ADMINISTRATIVE/OPERATIONS POLICY
FINANCIAL ASSISTANCE POLICY

Effective Date: September 1, 2017
Approval: Southwest Post-Acute Care Partnership, LLC Board of Managers

SCOPE: The provisions of this policy are applicable to all long term acute care hospitals operated by Southwest Post-Acute Care Partnership, LLC, and its subsidiaries, as listed in Attachment A.

PURPOSE: To describe the Southwest Post-Acute Care Partnership, LLC (the "Company") Financial Assistance Program, including how the Company's hospitals will determine patients' eligibility to receive free or discounted emergency and medically necessary health care. This Policy constitutes the Financial Assistance Policy and the Emergency Medical Care Policy (within the meaning of Section 501(r) of the Internal Revenue Code) for each hospital listed in Attachment A.

POLICY: The Company is committed to minimizing the financial barriers to health care, especially to those who are economically poor and underserved and to those who are not covered by health insurance or governmental health care programs. The Company will provide financial assistance to patients who qualify pursuant to this Policy. The Company's hospitals provide, without discrimination, care for emergency medical conditions to patients regardless of whether the patients are eligible for financial assistance.

PROCEDURES:

A. <u>Program Eligibility</u>

1. To be eligible for the Company's Financial Assistance Program under this Policy, the patient must be uninsured or participate in a government-sponsored program for the indigent, such as county health care assistance programs.

2. Patients interested in financial assistance will receive free financial counseling from the Company to identify potential public or private health coverage programs to assist with long-term health care needs.

3. Except as otherwise described in this Policy, uninsured or indigent patients who apply for the Financial Assistance Program will qualify if their gross family income is at or below 400% of the then-current Federal Poverty Guidelines. Uninsured patients who apply for the Financial Assistance Program may also qualify for assistance under this Policy, regardless of income level, if they have medical or hospital bills that exceed 10% of the their gross family income.

4. The Company reserves the right to deny assistance to patients who meet the income level criteria if, in the judgment of the Company, such patients have sufficient net assets to pay for Covered Services (as defined in Section B.1) at usual and customary charges. In reviewing available assets, the Company will not consider the value of a patient's primary residence,

primary vehicle, or retirement account. Patients who disagree with the denial may appeal as described below in Section D.8.

5. Before finding a patient eligible for assistance under this Policy, the Company may require patients to apply for public health coverage programs for which the Company presumes the patients are eligible, as instructed by the Company's financial counselors. The Company may deny eligibility for the Financial Assistance Program to patients who have been screened for a public health coverage program and are presumed to be eligible but are not cooperating with the process to apply for the health coverage program. As a condition to participation in the Financial Assistance Program, the Company may also require patients to apply for future health care coverage through the federal health care exchange if the individual is eligible for subsidized premiums.

6. Patients are not eligible for the Financial Assistance Program if the patient receives or is expected to receive a third-party financial settlement that includes payment intended to compensate the patient for charges related to medical care rendered by a Company facility. The patient is expected to use the settlement amount to satisfy any patient account balances.

7. In making eligibility determinations, the Company may consider factors such as: the patient's and family's earning status, sources of income and assets, nature and extent of liabilities, ability to obtain additional credit, amount of medical bills, and family size.

8. The Company may evaluate patients to determine if they meet presumptive eligibility criteria for the Financial Assistance Program without the patients completing an application. Uninsured patients are ordinarily presumed to be eligible for financial assistance in the following circumstances:

    a. The patient is homeless;

    b. The patient was not required to file a Federal tax return for the most recently concluded calendar year; or

    c. Electronic eligibility tools that use patient demographic data, credit reports, and other publicly available information indicate that the family's income is less than 200% of the Federal Poverty Guidelines.

   A patient presumptively found to be eligible may be asked to verify basic financial information before receiving financial assistance.

B. <u>Covered Services</u>

1. Benefits under the Financial Assistance Program may be applied to any emergency and medically necessary health care services provided at the hospitals listed in Exhibit A ("Covered Services"). This Policy uses the Medicare definition of "medically necessary," which is "health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

2. Certain services are not eligible for benefits and are not considered Covered Services under the the Company Financial Assistance Program. These include, but are not limited to, the following:

a. Elective or lifestyle services that are not considered emergent or medically necessary as determined by a physician at a Company facility;
b. Services provided for workers' compensation care or when a third party is liable for the injuries or illness requiring medical services; and
c. Services provided outside of the hospital setting, including at urgent care centers, ambulatory surgery centers, physician office clinics, home health and hospice.

3. The Company's hospitals do not have emergency departments. If an individual needs emergency care at a Company hospital, hospital personnel will appraise the emergency and provide initial treatment consistent with personnel qualifications. The Company's hospitals will transfer the patient to an emergency facility as appropriate. Appraisal, initial treatment, and transfer are provided in a non-discriminatory manner, consistent with federal regulations, regardless of whether individuals are eligible for assistance under this Policy.

C. How to Apply for Financial Assistance

1. The patient or patient's guarantor should complete and submit a Financial Assistance Program application to apply for financial assistance.

   a. Patients and guarantors may request applications by:

      i. Asking the Hospital Administrator at any Company hospital
      ii. Calling the Company's Business Office Manager at 318-448-4938, Monday through Friday, 9 a.m. to 5 p.m. (central time)
      iii. Mailing a written request to 3330 Masonic Drive, 4th Floor, Alexandria, LA 71301
      iv. Downloading an application at www.christushealth.org/patient-resources/financial-assistance.

   b. The application describes all the personal, financial, and other information or documentation that an individual must submit to be considered for eligibility in the Company's Financial Assistance Program.

   c. The Company may presumptively qualify some patients for the most generous discount offered under the Financial Assistance Program based on external data sources and electronic eligibility tools that use patient demographic data, credit reports and other publicly available information. Patients who do not presumptively qualify may apply for the Financial Assistance Program using the application.

2. The application for the Financial Assistance Program must be submitted to the Company within 8 months of the date of the first post-discharge billing statement that pertains to the care for which the patient or guarantor is seeking financial assistance.

3. Completed applications, including all required information and documentation, should be submitted to the Company for eligibility determination. Completed applications may be:

   a. Submitted by mail to Customer Service using the address on the application; **or**

   b. Delivered in person to the hospital admitting department.

4. Applicants are notified by mail when their application is incomplete and are given an opportunity to provide the missing documentation or information within 60 days of the date of notification. Written notices to persons with incomplete applications will include:

    a. Instructions for how to submit the requested documentation or information;

    b. A plain language summary of this policy;

    c. Information about Extraordinary Collection Actions (ECAs) that the hospital might take if it does not receive the information requested within the 60-day period; and

    d. Contact information for a Company department that can provide assistance with the application process.

    In addition to the written notice, applicants may also receive a phone call if their application is incomplete.

D. <u>Eligibility Determinations</u>

1. For completed applications, the Company will make a determination regarding the applicant's eligibility in a timely manner and consistent with this Policy.

    a. If the Company believes an individual who has submitted a completed application may qualify for Medicaid, the Company may postpone making a financial assistance eligibility determination until after a Medicaid application has been submitted and the Medicaid eligibility determination has been made.

    b. Upon receipt of a completed application, the Company may not initiate or resume any ECAs to obtain payment for the care at issue until the eligibility determination has been made.

2. If the Company finds the applicant is eligible for free care (100% discount), the Company will:

    a. Provide the applicant with a written notice that indicates the individual was determined to be eligible for free care;

    b. Refund to the individual any amount that he or she has previously paid for the care, unless that amount is less than $5; **and**

    c. Take all reasonably available measures to reverse any ECA taken against the individual, including removing any adverse information from a credit report that arose as a result of a Company credit disclosure made for the relevant episode of care.

3. If the Company finds the applicant is eligible for assistance other than free care, the Company will:

    a. Provide the applicant with a billing statement and written notice that indicates the amount the individual owes based on the financial assistance given, how that amount

was determined, and how the individual may obtain information regarding the amounts generally billed (AGB) for the care;

b. Refund to the individual any amount that he or she has previously paid for the care that exceeds the amount he or she is personally responsible for as a person eligible for financial assistance, unless that amount is less than $5; **and**

c. Take all reasonably available measures to reverse any ECA taken against the individual, including removing any adverse information from a credit report that arose as a result of a Company credit disclosure made for the relevant episode of care.

4. If the Company finds the applicant is not eligible for assistance, the Company will provide the applicant with a billing statement and written notice that indicates the amount the applicant owes and the basis for the determination that the applicant was ineligible for financial assistance. The denial letter will also include information on how the applicant may appeal the decision, as described in Section D.10 below.

5. Under the following circumstances, the Company may revoke, rescind, or amend the financial assistance provided:

    a. Fraud, theft, or misrepresentation by the patient or guarantor, or other circumstances that undermine the integrity of the Financial Assistance Program; **or**

    b. Identification of a third-party payor, including a public or private health coverage program, workers' compensation, or third-party liability insurance.

6. If a denied applicant believes that his or her application was not properly considered, he or she may submit a written request for reconsideration within 60 days of the date of determination. The request should include information that was not submitted with the original application that supports the applicant's reason for appealing. The denial letter provides additional information about the appeal process. Appeals are reviewed by designated hospital staff, and appeal decisions are final.

7. Eligibility determinations will not be based on information that the Company has reason to believe is unreliable or incorrect or on information obtained from the applicant under duress or through the use of coercive practices. Coercive practices include delaying or denying emergency medical care to an individual until the individual has provided information requested to determine whether the individual is eligible for assistance under this Policy.

E. Length of Eligibility Determination

At the discretion of the Company, Financial Assistance Program eligibility will apply:

a. To a particular episode of care or dates of service; or

b. For up to a 12-month period from the initial eligibility determination.

If the eligibility determination is expected to last for a period of time following the date of the eligibility determination, the Company, at its discretion, may ask for an updated application or adjust the financial assistance for future episodes of care based on changes to the patient's or guarantor's demonstrated financial need.

F. Discounts Available Under the Financial Assistance Program

1. Following a determination of eligibility under this Financial Assistance Policy, a patient deemed to be eligible for financial assistance ("Eligible Patient") will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care ("AGB").

2. In general, Eligible Patients with a gross family income at or below 200% of the Federal Poverty Level will qualify for 100% discount (free care) on all Covered Services.

3. In general, Eligible Patients with a gross family income between 200% and 400% of the Federal Poverty Level will qualify for a sliding scale discount on all Covered Services, ranging from 50% to 100% discount on eligible services.

4. There may be circumstances in which the Company has billed a patient more than AGB before the patient had submitted a completed application or before the Company determined the patient was an Eligible Patient. If an Eligible Patient has paid charges in excess of AGB, the hospital will refund any amount the individual has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as an individual eligible for financial assistance, unless such excess payment is less than $5.

5. Eligibility determinations will be made and discounts will be offered without regard to race, creed, color, religion, gender, orientation, national origin, or physical disability.

G. Amounts Generally Billed Calculation

The Company uses the Prospective Medicare Method to determine AGB, by using the billing and coding process it would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount it determines Medicare and the Medicare beneficiary together would be expected to pay for the care.

H. Actions in the Event of Non-Payment

1. Unpaid discounted balances of patients who qualify for the Financial Assistance Program are considered uncollectible bad debts.

2. The Company does not conduct, or permit collection agencies to conduct on its behalf, Extraordinary Collection Actions (ECAs), as defined under Internal Revenue Code Section 501(r), against individuals before reasonable efforts have been made to determine whether the patient is eligible for the Financial Assistance Program. Reasonable efforts include the hospital making a determination that the patient is ineligible for the Financial Assistance Program because the patient is covered by Medicare or commercial insurance.

3. The System Director of Patient Financial Services maintains oversight and responsibility for determining if the Company has made reasonable efforts and whether an ECA is appropriate. If a patient believes an ECA was initiated improperly, the patient should contact the Company's Integrity Line at 1-888-703-0301 and provide his/her contact information for follow up.

4. Under no circumstance will the Company pursue an ECA until 120 days after the date of the first post-discharge billing statement for the care at issue.

5. At least 30 days before initiating an ECA, the Company will:

    a. Provide the individual with a written notice that: indicates financial assistance is available for eligible individuals, identifies the ECAs that the hospital intends to initiate to obtain payment for the care, and states that ECAs will be initiated 30 days after the date of the written notice;

    b. Provide the individual with a plain language summary of this Policy; **and**

    c. Make a reasonable effort to orally notify the individual about this Policy and about how the individual may obtain assistance with the application process.

6. As authorized by state and federal law, the Company may file a hospital lien on the proceeds of a judgment, settlement, or compromise owed to a patient (or his or her representative) as a result of personal injuries for which a Company hospital provided care. This type of lien is not considered an ECA and does not require advance notice be given to the patient. The Company will notify the patient of such a lien in accordance with state law.

I. Providers Who Participate in the Financial Assistance Program

The Company's hospitals may contract with physician groups and other independent contractors that provide medically necessary care but do not participate in the Company's Financial Assistance Program. Therefore, a patient who is eligible for the Financial Assistance Program will not necessarily receive financial assistance from those non-participating providers. Attachment B lists these contracted providers and indicates whether or not they participate in this Policy. Patients who receive care from one of the non-participating providers are advised to contact the provider directly to determine whether the provider has its own financial assistance program.

J. Distribution of the Policy

1. Each Company hospital will offer a plain language summary of this Policy to patients as part of the admission or discharge process. The Company's financial counselors will also distribute the summary of this Policy to patients as appropriate during counseling sessions.

2. Each billing statement from the Company will include a conspicuous written notice informing patients about the availability of financial assistance, including both a telephone number and website address where the patient may obtain additional information and copies of the plain language summary of this Policy.

3. Each hospital will have public displays in the emergency department and admissions areas notifying patients of the Financial Assistance Program.

4. This Policy, the plain language summary, and the Financial Assistance Program application will be available at www.christushealth.org/patient-resources/financial-assistance and are also available upon request and without charge in each hospital's emergency department and admissions areas.

5. This Policy, the plain language summary, and the Financial Assistance Program application will be translated into the language spoken by each limited English proficiency group that constitutes the lesser of 1,000 individuals or 5% of the community served by the hospital facility.

Attachment A

Participating Hospitals

CHRISTUS Dubuis Hospital of Hot Springs
CHRISTUS Dubuis Hospital of Fort Smith
CHRISTUS Dubuis Hospital of Alexandria
CHRISTUS Dubuis Hospital of Beaumont
Dubuis Hospital of Paris

Attachment B

Provider Listing

Medically-necessary hospital services provided by Company hospital employees are covered under the Company Financial Assistance Policy. However, some services provided in Company hospitals are not provided by Company employees and instead are provided by independent physicians, groups or other entities. Payment arrangements for these services must be made directly with those individuals and groups. The following types of providers and/or lines of service have been identified as those services which are not covered under this financial assistance policy. A more extensive listing of the non-covered providers by entity can be obtained free of charge either electronically or on paper by calling 318-448-4938.

Cardiologist
Durable Medical Equipment
Outside Laboratory
Pathologist
Radiologist
Attending Physicians