Lourdes

part of Ascension

FINANCIAL ASSISTANCE POLICY
Reviewed: July 2022

POLICY/PRINCIPLES

It is the policy of the organizations listed below this paragraph (each one being the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

This policy excludes:

A. Any services provided at Lourdes by private businesses or professional groups (i.e., Radiology, Pathology, Anesthesiology, etc.)
B. Any services whereby the patient has received compensation directly from another source for hospital services (such as Ministry Shared Plans and third-party settlements.)

The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- **501(r)** means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- **Amount Generally Billed** or **AGB** means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- **Community** means the primary home where the patient lives with the intent to make their home a "fixed and permanent" place to live within the PFAP Service Area. To live in a house, a home, an apartment, a room or other similar place for 180 consecutive days within the PFAP Primary service area will be considered "presumptive evidence" that the

patient is a permanent resident. A part-time or full-time student whose primary residence is outside of the PFAP service area, who is attending classes at an accredited university or college within Broome, Chenango, Cortland, Delaware or Tioga counties in New York State (NYS) on the date they seek medical services at Lourdes will be considered a permanent resident. If under the age of 21, the parent's income will be considered as an income source, unless the student is not recognized as a dependent of that parent. PFAP Service Area shall mean NYS and Bradford, Wayne or Susquehanna counties in Pennsylvania.

Patients will also be deemed to be a member of the Lourdes' Community if the emergency and medically necessary care the patient requires is continuity of emergency and medically necessary care received at another Ascension Health facility where the patient has qualified for financial assistance for such emergency and medically necessary care.

- **Emergency care** means the rendering of "medically necessary service" that is required to prevent death or serious impairment of health and, because of the danger to life or health, require the use of the most accessible hospital
available and equipped to furnish those services.
- **Medically necessary care** " means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at Lourdes' discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- **Organization** means Lourdes.
- **Patient** means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

FINANCIAL ASSISTANCE PROVIDED

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

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250 % of the Federal Poverty Level income ("FPL"), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an "Application") on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.[1]

2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250 % of the FPL but not exceeding 400 % of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Gross Income as % of Federal Poverty Level (FPL)	Financial Assistance Discount %	Uninsured Discount %
Less than or equal to 250%	100%	N/A
Greater than 250% and less than or equal to 350%	75%	N/A
Greater than 350% and less than or equal to 400%	69%	N/A
Greater than 400%	N/A	50%

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400 % of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2 above, if such Patient submits an application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will

[1] Pursuant to New York Law Section 2807-K 9-a(b)(i), in no event shall patient at or below 100% of the FPL be charged more than a "nominal fee," which is defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to a scale.

be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test", only to the extent permitted by New York State law. The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.[2]

5. Eligibility for financial assistance may be determined at any point in the revenue cycle may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.

6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.

7. Patients that are eligible for financial assistance will not be charged a nominal flat fee for any services.

8. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of written notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance shall be included in the written notification of denial and is as follows:

a. Lourdes allows patients to appeal this decision by providing a written explanation. Our Healthcare Access Committee will consider all appeals. In addition, Lourdes does grant assistance in cases where patients are experiencing excessive medical debt. If you feel that you are experiencing excessive medical debts we

[2] To the extent required by New York State Law, the Asset Test shall not consider as assets a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.

encourage you to provide evidence of those outstanding bills. Please provide a written appeal and include your outstanding medical bills.

b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

9. If a patient's FAP has expired and is in an urgent need for prescription assistance only, the patient may apply for temporary FAP for 10 calendar days. This temporary determination can only be applied for once per household per year.

a. Temporary FAP will not be available for medical bills.

b. Temporary FAP follows the same eligibility criteria as FAP.

OTHER ASSISTANCE FOR PATIENTS NOT ELIGIBLE FOR FINANCIAL ASSISTANCE

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.

2. Uninsured and insured Patients who are not eligible for financial assistance may be eligible for a payment plan.

LIMITATIONS ON CHARGES FOR PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website or by contacting the Financial Counseling office at 607-584-5522

APPLYING FOR FINANCIAL ASSISTANCE AND OTHER ASSISTANCE

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website or by

contacting the Financial Counseling office at 607-584-5522. The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

BILLING AND COLLECTIONS

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by contacting the Financial Counseling office at 607-584-5522.

INTERPRETATION

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.