McLeod Health

The Choice for Medical Excellence

ADMINISTRATIVE POLICY
COMPASSIONATE CARE

I. Purpose Statement

McLeod Health is committed to providing hospital-sponsored charity care (herein referred to as "Compassionate Care") to persons who have healthcare needs and are Uninsured (as hereinafter defined), Underinsured (as hereinafter defined), ineligible for a government program, or otherwise unable to pay, for Medically Necessary (as hereinafter defined) care based on their individual financial situation.

This policy shall apply to all McLeod Health hospital services, ambulatory surgery center services, home health services, and hospice services. This policy does not apply to McLeod Physician Associates professional services. Additionally, services provided and/or billed by private or independent entities, practice groups, or other providers, are not covered by this policy. Patients should address any payment questions or concerns directly with the private physician/provider practice. These groups include, but are not limited to the following:

- Emcare
- Pee Dee Pathology
- Carolina Radiological Associates
- Florence Radiological Associates
- Pediatrix Medical Group
- American Anesthesiology
- Mednax Services
- All private or independent physicians not employed by McLeod Health or physician practices not owned by McLeod Health.

II. Policy

Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, McLeod Health strives to ensure that individuals who require health care services are not prevented from seeking or receiving care because of an inability to pay or whose limited means makes it difficult to pay for the costs incurred by obtaining such services. McLeod Health will provide, without discrimination, care of Emergency Medical Conditions (as hereinafter defined) to individuals regardless of their eligibility for Compassionate Care or for government assistance.

McLeod Health does not, however, consider Compassionate Care a substitute for personal responsibility. Information is an essential part of the process and patients and/or families are crucial to assist McLeod Health with procedures for obtaining Compassionate Care or other forms of payment or charity, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to

purchase health insurance shall be encouraged to do so, as a means of (1) assuring access to health care services, (2) for their overall personal health, and (3) for the protection of their individual assets.

In order to manage McLeod Health resources responsibly and to facilitate the provision of the appropriate level of assistance to the greatest number of persons in need, the McLeod Health Leadership or Administration establishes the following guidelines for the provision of patient Compassionate Care.

Accordingly, this written policy (hereinafter referred to as the "Policy"):

A. Includes eligibility criteria for Compassionate Care -- free and discounted (partial) Compassionate Care;
B. Describes the basis for calculating expected payments from patients eligible for Compassionate Care under this policy;
C. Describes the application method by which patients may apply for Compassionate Care; and,
D. Describes how McLeod Health will widely publicize the policy within the communities it serves.

Patients identified by McLeod Health as self-pay who are not covered by health insurance or another third party source, which is or may be responsible, are provided a 75% uninsured/self-pay discount prior to initiating billing.

Definitions

Compassionate Care: Healthcare services that have been or will be provided, but are not expected to result in cash inflows. Compassionate Care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the United States Census Bureau definition, a group of two (2) or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of Compassionate Care.

Family Income: Family Income is determined using the United States Census Bureau definition, which uses the following income when computing Federal Poverty Guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;

- Noncash benefits (such as food stamps, housing subsidies) do not count;

- Determined on a before-tax basis;

- Excludes capital gains or losses; and

- If a person lives with a family, includes the income of all family members (Non-Family persons do not count).

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: Shall in general mean non-elective inpatient and outpatient acute hospital services that are normally reimbursable under the Medicare and/or Medicaid programs.

III. Procedure

A. Services Eligible under This Policy.

1. Emergency Medical Services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically Necessary services, evaluated on a case-by-case basis at McLeod Health's discretion.

B. Eligibility for Compassionate Care.

Eligibility for Compassionate Care will be considered for those individuals who are Uninsured, Underinsured, or 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 Compassionate Care shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Completed Compassionate Care applications must be received within 240 days of the date on McLeod Health's first post-discharge billing statement. However, collection activities may begin if a completed application is not received within 120 days of the first statement. Notwithstanding the meeting of the qualifications per the criteria described above, it is a McLeod Health policy not to offer Compassionate Care in situations where the individual (hereinafter referred to as the "Applicant") fails to cooperate with insurance or other identified payment source(s), which results in non-payment or has liability coverage or other insurance where the Applicant is paid benefits directly;

C. Methods of Qualification for Compassionate Care.

1. Presumptive Eligibility for Compassionate Care**.**

Upon registration for Medically Necessary services in selected registration points within McLeod Health, all patients who are Uninsured shall be screened by McLeod Health registration personnel for possible Compassionate Care qualification. In doing so, data elements such as the patient's or guarantor's credit score, estimated family income, estimated Federal Poverty Level (FPL) score, and propensity to pay shall be reviewed and compared to the qualification guidelines herein.

Patients that meet the prescribed guidelines will be eligible for One hundred percent (100%) of the associated account balance credited from the patient's account(s) and debited to the Compassionate Care general ledger account. Related account(s) shall be altered to reflect a financial class of "R" and a payor code of "699" in the active accounts receivable file, inclusive of all associated accounts with balances. The responsible Patient Account Representative shall be notified to manually demand a bill to drop for submission to the South Carolina Budget and Control Board, Office of Research and Statistics.

In the event a first screening effort does not result in Compassionate Care qualification, McLeod Health may use outside agencies in determining final presumptive qualification. As such, presumptive eligibility may also be determined on the basis of individual life circumstances that may include, but is not limited to, the following:

(a) Eligibility for Medically Indigent Assistance Program (MIAP)
(b) State-funded prescription programs;
(c) Homeless or received care from a homeless clinic;
(d) Participation in Women, Infants and Children programs (WIC);
(e) Food stamp eligibility;
(f) Subsidized school lunch program eligibility;
(g) Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
(h) Low income/subsidized housing is provided as a valid address; and
(i) Patient is deceased with no known estate.

Patients that meet any of the life circumstances listed above will be eligible for One hundred percent (100%) of the associated account balance credited from the patient's account(s) and debited to the Compassionate Care general ledger account. Related account(s) shall be changed to reflect a financial class of "R" and a payor code of "699" in the active accounts receivable file, inclusive of all associated accounts with balances. The responsible Patient Account Representative shall be notified to manually demand a bill to drop for submission to the South Carolina Budget and Control Board, Office of Research and Statistics.

If documentation of program eligibility, as listed above is not readily available at the time of registration, the patient shall be given 30 days to return such documentation. During that time the account shall be changed to reflect a financial class of "R" and a payor code of "697" in the active accounts receivable file. If

documentation is received then the process will continue as described above. If documentation is not received, the account shall be transferred to the self play plan code, "S01" and the normal billing process will occur.

2. Application of Sliding Fee Schedule

Should a patient not qualify for Compassionate Care through the above presumptive qualification screening processes, eligible services as outlined under this Policy for a Sliding Fee Schedule through a written application process, in accordance with financial need, as determined according to the Federal Poverty Level (FPL) in effect at the time of the determination.

The Sliding Fee Schedule applicable shall be as follows:

- Family Income < 200% of FPL; eligible to receive free care;

- Family Income >= 200% and < 225% of FPL; 10% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;

- Family Income >= 225% and < 250% of FPL; 30% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;

- Family Income >= 250% and < 275% of FPL; 50% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;

- Family Income >= 275% and < 300% of FPL; 70% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;

- Family Income > 300% of FPL; may be eligible to receive discounted rates on a case-by- case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of McLeod Health; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital as expected payment from) patients with insurance coverage.

The Amount Generally Billed is a discount applied to financial assistance eligible patients receiving emergency and non-elective medically necessary care at our covered locations. McLeod Health uses the Look Back Method to calculate this discount which is derived from the average amount received by the hospital for insured patients.

A Compassionate Care Application Form shall be provided to any person requesting Compassionate Care. Referral of patients for Compassionate Care may be made by any member of the McLeod Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for Compassionate Care may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

The Compassionate Care Application form must be completed and returned within 240 days of the first post-discharge billing statement. Compassionate Care may only be granted if sufficient information is available to allow for a determination to be made that establishes that the patient satisfies all applicable criteria.

Qualification for the Sliding Fee Schedule shall be determined in accordance with procedures that involve an individual assessment of financial need; and may:

- Include personal, financial and other information and documentation relevant to making a determination of financial need;

- Include the use of external publicly available data sources that provide information on a patient's or a patient guarantor's ability to pay (such as credit scoring);

- Include reasonable efforts by McLeod Health to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients in applying for such programs;

- Take into account the patient's available assets and all other financial resources available to the patient. Collectively, checking and savings account balances are not to exceed two (2) months gross income/expenses. Reverse Mortgages issued on a residence shall also be evaluated as income. Based on the terms of the Reverse Mortgage, financial assistance may be denied**;** and

- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

The determination may be done at any point in the collection cycle. The need for Compassionate Care shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six (6) months prior, or at any time additional information relevant to the eligibility of the patient for Compassionate Care becomes known.

Because McLeod Health values human dignity and the value of the person, financial stewardship shall be reflected in the processing of Compassionate Care applications. Such applications shall be processed promptly. McLeod Health shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D. Application Review & Account Management

All Compassionate Care Applications received shall be reviewed and evaluated as follows:

1. Upon receipt of an application submitted and signed by the patient or guarantor, the eligibility vendor (hereinafter referred to as the "Eligibility Vendor") shall review the application using all guidelines outlined in this policy to determine eligibility.

   If the application is deemed incomplete, it shall be returned to the patient or guarantor

along with specific directions for re-submission in a complete and accurate manner not more than 30 days from receipt. In such cases, the patient or guarantor may provide the required missing or incomplete information and request the application be reconsidered if such reconsideration is requested within a period of 120 days from the first post-discharge billing statement.

If the application is deemed complete, it shall continue through this procedure.

2. Related account(s) shall be changed to reflect a financial class of "R" and a payor code of "603" in the active accounts receivable file, inclusive of all accounts with balances after insurance payments.

3. Review of Family Income shall take place through recent pay stubs, W-2's, prior year tax returns, or written statements from employers. Review of other supporting documentation, as available and necessary, shall also take place.

4. If criteria are met, the Eligibility Vendor shall forward the application, including written recommendation for approval to the appropriate individual(s) for management approval:

    - <= $ 50,000.00 per Account – Director of Registration;
    - > $50,000.00 <= $100,000.00 per Account – Vice President, Business Operations;
    - > $100,000.00 per Account – Chief Financial Officer.

5. If the application is approved by management, the Eligibility Vendor shall notify the applicant of the approval in writing within thirty (30) days of initial receipt of the completed application and it shall continue through this procedure directly to item "(7)" below.

6. If an application is denied, due to failure to meet criteria, disapproval by management or for any other valid reason, the Eligibility vendor shall notify the applicant of the denial, and the specific reason(s) for that determination in writing within thirty (30) days of initial receipt of the application.

    In such cases, related account(s) shall be re-altered to reflect the appropriate (original) financial class and payor code in the active accounts receivable file. If the patient or guarantor fails to pay the account(s) in a timely manner, the accounts(s) may be reported to the appropriate credit bureau and the account(s) will be referred to PDMCS and collection procedures will begin.

    If patient or guarantor provides supplemental information and requests that the denied application be reconsidered, reconsideration shall be granted if the reconsideration request is made within 240 days from the date of the first post-discharge billing statement.

7. The responsible Patient Account Representative shall be notified to manually demand a bill to drop for submission to the South Carolina Budget and Control Board, State Office of Research and Statistics.

8. If an applicant is determined to be eligible for financial assistance under this policy after collection activity has been initiated, McLeod Health will refund any excess funds it collected from the applicant over the amount the applicant actually owes.

Copies of all written notifications and related correspondence, inclusive of the original application and associated information, shall be retained by McLeod Health as part of the patient's account records.

E. Disqualification for Compassionate Care.

The following patients shall be disqualified from Compassionate Care:

1. Patients who have not cooperated with insurance or other payment source, which results in non-payment;
2. Patients who had liability coverage or where the patient's insurance company paid directly to the patient;
3. Patients eligible for Medicaid or Medicare are not eligible for Compassionate Care unless coverage is denied;
4. Patients with income >= 300% of FPL;
5. If the applicant was eligible for group health insurance that would have covered services provided but elected not to have coverage through the employer, the account will not be eligible for Compassionate Care; or
6. Patients who have not met other enrollment criteria as determined by McLeod Health.

F. Communication of the Compassionate Care Program to Patients and Within the Community.

Any person seeking health care services at McLeod Health should be provided written information about the McLeod Health Compassionate Care Program as part of the admission process. Such information shall include a contact telephone number and shall be disseminated by various means, which may include but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the appropriate admission- related consent form, in admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as McLeod Health may elect. McLeod Health shall also publish and widely publicize a summary of this Compassionate Care policy on facility websites, in brochures available in patient access sites and at other places within the community served as determined by McLeod Health. Such notices and summary information shall be provided in the primary languages spoken by the populations' served by McLeod Health, but at a minimum shall be provided in English and Spanish.

G. Relationship to Collection Policies.

McLeod Health management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for Compassionate Care, a patient's good faith effort to apply for a governmental program or for Compassionate Care from McLeod Health, and a patient's good faith effort to comply with his or her payment agreements

with McLeod Health. For patients who qualify for Compassionate Care and who are cooperating in good faith to resolve their discounted hospital bills, McLeod Health may offer extended payment plans. McLeod Health will not impose extraordinary collections actions for non-payment such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for the Compassionate Care Program under this Policy.

Reasonable collection efforts shall include:

- Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by McLeod Health;

- Documentation that McLeod Health has or has attempted to offer the patient the opportunity to apply for Compassionate Care pursuant to this Policy and that the patient has not complied with McLeod Health application requirements;

- Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

H. Regulatory Requirements.

In implementing this Policy, McLeod Health and its management shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

II. Reference Information

Policy Number: MHIC-18310-C203
Initial Date: 03/01/2001
Effective Date: 01/01/2014
Revision Date: 10/01/2016