St. Vincent's Medical Center
FYE 9/30/2016
Annual Filing Requirements

Report 15
Docket # 16-035AR

Listing of Uncompensated Care Policies and Procedures Enclosed

Item 1 - St. Vincent's Medical Center Patient Financial Services Policy for Collection and Bad Debt Referral
Item 2 - St. Vincent's Medical Center Patient Financial Services Policy for Collection - Judgment
Item 3 - St. Vincent's Medical Center Administrative Policy for Financial Assistance (Charity Care)
Item 4 - St. Vincent's Medical Center Administrative Policy for Patients with No Medical Insurance
Item 5 - Ascension Health Policy 16 Billing and Collection for the Uninsured (Referenced in Items 3 and 4)
Item 6 - Ascension Health Policy 9 Community Benefit Goal Setting, Planning and Reporting (Referenced in Item 4)
Item 7 - Ascension Health Procedures M-1 Care of Persons Living in Poverty and Other Vulnerable Persons/Comm
Item 8 - Ascension Health Procedures M-2 Cost of Bad Debt Attributable to Charity Care (Referenced in Items 5)
Item 9 - Financial Assistance Eligibility Matrix

ITEM # 1

ST. VINCENT'S MEDICAL CENTER
PATIENT FINANCIAL SERVICES

Subject: Collection & Bad Debt Referral

Effective Date: 12/1/13 Category: Financial

Policy: All patients receiving services are given the opportunity to take advantage of policies developed to assist them financially. These policies include Charity Care, Free Bed Funds, financial counseling as well as State & Federal programs In addition, patients are given the opportunity to make payment within a reasonable amount of time. The Medical Center reserves the right to refer patients who choose not to pay an amount determined to be their responsibility to a licensed collection agency.

Purpose: To collect outstanding balances from patients as a result of deductibles, co-payments or services rendered within a reasonable time-frame. If amount due is determined to be uncollectable, the balances are adjusted and referred to a licensed collection agency.

1. A determination is made that a balance is the responsibility of the patient based as a result of carrier payments or a review of the account by a representative of Patient Financial Services. At that point GE CENTRICITY accounts are changed, manually or by system functions, to Phase 7; CERNER accounts are changed, manually or by system functions, to SELFPAY or SELFPAY AFTER INSURANCE depending on the circumstances.

2. The changing of the account to Phase 7 (GE CENTRICITY) or SELFPAY/SELFPAY AFTER INSURANCE (CERNER) triggers the dunning cycle for follow-up and processing. The account retains an active Accounts Receivable status.

3. All self pay balances (either true self pay or balance after insurance), regardless of payor type, shall receive the minimum of an initial statement to be sent upon receipt of the account, 2 guarantor statements (SP2 & SP3 – CERNER) as well as a final notice sent 15 days prior to referral to bad debt. Referral to bad debt, total number of calls and total number of letters sent will be at the discretion of SVMC who agrees to initiate every reasonable effort to collect the amount placed with them. SVMC is required to initiate collection activity for a period of no less than 120 days before referral for bad debt with the exception of skips, bankruptcies, and deceased patients.

4. Accounts will be followed up for a minimum of 120 days with the following exceptions:

    - Upon notification DECEASED PATIENTS with a balance under $2500.00 in these categories will be placed on a Bad Debt Report and placed with our

licensed collection agency as referenced in Step #5. Encounters will proceed through the dunning cycle until at which time it's noted A): there is no estate and/or B): there is no spouse. At that point the encounter would be eligible for placement with a collection agency.

- SKIPS with a balance under $2500.00 will be placed on a Bad Debt Report and placed with our licensed collection agency as referenced in Step #5. GE accounts over $2500 will remain with the billing vendor and a skip tracing process/mechanism is utilized to determine the correct address and/or phone number. CERNER encounters upon receipt of a return address will be reviewed utilizing the established process in place. If an address is not obtained encounters with a balance over $2500 will be eligible for placement with a collection agency.

- BANKRUPTCY ACCOUNTS will be closed regardless of the balance and placed on a Bad Debt Report and placed with our licensed collection agency.

- Based on their review of the account at the conclusion of this activity, a recommendation is made to adjust the account to a Bad Debt status and refer the account to an outside collection agency.

5. Based on this recommendation, the account is adjusted to reflect a $0.00 balance utilizing a Bad Debt Allowance Code. The account is also manually changed to reflect Phase 8 (CENTRICITY), which allows the account to be referred to a collection agency. CERNER Accounts move automatically through the dunning cycle and placed in a bad debt placement file 15 days after receiving an SP4 (final) statement.

6. The account remains with the agency until requested or returned. Accounts returned from our agency are deemed uncollectible and no further activity takes place.

7. Based on the nature of circumstances, both medical and financial, the necessity of promoting a positive public/community image and as well as patient satisfaction, the manager as well as Senior Management can make exceptions on a case by case basis. Exceptions would include but not be limited to changes in the dunning cycle as well as placement conditions and/or requirements. Such exceptions will be documented in the Comments Field of the account as well as part of established reporting appropriate for the changes initiated.

Reviewed & Updated: 10/21/15

Item #2

ST. VINCENT'S MEDICAL CENTER
PATIENT FINANCIAL SERVICES

Subject: Collection - Judgment

Effective Date: 03/11/08 Category: Financial

Policy: All patients receiving services are given the opportunity to make payment within a reasonable amount of time. The Medical Center reserves the right to file a judgment/lien when patients choose not to pay an amount determined to be their responsibility.

Purpose: To utilize legal options in the form of a judgment/lien to collect outstanding balances from patients as a result of deductibles, co-payments or services rendered within a reasonable time-frame.

1. Upon review our licensed collection agency makes a determination the patient is eligible for judgment based on the following conditions:
   - Patient must be a property owner.
   - Patient must be gainfully employed for at least 6 months
   - Patient's credit record reflects current activity and a pattern of regular payments to other creditors.
   - Patient's mortgage must be no more than one payment in arrears.
   - Combined debt to The Medical Center must exceed $2,000.00.

2. The agency will complete an Approval to File Form and send it to the Accounts Receivable Manager who is responsible for the agency as a vendor. A copy of the debtor's credit report and all applicable documentation including all agency notes are to accompany the form.

3. Upon review the Accounts Receivable Manager will determine if legal activity will be pursued.
   - Legal activity will be limited to filing a judgment/lien only.
   - Judgments/liens will be filed against homeowner property only.
   - Wages are not to be garnished nor are bank accounts to be frozen.
   - No foreclosure will be initiated.

4. The Approval to File Form will be returned to the agency with all documents maintained by the Accounts Receivable Manager.

Reviewed 12/2/13
Reviewed 10/10/16

ITEM #3

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Financial Assistance Policy	Classification: 700-1
Effective Date: Revision Date:	Feb 3, 1992 Jan. 1, 1998, Aug. 22, 1994, April 16, 1996, March 9, 1998 May 20, 2002, Aug. 2, 2004 June 5, 2006, Nov. 29, 2010 April 11, 2011, May 17, 2013 July 21, 2016	Category: Finance
Reference Material:	Finance Department Ascension Health System Policy # 16	Administrative Approval:

Policy: It is the policy of St. Vincent's Medical Center (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 there under.

- "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 the City of Bridgeport, Milford and Shelton, Connecticut, and the Towns of Fairfield, Easton, Monroe, Trumbull and Stratford, Connecticut.
- "Emergency Care" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention may result in:
  a. Placing the health of the individual (or, with respect to a pregnant woman, her unborn child) in serious jeopardy; or
  b. Serious impairment to bodily functions; or
  c. Serious dysfunction of any bodily organ or part; or
  d. With respect to a pregnant woman who is having contractions –
     1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
     2. That transfer may pose a threat to the health or safety of the woman or the unborn child.
- "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 to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "Organization" means St. Vincent's Medical Center.
- "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:

Financial assistance described in this section is limited to Patients that live in the Community:

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 set forth on Attachment 1 to this Policy.
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. To complete the "Means Test" assessment, St. Vincent's Medical Center will require the following documentation:
   a. household family size

b. annual income
c. household expenses
d. medical expenses
e. disability expenses

A Patient eligible for the "Means Test" discount will not be charged more than the calculated AGB charges.

4. 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").
5. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
6. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:
    a. The patient or family member may submit a letter in writing to the St. Vincent's Medical Center's Charity Appeals Committee (the "Appeals Committee") appealing the financial assistance decision. The financial assistance decision will include instructions on how to submit a request to the appeals committee.
    b. All appeals will be considered by the Appeals Committee, and decisions of the Appeals 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 St. Vincent's Medical Center.

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 and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.
3. Free Bed Funds – are gifts provided to the Organization to endow a "free bed" that can be used to provide medical care to those who cannot afford it. It is not a governmental program but a charitable donation administered by the Organization.
4. Other Assistance Funds such as, but not limited to, grants and St. Vincent's Medical Center Foundation, Inc. (Swim Across the Sound).

To be eligible for the Free Bed Fund and Other Assistance Funds, a patient must meet the specific criteria of the fund. See Attachment 2.

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 calculates one or more AGB percentages 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 description and percentage(s) may be obtained by contacting the Charity Financial Counselor at St. Vincent's Medical Center at 203-576-6257, in writing at 2800 Main Street, Bridgeport CT, 06606, Attention: Charity Financial Counselor or emailing Financial.Assistance@Stvincents.org.

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 on line at [Insert Web Address] or by contacting the Charity Financial Counselor at St. Vincent's Medical Center at 203-576-6257, in writing at 2800 Main Street, Bridgeport CT, 06606, Attention: Charity Financial Counselor or emailing Financial.Assistance@Stvincents.org.

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 calling the Patient Customer Service Call Center at 203-576-5384, in writing at 2720 Main Street, Bridgeport CT, 06606 Attention: Customer Service Department or visit us on line at [Insert Web Address].

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.

Attachment 1

ST. VINCENT'S MEDICAL CENTER

SLIDING SCALE DISCOUNT

Effective as of July 1, 2016

Based on Federal Poverty Guidelines (FPL)

Hospital Based Inpatient & Outpatient Services				
Monthly Income		250%	350%	400%
		Charity Care		
Family Size	1	2,475	3,465	3,960
	2	3,338	4,673	5,340
	3	4,200	5,880	6,720
	4	5,063	7,088	8,100
	5	5,925	8,295	9,480
	6	6,788	9,503	10,860
	7	7,652	10,713	12,243
	8	8,519	11,926	13,630
Annual Income				
Income as a % of FPL		250%	350%	400%
Family Size	1	$29,700	41,580	47,520
	2	$40,050	56,070	64,080
	3	$50,400	70,560	80,640
	4	$60,750	85,050	97,200
	5	$71,100	99,540	113,760
	6	$81,450	114,030	130,320
	7	$91,825	128,555	146,920
	8	$102,225	143,115	163,560
SVHS Discount		**100%**	**80%**	**70%**

Attachment 2

St. Vincent's Medical Center
Free Bed Funds

Below is a listing of the Free Bed Funds listing of St Vincent's Medical Center.
If you believe you may qualify for one of the Free Bed funds listed below, you may request to have your case for financial assistance presented to St. Vincent's Medical Center. The Executive Director of Revenue Cycle has the authority to grant free bed funds based on financial and personal need. To obtain further information, including an application, please contact a Financial Counselor at 203-576-6257.

Baker Fund
Available to Bridgeport Fire & Police Departments. The patient must present verification that he/she is a member of the Bridgeport Fire or Police department.

Harral Fund
Member of St. Augustine's Parish. The patient must present a letter from St. Augustine's Parish (Bridgeport, CT) confirming patient's membership status.

Hubbell Fund
Alumni of St. Vincent's College or Bridgeport Hospital School of Nursing, who reside in Bridgeport and are active in the Nursing of the Sick.

Klein Fund
Funds to assist pediatric patients. Must provide a copy of patient's birth certificate or Baptismal certificate.

Ladies of Charity Fund
Letter verifying membership in the Ladies of Charity organization.

Conlin Fund
Assistance for low-income patients. Must provide proof of income and assets and a letter of denial from available third party sources.

Brodbeck Fund
Emergency room services. Must provide proof of income and assets and a letter of denial from available third party sources.

ITEM #4

ST. VINCENT'S MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

Subject:	Patients With No Medical Insurance	Classification: 700-12
Effective Date: Revision Date:	May 18, 1977 May 26, 1987, October 30, 1989 October 29, 1990, March 16, 1992 December 18, 1995, August 9, 1999 December 11, 2000, June 17, 2002 June 7, 2004, June 5, 2006	Category: Fiscal
Reference Material:	Patient Access Services Manuals Admission Policy (600-1) Financial Assistance Policy (700-1) Ascension Policy #16 (Billing and Collecting for the uninsured)	Administrative Approval: Susan L Davis

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Policy: Outpatients and Inpatients receiving medical care at St. Vincent's who do not have third party payment coverage are personally responsible for their bill. Uninsured patients with the ability to pay will be provided a discount per Ascension Policy #16. This discount will be adjusted annually.

Purpose: To maintain the financial integrity of the Medical Center.

Special Instructions, Information, Implementation Procedures:

I. Elective Patients

A. The physicians' offices shall schedule patients in accordance with St. Vincent's Medical Center policies and procedures. (600-1 and 600-18)

B. When a physician schedules a self pay patient, the arrival date is to be held in a pending status until the Patient Access Services Financial Counselor is able to establish a financial source.

C. Prior to the pending arrival date, the Financial Counselor will do the following in accordance with hospital procedures to establish a payment plan:

- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Financial Assistance Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.

D. Once a financial source is determined the pending date will be finalized and detailed information provided to the physician's office.

E. If a financial source cannot be determined, the physician's office will be notified of this and the patient will be held in pending status until a financial source has been determined.

F. In the event a financial source cannot be established, the decision to treat the patient will be made by Senior Management of the Medical Center.

II. Urgent or Emergent Patients

A. Emergent or urgent services will never be refused to a patient due to the inability to pay the Medical Center.

B. The Financial Counselor will interview the patient or appropriate family member either after initial screening and stabilization or by the next business day in accordance with hospital procedures to establish a payment plan:

- Assess the patient's income and assets with the patient.
- Determine whether the patient is eligible for Federal, State or City health insurance.
- Determine whether or not the Financial Assistance Policy (700-1) is applicable.
- Obtain written certification from the patient indicating intent to pay all hospital bills resulting from the treatment if a payment plan is established by the Medical Center.

C. If a financial source cannot be established, the Director of Patient Financial Services and Patient Access will refer the account over to the Collection agency utilized by the Medical Center.

Reviewed: May 1979, March 1981, April 23, 1984, March 28, 1994

/bjk

ITEM # 5

POLICY#: 16 **SUBJECT:** **Financial Assistance for Those in Need and Billing and Collection Practices**

BOARD APPROVAL DATE: **12/10/03**
REVISON DATES: **07/01/04**
12/08/10
03/03/16

President and Chief Executive Officer, Ascension Health

In light of its Catholic identity and Mission, Ascension Heath is committed to the principles of Catholic Social Teaching. This policy is informed by the principle of human dignity, which acknowledges the intrinsic worth of each person by virtue of his or her existence as a human being. The principle of the common good is also foundational to this policy, which promotes collaboration in the goods we hold in common so that each person may flourish. Lastly, the principle of solidarity with those in poverty strives to identify with those affected by poverty, serve their needs and advocate on their behalf.

As such, Ascension Health intends to ensure a socially just practice for providing health care services for all patients at any of its subsidiaries' facilities or locations, with special attention to financial assistance and billing and collection practices for patients who are in need of financial assistance. All Ascension Health controlled subsidiaries' financial assistance and billing and collection practices 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.

PRINCIPLES

It is Ascension Health's intent that patients across all of Ascension Health are treated consistently, regardless of place of service. This includes extension of this policy to all services provided by an Ascension Health controlled subsidiary. This policy does not apply to elective procedures or services.

Ascension Health will also adopt procedures for its subsidiaries that engage in the provision of health care services to ensure that:

1. they are providing financial assistance to patients that qualify for assistance according to the guidelines established by the Office of the President of Ascension,
2. their employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion,
3. information regarding financial assistance is widely publicized and patients and their families are advised of the applicable policies, including the availability of all need-

based financial assistance in easily understood terms,

4. outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic-sponsored facility in the community it serves,
5. our subsidiaries comply with applicable laws and preserve the tax-exempt status of our entities as applicable, and
6. financial counselors are available to all patients.

APPLICABILITY TO SUBSIDIARIES

This policy applies to all organizations controlled by Ascension Health. Such organizations also will be expected to comply with System reporting requirements regarding care of persons living in poverty and other vulnerable persons and community benefits.

ASCENSION HEALTH PROCEDURES

Procedures for Financial Assistance for Those in Need and Billing and Collection Practices can be found in the Ascension Health Procedures M-1 and M-2.

ITEM #6

POLICY #: 9 **SUBJECT: Community Benefit Goal Setting, Planning and Reporting**

BOARD APPROVAL DATE: 09/06/00
REVISION DATES: 03/12/03
12/08/10
03/03/16

President and Chief Executive Officer, Ascension Health

POLICY

In light of its Catholic identity and Mission, Ascension Heath is committed to the principles of Catholic Social Teaching. This policy is informed by the principle of human dignity, which acknowledges the intrinsic worth of each person by virtue of his or her existence as a human being. The principle of the common good is also foundational to this policy, which promotes collaboration in the goods we hold in common so that each person may flourish. Lastly, the principle of solidarity with those in poverty strives to identify with those affected by poverty, serve their needs and advocate on their behalf.

As such, Ascension Health will annually plan for community benefit with special attention to persons affected by poverty and other vulnerable persons to address community health needs and health disparities and will report annually on this plan. Each Health Ministry, providing services in an inpatient, outpatient, clinic, ambulatory setting or physician practice, guided by the Mission, Vision, Values, and Philosophy of the Ascension Health System, will plan for care of persons living in poverty and other vulnerable persons and for community benefit and will report annually on this plan.

PRINCIPLES

1. The principle of the common good obliges government, church and civic communities to address the needs and advocate for those who lack resources for a reasonable quality of life. Ascension Health desires to express commitment to this principle through a unified system of planning and accountability.

2. Health Ministries will collaborate in assessing the needs and resources of individuals and communities they serve and will establish substantive goals directed toward those needs in the context of their integrated strategic, operational and financial planning.

3. Health Ministries will account annually to appropriate constituencies for progress toward achievement of these goals.

4. Annually, Ascension Health will produce an aggregate report highlighting the best practices and

innovative programs in the System.

APPLICABILITY TO SUBSIDIARIES

This policy applies to all organizations controlled by Ascension Health. Such organizations also will be expected to comply with System reporting requirements regarding care of persons living in poverty and other vulnerable persons and community benefits.

ASCENSION HEALTH PROCEDURES

Procedures for planning and reporting on Community Benefit Goal Setting, Planning and Reporting can be found in the Ascension Health Procedure M-3.

ITEM # 7

PROCEDURE #: M-1 **SUBJECT:** **Financial Assistance for Those in Need**

EFFECTIVE DATE: **July 01, 2004**
DATES REVISED: **April 23, 2007**
June 9, 2010
March 3, 2016
April 26, 2016

Chief Operating Officer, Ascension Health

REFERENCE TO ASCENSION HEALTH POLICIES AND PROCEDURES:

Policy No. 16	Financial Assistance for Those in Need and Billing and Collection Practices
Policy No. 9	Community Benefit Goal Setting, Planning and Reporting
Procedure No. M-2	Billing and Collection Practices
Procedure No. M-3	Community Benefit Goal Setting, Planning and Reporting

Subject

In light of its identity and Mission, Ascension Health is committed to the principles of Catholic Social Teaching. This procedure is informed by the principle of human dignity which acknowledges the intrinsic worth of each person by virtue of his or her existence as a human being. The principle of the common good is also foundational to this procedure, which promotes collaboration in the goods we hold in common so that each person may flourish. Lastly, the principle of solidarity with those in poverty strives to identify with those affected by poverty, serve their needs and advocate on their behalf. This procedure sets forth the requirement that each Ascension Health ministry have an effective financial assistance policy. Each of our health ministry's financial assistance practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons who live in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. Each health ministry must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

Financial Assistance Policy

Ascension and Ascension Health intend for themselves and for each Ascension Health ministry that provides medical care ("Health Ministry," for purposes of this procedure) to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder (collectively, "501(r)"), as applicable. This procedure, together with Exhibits A, B and C, shall be interpreted and applied in accordance with 501(r), except where specifically indicated. Ascension and Ascension Health further intend that the following organizations (or billing arrangements) that provide emergency and other medically necessary health care services within each Health Ministry will likewise comply with 501(r):

- State-licensed hospital facilities;
- Organizations operating an emergency department on behalf of a hospital facility;
- Employed physician practices;
- Physician practices controlled by a Health Ministry;
- Joint venture operations where Ascension Health or any of its direct or indirect subsidiaries is the controlling member;
- Billing-under-arrangement bills; and
- Substantially related entities, meaning
  - any partnership (for tax purposes) in which Ascension Health or any of its direct or indirect subsidiaries owns a capital or profits interest that provides emergency or medically necessary care in a hospital facility, or
  - a disregarded entity of which Ascension Health or any of its direct or indirect subsidiaries is the sole member that provides emergency or medically necessary care in a hospital facility,

  but excluding (even if such entity also meets the criteria above), subject to written approval for exclusion by the Ascension Health Chief Financial Officer and Ascension's Tax Department,
  - any entity that Ascension Health treats as providing such care as an unrelated trade or business, or
  - an organization that is operated primarily for educational or scientific purposes.

In furtherance of this objective, the general objectives of this procedure and the objectives of Ascension Health Policies 9 and 16, the Board of Directors of each Health Ministry will adopt a Financial Assistance Policy ("FAP"), the form of which is attached to this procedure as Exhibit A. Health Ministries shall have authority to customize certain limited aspects of the FAP (e.g., to comply with applicable state law), subject to this procedure. Once customization has been completed, the italicized prompts or footnotes providing direction to the Health Ministry should be deleted from the version of the FAP that will be widely publicized. It is expected, however, that all hospital facilities and other organizations that are subject to a particular Health Ministry's authority will adopt an identical FAP. When it approves the FAP, the Health Ministry also is to direct that the FAP be ratified (and thus adopted) by each hospital facility and other applicable organization under the authority of that Health Ministry. For each hospital facility, the FAP will have an effective date no later than July 1, 2016 which also will be the target effective date for other applicable organizations.

Each Health Ministry also will ensure that each of its hospital facilities maintains, and makes available upon request, (1) a list of all service providers delivering care in the hospital facility and specifying which are covered by the FAP and which are not covered by the FAP, the form of which is attached to this procedure as Exhibit B, and (2) a description of the calculation of the amount generally billed ("AGB") applicable to that hospital facility, the form of which is attached as Exhibit C. Each Health Ministry will develop and maintain its own FAP application form (the "FAP Application") and instructions for its FAP Application (the "FAP Application Instructions), to be publicized and disseminated as described below.

Elements of Financial Assistance Policy

Minimum Standards

1. Patients with income less than or equal to 250[1]% 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. 100% charity care is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

2. At a minimum, patients with incomes above 250[2]% of the FPL, but not exceeding 400[3]% 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 will be determined by each Health Ministry in accordance with principles established in Ascension Health Policies 9 and 16. This financial assistance is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

3. 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"). Presumptive eligibility may be based on a prior FAP-eligibility determination for such Patient or based on information provided by the Patient. In the event that a determination is made that the Patient is eligible for less than 100% charity care, then the Health Ministry must notify the Patient of the basis for the determination and inform the Patient as to how to apply for more generous financial assistance. In making determinations about presumptive eligibility, Health Ministries should utilize the following guidelines:

   a. For the purpose of helping patients that need financial assistance, a Health Ministry may utilize a third-party to review patient's information to assess financial need. This review utilizes a healthcare industry recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Health Ministry. The predictive model enables the Health Ministry to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the FAP Application.
   b. After efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive financial assistance to patients with appropriate financial needs. When predictive modeling is the basis for presumptive eligibility, an appropriate discount based upon the score will be granted for eligible

[1] Health Ministries may adjust the 250% threshold higher, but not lower, for cost of living utilizing the local wage index compared to national wage index.
[2] As adjusted at the Health Ministry for any adjustment made pursuant to footnote 1.
[3] Health Ministries may adjust the 400% threshold higher or lower for cost of living utilizing the local wage index compared to national wage index.

services for retrospective dates of service only. For those patients not awarded 100% charity care, a letter should be generated notifying the patient of the level of financial assistance awarded and giving instructions on how to appeal the decision.

c. In the event a patient does not qualify under the presumptive eligibility rule set, the patient may still be considered for financial assistance pursuant to a FAP Application.
d. In addition to the use of the predictive model outlined above, presumptive financial assistance should 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).

4. Eligibility for 100% charity care must be determined for any balance for which the patient with financial need is responsible.

5. Each Health Ministry shall develop and include within its FAP a "Means Test" by which a hospital facility or other organization may assess whether a patient with income greater than 400[4]% of the FPL has demonstrated financial needs and therefore should be eligible for some discount of their charges for services. The Means Test shall involve a determination based on eligible assets and income, including, but not be limited to, income, medical bill obligations, mortgage payments, utility payments, number of family members and disability considerations. Eligibility under the Means Test may be determined at any point in the revenue cycle and must be determined for any balance for which the patient is responsible. This financial assistance is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below.

6. Uninsured patients who are not eligible for the financial assistance described under items 1, 2 or 5 above will be provided a discount based on the discount provided to the highest-paying payor for that Health Ministry. The highest paying payor must account for at least 3% of the Health Ministry'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 Health Ministry's business for that given year. This discount for uninsured patients is not intended to be subject to 501(r) (and therefore not subject to, among other things, the application of the AGB limitation described below) for a patient that is not eligible for financial assistance under items 1, 2 and 5 above.

7. All uninsured patients, regardless of whether they are eligible for financial assistance, 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. A Health Ministry may also extend a similar prompt pay discount to insured patients only after the Health Ministry's Managed Care leader has

[4] As adjusted at the Health Ministry for any adjustment made pursuant to footnote 3.

determined that such discounts can be offered pursuant to all applicable managed care contracts. The Managed Care leader must review and approve of the language included in the FAP describing the prompt pay discount for insured patients. The prompt pay discount is intended to be subject to 501(r), including, but not limited to, the application of the AGB limitation described below, only in the case of a patient that is eligible for financial assistance under items 1, 2 and 5 above; a prompt pay discount is not intended to be subject to 501(r) (and therefore not subject to, among other things, the application of the AGB limitation described below) for a patient that is not eligible for financial assistance under items 1, 2 and 5 above.

8. Each Health Ministry must establish a process for patients and families to appeal an organization's decision regarding eligibility for financial assistance consistent with the following:

a. Patients and families, as applicable, can appeal the decision regarding eligibility for 100% charity care or financial assistance by submitting a written appeal and should be encouraged to provide additional information to evaluate their case.
b. Appeals should be initially received by Patient Financial Services for review and follow up questions, if applicable.
c. A committee shall then meet on a monthly basis to review all appeals. The committee membership should include representation from Patient Financial Services, Mission Integration, Case Management/Social Services and Finance/CFO. Appeals shall be distributed to the committee members prior to the monthly committee meeting for review.
d. A Patient Financial Services representative should be present at the committee meeting to discuss each case and provide additional input that the patient may have provided.
e. The committee will review the applicant's FAP Application with special attention to additional information and points made by the applicant in the appeal process.
f. The committee may approve, disapprove or table the appeal. The committee may table an appeal if additional information is required based on questions asked during the appeal discussion.
g. Patient Financial Services will communicate in writing the outcome of the appeal to the Patient or family members.

Other Requirements and Exceptions[5]

1. Health Ministries may require the uninsured to work with a financial counselor and apply for Medicaid or other public assistance programs to qualify for 100% charity care. If a Health Ministry chooses to apply this requirement, it should be reflected as a requirement in the applicable FAP Application or FAP Application Instructions.

2. Other programs that allow for "packaging" payment programs are acceptable. For example, many Health Ministries package prenatal care and delivery charges into a "package" price for the uninsured.

[5] See also Ascension Health Policy #16 - Financial Assistance for Those in Need and Billing and Collection Practices.

3. A nominal amount may be charged to patients qualifying for 100% charity care. The participation of individuals in the financial obligation of their health care is recommended by those who work with persons living in poverty since it respects their dignity as well as their sense of responsibility. If a Health Ministry chooses to apply this requirement, it should be reflected in the applicable FAP.

4. Large deductible or coinsurance balances will be considered when determining qualification for 100% charity care, financial assistance or applicable discount, regardless of patient's insured status.

5. Ascension Health intends that each hospital facility will cause its FAP to apply to emergency room operations, even if such operations are outsourced to a third party.

FAP Summary

In order to comply with 501(r), a hospital facility must prepare a plain language summary of its FAP (the "FAP Summary"), which must be widely publicized (as described below) and must be provided to patients as part of the hospital facility's billing and collection processes, as may be required by Ascension Health Procedure M-2. To satisfy 501(r), this FAP Summary must notify individuals that the hospital facility offers financial assistance under a FAP and must provide the following additional information:

- A brief description of the eligibility requirements and assistance offered under the FAP;
- A brief summary of how to apply for assistance under the FAP;
- The direct Web site address and physical locations where the individual can obtain copies of the FAP and the FAP Application;
- Instructions on how the individual can obtain a free copy of the FAP and FAP Application form by mail;
- Contact information (including telephone number and physical location) of the Hospital Facility office that can provide information about the FAP and of either (A) the Hospital Facility office or department that can provide assistance with the FAP Application process; or (B) if the Hospital Facility does not provide assistance with the FAP Application process, at least one nonprofit organization or government agency that the hospital facility has identified as an available source of assistance with FAP Applications;
- A statement that translations of FAP, FAP Application, and plain language summary are available in other languages; and
- A statement that an individual eligible for financial assistance may not be charged more than AGB for emergency or other medically necessary care.

The FAP Summary must present all of this information in language that is clear, concise and easy to understand.

Widely Publicizing the FAP

Under 501(r), each hospital facility must "widely publicize" its FAP and certain related

documents. Each Health Ministry must ensure that each hospital facility under its authority takes the following steps:

- Makes its FAP, "FAP Application," and "FAP Summary" widely available on the hospital facility's website;
- Makes paper copies of the FAP, FAP Application, and FAP Summary available upon request and without charge, both by mail and in public areas in the hospital facility (including, at a minimum, in the emergency room, if any, and admissions areas);
- Notifies and informs members of the community it serves about the FAP in manner reasonably calculated to reach those most likely to need financial assistance; and
- Notifies and informs its patients of the FAP by: (1) offering paper copies of the FAP Summary to patients as part of intake or discharge; (2) including conspicuous notice on billing statement about availability of financial assistance, including phone number and web address where more information may be found; and (3) setting up conspicuous public displays or other measures reasonably calculated to attract attention of patients, including at a minimum the emergency room and admissions areas.

Additionally, each hospital facility must make these notifications and documents available not only in English but also for certain limited English proficiency ("LEP") populations – meaning a group with a LEP population exceeding the lesser of 1,000 individuals or 5% of the community the hospital facility serves. The hospital facility may determine the percentage or number of LEP individuals in the hospital facility's community or likely to be affected or encountered by the hospital facility using any reasonable method, but in any event, not inconsistent with any similar determination made by the hospital facility in connection with its applicable Community Health Needs Assessment.

Emergency Medical Care Policy

Under 501(r), a hospital facility also must have a written policy that requires it to provide care for emergency medical conditions to individuals, without discrimination, regardless of whether they are eligible under the FAP. A hospital's EMTALA policy typically will satisfy this requirement. Additionally, the emergency care policy must prohibit the hospital from engaging in activities that discourage individuals from seeking emergency care, such as demanding payment from patients before providing emergency care. Each Health Ministry should ensure that any hospital facility under its authority has adopted an appropriate emergency care policy.

Calculation of AGB

Patients that are eligible for financial assistance that is subject to 501(r), as described in Paragraphs 1 and 2 under *Elements of Financial Assistance Policy* above, will not be charged more than AGB for emergency and other medically necessary care. The amount "charged" to the patient means the amount the patient is personally responsible for paying, after all deductions, discounts (including discounts available under the FAP), and insurance reimbursements are applied. AGB will be determined by multiplying the gross charges for the care by the applicable AGB percentage, which is calculated as described below.

Each hospital facility will calculate its AGB percentage (or multiple AGB percentages) in accordance with the "look-back" method. A hospital facility shall, to the extent applicable, calculate two AGB percentages, one for inpatient services and one for outpatient services. The AGB calculations must be updated at least annually, and the hospital facility must begin applying the AGB percentage by the 120th day after the end of the 12-month period the hospital facility used in calculating its most recent AGB percentage.

The AGB percentage will be calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that should be utilized for purposes of determining the AGB percentage should be those that were allowed by a health insurer during the 12 month period prior to the AGB percentage calculation (rather than those claims that relate to care provided during the prior 12 months). If the hospital facility is covered under the same Medicare provider agreement as other hospitals facilities, the hospital facility may use the same AGB percentage based on the claims and gross charges for all such hospital facilities and implement the AGB percentage across all hospitals.

State Law Compliance

In addition to the requirements of 501(r), certain states in which hospital facilities are located may impose additional requirements on hospital facilities related to the financial assistance provided to patients. To the extent 501(r) and other aspects of this policy conflict with or are inconsistent with state law requirements, the hospital facility must fulfill the greater level of obligation imposed by 501(r) or state law so long as that will also fulfill the hospital facility's obligations under the lesser standard. To the extent state law requirements are additive to the requirements of this policy and 501(r), hospital facilities must fulfill both sets of obligations. Each Health Ministry should ensure that the FAP or an accompanying procedure includes language that addresses any additional applicable state requirements.

Exhibit A

[*INSERT NAME OF HEALTH MINISTRY*]

FINANCIAL ASSISTANCE POLICY

[*Insert Date on which the FAP was last updated*]

POLICY/PRINCIPLES

It is the policy of [*insert name of organization*] (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. Attachment ___ 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 [*each Health Ministry to insert definition that covers at least the same geographic area as the definition of Community for the Community Health Needs Assessment*].
- "**Emergency Care**" means [*each Health Ministry to insert definition from its EMTALA policy; if no EMTALA policy applies, the following definition can be used: care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy*].
- "**Medically Necessary Care**" means care that is determined to be medically necessary

following a determination of clinical merit by a licensed physician in consultation with the admitting physician.

- "**Organization**" means [*insert name of organization*].
- "**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[6]% 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[7]% of the FPL but not exceeding 400[8]% 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:

   [*Each Health Ministry to insert details of the sliding scale discount.*[9]]

   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 [*insert types of balances eligible for the prompt pay discount under managed care agreements*] 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 [*insert types of balances that are ineligible for the prompt pay discount due to conflicts with managed care agreements*].][10]
3. Patients with demonstrated financial needs with income greater than 400[11]% 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. [*Detail regarding Means Test to be added by Health Ministry.*]
4. [Patients that are eligible for 100% charity care may be charged a nominal flat fee of up to $[*insert maximum amount of flat fee*] for services.][12]
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

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[6] Health Ministries may adjust the 250% threshold higher, but not lower. (Any adjustments should be uniform across an entire Health Ministry, as opposed to being made at the hospital facility level.)

[7] As adjusted at the Health Ministry for any adjustment made pursuant to footnote 5.

[8] Health Ministries may adjust the 400% threshold higher or lower for cost of living utilizing the local wage index compared to national wage index.

[9] The sliding scale will be determined by each Health Ministry in accordance with guidelines established in Ascension Health Procedure M-1.

[10] A prompt pay discount for insured Patients may only be included in an Organization's FAP after the Organization's Managed Care leader has reviewed the Organization's managed care contracts and edited and approved the language to be included in the FAP in compliance with those contracts.

[11] As adjusted at the Health Ministry for any adjustment made pursuant to footnote 8.

[12] To be included if the Organization charges such a flat fee and revised to reflect the Organization's practices.

an applicant's failure to complete a financial assistance application ("FAP Application").

6. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
7. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:
   a. [*Organization to insert brief instructions as to where a Patient or family can appeal the Organization's decision regarding eligibility for 100% charity care or financial assistance, and whether a specific appeal form or other documentation is required.*]
   b. All appeals will be considered by [*insert name of Organization*]'s 100% charity care and 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 [*insert name of Organization*].

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 [*insert types of balances eligible for the prompt pay discount under managed care agreements*] 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 [*insert types of balances that are ineligible for the prompt pay discount due to conflicts with managed care agreements*].][13]

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-

[13] See footnote 10.

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 [*insert method of obtaining the AGB calculation*].

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. The FAP Application and FAP Application Instructions are available [*insert instructions as to how the FAP Application and FAP Application Instructions can be obtained in compliance with Procedure M-1*].[14]

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 [*insert method of obtaining the policy*].

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.

[14] Each Health Ministry is permitted to use its own FAP Application and FAP Application instructions to document income and expenses (except for a Patient who meets the presumptive eligibility criteria). Either the FAP or the FAP Application must describe the information and documentation the Organization may require a Patient to provide, and provide contact information, including telephone number and physical location, of the hospital facility office(s) or department(s) that can provide information about the FAP and assistance with the FAP Application process. If applicable, the FAP must also include (A) a list of any information obtained from sources other than an individual seeking financial assistance that the hospital facility uses, and (B) whether and under what circumstances it uses prior FAP-eligibility determinations, to presumptively determine that the individual is FAP-eligible.

Exhibit B

[INSERT NAME OF HEALTH MINISTRY]

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

[Insert date on which the list below was last updated]

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F) and Notice 2015-46, this list specifies which providers of emergency and medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP).

Providers covered by FAP	Providers not covered by FAP

[Each organization adopting a FAP must complete the list with respect to its facility and its applicable service providers and update it at least quarterly.]

Exhibit C

[*INSERT NAME OF HEALTH MINISTRY*]

AMOUNT GENERALLY BILLED CALCULATION

[*Insert date on which the AGB calculations were last updated*]

[*Insert name of Organization*] calculates 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 IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of that calculation and AGB percentage are described below.

The AGB percentages for [*Insert name of Organization*] are as follows:

Inpatient Services: [insert AGB calculation]
Outpatient Services: [insert AGB calculation]

These AGB percentages are calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12 month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

ITEM #8

PROCEDURE # M-2 **SUBJECT:** Cost of Bad Debt Attributable to Charity Care

EFFECTIVE DATE: September 2009

Chief Operating Officer

REFERENCE TO SYSTEM POLICIES:

Policy No. 9	Care of Persons Living in Poverty and Other Vulnerable Persons and Community Benefit
Policy No. 16	Billing and Collection for the Uninsured

Subject

In accord with the Catholic Social Tradition, this procedure sets forth the requirement that each Health Ministry have an effective Policy for Care of Persons Living in Poverty and Other Vulnerable Persons. The Policy will include establishing a process to develop annual goals for the Care of Persons Living in Poverty and Other Vulnerable Persons /and Community Benefit and to report progress towards those goals. All activities related to Care of Persons Living in Poverty and Other Vulnerable Persons will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons who live in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. Each Health Ministry must ensure that its employees and agents behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating patients and their families with dignity, respect and compassion.

Rationale

Care of Persons Living in Poverty and Other Vulnerable Persons / Community Benefit planning and goals are incorporated into the existing Integrated Strategic, Operational and Financial Planning process. Progress towards established goals will be reported upon annually. Procedure M-1 Care of Persons Living in Poverty and Other Vulnerable Persons / Community Benefit Goal Planning & Reporting establishes specific processes for measuring and reporting Categories I through V cost of providing care to persons living in poverty and other vulnerable persons. This procedure provides guidelines to assist Health Ministries:

a. establish goals for the cost of bad debt attributable to charity care within the framework of the Integrated Strategic, Operational and Financial Planning process and report progress towards those goals, and
b. report costs for CategoryV associated with allowable care of persons living in poverty and other vulnerable persons / community benefit programs and services.

Procedure

1. Guidelines for Category V. The following should serve as guidelines for reporting Category V – Cost of Bad Debt attributable to Charity Care.

   Bad debt cost of services can be calculated for certain bad debt write-offs. This acknowledges that there are charity care patients that may not be identified initially as eligible for charity care. The following considerations apply in determining the cost of bad debt for services provided to charity care patients include:

   a. *Cost of bad debt related to care provided to uninsured persons, i.e.(excluding the portion related to coinsurance and deductibles)* Patients who have a coinsurance payment or deductible are assumed to have insurance.

   b. *Based upon the economic environment of each Health Ministry, appropriate approaches may be utilized to identify those uninsured patients who are considered to be living in poverty, but for whom the written charity care application paperwork has not been completed. As an example, identify the zip code average income that constitutes "poor" and count all bad debts from those zip codes, excluding the portion related to coinsurance and deductibles.*
      It is recognized that while this methodology may count patients with the ability to pay who reside in these zip codes, the methodology also excludes patients from other zip codes that may not be able to pay.

St Vincent's Medical Center
Financial Assistance Eligibility Matrix
Based on Federal Poverty Guidelines (FPL)

Hospital Based Inpatient & Outpatient Services						
						All Uninsured Patients regardless of Income (d)
Monthly Income	100%a	200%	250%	350%	400%	44% OP/ 44%IP Discount
	Charity Care					
Family Size	1,005	2,010	2,513	3,518	4,020	
2	1,353	2,707	3,383	4,737	5,413	
3	1,702	3,403	4,254	5,956	6,807	
4	2,050	4,100	5,125	7,175	8,200	
5	2,398	4,797	5,996	8,394	9,593	
6	2,747	5,493	6,867	9,613	10,987	
7	3,095	6,190	7,738	10,833	12,380	
8	3,443	6,887	8,608	12,052	13,773	
Annual Income			(C)			
Income as a % of	100%a	200%	250%	350%	400%	
Family Size	$12,060	$24,120	$30,150	42,210	48,240	
2	$16,240	$32,480	$40,600	56,840	64,960	
3	$20,420	$40,840	$51,050	71,470	81,680	
4	$24,600	$49,200	$61,500	86,100	98,400	
5	$28,780	$57,560	$71,950	100,730	115,120	
6	$32,960	$65,920	$82,400	115,360	131,840	
7	$37,140	$74,280	$92,850	129,990	148,560	
8b	$41,320	$82,640	$103,300	144,620	165,280	
SVHS Discount	100%	100%	80%	60%		

a) Federal Register, Vol. 81, No. 15, January 25, 2016 Federal Poverty Guidelines.
b) For each additional person after 8 add $4,180
c) St Vincent's Charity Care % exceeds OHCA's requirement that care be provided at cost for income between 200% and 250% of FPL. Also CT Public Act #03-266
(d) Note: All uninsured patients with the means to pay are eligible for an additional prompt pay discount per Ascension. We have determined a 2% prompt pay discount .

Exhibit #6