

## **ST. VINCENT'S HEALTH SYSTEM FINANCIAL ASSISTANCE POLICY**

### **POLICY/PRINCIPLES**

It is the policy of St. Vincent's Health System (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. Each acute care hospital within the Organization has adopted its own Financial Assistance Policy in accordance with Section 501(r) of the Internal Revenue Code. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from non-hospital facilities within the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.
2. This policy applies to all medically necessary services provided by non-hospital facilities within the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not medically necessary.

### **DEFINITIONS**

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

- **"501(r)"** means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- **"Amount Generally Billed"** or **"AGB"** means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- **"Community"** means the St. Vincent's Health System eight county service area of Blount, Cullman, Jefferson, Shelby, St. Clair, Talladega, Walker and Chilton Counties.
- **"Medically Necessary Care"** means care that is determined to be medically necessary following a determination of clinical merit by a licensed provider who is authorized to provide services in one of the Organization's facilities.
- **"Organization"** means St. Vincent's Health System.
- **"Patient"** means those persons who receive emergency or medically necessary care at non-hospital facilities controlled by the Organization and the person who is financially responsible for the care of the patient.

### **Financial Assistance Provided**

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

1. Patients with income less than or equal to 250% of the Federal Poverty Level (“FPL”), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. At a minimum, Patients with incomes above 250% of the FPL, but not exceeding 327% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

<b>FINANCIAL ASSISTANCE (FAP) CHARITY GUIDELINES SLIDING SCALE</b>	
Adjustment of Charges	Sliding Scale based on Federal Poverty Guidelines (FPL)
100%	250% or Greater of FPL Base
93%	251% - 289% of FPL Base
85%	290% - 327% of FPL Base

3. Patients with demonstrated financial needs with income greater than 327% of the FPL may be eligible for consideration under a “Means Test” for some discount of their charges for services from the Organization based on a substantive assessment of their ability to pay. A Patient who is not eligible for FAP under presumptive eligibility will be able to complete a FAP application for consideration of qualifying for Charity under the “Means Test”. The Means Test shall be applied in individual cases of hardship under particular circumstances of patients with income greater than the FPL base. A Patient eligible for the “Means Test” discount will not be charged more than the calculated AGB charges for the care provided.
4. 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.
5. Eligibility for financial assistance will be granted only to patients who complete a financial assistance application (“FAP Application”).
6. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
7. The process for Patients and families to appeal an Organization’s decisions regarding eligibility for financial assistance is as follows:
  - a. Once, a Determination Letter has been received by the patient. A Letter of Appeal can be submitted to:

Senior Manager Patient Access  
 St Vincent’s Health System  
 c/o Carol L Jones  
 810 St Vincent’s Drive  
 Health System, AL 35205

No particular form for the Letter of Appeal is required. The patient may submit such additional information, or make such additional arguments, as the patient deems appropriate for consideration.

- b. All appeals will be considered by the Organization's 100% charity care and financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

### **Limitations on Charges for Patients Eligible for Financial Assistance**

Patients eligible for Financial Assistance will not be charged individually more than AGB for medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by submitting a letter of request for AGB calculations to:

Senior Manager Patient Access  
St Vincent's Health System  
c/o Carol Jones  
810 St Vincent's Drive  
Health System, AL 35205.

### **Applying for Financial Assistance and Other Assistance**

A Patient may qualify for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application. The FAP Application and FAP Application Instructions are available by contacting the following:

- A St. Vincent's Health System facility Business Office
- A St. Vincent's Health System facility Cashier Office,
- Customer Service @ 877-202-0356;
- Email at (<mailto:stvhsfinancialassistance@stvhs.com>) or
- Information may be obtained at any registration point in a St. Vincent's Health System facility.

### **Billing and Collections**

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by submitting a letter of request to:

Senior Manager Patient Access,  
St Vincent's Health System  
c/o Carol Jones  
810 St Vincent's Drive

Health System, AL 35205

**ST. VINCENT’S HEALTH SYSTEM**  
**AMOUNT GENERALLY BILLED CALCULATION**

July 1, 2017

St. Vincent’s Health System calculates two AGB percentages – one for hospital facility charges and one for professional fees – both using the “look-back” method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of those calculations and AGB percentages are described below.

The AGB percentages for St. Vincent’s Health System are as follows:

St. Vincent’s Birmingham	21.70%
St. Vincent’s Blount	23.50%
St. Vincent’s Chilton	16.30 %
St. Vincent’s East	19.60%
St. Vincent’s St. Clair	16.10%

The AGB percentage for physicians’ professional fees: 31%

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

Notwithstanding the foregoing AGB calculations, St. Vincent’s Health System has chosen to apply a lower AGB percentage as follows for all facility and joint venture charges, excluding physician professional fees:

AGB: 16.10%

**Exhibit B**  
**ST. VINCENT'S HEALTH SYSTEM**  
**BILLING AND COLLECTION POLICY**

**POLICY/PRINCIPLES**

It is the policy of St. Vincent's Health System (the "Organization") to ensure a socially just practice for providing emergency or medically necessary care at the Organization pursuant to its Financial Assistance Policy (or FAP). This Billing and Collection Policy is specifically designed to address the billing and collection practices for Patients who are in need of financial assistance and receive care at non-hospital facilities that are part of the Organization.

All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. The Organization's employees and agents shall behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating Patients and their families with dignity, respect and compassion.

Each acute care hospital within the Organization has adopted its own Billing and Collection Policy in accordance with Section 501(r) of the Internal Revenue Code. This Billing and Collection Policy applies to all medically necessary services provided by non-hospital facilities in the Organization, including employed physician services and behavioral health. This Billing and Collection Policy does not apply to payment arrangements for elective procedures.

**DEFINITIONS**

1. "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

2. "**Application Period**" means the period during which a FAP Application may be submitted to the Organization. The Application Period begins on the earlier of the date the FAP Application is submitted or the date care is provided and ends on the date specified in an Application Period Termination Notice.

3. "**Application Period Termination Notice**" means a written notice stating the deadline after which the Organization will no longer accept and process a FAP Application completed by the Patient for the previously provided care at issue, with the deadline specified in the written notice being no earlier than the later of (a) thirty (30) days after the date that the written notice and a copy of the FAP Application is provided to the Patient.

4. "**Extraordinary Collections Actions**" or "**ECAs**" means any of the following collection activities that are subject to restrictions under 501(r):

- a. Selling a Patient's debt to another party, unless the purchaser is subjected to certain restrictions as described below. (NOTE: the Organization does not sell a Patient's debt.)
- b. Reporting adverse information about the Patient to consumer credit reporting agencies or credit bureaus.
- c. Deferring or denying, or requiring a payment before providing, medically necessary care because of a Patient's nonpayment of one or more bills for previously provided care covered under the FAP.
- d. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding. These actions include, but are not limited to,
  - i. placing a lien on the Patient's property,
  - ii. foreclosing on a Patient's property,
  - iii. placing a levy against or otherwise attaching or seizing a Patient's bank account or other personal property,
  - iv. commencing a civil action against a Patient, and
  - v. garnishing a Patient's wages.

An ECA does not include any of the following (even if the criteria for an ECA as set forth above are otherwise generally met):

- a. the sale of a Patient's debt if, prior to the sale, a legally binding written agreement exists with the purchaser of the debt pursuant to which
  - i. the purchaser is prohibited from engaging in any ECAs to obtain payment for the care;
  - ii. the purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) of the Internal Revenue Code at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
  - iii. the debt is returnable to or recallable by the Organization upon a determination by the Organization or the purchaser that the Patient is eligible for Financial Assistance; and
  - iv. the purchaser is required to adhere to procedures specified in the agreement that ensure that the Patient does not pay, and has no obligation to pay, the purchaser and the Organization together more than he or she is personally responsible for paying pursuant to the FAP if the Patient is determined to be eligible for Financial Assistance and the debt is not returned to or recalled by the Organization;
- b. any lien that the Organization is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to a Patient as a result of personal injuries for which the Organization provided care; or
- c. the filing of a claim in any bankruptcy proceeding.

5. "FAP" means the Organization's Financial Assistance Policy, which is a policy to provide Financial Assistance to eligible non-hospital Patients in furtherance of the Organization's and Ascension Health's mission.

6. “**FAP Application**” means the application for Financial Assistance to be made by a non-hospital Patient.

7. “**Financial Assistance**” means the assistance the Organization may provide to a non-hospital Patient pursuant to the Organization’s FAP.

8. “**Organization**” means St. Vincent’s Health System, which is part of Ascension Health.

9. “**Patient**” means an individual receiving care (or who has received care) from a non-hospital facility within the Organization and any other person financially responsible for such care (including family members and guardians).

## **BILLING AND COLLECTION PRACTICES**

The Organization maintains an orderly process for regularly issuing billing statements to Patients for services rendered and for communicating with Patients. In the event of nonpayment by a Patient for services provided by the Organization, the Organization may engage in actions to obtain payment, including, but not limited to, attempts to communicate by telephone, email, and in-person, and one (1) or more ECAs, subject to the provisions and restrictions contained in this Billing and Collection Policy.

This Billing and Collection Policy identifies the reasonable efforts the Organization must undertake to determine whether a Patient is eligible under its FAP for Financial Assistance before it engages in an extraordinary collection action, or ECA. Once a determination is made, the Organization may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. A Patient may submit a FAP Application at any time during the Application Period. The Organization will not be obligated to accept a FAP Application after the expiration of the Application Period. Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

- a. Complete FAP Applications. In the case of a Patient who submits a complete FAP Application during the Application Period, the Organization shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.
- b. Incomplete FAP Applications. In the case of a Patient who submits an incomplete FAP Application during the Application Period, the Organization shall notify the Patient in writing about how to complete the FAP Application and give the Patient up to ten (10) calendar days after the original Application Period to do so. Any pending ECAs shall be suspended during this time, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.



2. Restrictions on Deferring or Denying Care. In a situation where the Organization intends to defer or deny, or require a payment before providing, medically necessary care, as defined in the FAP, because of a Patient's nonpayment of one or more bills for previously provided care covered under the FAP, the Patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible Patients.

3. Determination Notification.

- a. Determinations. Once a completed FAP Application is received on a Patient's account, the Organization will evaluate the FAP Application to determine eligibility and notify the Patient in writing of the final determination within forty-five (45) calendar days. The notification will include a determination of the amount for which the Patient will be financially responsible to pay. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.
- b. Refunds. The Organization will provide a refund for the amount a Patient has paid for care that exceeds the amount the Patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than \$5.00.
- c. Reversal of ECA(s). To the extent a Patient is determined to be eligible for Financial Assistance under the FAP, the Organization will take all reasonably available measures to reverse any ECA taken against the Patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

4. Appeals. The Patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of 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. An appeal does not otherwise extend or reset the application process provided in this Billing and Collection Policy.

5. Collections. Upon conclusion of the above procedures, the Organization may proceed with ECAs against uninsured and underinsured Patients with delinquent accounts, as determined in the Organization's procedures for establishing, processing, and monitoring Patient bills and payment plans. Subject to the restrictions identified herein, the Organization may utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts, and such agencies or service providers shall comply with the provisions of 501(r) applicable to third parties.