COMMONSPIRIT HEALTH
GOVERNANCE POLICY ADDENDUM

ADDENDUM Finance G-003A-3 **EFFECTIVE DATE:** July 1, 2022

SUBJECT: Financial Assistance - Washington

ASSOCIATED POLICIES

CommonSpirit Governance Policy	Finance G-003, *Financial Assistance Policy*
CommonSpirit Governance Policy	Finance G-004, *Billing and Collections*

This Washington addendum (Addendum) supplements CommonSpirit Governance Policy G-003, *Financial Assistance* (the Financial Assistance Policy), as necessary, in light of and to comply with Washington statutes and regulations regarding provision of Hospital Charity Care, in accordance with the "Coordination with Other Laws" section of the Financial Assistance Policy.

This Addendum applies to all CommonSpirit Health Direct Affiliates and Tax-Exempt Subsidiaries in the state of Washington, as defined in the Financial Assistance Policy. If any provision of this Addendum is in conflict with, or inconsistent with, any provision of the Financial Assistance Policy, this Addendum shall control.

References in the Financial Assistance Policy to Medically Necessary Care and Emergent Medical Care are to be interpreted consistently with the definitions of "Appropriate Hospital Based Medical Services" and "Emergency Care or Emergency Services" contained in WAC 246-453-010(7) and (11), respectively. However, this addendum shall use the terms "Appropriate Hospital Based Medical Services" and "Emergency Care or Emergency Services".

DEFINITIONS

A. "Family Income" means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual, in accordance with WAC 246-453-010 (17).

B. "Appropriate Hospital-Based Medical Services" means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all; WAC 246-453-010 (7).

C. "Emergency Care or Emergency Services" means services provided for care related emergency medical or mental condition; WAC 246-453-010 (11).

D. "Eligibility Qualification Period" means that Patients approved to be eligible shall be granted Financial Assistance for all eligible accounts incurred for services received twenty-

four (24) months prior to the determination date (plus the fourteen (14) day determination period), and prospectively for a period of six (6) months following the determination date. If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twenty-four (24) months prior to the determination date.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

A. No minimum account balance shall be required for a patient to qualify for Financial Assistance.

B. Pursuant to the terms of the Financial Assistance Policy, unless eligible for Presumptive Financial Assistance, certain eligibility criteria must be met in order for a patient to qualify for Financial Assistance. This Addendum updates such eligibility criteria with the following:

- Any patient whose Family Income is at or below 300% percent of the FPL shall receive a full discount from his or her account balance for Appropriate Hospital Based Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by third-party payers or sponsors.
- Any patient whose Family Income is between 301% to 350% of the FPL shall receive discounted care up to 75%, which may be reduced from his or her account balance for Appropriate Hospital Based Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by third-party payers or sponsors, and any amounts reasonably related to assets considered as set forth in the Hospital Facility's Policy on Asset Testing.
- Any patient whose Family Income is between 351% to 400% of the FPL shall receive discounted care up to 50% from his or her account balance for Appropriate Hospital Based Medical Services and Emergency Care or Emergency Services provided to the patient after payment, if any, by any third-party payers or sponsors, and any amounts reasonably related to assets considered as set forth in the Hospital Facility's Policy on Asset Testing.
- In the event a Hospital Facility provides discounted care greater than what is required above (either through amounts generally billed ("AGB"), self-pay, or other discounts) the patient shall receive that greater discounted care amount.

C. With respect to those assets that may be taken into consideration, Hospital Facility will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of such assets.

- Hospital Facility will consider assets and collect information related to such assets as required by the Centers for Medicare and Medicaid ("CMS") for Medicare cost reporting. Such information may include reporting of assets convertible to cash and unnecessary for the patient's daily living.
- Duplicate forms of verification will not be requested and only one current account statement is required to verify monetary assets.
- If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.

- Asset information will not be used for collection activities.
- The following types of assets shall be excluded from consideration:
    - The first $5,000 of monetary assets for an individual or $8,000 of monetary assets for a family of two, plus an additional $1,500 of monetary assets for each additional family member. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid;
    - Any equity in a primary residence;
    - Retirement plans other than 401(k) plans;
    - One motor vehicle and a second motor vehicle if it is necessary for employment or medical purposes;
    - Any prepaid burial contract or burial plot; and
    - Any life insurance policy with a face value of $10,000 or less.

D. "Patient Cooperation Standards," as defined in the Financial Assistance Policy, shall only apply to the extent they:

- allow the Hospital Facility to pursue reimbursement from any third-party coverage that may be identified to the Hospital Facility, in accordance with WAC 246-453-020(1);
- allow the Hospital Facility to make every reasonable effort to determine the existence or nonexistence of third-party sponsorship that might cover in full or in part the charges for services provided to each patient, in accordance with WAC 246-453-020(4); and
- do not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures, in accordance with WAC 246-453-020(5).

E. Eligibility for Financial Assistance requires that a person be a Washington State resident and that the medical services sought are Appropriate Hospital-Based Medical Services, as opposed to services which are investigational, elective or experimental in nature. If a person is not a Washington State resident, that person is not eligible for Financial Assistance when that person enters Washington State solely for the purpose of seeking medical care. Refugees, asylees, and those seeking asylum are exempt from the Washington State residency requirement for Financial Assistance eligibility. Also exempt from the Washington State residency requirement are those patients in need of Emergency Care or Emergency Services. Financial Assistance will not be denied based on immigration status. Exceptions to residence and scope of services requirements outlined in this paragraph may be made with the approval of the Hospital Facility Chief Financial Officer or their designee.

THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

A. For the purposes of reaching an initial determination of sponsorship status, Hospital Facilities shall rely upon information provided orally by the responsible party. The Hospital Facility may require the responsible party to sign a statement attesting to the accuracy of the information provided to the Hospital Facility for purposes of the initial determination of

sponsorship status, in accordance with WAC 246-453-030(1). In accordance with WAC 246-453-020(1), if the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the Hospital Facility's reasonable efforts to reach a final determination of sponsorship status.

B. In accordance with WAC 246-453-030(2), in addition to the documents listed in the Financial Assistance Policy, any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:

- Forms approving or denying eligibility for Medicaid or state-funded medical assistance;
- Forms approving or denying unemployment compensation; or
- Written statements from employers or welfare agencies.

C. If there is indication that due to the patient's mental, physical or intellectual capacity, or due to a language barrier, completing the application procedure would place an unreasonable burden on the patients, the Hospital Facility will take reasonable measures to facilitate the application process, including engaging an interpreter to assist the patient through the application process if necessary.

D. Hospital Facilities shall make every reasonable effort to reach initial and final determinations of eligibility for financial assistance in a timely manner. Nevertheless, Hospital Facilities shall make those determinations at any time, even after the Application Period, upon learning of facts or receiving the documentation described herein, indicating that the responsible party's income is equal to or below three hundred percent (300%) of the federal poverty guidelines as adjusted for family size. The timing of reaching a final determination of eligibility for financial assistance shall have no bearing on the Hospital Facility's identification of charity care deductions from revenue as distinct from bad debts. WAC 246-453-020(10).

E. Any responsible party who has been initially determined to meet the criteria for receiving financial assistance shall be provided with at least fourteen (14) calendar days or such time as the person's medical condition may require, or such time as may be reasonably necessary to secure and to present documentation described within WAC 246-453-030 prior to receiving a final determination of sponsorship status.

F. In accordance with WAC 246-453-030(4), in the event that the responsible party is not able to provide any of the documentation described above, the Hospital Facility shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

G. In accordance with WAC 245-453-030(5), information requests from the Hospital Facility to the responsible party for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship, and may not be used to discourage applications for such sponsorship. Only those facts relevant to eligibility may

be verified, and duplicate forms of verification shall not be demanded.

H. The Hospital Facility shall notify persons applying for financial assistance of their final determination of sponsorship status within fourteen (14) calendar days of receiving information in accordance with WAC 246-453-020(7); such notification shall include a determination of the amount for which the responsible party will be held financially accountable.

I. In the event that the Hospital Facility denies the responsible party's application for financial assistance, the Hospital Facility shall notify the responsible party of the denial within fourteen (14) days and provide the basis for the denial.

J. In the event that a responsible party pays a portion or all of the charges related to Appropriate Hospital Based Medical Services and Emergency Care or Emergency Services, and is subsequently found to have met the financial assistance criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate shall be refunded to the patient within thirty (30) days of achieving the charity care designation. WAC 246-453-020(11).

K. In accordance with WAC 246-453-020(6), Hospital Facilities shall not require deposits from those responsible parties whose income is equal to or below three hundred percent (300%) of the federal poverty guidelines as adjusted for family size, as indicated through an initial determination of sponsorship status.

L. For services provided to patients on or after July 1, 2022, the following procedures will apply for identifying patients and/or their guarantors who may be eligible for health care coverage through Washington medical assistance programs or the Washington Health Benefit Exchange:

- As a part of the application process for determining eligibility for Financial Assistance and charity care, Hospital Facility will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange.
- As part of the Financial Assistance process, Hospital Facility staff will also work with patients/families who do not have applicable third-party coverage to assess whether such patients/families may be eligible for Medicaid and/or health care coverage through Washington's Health Benefit Exchange (RCW 43.71). Staff will provide assistance with Medicaid and Qualified Health Plan applications and including but not limited to providing the patient/family with information about the application process, assisting patients through the application process, providing necessary forms that must be completed, and/or connecting the patient/family with other agencies or resources who can assist the patient/family in completing such applications.
- In providing assistance to the application process, Hospital Facility will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.
- If the patient or guarantor fails to make reasonable efforts to cooperate with

Hospital Facility in applying for coverage under chapter 74.09 RCW or the Washington Health Benefit Exchange, Hospital Facility is not obligated to provide charity care to such patient.

- The Hospital Facility shall not require a patient to apply for any public or private programs where the patient is categorically ineligible or has been deemed ineligible in the prior 12 months.

PRESUMPTIVE ELIGIBILITY

In the event the responsible party's identification as an indigent person is obvious to Hospital Facility personnel, and the Hospital Facility personnel are able to establish the position of the income level within the broad criteria described in RCW 70.170.060, based on the individual life circumstances contained within the Financial Assistance Policy or otherwise, the Hospital Facility is not obligated to establish the exact income level or to request documentation from the responsible party, unless the responsible party requests further review.

APPEALS

A. All responsible parties denied financial assistance shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the Hospital Facility's chief financial officer.

B. Responsible parties shall be notified that they have thirty (30) calendar days within which to request an appeal of the final determination of their eligibility for financial assistance. Within the first fourteen (14) days of this period, the Hospital Facility shall not refer the account at issue to an external collection agency. If the Hospital Facility has initiated collection activities and discovers an appeal has been filed, it shall cease collection efforts until the appeal is finalized. After the fourteen (14) day period, if no appeal has been filed, the hospital may initiate collection activities.

C. If the final determination of the appeal affirms the previous denial of financial assistance, the Hospital Facility shall send written notification to the responsible party and the Department of Health in accordance with state law.

All other terms set forth in CommonSpirit Governance Policy Finance G-003, *Financial Assistance*, remain unaltered.

COMMONSPIRIT HEALTH
GOVERNANCE POLICY

SUBJECT: Financial Assistance	**EFFECTIVE DATE:**
	July 1, 2022
POLICY NUMBER: Finance G-003	**ORIGINAL EFFECTIVE DATE:**
	July 1, 2021

POLICY

Pursuant to Internal Revenue Code (IRC) Section 501(r), in order to remain tax-exempt, each CommonSpirit Health Hospital Organization is required to establish a written Financial Assistance Policy (FAP) and an Emergency Medical Care Policy which apply to all Emergency Medical Care and Medically Necessary Care (herein referred to as EMCare) provided in a Hospital Facility. The purpose of this Policy is to describe the conditions under which a Hospital Facility provides Financial Assistance to its patients. In addition, this Policy describes the actions a Hospital Facility may take in the event of nonpayment of a patient account.

SCOPE

This Policy applies to CommonSpirit and each of its tax-exempt Direct Affiliates[1] and tax-exempt Subsidiaries [2] that operate a Hospital Facility (referred to individually as a CommonSpirit Hospital Organization and collectively as CommonSpirit Hospital Organizations). It is the policy of CommonSpirit to provide, without discrimination, EMCare in CommonSpirit Hospital Facilities to all patients, without regard to a patient's financial ability to pay.

PRINCIPLES

As Catholic health care providers and tax-exempt organizations, CommonSpirit Hospital Organizations are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for services provided.

The following principles are consistent with CommonSpirit's mission to deliver compassionate, high-quality, affordable healthcare services and to advocate for those who are poor and vulnerable. It is the desire of CommonSpirit Hospital Organizations that the financial ability of people who need health care services does not prevent them from seeking or receiving care.

1 A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.

2 A Subsidiary refers to either an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50%) or more of the voting members of the governing body of such organization or holds fifty percent (50%) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

CommonSpirit Hospital Organizations will provide, without discrimination, Emergency Medical Care to individuals regardless of their eligibility for Financial Assistance or for government assistance in CommonSpirit Hospital Facilities.

CommonSpirit Hospital Organizations are dedicated to providing Financial Assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for non-emergent Medically Necessary Care provided in CommonSpirit Hospital Facilities.

APPLICATION

A. This Policy applies to:

- All charges for EMCare provided in a Hospital Facility by a CommonSpirit Hospital Organization.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a CommonSpirit Hospital Organization if such care is provided within a Hospital Facility.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a Substantially-Related Entity that occurs within a Hospital Facility.
- Non-covered Medically Necessary Care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted.
- Collection and recovery activities shall be conducted in accordance with the CommonSpirit Governance Policy Finance G-004, *Billing and Collections*.

B. Coordination with Other Laws

The provision of Financial Assistance may be subject to additional laws or regulations pursuant to federal, state or local laws. Such law governs to the extent it imposes more stringent requirements than this Policy. In the event that a subsequently adopted state or local law directly conflicts with this Policy, the CommonSpirit Hospital Organization shall, after consultation with its local CommonSpirit Legal Team representative, CommonSpirit Revenue Cycle leadership, and CommonSpirit Tax leadership, be permitted to adopt an addendum to this Policy before the next policy review cycle, with such minimal changes to this Policy as are necessary to achieve compliance with any applicable laws.

DEFINITIONS

Amounts Generally Billed (AGB) means the maximum charge a patient who is eligible for Financial Assistance under this Financial Assistance Policy is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AGB for EMCare provided to the patient. CommonSpirit calculates the AGB on a Facility-by-Facility basis using the "lookback" method by multiplying the "Gross Charges" for any EMCare that it provides by AGB percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in

federal law. “Gross Charges” for these purposes means the amount listed on each Hospital Facility’s chargemaster for each EMCare service.

Application Period means the time provided to patients by the CommonSpirit Hospital Organization to complete the Financial Assistance application. It expires on the later of (i) 365 days from the patient’s discharge from the Hospital Facility or the date of the patient’s EMCare, or (ii) 240 days from the date of the initial post-discharge bill for the EMCare received at a Hospital Facility.

CommonSpirit Entity Service Area means, for purposes of this Policy, the community served by a Hospital Facility as described in its most recent Community Health Needs Assessment, as described in IRC Section 501(r)(3).

Community Health Needs Assessment (CHNA) is conducted by a Hospital Facility at least once every three (3) years pursuant to IRC Section 501(r)(1)(A); each CommonSpirit Hospital Organization then adopts strategies to meet the community health needs identified through the CHNA.

Eligibility Determination Period - For purposes of determining Financial Assistance eligibility, a Hospital Facility will review annual Family Income from the prior six-month (6) period, or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date Family Income, taking into consideration the current earnings rate.

Eligibility Qualification Period - After submitting the Financial Assistance application and supporting documents, patients approved to be eligible shall be granted Financial Assistance for all eligible accounts incurred for services received twelve (12) months prior to the determination date, and prospectively for a period of six (6) months from the determination date. If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date.

Emergency Medical Care, EMTALA - Any patient seeking care for an emergency medical condition within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd) at a Hospital Facility shall be treated without discrimination and without regard to a patient’s ability to pay for care. Furthermore, any action that discourages patients from seeking EMCare, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of EMCare, is prohibited. Hospital Facilities shall also operate in accordance with all federal and state requirements for the provision of care relating to emergency medical conditions, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Labor Act (EMTALA) and in accordance with 42 CFR 482.55 (or any successor regulation). Hospital Facilities should consult and be guided by any CommonSpirit EMTALA Policy, EMTALA regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an emergency medical condition and the processes to be followed with respect to each.

Extraordinary Collection Actions (ECAs) - The Hospital Facility will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under this

Policy. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal law; and
- Reporting adverse information about the individual to consumer credit bureaus.

ECAs do not include any lien that a Hospital Facility is entitled to assert under state law on the proceeds of a judgment or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Facility provided care.

Family means (using the Census Bureau definition) a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service (IRS) rules, if the patient claims someone as a dependent on his or her income tax return, that person may be considered a dependent for purposes of the provision of Financial Assistance. If IRS tax documentation is not available, family size will be determined by the number of dependents documented on the Financial Assistance application and verified by the Hospital Facility.

Family Income is determined consistent with the IRS definition of Modified Adjusted Gross Income for the applicant and all members of the applicant's Family. In determining eligibility, CommonSpirit Hospital Organization may consider the 'monetary assets' of the patient's Family. However, for purposes of this determination, monetary assets will not include retirement or deferred compensation plans.

Federal Poverty Level Guidelines (FPL) are updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided in a Hospital Facility and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Guarantor means an individual who is legally responsible for payment of the patient's bill.

Hospital Facility (or Facility) means a healthcare facility that is required by a state to be licensed, registered or similarly recognized as a hospital and that is operated by a CommonSpirit Hospital Organization.

Medically Necessary Care means any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers life, cause suffering or pain, results in illness or infirmity, threatens to cause or aggravate a handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no other equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures only to improve aesthetic appeal of a normal, or normally functioning, body part.

Operates a Hospital Facility - A Hospital Facility is considered to be operated either by use of its own employees or by contracting out the operation of the Facility to another organization. A Hospital Facility may also be operated by a CommonSpirit Hospital Organization if the CommonSpirit Hospital Organization has a capital or profits interest in an entity taxed as a partnership which directly operates a state licensed Hospital Facility or which indirectly operates a state licensed Hospital Facility through another entity taxed as a partnership.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free or discounted EMCare for the period during which the individual is presumptively eligible.

Substantially-Related Entity means, with respect to a CommonSpirit Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides EMCare in a state licensed Hospital Facility, unless the provision of such care is an unrelated trade or business described in IRC Section 513 with respect to the Hospital Organization.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

A. Financial Assistance Available for EMCare

A patient who qualifies for Financial Assistance will receive free or discounted EMCare, and as such will never be responsible for more than AGB for EMCare. Financial Assistance shall be provided to patients who meet the eligibility requirements as described herein and have established residency within the CommonSpirit Entity Service Area as defined by the most recent Hospital Facility CHNA, unless the visit is urgent or emergent or occurs within a California Hospital Facility. Residents of countries outside the United States of America are not eligible for financial assistance without prior approval from the Hospital Facility Chief Financial Officer (or his or her designee), unless the visit is urgent or emergent. All scheduled services for patients who reside outside the CommonSpirit Entity Service Area require prior approval from the Hospital Facility Chief Financial Officer (or his or her designee). If an ordering provider has requested services at a Hospital Facility and the same service is also provided at another facility closer to the patient's residence and outside the CommonSpirit Entity Service Area, the Hospital Facility may request the ordering provider to re-evaluate the services and request the services be performed closer to the patient's residence.

B. Financial Assistance Not Available for Other than EMCare

Financial Assistance is not available for care other than EMCare. In the case of care other than EMCare, no patient will be responsible for more than the net charges for such care (gross charges for such care after all deductions and insurance reimbursements have been applied).

C. Amount of Financial Assistance Available

Eligibility for Financial Assistance will be considered for those individuals who are Uninsured, Underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account any potential discriminatory factors such as age, ancestry, gender, gender identity, gender expression, race, color, national origin, sexual orientation, marital status, social or immigrant status, religious affiliation, or any other basis prohibited by federal, state, or local law.

Unless eligible for Presumptive Financial Assistance, the following eligibility criteria must be met in order for a patient to qualify for Financial Assistance:

- The patient must have a minimum account balance of ten dollars ($10.00) with the CommonSpirit Hospital Organization. Multiple account balances may be combined to reach this amount. Patients/Guarantors with balances below ten dollars ($10.00) may contact a financial counselor to make monthly installment payment arrangements.
- The patient must comply with Patient Cooperation Standards as described herein.
- The patient must submit a completed Financial Assistance Application (FAA).

D. Charity Care

- Up to 200% of the FPL – Any patient whose Family Income is at or below 200% of the FPL, including, without limitation, any Uninsured or Underinsured patient, is eligible to receive Financial Assistance up to a 100% discount from his or her account balance for eligible services provided to the patient after payment, if any, by any third-party(ies).

- 201% - 400% of the FPL – Any patient whose Family Income is at or above 201% but lower than 400% of the FPL, including, without limitation, any Uninsured or Underinsured patient, is eligible to receive Financial Assistance reducing his or her account balance for eligible services provided to the patient after payment, if any, by any third-party(ies), to an amount no more than the Hospital Facility's AGB.

E. Patient Cooperation Standards

A patient must cooperate with the Hospital Facility in providing the information and documentation necessary to determine eligibility. Such cooperation includes completing any required applications or forms. The patient is responsible for notifying the Hospital Facility of any change in financial situation that would impact the assessment of eligibility.

A patient must exhaust all other payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties prior to being approved. An applicant for Financial Assistance is responsible for applying to public programs for available coverage. He or she is also expected to pursue public or private health insurance payment options for care provided by a CommonSpirit Hospital Organization within a Hospital Facility.

A patient's and, if applicable, any Guarantor's cooperation in applying for applicable programs and identifiable funding sources, shall be required. A Hospital Facility shall make affirmative efforts to help a patient or patient's Guarantor apply for public and private programs, which may include coverage under a health insurance exchange, commercial health insurance, or health plan coverage purchased through COBRA. If a Hospital Facility determines that coverage under a health insurance exchange, commercial health insurance, or a COBRA plan is potentially available, and that a patient is not a Medicare or Medicaid beneficiary, the Hospital Facility may require that the patient or Guarantor (i) provide the Hospital Facility and applicable foundation with information necessary to determine the monthly premium for such patient, and (ii) cooperate with Hospital Facility and foundation staff to determine whether he or she qualifies for premium assistance, which may be offered (through designated foundation funds) for a limited time to assist in securing the insurance coverage mentioned above.

F. Uninsured Patient Discount

Non-covered services under an insurance policy and patients/Guarantors that provide evidence that no health insurance coverage exists either through an employer-provided program or a governmental program such as Medicare, Medicaid or other state and local program to pay for the medically necessary health care services rendered to the patient, shall be eligible for an Uninsured Patient Discount. This Discount shall not apply to cosmetic or non-medically necessary procedures and will only be available for eligible services.

Each Hospital Facility shall calculate and determine the discount from gross charges available to eligible patients. The Financial Assistance described above supersedes this Uninsured Patient Discount. If it is determined that the application of Financial Assistance will further reduce the patient's bill, Hospital Facility will reverse the Uninsured Patient Discount and apply the applicable adjustments under the Financial Assistance Policy.

G. Self-Pay Discount

For those Uninsured patients who do not qualify for any of the financial assistance discounts described in this Policy, Hospital Facilities may apply an automatic (self-pay) discount to a patient's bill in accordance with CommonSpirit Revenue Cycle guidelines and procedures. This self-pay discount is not means-tested.

THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

All patients must complete the CommonSpirit FAA to be considered for Financial Assistance, unless they are eligible for Presumptive Financial Assistance. The FAA is used by the Hospital Facility to make an individual assessment of financial need.

To qualify for assistance, patient must provide bank or checking account statements evidencing the patient's available resources (those convertible to cash and unnecessary for the patient's daily living) and at least one (1) piece of supporting documentation that verifies Family Income is required to be submitted along with the FAA. Supporting documentation may include, but is not limited to:

- Copy of the individual's most recently filed federal income tax return;
- Current Form W-2;

- Current paystubs; or
- Signed letter of support.

The Hospital Facility may, at its discretion, rely on evidence of eligibility other than described in the FAA or herein. Other evidentiary sources may include:

- External publicly available data sources that provide information on a patient/Guarantor's ability to pay;
- A review of patient's outstanding accounts for prior services rendered and the patient/Guarantor's payment history;
- Prior determinations of the patient's or Guarantor's eligibility for assistance under this Policy, if any; or
- Evidence obtained as a result of exploring appropriate alternative sources of payment and coverage from public and private payment programs.

In the event no income is evidenced on a completed FAA, a written document is required which describes why income information is not available and how the patient or Guarantor supports basic living expenses (such as housing, food, and utilities). Financial Assistance applicants who participate in the National Health Services Corps (NHSC) Loan Repayment Program are exempt from submitting expense information.

PRESUMPTIVE ELIGIBILITY

CommonSpirit Hospital Organizations recognize that not all patients and Guarantors are able to complete the FAA or provide requisite documentation. Financial counselors are available at each Hospital Facility location to assist any individual seeking application assistance. For patients and Guarantors who are unable to provide required documentation, a Hospital Facility may grant Presumptive Financial Assistance based on information obtained from other resources. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Recipient of state-funded prescription programs;
- Homeless or one who received care from a homeless or free care clinic;
- Participation in Women, Infants and Children programs (WIC);
- Food stamp eligibility;
- Eligibility or referrals for other state or local assistance programs (e.g., Medicaid);
- Low income/subsidized housing is provided as a valid address; or
- Patient is deceased with no known spouse or known estate.

This information will enable Hospital Facilities to make informed decisions on the financial needs of patients, utilizing the best estimates available in the absence of information provided directly by the patient. A patient determined eligible for Presumptive Financial Assistance will receive free or discounted EMCare for the period during which the individual is presumptively eligible.

Medicaid patients who receive non-covered medically necessary services will be considered for Presumptive Financial Assistance. Financial assistance may be approved in instances prior to the Medicaid effective date.

If an individual is determined to be presumptively eligible, a patient will be granted Financial Assistance for a period of twelve (12) months ending on the date of presumptive eligibility

determination. As a result, Financial Assistance will be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date. The presumptively eligible individual will not receive financial assistance for EMCare rendered after the date of determination without completion of a FAA or a new determination of presumptive eligibility.

For patients, or their Guarantors, who are non-responsive to a Hospital Facility's application process, other sources of information may be used to make an individual assessment of financial need. This information will enable the Hospital Facility to make an informed decision on the financial need of non-responsive patients, utilizing the best estimates available in the absence of information provided directly by the patient.

For the purpose of helping financially needy patients, a Hospital Facility may use a third-party to review a patient's, or the patient's Guarantor'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 capability score. The model's rule set is designed to assess each patient based upon the same standards and is calibrated against historical Financial Assistance approvals by the Hospital Facility. This enables the Hospital Facility to assess whether a patient is characteristic of other patients who have historically qualified for Financial Assistance under the traditional application process.

When the model is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows a Hospital Facility to screen all patients for Financial Assistance prior to pursuing any ECAs. The data returned from this review will constitute adequate documentation of financial need under this Policy.

In the event a patient does not qualify for presumptive eligibility, the patient may still provide requisite information and be considered under the traditional FAA process.

Patient accounts granted presumptive eligibility status will be provided free or discounted care for eligible services for retrospective dates of service only. This decision will not constitute a state of free or discounted care as available through the traditional application process. These accounts will be treated as eligible for Financial Assistance under this Policy. They will not be sent to collection, will not be subject to further collection action, and will not be included in Hospital Facility bad debt expense. Patients will not be notified to inform them of this decision. Additionally, any deductible and coinsurance amount claimed as a Medicare bad debt shall be excluded from the reporting of charity care.

Presumptive screening provides a community benefit by enabling a CommonSpirit Hospital Organization to systematically identify financially needy patients, reduce administrative burdens, and provide Financial Assistance to patients and their Guarantors, some of whom may have not been responsive to the FAA process.

NOTIFICATION ABOUT FINANCIAL ASSISTANCE

Notification about the availability of Financial Assistance from CommonSpirit Hospital Organizations shall be disseminated by various means, which may include, but not be limited to:

- Conspicuous publication of notices in patient bills;

- Notices posted in emergency rooms, urgent care centers, admitting/registration departments, business offices, and at other public places as a Hospital Facility may elect; and
- Publication of a summary of this Policy on the Hospital Facility's website, as provided in Addendum A, and at other places within the communities served by the Hospital Facility as it may elect.

Patients may obtain additional information regarding the Hospital Facility's AGB percentage and how the AGB percentages were calculated from a Hospital Facility's financial counselor as provided in Addendum A.

Such notices and summary information shall include a contact number and shall be provided in English, Spanish, and other primary languages spoken by the population served by an individual Hospital Facility, as applicable.

Referral of patients for Financial Assistance may be made by any member of the CommonSpirit Hospital Organization non-medical or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

CommonSpirit Hospital Organizations will provide financial counseling to patients about their bills related to EMCare and will make the availability of such counseling known. It is the responsibility of the patient or the patient's Guarantor to schedule consultations regarding the availability of Financial Assistance with a financial counselor.

A provider listing will be published by each CommonSpirit Hospital Facility on its website, on or before July 1, 2021, and will be updated by management periodically (but no less than quarterly) thereafter.

ACTIONS IN THE EVENT OF NON-PAYMENT

The actions a CommonSpirit Hospital Organization may take in the event of nonpayment with respect to each Hospital Facility are described in a separate policy, CommonSpirit Governance Policy Finance G-004, *Billing and Collections*. Members of the public may obtain a free copy of this Policy by contacting the Hospital Facility Patient Access/Admitting department, as provided in Addendum A.

APPLICATION OF PROCEDURES

CommonSpirit Revenue Cycle leadership is responsible for the implementation of this Policy.

ATTACHMENTS

Financial Assistance Application (FAA)

REFERENCES

CommonSpirit Governance Policy	Finance G-004, *Billing and Collections*

ASSOCIATED DOCUMENTS

CommonSpirit Governance Addendum	Finance G-003A-1, *Financial Assistance - California*
CommonSpirit Governance Addendum	Finance G-003A-2, *Financial Assistance - Oregon*
CommonSpirit Governance Addendum	Finance G-003A-3, *Financial Assistance - Washington*
CommonSpirit Governance Addendum	Finance G-003A-A, *Hospital Facility Financial Assistance Contact Information Addendum Template*

ANNUAL APPROVAL

APPROVED BY COMMONSPIRIT HEALTH BOARD: March 17, 2021

COMMONSPIRIT HEALTH
GOVERNANCE POLICY

SUBJECT: Billing and Collections	**EFFECTIVE DATE:** July 1, 2022
POLICY NUMBER: Finance G-004	**ORIGINAL EFFECTIVE DATE:** July 1, 2021

POLICY

The purpose of this Policy is to provide clear and consistent guidelines for conducting billing, collections, and recovery functions in a manner that promotes compliance with Internal Revenue Code (IRC) Section 501(r) and applicable collection laws and regulations, patient satisfaction, and efficiency. This Policy outlines the circumstances under which Hospital Facilities will undertake collections actions on delinquent patient accounts related to the provision of Emergency Medical Care and Medically Necessary Care (herein referred to as EMCare) and identifies Permissible Collections Activities. This Policy describes the actions that a Hospital Facility may take to obtain payment of a bill for EMCare in the event of non-payment, including, but not limited to, any permissible collection actions.

SCOPE

This Policy applies to CommonSpirit Health and each of its tax-exempt Direct Affiliates[1] and tax-exempt Subsidiaries[2] that operate a Hospital Facility (referred to individually as a CommonSpirit Hospital Organization and collectively as CommonSpirit Hospital Organizations). It is the policy of CommonSpirit to follow the highest standards of ethics and integrity in their conduct of collections and recovery activities and to follow collections protocols for the fair treatment to all CommonSpirit Hospital Organizations patients at each Hospital Facility.

PRINCIPLES

After CommonSpirit Hospital Organization patients have received services, Hospital Facilities will bill patients/Guarantors and applicable payers accurately and in a timely manner. During this billing and collections process, staff will provide quality customer service and timely follow-up, and all outstanding accounts will be handled in accordance with all applicable laws and regulations. In addition, CommonSpirit values require that all individuals be treated with

1 A Direct Affiliate is any corporation of which CommonSpirit Health is the sole corporate member or sole shareholder, as well as Dignity Community Care, a Colorado nonprofit corporation.

2 A Subsidiary refers to either an organization, whether nonprofit or for-profit, in which a Direct Affiliate holds the power to appoint fifty percent (50%) or more of the voting members of the governing body of such organization or holds fifty percent (50%) or more of the voting rights in such organization (as evidenced by membership powers or securities conferring certain decision-making authority on the Direct Affiliate) or any organization in which a Subsidiary holds such power or voting rights.

reverence and compassion. CommonSpirit has defined certain collections actions to be in conflict with CommonSpirit's organizational values and have prohibited their use at any time.

APPLICATION

A. This Policy applies to:

- All charges for EMCare provided in a Hospital Facility by a CommonSpirit Hospital Organization.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a CommonSpirit Hospital Organization, to the extent such care is provided within a Hospital Facility.
- All charges for EMCare provided by a physician or advanced practice clinician who is employed by a Substantially-Related Entity that occurs within a Hospital Facility.
- Non-covered Medically Necessary Care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted.
- Any collection and recovery activities conducted by the Hospital Facility or a designated supplier of billing and collections services (Designated Supplier), or its third-party collection agents of a Hospital Organization to collect amounts owed for EMCare described above. All third-party agreements governing such collection and recovery activities must include a provision requiring compliance with this Policy and indemnification for failures as a result of its noncompliance. This includes, but is not limited to, agreements between third-parties who subsequently sell or refer debt of the Hospital Facility.

B. **Coordination with other laws**

The provision of Financial Assistance and billing and collection of patient accounts may now or in the future be subject to additional regulation pursuant to federal, state, or local laws. Such law governs to the extent it imposes more stringent requirements than this Policy. In the event that a subsequently adopted state or local law directly conflicts with this Policy, the CommonSpirit Hospital Organization shall, after consultation with its local CommonSpirit Legal Team representative, CommonSpirit Revenue Cycle leadership and CommonSpirit Tax leadership, be permitted to adopt an addendum to this Policy before the next policy review cycle, with such minimal changes to this Policy as are necessary to achieve compliance with any applicable laws.

PRINCIPLES

Through the use of billing statements, written correspondence, and phone calls, CommonSpirit Hospital Organizations will make diligent efforts to inform patients/Guarantors of their financial responsibilities and available Financial Assistance options, as well as follow up with patients/Guarantors regarding outstanding accounts. As Catholic health care providers, CommonSpirit Hospital Organizations are called to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for the services provided.

Finally, CommonSpirit Hospital Organizations are designated as charitable (i.e., tax-exempt) organizations under IRC Section 501(c)(3). Pursuant to IRC Section 501(r), among other

things, in order to remain tax-exempt, each CommonSpirit Hospital Organization must do the following with respect to patients receiving EMCare at any Hospital Facility:

- Limit the amounts individuals eligible for Financial Assistance are charged for EMCare to not more than the Amounts Generally Billed (AGB) to individuals who have insurance covering such Care;
- Bill less than gross charges to individuals eligible for Financial Assistance for all other medical care; and
- Not engage in Extraordinary Collections Actions before the Hospital Facility has made reasonable efforts to determine whether the individual is eligible for assistance under CommonSpirit Governance Policy Finance G-003, *Financial Assistance.*

DEFINITIONS

Amounts Generally Billed (AGB) means the maximum charge a patient who is eligible for Financial Assistance under this Financial Assistance Policy is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AGB for EMCare provided to the patient. CommonSpirit calculates the AGB on a Facility-by-Facility basis using the "lookback" method by multiplying the "Gross Charges" for any EMCare that it provides by AGB percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in federal law. "Gross Charges" for these purposes means the amount listed on each Hospital Facility's chargemaster for each EMCare service.

Application Period means the time provided to patients by the CommonSpirit Hospital Organization to complete the Financial Assistance application. It expires on the later of (i) 365 days from the patient's discharge from the Hospital Facility or the date of the patient's EMCare, or (ii) 240 days from the date of the initial post-discharge bill for the EMCare received at a Hospital Facility.

Emergency Medical Care, EMTALA - Any patient seeking care for an emergency medical condition within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd) at a Hospital Facility shall be treated without discrimination and without regard to a patient's ability to pay for care. Furthermore, any action that discourages patients from seeking EMCare, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of EMCare, is prohibited. Hospital Facilities shall also operate in accordance with all federal and state requirements for the provision of care relating to emergency medical conditions, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Labor Act (EMTALA) and in accordance with 42 CFR 482.55 (or any successor regulation). Hospital Facilities should consult and be guided by any CommonSpirit EMTALA Policy, EMTALA regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an emergency medical condition and the processes to be followed with respect to each.

Extraordinary Collection Actions (ECAs) - The Hospital Facility will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under the Hospital Facility's FAP. An ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

- Selling an individual's debt to another party except as expressly provided by federal law; and
- Reporting adverse information about the individual to consumer credit bureaus.

ECAs do not include any lien that a Hospital Facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Facility provided care.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided in a Hospital Facility and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Financial Assistance Policy (FAP) means CommonSpirit Governance Policy Finance G-003, *Financial Assistance*, which describes CommonSpirit's Financial Assistance program, including the criteria patients/Guarantors must meet in order to be eligible for Financial Assistance as well as the process by which individuals may apply for Financial Assistance.

Guarantor means an individual who is legally responsible for payment of the patient's bill.

Hospital Facility (or Facility) means a healthcare facility that is required by a state to be licensed, registered, or similarly recognized as a hospital and that is operated by a CommonSpirit Hospital Organization. In reference to the performance of billing and collection activities, the term "Hospital Facility" may also include a Designated Supplier.

Medically Necessary Care means any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers life, cause suffering or pain, results in illness or infirmity, threatens to cause or aggravate a handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no other equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures only to improve aesthetic appeal of a normal, or normally functioning, body part.

Notification Period means the 120-day period beginning on the date the Hospital Facility provides the first post-discharge billing statement for the EMCare. A Facility will refrain from engaging in an ECA during the Notification Period, unless reasonable efforts have been made to determine a patient is eligible for Financial Assistance.

Operates a Hospital Facility - A Hospital Facility is considered to be operated either by use of its own employees or by contracting out the operation of the Facility to another organization. A Hospital Facility may also be operated by a CommonSpirit Hospital Organization if the CommonSpirit Hospital Organization has a capital or profits interest in an entity taxed as a partnership which directly operates a state licensed Hospital Facility or which indirectly operates a state licensed Hospital Facility through another entity taxed as a partnership.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free or discounted EMCare for the period during which the individual

is presumptively eligible. See also Presumptive Eligibility in CommonSpirit Governance Policy Finance G-003, *Financial Assistance.*

Substantially-Related Entity means, with respect to a CommonSpirit Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides EMCare in a state licensed Hospital Facility, unless the provision of such care is an unrelated trade or business described in IRC Section 513 with respect to the Hospital Organization.

Suspending ECAs when a Financial Assistance Application (FAA) is Submitted means a Facility (or other authorized party) does not initiate an ECA, or take further action on any previously initiated ECAs, to obtain payment for the EMCare until either:

- The Facility has determined whether the individual is FAP-eligible based on a complete FAP application and met the reasonable efforts requirement, as defined herein, with respect to a completed FAA; or
- In the case of an incomplete FAA, the individual has failed to respond to requests for additional information or documentation within a reasonable period of time (thirty (30) days) given to respond to such requests.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

BILLING PRACTICES

CommonSpirit Hospital Organizations will follow standard procedures in collecting on accounts related to EMCare provided at a CommonSpirit Hospital Facility as follows:

A. Insurance Billing

- For all insured patients, Hospital Facilities will bill applicable third-party payers (based on information provided or verified by the patient/Guarantor, or appropriately verified from other sources) in a timely manner.
- If an otherwise valid claim is denied (or not processed) by the payer due to an error by a Hospital Facility, the Hospital Facility will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
- If an otherwise valid claim is denied (or not processed) by a payer due to factors outside of the Hospital Facility's control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, Hospital Facilities may bill the patient or take other actions consistent with payer contracts.

B. Patient Billing

- All patients/Guarantors will be billed directly and timely and receive a statement as part of the Hospital Facility's normal billing process.
- For insured patients, after claims have been processed by all available third-party payers, Hospital Facilities will bill patients/Guarantors in a timely manner for their respective liability amounts as determined by their insurance benefits.
- All patients/Guarantors may at any time request, and the Hospital Facility will provide, an itemized statement for their accounts.
- If a patient disputes his or her account and requests documentation regarding the bill, staff will provide the requested documentation in writing within ten (10) days (if possible) and will hold the account for at least thirty (30) days before referring the account for collection.
- Hospital Facilities shall approve payment plan arrangements for patients/Guarantors who indicate they may have difficulty paying their balance in a single installment.
- Revenue Cycle leadership has the authority to make exceptions to this provision on a case-by-case basis for special circumstances (in accordance with operating procedures).
- Hospital Facilities are not required to accept patient-initiated payment arrangements and may refer accounts to a third-party collection agency as outlined below if the patient defaults on an established payment plan.

C. Collection Practices

- Any collection activities conducted by the Facility, a Designated Supplier, or its third-party collection agents will be in conformance with all federal and state laws governing debt collection practices.

- All patients/Guarantors will have the opportunity to contact the Hospital Facility regarding Financial Assistance, payment plan options, and other applicable programs that may be available with respect to their accounts, as provided in Addendum A.
  - A Hospital Facility's FAP is available free of charge.
  - Individuals with questions regarding a Hospital Facility's FAP may contact the financial counseling office by phone or in person.
- In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Policy, Hospital Facilities may engage in collection activities, including Permissible ECAs, to collect outstanding patient balances.
  - General collection activities may include phone calls, statements, and other reasonable efforts in accordance with standard industry practices.
  - Patient balances may be referred to a third-party for collection at the discretion of the Facility and in compliance with all applicable federal, state, and local non-discrimination practices. The Facility will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
    - There is a reasonable basis to believe the patient owes the debt.
    - All third-party payers identified by the patient/Guarantor in a prompt and timely manner that have been properly billed, and the remaining debt is the financial responsibility of the patient. Hospital Facilities shall not bill a patient for any amount the insurance company or a third-party is obligated to pay.
    - Hospital Facilities will not refer accounts for collection while a claim on the account is pending payment from a third-party payer. However, claims which remain in "pending" status with a third-party payer for an unreasonable length of time despite efforts to facilitate resolution may be re-classified as "denied."

- Hospital Facilities will not refer accounts for collection when the insurance claim was denied due to a Hospital Facility error. However, a Hospital Facility may still refer the patient liability portion of such claims for collection if unpaid.
- Hospital Facilities will not refer accounts for collection where the patient has initially applied for Financial Assistance, and the Hospital Facility has not yet made reasonable efforts (as defined below) with respect to the account.
- Upon receipt of a notice of Bankruptcy Discharge, CommonSpirit Hospital Organizations will cease all collection attempts, including assignment to a collection agency. The patient/debtor will not be contacted by any method, including phone calls, letters, or statements after receipt of the notification. All communication, if necessary, must occur with the trustee or the attorney assigned to the case.
  - No Facility shall send any unpaid self-pay account to a third-party collection agent as long as the patient or Guarantor is engaged in Patient Cooperation Standards, as defined in CommonSpirit Governance Policy Finance G-003, *Financial Assistance*.

REASONABLE EFFORTS AND EXTRAORDINARY COLLECTION ACTIONS

Before engaging in ECAs to obtain payment for EMCare, Hospital Facilities must make reasonable efforts to determine whether an individual is eligible for Financial Assistance. In no event will an ECA be initiated prior to 120 days (or longer, if required by applicable law) from the date the Facility provides the first post-discharge billing statement (i.e., during the Notification Period) unless all reasonable efforts have been made. The following scenarios describe the reasonable efforts that a Facility must take before engaging in ECAs.

A. Engaging in ECAs – Notification Requirement

- With respect to any EMCare provided in the Facility, a patient must be notified about the FAP as described herein, prior to initiating an ECA. The notification requirement is as follows:
  - **Notification Letter -** The Hospital Facility will notify a patient about the FAP by providing the individual with a written notice (Notification Letter) at least thirty (30) days prior to initiating an ECA. The Notification Letter must:
    - Include a plain language summary of the FAP;
    - Indicate Financial Assistance is available for eligible individuals; and
    - Identify the ECA(s) that the Hospital Facility (or other authorized party) intends to initiate to obtain payment for the EMCare if the amount due is not paid or an FAA is not submitted before a specified deadline, which is no earlier than the last day of the Application Period.
  - **Oral Notification -** In conjunction with the provision of the Notification Letter, the Hospital Facility will attempt to orally notify the patient about how to obtain assistance under the FAP during the registration process, using the most current telephone number provided by the patient. This attempt will be documented contemporaneously.
  - **Notification in the Event of Multiple Episodes of Care** - The Hospital Facility may satisfy this notification requirement simultaneously for multiple episodes of EMCare and notify the individual about the ECAs the Facility intends to initiate to obtain payment for multiple outstanding bills for EMCare. However, if a Facility aggregates an individual's outstanding bills for multiple episodes of EMCare before initiating one or more ECAs to obtain payment for those bills, it will have not have made reasonable efforts to determine whether the individual is FAP-eligible unless it refrains from initiating the ECA(s) until 120 days after the first post-discharge billing statement for the most recent episode of EMCare included in the aggregation.

B. Reasonable Efforts when a Patient Submits an Incomplete FAA

- The Hospital Facility will suspend any ECAs already initiated against the patient/Guarantor until Financial Assistance eligibility has been determined.
- The Hospital Facility will provide a written notification to the patient with a list of required documentation the patient or Guarantor must provide to consider the FAA complete and give the patient thirty (30) days to provide the necessary information. The notification will include the contact information, including telephone number and physical location of the Facility or department within the Facility that can provide information about and assist with the preparation of the FAP.

C. Reasonable Efforts when a Completed FAA Is Submitted

- If a patient submits a completed FAA during the Application Period, the Hospital Facility must:
  - Suspend any ECAs to obtain payment for the EMCare.
  - Make a determination as to whether the individual is FAP-eligible for the EMCare and notify the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.
  - If the Hospital Facility determines the individual is FAP-eligible for the EMCare, the Hospital Facility must do the following:
    - Refund the individual any amount he or she has paid for the EMCare (whether to the Hospital Facility or any other party to whom the Hospital Facility has referred or sold the individual's debt for the EMCare) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual.
    - Take all reasonably available measures to reverse any ECA, including the removal of any adverse information that was reported to a consumer reporting agency or credit bureau from the individual's credit report.
  - If the Hospital Facility determines the individual is not FAP-eligible for the EMCare, the Facility will have made reasonable efforts and may engage in the Permissible ECAs.

D. Reasonable Efforts when No FAA Is Submitted within ninety (90) days after the First Post-Discharge Billing Statement for the Most Recent Episode of EMCare

- The Facility will issue the Notification Letter as described under Reasonable Efforts – Engaging in ECAs – Notification Requirement. If no FAA is received within thirty (30) days after the Notification Letter has been sent, the requirement to engage in reasonable efforts to determine FAP-eligibility will have been satisfied. Thus, the Hospital Facility may engage in ECAs that are permitted under this Policy beginning 120 days after the first post-discharge billing statement.
- **Waiver** - Under no circumstances will a Hospital Facility accept from any individual a waiver, whether oral or written, that an individual does not wish to apply for Financial Assistance, for the purpose of satisfying the requirements to engage in reasonable efforts described in this Policy.

E. Permissible Extraordinary Collections Actions

- After making reasonable efforts, which includes the notification requirement, to determine Financial Assistance eligibility as outlined above, a Hospital Facility (or other authorized party) may engage in the following ECAs to obtain payment for EMCare:
  - Selling an individual's debt to another party except as expressly provided by federal law; and
  - Reporting adverse information about the individual to consumer credit bureaus.

A Hospital Facility will refrain from ECAs against a patient if he or she provides documentation that he or she has applied for health care coverage under Medicaid, or other publicly-sponsored healthcare programs, unless or until the individual's eligibility for such programs has been determined and any available coverage from third parties for the EMCare has been billed and processed.

F. Reasonable Efforts - Third-Party Agreements

- With respect to any sale or referral of an individual's debt related to EMCare to another party (except for those debt sales not considered an ECA as described in the Internal Revenue Service Treasury Regulations) the Hospital Facility will enter into and, to the extent applicable, enforce a legally binding written agreement with the party. To meet the requirement to engage in reasonable efforts to determine an individual's FAP-eligibility, these agreements must, at a minimum, include the following provisions:
  - If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt but before the end of the Application Period, the party will Suspend ECAs to obtain payment for the EMCare.
  - If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt but before the end of the Application Period and is determined to be FAP-eligible for the EMCare, the party will do the following in a timely manner:
    - Adhere to procedures specified in the agreement and this Policy so that the individual does not pay, and has no obligation to pay, the party and the Hospital Facility together more than he or she is required to pay for the EMCare as a FAP-eligible individual.
    - If applicable, and if the party (rather than the Hospital Facility) has the authority to do so, take all reasonably available measures to reverse any ECA (other than the sale of a debt) taken against the individual.
  - If the third-party contractor refers or sells the debt to a subsequent party (the fourth party) during the Application Period, the third-party will obtain a written agreement from that subsequent party including all the elements described under this section.
  - The third-party contractor must make reasonable attempts to work with a patient with unpaid bills to resolve his/her account. Aggressive or unethical collection practices are not tolerated.

G. Reasonable Efforts – Providing Documents Electronically

- A Hospital Facility may provide any written notice or communication described herein electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

FINANCIAL ASSISTANCE DOCUMENTATION

A. Processing Requests

- CommonSpirit's values of human dignity and stewardship shall be reflected in the application process, financial need determination, and granting of assistance.
- Requests for Financial Assistance shall be processed promptly, and Hospital Facilities shall notify the patient or applicant in writing within thirty (30) to sixty (60) days of receipt of a completed application.
- A Hospital Facility will not make a determination of eligibility on information it has reason to believe is false or unreliable or obtained through the use of coercive practices.
- If eligibility is approved based on the completion of an FAA, the patient will be granted Financial Assistance for all eligible accounts incurred for services received twelve (12) months prior to the determination date and prospectively for a period of six (6) months from the determination date.
- If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services received twelve (12) months prior to the determination date. The Presumptively Eligible individual will not receive Financial Assistance for EMCare rendered after the date of determination without completion of an FAA or a new determination of Presumptive Eligibility.
- If denied eligibility for Financial Assistance offered by a Hospital Facility, a patient or Guarantor, may re-apply whenever there has been a material change of income or status.
- Patients/Guarantors may seek a review from a Hospital Facility in the event of a dispute over the application of this Policy or the FAP. Patients/Guarantors denied Financial Assistance may also appeal their eligibility determination, as provided in Addendum A.
- The basis for the dispute or appeal should be in writing and submitted within three (3) months of the decision on Financial Assistance eligibility.
- The Hospital Facility will postpone any determination of FAP eligibility because the Hospital Facility is awaiting the results of a Medicaid application.

B. Presumptive Financial Assistance

- Reasonable efforts to determine FAP-eligibility are not required when an individual is determined eligible for Presumptive Financial Assistance.
- **Medicaid** - Medicaid patients who receive non-covered medically necessary services will be considered for Presumptive Financial Assistance. Financial assistance may be approved in instances prior to the Medicaid effective date.

RESPONSIBILITY

CommonSpirit Revenue Cycle leadership is ultimately responsible for determining whether a Hospital Facility has made reasonable efforts to determine whether an individual is eligible for Financial Assistance. This body also has final authority in deciding whether the Hospital Organization may proceed with any of the ECAs outlined in this Policy.

REFERENCES

CommonSpirit Governance Policy Finance G-003, *Financial Assistance*

ANNUAL APPROVAL

APPROVED BY THE COMMONSPIRIT HEALTH BOARD: March 17, 2021