BAPTIST

OPERATIONS POLICY, PROCEDURE, AND GUIDELINE MANUAL

Effective Date: 9/03	**HOSPITAL FINANCIAL ASSISTANCE POLICY**
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PURPOSE: To establish a framework for providing financial assistance to the uninsured and underinsured, consistent with our charitable mission, to qualify patients with an effective and consistent method of administration and allocation. Financial assistance may be provided in the form of free care or discounted care for qualifying patients for inpatient and/or outpatient service charges (excluding cosmetic or other procedures which are not Medically Necessary).

POLICY:

Baptist Memorial Health Care Corporation and its affiliated entities ("Baptist") is committed to treating all patients equitably, with dignity, respect, and compassion. Baptist facilities are open for medical care services to the general public, and it is our policy that no patient will be denied medical care services due to inability to pay. For those with ability to pay, Baptist provides services in anticipation of payment by the patient and/or guarantor for services rendered. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), emergency and medically necessary care will not be delayed or withheld based on a patient's ability to pay. Any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with EMTALA and all applicable State and Federal regulations.

Good stewardship of resources in light of expenses make it necessary to establish procedures and guidelines. These procedures are not designed to turn away, impede or discourage those in need from seeking Medically Necessary treatment, but rather to assure that the resources of Baptist are devoted to ongoing quality medical care and the provision of financial assistance for those patients who are in need and least able to pay, rather than those who chose not to pay. Financial assistance under this policy is conditioned upon the patient meeting the income eligibility criteria based on the Federal Poverty Income Guidelines (FPG) as described herein. **Completion of the Baptist Financial Assistance Application is the initial necessary step in this process.** No patient will be denied financial assistance due to his or her race, religion, national origin, or any other basis prohibited by law.

SCOPE:

This Baptist Hospital Financial Assistance Policy ("FAP") applies to charges for emergency and Medically Necessary services by BMHCC owned and operated medical care facilities, with the exception of physician professional services at BMHCC owned clinics, which are covered under the Baptist Financial Assistance Policy for Professional Services ("Pro-FAP"). Reference our Baptist website under "Financial Assistance" to view the current list of Hospital FAP and Pro-FAP participating entities, as well as the entities not participating in either program. www.baptistonline.org/patients-and-visitors/financial-assistance.

DEFINITIONS:

Amounts Generally Billed (AGB) - The percentage of Gross Charges for medical care after contractual adjustments for patients who have insurance covering such care. Baptist FAP-eligible patients will not be charged more than this AGB percentage. In accordance with Internal Revenue Code Section §1.501(r) requirements, Baptist uses the "Look Back Method" to determine the AGB percentage based on claim data from the prior year. AGB percentages are calculated separately for each hospital facility by totaling the amounts allowed by Medicare fee for service, plus all other commercial and private health insurers, then dividing by the respective gross charges.

Application Period - Period of time a patient has to submit a completed application for financial assistance. The application period begins on the date medical care is provided (or earlier if the patient choses to apply) and ends on the later of 240 days after the first post-discharge billing statement or thirty days after the hospital (or an authorized third party) provides a written notice (final bill) to the patient outlining pending Extraordinary Collection Actions.

Encounter - An interaction or visit with a care provider. For outpatient treatments, an encounter generally refers to one treatment date or one clinic visit. The exception being series accounts as defined below. If the patient's Encounter was an inpatient stay, the Encounter charges would include all applicable technical charges incurred during the stay.

Episode of Care - Consists of all clinically-related services for one patient for a discrete diagnostic condition from the onset of symptoms until treatment is complete.

Extraordinary Collection Actions (ECA) - Collection activities that Baptist will undertake only after making reasonable efforts to determine if the patient is eligible for financial assistance. As defined by §1.501(r) regulations, ECA are certain actions taken against an individual related to obtaining payment for a hospital bill. No ECA will be taken sooner than 120 days from the date of the first post-discharge bill and at least 30 days after the patient was sent a written notice outlining pending ECA.

Family Unit - A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered to be members

of one family. For instance, if an older married couple, their daughter, her husband and two children, plus the couple's nephew lived in the same house or apartment, they would be considered members of a family unit of seven.

Financial Assistance - A reduction in the amount of a patient's bill for medical services as determined by the provisions of this FAP. This reduction is generally determined as a percentage discount applied to the Gross Charges.

Gross Charges - The full, undiscounted price of medical services uniformly charged to patients before applying any contractual allowances, discounts, or deductions.

Insured - Patients with any type of health insurance coverage and/or third-party payor program, policy, or responsibility, including any governmental payor program or responsibility, (but excluding Limited Benefit Plans and Limited Benefit Policies), which discounts, or is obligated to reimburse or compensate for, medical charges for the Encounter or Episode of Care. For the purpose of this policy, patients who have an active medical policy, but are out of network are considered insured. If the insurance policy pays the lessor of 5% of the charges, the patient will be considered underinsured and receive an adjustment equivalent to the self-pay discount.

Limited Benefit Plans – Medical plans with significantly lower and more restrictive benefits than ordinary major medical insurance. This may include some critical illness plans, indemnity plans (policies that only pay a pre-determined amount, regardless of total charges), and "hospital cash" policies.

Limited Benefit Policies - Insurance coverage that provides less than 5% of reimbursement for medical charges.

Medically Necessary - 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 as determined by a medical care provider. Services or supplies provided primarily for the convenience or personal preference of a patient are not included.

Medically Underinsured - For the purposes of this policy, any Insured patient who has incurred an out-of-pocket liability for hospital Technical Charges in excess of $5,000 for a single Encounter is deemed Medically Underinsured and is eligible for the Medically Underinsured discount. Medically Underinsured patients are not required to complete the financial assistance application.

Out of Network - A patient covered under a health insurance policy or plan with an insurance company that has not contracted with Baptist for reimbursement at a negotiated rate and the patient's policy or plan does not include Baptist as part of their provider network.

Professional Services - Billing for medical services provided by physicians, advanced practice providers, suppliers and other non-employed providers for both outpatient and inpatient services.

Series Account - Accounts that combine multiple encounters of repetitive services on one claim. This claim is generally reflective of charges for a thirty-day period for which services were ordered by the same physician under the same diagnosis set.

Technical Charges - Charges billed for medical services for the use of equipment, facilities, non-physician medical staff, supplies, and other charges in hospitals, skilled nursing facilities, hospital-based clinics and other Baptist institutions providing outpatient and inpatient services.

Third-Party Liability – An obligation of any person or entity (other than the patient) for partial or complete financial responsibility for payment of a patient's charges for medical services provided.

Uninsured - A patient for whom there is no third party, insurance company, or governmental entity responsible for all or any portion of the patient's medical expenses for the Encounter or Episode of Care, and who is not Insured as defined herein.

Uninsured Discount - The flat-rate discount applied to eligible Gross Charges for Uninsured patients. The applicable discount rate considers the AGB calculation which varies based upon the Baptist facility where services were received.

POLICY EXCLUSIONS:

Patients are not eligible for financial assistance under this FAP if:

1. If the patient is insured unless the patient qualifies for a discount herein as Medically Underinsured.

2. The patient is eligible for Financial Assistance under another city, county, state, federal or any other assistance program that supersedes this policy, for that portion of the charges covered by the superseding financial assistance.
3. The patient charges resulted from medical care arising from a work-related accident, unless the patient provides verification of no third-party coverage.
4. The patient charges resulted from an auto accident, unless the patient provides verification of no third-party coverage.

Additionally, this FAP does not discount the following charges:

1. Charges for medical services that may be provided but which are not Medically Necessary to the specific patient (including but not limited to cosmetic or appearance-enhancing procedures).

2. Services furnished by providers who are not obligated to participate in this FAP program, which include, but are not limited to the following: outside or specialty laboratory services, radiologists, pathologists, ambulance services, non-employed physicians, as well as services provided at select facilities that are not fully owned and operated by Baptist. Reference the Baptist website under "Financial Services" to view the current lists of entities that fall under the Hospital FAP and the Pro-FAP.

3. Charges for purchases of convenience retail items which are not Medically Necessary, including, but not limited to the following: eyeglasses, contacts, hearing aids, wigs, cosmetic goods, and any items to which sales tax is applied. NOTE: There are oftentimes other charitable programs available to assist with the cost of these non-Medically Necessary items, and available information will be provided upon request.

POLICY APPLICATIONS:

I. Financial Assistance for the Medically Underinsured

The Medically Underinsured patient discount applies under the following terms and conditions:

A. The patient has insurance coverage for the applicable Encounter or Episode of Care.

B. All available insurance has been billed and all applicable payments have been received.

C. The patient meets the definition of Medically Underinsured after completion of A and B.

D. Medically Underinsured patients will receive a 25% discount off the patient liability greater than $5,000. NOTE:

a) Mother and newborn accounts are to be combined when applying this discount.

b) Series accounts are considered one Encounter when applying this discount.

Patients should contact the Central Business Office at (877) 348-1281 if they qualify or if they have questions about this discount.

II. Provision for Non-Credentialed Medicaid Providers

When a Baptist entity is not credentialed with a patient's out-of-state Medicaid program and therefore ineligible to receive Medicaid reimbursement for services provided, account balances will be classified as charity as the Medicaid patients are classified as indigent.

III.Financial Assistance for Uninsured Patients

i. All uninsured patients are evaluated for eligibility for Medicaid by Baptist's third-party Medicaid eligibility vendor, which will work with the patient and Baptist to determine if the patient is eligible for any federal, state, or local assistance programs.

ii. After Medicaid eligibility has been determined, all remaining uninsured patients are evaluated for eligibility for an Affordable Care Act (ACA) marketplace plan by Baptist's third-party ACA eligibility vendor, which will work with the patient and Baptist to determine if the patient is eligible for any in-network ACA marketplace plan. In the event that the uninsured patient is not eligible for Medicaid or other federal, state or local assistance programs, the patient will receive the Uninsured Discount and may apply for additional Financial Assistance based upon financial need as provided by this policy.

iii. If a patient refuses or is uncooperative with Baptist or its designated vendor in providing the necessary information needed to determine their eligibility for Medicaid or ACA assistance, the patient will therefore forfeit their right to be considered for, and/or receive Financial Assistance.

A. The Uninsured Discount

1. If the patient qualifies as Uninsured, total charges are adjusted to the AGB by applying the Uninsured Discount to total Gross Charges. The AGB rates are different for each Baptist facility so the discount rate applied will be the discount rate of the Baptist facility where the patient received the service. AGB discount tables are updated annually; the most recent for each facility can be located on the Baptist website, www.baptistonline.org/patients-and-visitors/financial-assistance.

2. The Uninsured Discount will automatically be applied before the first post-discharge billing statement if the patient's status as Uninsured has been determined at that time. Application of this discount ensures that charges for emergency and/or other Medically Necessary care for FAP-eligible individuals are limited to and not more than, the average billed to individuals with insurance covering such care, in accordance with §1.501(r)(5).

3. Completion of a Financial Assistance Application is not necessary for eligibility for the Uninsured Discount.

B. The Financial Need Discount

All applying Uninsured patients are eligible for an additional discount based upon financial need. The eligibility for this discount is determined as follows:

1. The size of the patient's family unit is determined using documentation provided including, but not limited to, the application and supporting financial documents.

(a) A family unit is a group of two or more persons related by birth, marriage, or adoption who live together. Generally, all related persons living in one physical location are considered members of one family unit. A child who is a full-time student living away from home at an accredited college can be counted in the family size.

(b) Unrelated individuals are excluded from the household size determination. An unrelated individual is one not related to the patient by birth, marriage, or adoption. Examples include friends, roommates, lodgers, foster children, employees or others living in group quarters such as a rooming house.

(c) If needed, the primary address/residence of individuals claimed in a family unit will be verified using tax returns and/or federal, state or governmental court documents establishing residency.

2. The total gross income for the patient's family unit is determined by consideration of the following:

(a) Money income including: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, disability payments, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates and/or trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.

1. Minor children's earned wages are not included in the income calculation.

2. Court-ordered and state or federally issued assistance related to a minor is included in the income calculation.

(b) The value of non-cash benefits (such as food stamps and housing subsidies) is not counted as income; however, these documents may be used to substantiate the family size and/or corresponding income totals.

(c) The patient must provide supporting financial documentation to verify the total gross income of all family members in the household. Gross income is always used for determining the patient's financial status. Most recent income information is given priority in assessing financial status. In order to accurately substantiate the family income, any of the following documents are acceptable proof of income; however, preference is the order listed:

1. Pay stubs for the last three months
2. Income tax return for the previous year
3. W2 forms for the previous year
4. State/Federal assistance documents
5. Bank statements for the last three months
6. Pension/retirement statements

7. Legal documents including divorce decree and/or child support and alimony

3. The Baptist FAP financial need discount percentages are determined by the family unit size and the total family income in the appropriate Baptist FAP Discount Table. A copy of the Discount Table is available from the Business Office where services were received or at www.baptistonline.org/patients-and-visitors/financial-assistance then click on the "Baptist Hospital's Self-pay Minimum Discounts" link.

(a) The following table summarizes the Baptist FAP discounts:

Baptist FAP Discount Summary	
FPG Income Range	**FAP Discount**
< 200%	100%
201-250%	95%
251-300%	90%
301-350%	85%
351-400%	80%
> 400%	Varies by Facility

(b) The income levels for the Discount Table are established by the United States Federal Poverty Guidelines ("FPG"). These levels are published annually by the U.S. Department of Health and Human Services and the FPG income thresholds can be found by searching "*current poverty guidelines*" at www.federalregister.gov. The AGB calculations and current FPG income thresholds for the Baptist discount tables are updated annually.

(c) Once the financial need discount determination has been made, qualifying patients will be sent a letter indicating the applicable discount percentage and how much, if any, the patient owes after the discount has been applied. This letter will also include contact information if the patient has questions regarding the discounts, the approval process or payment arrangements.

Baptist reserves the right to request additional information and/or to decline or rescind Financial Assistance provided under this FAP in the event of incorrect information, misrepresentation, or fraud. Financial Assistance provided pursuant to this FAP is principally intended to benefit the Uninsured and Medically Underinsured patients in the communities served by each of the Baptist affiliated entities. In the event a particular affiliated entity determines that its continued viability and ability to continue to provide charitable care within the served community is impaired due to patients from outside of those communities obtaining

Financial Assistance from that entity, that entity reserves the right to amend or modify this FAP as needed to remain viable and to maintain its charitable mission. Notwithstanding, emergency and Medically Necessary care will never be delayed or withheld based upon any patient's ability to pay.

IV. Financial Assistance Application Process for Financial Need Discount.

A. General Information.

1. Uninsured patients applying for Financial Assistance based upon financial need under the Baptist FAP must complete the Financial Assistance Application, so that reasonable efforts can be made to determine whether a patient is eligible for Financial Assistance. Free copies of the application and/or a plain language statement explaining the FAP are readily available from several sources.

(a) A copy is offered to the patient during the admissions and/or

(b) Copies are posted and available upon request at all Admissions, Emergency and Business Office department areas at all Baptist facilities.

(c) Copies are also available for download and printing online on the Baptist website, www.baptistonline.org/patients-and-visitors/financial-assistance or by contacting the facility where services were received and requesting a copy by mail or email at FAP@BMHCC.org.

(d) In addition, Baptist will provide all FAP-related documents electronically to any individual who indicates that is their preference.

(e) A copy is also sent in the "final bill notice" with the patient's billing statement.

2. If a patient's Financial Assistance eligibility status has been determined in the previous ninety days, the patient does not need to reapply.

3. The approved discount will remain in place for a period of ninety (90) days from the date of approval, and will also be applied to the Gross Charges for all other open, qualified accounts (not older than 240 days) related to this Episode of Care or for other Medically Necessary services. Eligibility under the FAP will be reassessed every ninety (90) days. The process to reapply is the same as the initial process; an application and the updated financial information shall be submitted to the Business Office at the facility where services were received.

4. The approved discount will apply under the same terms for open accounts or other Medically Necessary care at Baptist facilities participating in the Hospital FAP. Patients do not need to apply at each facility. In these situations:

-Patients may need to submit a copy of their approval letter as proof of a previous approval.

-The discount percentage applied is determined by the facility where the medical care was received.

5. Charges which are not eligible for Financial Assistance under this FAP may be eligible for a discount under the Baptist Pro-FAP. Information and instructions for applying for financial assistance under the Pro-FAP can also be found on the Baptist website, www.baptistonline.org/patients-and-visitors/financial-assistance. For any FAP-eligible accounts, the amount the patient is personally responsible for paying will be reduced by any amounts already paid. The patient will be refunded any net-overpayments in excess of $5.

6. Baptist reserves the right to use external scoring systems to predict presumptive charity.

i. Baptist will have made reasonable efforts to determine FAP-eligibility for the care if it determines that the individual is FAP-eligible for the care based on information other than that provided by the individual or based on a prior FAP-eligibility determination, and if the individual is presumptively determined to be eligible for less than the most generous assistance available under FAP, the facility:
    a. Will adjust the patient's balance to zero as a result of the basis for the presumptive FAP-eligibility determination.
    b. Gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care.
    c. If the individual submits a complete FAP application seeking more generous assistance during the application period, the facility determines whether the individual is eligible for a more generous discount and otherwise meets the requirements as described in this policy.

B. Financial Assistance Application Processing.

1. The review for FAP eligibility will be completed within thirty days.

2. ECA efforts will be suspended after the application has been received and during review. Baptist will resume, or take all reasonably available measures to reverse, the ECA, as appropriate, after the eligibility determination. Once the eligibility determination has been made, a letter will be sent to the patient advising them of the decision.

3. For patients who are eligible for a financial need discount, the notification letter will indicate the qualifying discount percentage and how much the patient owes after the discount has been applied. This letter will also include contact information for assistance with patient questions regarding the discount, the approval process or payment arrangements.

4. If the application is incomplete or lacks the necessary supporting documentation, a letter will be sent notifying the patient and requesting the missing information. All supporting information must be received before the end of the patient's

application period. This letter will include contact information for assistance with patient questions regarding the discount, the approval process or payment arrangements. If the patient is unable or unwilling to provide the necessary financial documentation, the patient will not be eligible for a financial need discount.

5. For patients who are deemed ineligible for a financial need discount above the Uninsured Discount, their notification letter will include contact information for assistance with patient questions or concerns regarding the discount, the approval process, or payment arrangements. Patients are eligible to reapply for a financial need discount after ninety days or if they have experienced a material change in family unit or income status.

6. Baptist reserves the right to reverse financial assistance and pursue appropriate reimbursement in the event of newly discovered information regarding insurance coverage, or payment to the applicant pursuant to a personal injury claim related to the services in question, and/or verification that requested information was falsified or inaccurate.

V. Financial Assistance Partnerships with Community Health Clinics

A. Church Health (CH) is a healthcare ministry operating in Shelby County. Baptist has an established partnership and sponsorships with CH uniting our missions of providing quality health care to the underserved in our community. Where applicable, BMHCC has delegated our financial assistance process to CH, streamlining the process of relying on the CH-calculated FPL levels for our financial assistance determination. This process expedites the approval process and eliminates duplication of efforts, while enhancing patient convenience by enabling easier access to medical services**.**

B. Oxford Medical Ministries Clinic (OMMC) is a privately funded clinic for patients who are 18-65 years old, uninsured, work at least 27-30 hours a week and reside in Mississippi's Lafayette or Yalobusha counties. Baptist has established partnerships with OMMC to unite our missions of providing quality health care to this community. Where applicable, the financial assistance process has been delegated to OMMC as they use the same methodology to qualify patients for their program. This process expedites the approval process and eliminates duplication of efforts, while enhancing patient convenience by enabling easier access to medical services.

C. Mission First (MF) is a healthcare ministry located in Jackson, Mississippi which provides medical and dental services as well as an extensive line-up of community health and wellness programs to uninsured residents of Mississippi's Heinz, Rankin and Madison counties. Baptist Jackson has partnered and aided as a benefactor, uniting our missions of providing quality

health care, education and wellness programs to the underserved in our community.

VI. Billing and Collections

A. Patient Billing Process:

I. Insurance Collections: BMHCC will maintain and comply with policies and procedures to ensure the timely and accurate submission of claims to all known primary health plans or insurance payers ("Payer") clearly identified by the patient. If BMHCC receives the complete and accurate payer information from the patient in a timely manner but does not submit the claim timely to the Payer and subsequently receives a timely filing denial, the patient will be responsible for only the amount they would be liable to pay had the Payer paid the claim. However, if BMHCC determines that the claim was filed timely and/or inaccurate or incomplete information was provided by the patient, the patient will be held responsible. Liability insurance is not covered by these provisions. BMHCC will make every reasonable attempt to collect from all known Payers with whom BMHCC has a contract and non-contracted payers for services provided to assist patients in resolving their bill. Patients must sign an authorization allowing BMHCC to bill the patient's health plan, insurance company or any other third-party payer, and must cooperate with BMHCC in a reasonable manner by providing requested information to facilitate proper billing to a patient's health plan or insurance company.

II. Billing Statements: BMHCC and/or an outside vendor will mail billing statements to the patient and/or the patient's guarantor for balances due on services rendered. Each billing statement will include a brief statement, in easy-understandable language describing the services rendered, date of services, charges for such services, balance due on the account, and a telephone number and contact information to connect the patient or patient's guarantor to the BMHCC Business Office. To make patients aware of the BMHCC Hospital FAP, the billing statements will also advise patients how to obtain information regarding the FAP.

III. Other Contact Methods to Patients: Concurrently with the billing statement process previously outlined, balances may be pursued by method of telephone calls to reach the patient or the patient's guarantor. The method of making telephone calls to a patient or the patient's guarantor may include calls made by an outside vendor working on behalf of BMHCC or with the use of automated dialer technology. Telephone contact with the patient or the patient's guarantor is intended to supplement the billing statement process to ensure all patients are aware they have an outstanding balance and what payment options are available. All calls will be made in a professional manner that is consistent with the goals and objectives of the billing

collection process of the hospitals. All calls are recorded for quality assurance and training purposes. Other methods used to contact patients regarding their balances include text messages and MyChart notifications.

B. Patient Collection (Bad Debt) Process:

Sending an account to collections (also known as Bad Debt) will be used only after BMHCC has taken the steps as described in this Policy to advise the patient of their outstanding balance with BMHCC or the patient and/or the patient's guarantor has refused to cooperate or been unresponsive in establishing a payment plan, modifying a payment plan, or adhering to an established plan. If the patient or patient's guarantor fails to pay the balance owed in full or to establish a payment plan by the 120th day following the date of the first post discharge billing statement mailed and at least 30 days after the patient was sent a written notice outlining pending ECA, the account will be recommended for external collections. Once the account has been sent to a collection agency, the agency will follow collection processes for a period of at least 365 days following the date of the hospitals' first post discharge billing statement mailed before reporting any outstanding balances to a credit bureau.

Use of Vendors:

Any vendors used to implement these guidelines shall be contractually required to adhere to the standards of these guidelines, including, without limitation, the conduct requirements for all communications with patients.

A. <u>Understanding of BMHCC Guidelines and Policies</u>: Vendors are expected to understand the BMHCC FAP and all elements contained within. While working on BMHCC's behalf, vendors are expected to appropriately direct patients or the patient's guarantor to BMHCC for financial assistance when appropriate and are expected to explain, in plain and respectful language, the next step(s) in the billing and collection process and how to restore the account to current status.

B. <u>Compliance with Law and ACA International Guidelines</u>: At all times, vendors are expected to adhere to all applicable laws and regulations, including, without limitation, the Fair Debt Collection Practices Act, the Health Insurance Portability and Accountability Act, the Affordable Care Act, the Fair Credit Reporting Act, and to provide services in accordance with any and all applicable consumer protection laws and mandates. All vendors providing services pursuant to this policy shall be required to adopt and abide by the "Health Care Collection, Servicing and Debt Purchasing Practices – Statement of Principles and Guidelines" of ACA International. In no event shall any vendor resell any of BMHCC's account receivables. This limitation does not preclude BMHCC from selling account receivables if deemed appropriate.