the Financial Assistance Application. The Financial Assistance Application should be complete, accurate, and include verifiable proof of income, expenses (including unusual expenses) and/or assets.

A Financial Assistance Application may also be completed verbally, either over the phone or face to face with a SSM Health representative. The SSM Health representative will document the patient/guarantor responses onto the Financial Assistance Application and the patient/guarantor will verify and attest to all the information. All supporting documentation must be supplied for the Financial Assistance Application to be considered complete. Patients who would qualify for Financial Assistance but who do not provide the necessary documentation may be eligible for Presumptive Financial Assistance as defined in "III.C. Presumptive Financial Assistance Eligibility".

SSM Health's values of respect and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Financial Assistance Applications shall be processed promptly and SSM Health shall notify the patient or applicant in writing within a reasonable time from receipt of a completed Financial Assistance Application. Each patient has the opportunity to apply for Financial Assistance any time during the Application Period.

Financial Assistance Applications will not be considered complete unless the required documentation is received and evaluated by a SSM Health representative. If the Financial Assistance Application is incomplete, the patient (or guarantor) will receive written correspondence requesting the missing information. For complete Financial Assistance Applications, as well as Presumptive Financial Assistance eligibility determinations, the patient will receive a notice explaining the patient's eligibility for Financial Assistance.. In the event that SSM Health determines that a patient is not eligible for Financial Assistance, the patient will receive a letter along with an updated statement(s) reflecting any financial assistance discounts or self-pay balances during their next regular billing cycle.

Financial Assistance Applications require the following supporting documents (Please note submitted documents will not be returned and altered documented will not be accepted):

1. Completed Financial Assistance Application (signed by the patient/guarantor).
 - a. If the Financial Assistance Application is completed verbally, a SSM Health representative will notate circumstances.
 2. Verification of Gross Income for Applicant/Guarantor.
 - a. Verification of income may include (not an inclusive listing): pay stubs, unemployment checks/payment history, social security award letters/checks, disability award letters, child support documentation, and pension verification.
 - b. If patient/guarantor is legally married, income verification is required for spouse.
 3. Federal Tax Return Documentation.
 - a. Most recently filed federal tax return or non-filing letter from the IRS. Tax return must be accompanied by all supporting schedules (A-J and/or 1/3) and documents (W-2s, 1099s) to be considered complete.
 4. Bank/Savings Statements.
 - a. The most recent three (3) months for all accounts.
 - b. An explanation of any unusual deposits/expenses on the bank/savings statements.
 - c. Documents must reflect all deposits.
 5. Medicaid Approval/Denial Letter.
 - a. This is only a requirement if the SSM Health representative and/or SSM Health vendor has pre-screened the patient for Medicaid eligibility.
 - b. If patient is pre-screened as potentially eligible, they must cooperate with the Medicaid application process to be eligible for Financial Assistance with SSM Health.
 6. Additional Documents (may be requested to qualify patient for financial and/or medical indigence).
 - a. Verification of monthly expenses.
 - b. All medical bills, housing bill, and any other bill essential to the basic needs of living.
 - c. An attestation of income and/or supporter statement.
- B. Consideration for Patient Assets:** Available assets in excess of \$5,000, excluding the protected assets listed below, will be added to current year's income in determining a patient's eligibility for Financial Assistance.

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. **Presumptive Financial Assistance Eligibility:** SSM Health understands that certain patients may be unable to complete a Financial Assistance Application. As a result, the patients' eligibility for Financial Assistance may be established using externally available third-party data sources such as credit agencies and public records (See Exhibit B for criteria). In addition, Presumptive Financial Assistance may be granted to patients without the necessary documentation, including but not limited to patients who are homeless or received care from a homeless clinic, deceased patients with no known estate, or patients seeking/granted relief by the courts for bankruptcy. Presumptive Financial Assistance eligibility is valid for ninety (90) days. Presumptive Financial Assistance eligibility may also be applied/communicated to the guarantor prior to service.

D. **Incomplete Applications:** Patients/guarantors submitting an incomplete Financial Assistance Application will receive a notification letter detailing the information needed to satisfy the documentation requirements for eligibility. If the patient/guarantor submits incomplete documentation a second time, the patient/guarantor will receive a letter and a phone call attempt to notify the patient that their application is incomplete. Presumptive Financial Assistance may still be applied if the patient is otherwise eligible.

Applications for Financial Assistance can be returned to a SSM Health representative at the facility in which care was provided or mailed to:

SSM Health
Attention: Financial Assistance
PO Box 411997
St. Louis MO 63141
Fax: (314) 989-6734
Email: financialaid@ssmhealth.com

Questions about the FAP may be directed to SSM Health Customer Service at 888-918-3512; billingquestions@ssmhealth.com, or through MyChart.

IV. **Cooperation to Establish Coverage:** SSM Health, supported by some specialist vendors, may proactively help patients apply for public and private programs to establish coverage for health care services or refer to other providers of care. SSM Health may deny Financial Assistance 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.

V. **Out-of-Network Services:** SSM Health hospitals are not in-network for certain insurance plans, and SSM Health may work with insurance plans on "single case agreements" for these cases. Although SSM Health may agree to the terms of the negotiations with insurance plans for single case agreements, this agreement is not representative of a patient "under contract" with SSM Health. As an out-of-network provider, SSM Health may not receive any reimbursement from the insurance carrier. Patients that seek non-emergent services at SSM Health hospitals, out of network of their insurance plan, are not eligible for Financial Assistance if other providers within SSM Health hospital Eligible Service Area has in-network providers capable of providing the service. Exceptions may be reviewed

on a case-by-case basis.

- VI. **International/Traveling Patients:** Financial Assistance will not be available to International/Traveling patients. Exceptions may be made for emergent occurrences, or in situations where there were no other providers within the SSM Health hospital's Eligible Service Area.
- VII. **Plain Community Patients:** Due to the inability to apply for insurance coverage and provide necessary supporting documentation, patients who are Plain Community members will not be eligible for Financial Assistance. A discount (see section VIII) will be provided to Plain Community patients.
- VIII. **Discounts to Patients**
1. **Financial Assistance Discounts:** SSM Health provides Financial Assistance for eligible patients based on Federal Poverty Guidelines. The discount is applied to the patient's remaining liability after insurance for insured patients and after the uninsured discount is applied for uninsured patients (See Exhibit A). Any non-covered or denied service provided to a Medicaid eligible patient is considered a Financial Assistance discount.
 2. **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 points below the average.
 3. **Medical Indigence 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 Health. In such cases, other factors may be considered in determining eligibility for discounted or free services, including:
 1. Bank accounts, investments and other assets.
 2. Employment status and earning capacity.
 3. Amount and frequency of bills for health care services.
 4. Other financial obligations and expenses.
 5. Generally, patient liability will be adjusted to no more than 25% of gross family income.
 6. Attestation(s) for income/support to assist in determining Family Income, in the case of missing documents ("Declaration of Income/Supporter Statement").
 7. Credit report(s).
- IX. **Amount Generally Billed (AGB)/Limitation of Charges:** SSM Health limits the amount charged for emergency and medically necessary care provided to patients who are eligible for Financial Assistance under this FAP 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 Exhibit C).
- The AGB percentage is calculated at a hospital level, at a minimum annually, with implementation not more than 120 days after the end of the 12 month period utilized above.
- X. **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. During the process of collection procedures, it may be identified the patient is eligible for Financial Assistance. In these circumstances, the patient will not be responsible for the respective liability and the amount will be recorded by SSM Health as Financial Assistance. Please see SSM

Health Billing and Collection Policy for a comprehensive schedule of collection activities to which an account will be subjected. A copy of the SSM Health Billing and Collection Policy may be obtained at no charge from the SSM Health Customer Service Center (888-918-3512), from a SSM Health representative at any local SSM Health hospital, or SSM Health's website (www.ssmhealth.com/financialaid).

- XI. **Providers Covered:** A list of providers that are covered under this FAP, and those that are not covered, is maintained and available for free at www.ssmhealth.com/financialaid. A copy of this provider list may also be obtained at no charge by calling the SSM Health Customer Service Center (888-918-3512) or visiting a financial counselor at any local SSM Health hospital or clinic location.

Any questions about inclusion or exclusion of providers that are covered under this policy can be directed to SSM Health Customer Service at 888-918-3512.

- XII. **Regulatory Requirements:** In implementing this FAP, SSM Health 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.

- XIII. **Documentation:** SSM Health 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 FAP. Records will be maintained in accordance with SSM Health's policy on record retention and destruction.

- XIV. **Annual Reporting:** Each SSM Health hospital may 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.

- XV. **Healthcare Crisis:** In situations where an emergent situation exists affecting the immediate healthcare needs of a SSM Health hospital's community, such as a pandemic or federal or state declared emergency, SSM Health senior leadership may proclaim that a healthcare crisis exists ("Healthcare Crisis"). During a Healthcare Crisis, SSM Health may modify application of this FAP as appropriate for the circumstances of the Healthcare Crisis. Any changes to the FAP based on a Healthcare Crisis will be attached to this FAP as an addendum. Patient discounts related to a Healthcare Crisis may be provided at the time of the Healthcare Crisis in order to meet the community's needs, regardless of the effective date of the current FAP (in order to avoid delays based on timing for adopting formal amendments to the FAP).

- XVI. **Policy Administration:** SSM Health's Revenue Cycle Organization shall be responsible for administering the FAP and shall have sole authority to review and interpret this FAP, including determining what constitutes emergency and medically necessary services, evaluating Financial Assistance Applications, and making eligibility decisions.
- XVII. **Policy Questions:** If operational questions arise as to the application of certain guidelines contained within this FAP, they should be referred to Vice President, Patient Financial Experience or System Vice President, Revenue Cycle Organization. Any additional guidelines for implementation should be reviewed by SSM Health Senior Leadership for consideration and approval.

Exhibit A: Financial Assistance Discounts

Sliding Eligibility Scale for All Regions, based on Federal Poverty Guidelines.

Federal Poverty Guidelines	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%

Current Federal Poverty Guidelines, which are calculated and published annually by the Department of Health and Human Services, are available here: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.

Exhibit B: Presumptive Financial Assistance Discount

PARO Score	Presumptive Financial Assistance Discount
PARO 1, 3, or 5	100%
PARO 2, 4, or 6	0%

Exhibit C: Limitation of Charges/AGB

Effective 05/01/2025, Based on 2024 Calendar Year Data

Hospital	AGB %	Method
St. Mary's Health Center, St. Louis, MO	28.5%	1
Cardinal Glennon Children's Hospital	43.1 %	1
DePaul Health Center	29.5 %	1
St. Clare Health Center	31.0%	1
St. Joseph Hospital West	30.4%	1
St. Joseph Health Center	30.2%	1
St. Mary's Hospital – Jefferson City	28.8%	1
Saint Louis University Hospital	23.2 %	1
St. Anthony Hospital	20.9 %	1
St. Anthony Hospital - Midwest	26.8%	1
St. Anthony Shawnee Hospital	11.9%	1
St. Agnes Hospital Fond Du Lac, WI	38.1%	1
Ripon Medical Center Ripon, WI	42.8%	1
Waupun Memorial Hospital Waupun, WI	38.6%	1
St. Mary's Hospital Madison, WI	36.8%	1
St. Clare Hospital Baraboo, WI	33.0%	1
St. Mary's Janesville, WI	33.4 %	1
Monroe Hospital	34.3%	1
Good Samaritan Regional Health Center	45.0%	1
St. Mary's Hospital Centralia, Illinois	42.3%	1

Methods:

1. Under this method all claims paid by Medicare fee-for-service and private health insurers over the last 12 months are used. For these claims the sum of all allowable reimbursement amounts is divided by the sum of the associated gross charges.
2. Under this method, the hospital sets the amount generally billed (AGB) to the amount the hospital determines would be the total amount Medicare or Medicaid would allow for the care (including both the amount that would be reimbursed by Medicare or Medicaid and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductible).