

PURPOSE:

Freeman Health System is a non-for-profit health system offering financial assistance to the community we serve. Freeman provides assistance without regard to race, color, ethnicity, gender, religion, age, disability, sexual orientation, or religious affiliation, or national origin. Services covered under the Financial Assistance (FA) policy must be deemed as: Emergency Medical care or Medically Necessary care and may follow CMS Medical Necessity Guidelines as appropriate.

POLICY STATEMENT:

Freeman Health System financial assistance policy covers the following entities: Freeman Hospital West/East, Urgent Care, Home Health, Neosho Hospital, Freeman Physician Groups, and Surgery Center of Pittsburg.

The Freeman Health System program offers Financial Assistance for the following:

- Medical Care (Emergent and Medically Necessary)
- Catastrophic Emergent and Medically Necessary Care
- Premium Assistance
- Outpatient Pharmaceuticals

Freeman Health System will make reasonable efforts to notify patients that they may qualify for financial assistance and how to apply including but not limited to: postings in the admitting office, emergency rooms, physician offices, and other non-obscure areas within our patient care locations. Freeman will also notify customers of our financial assistance program on billing statements, letters and other printed material. Financial assistance information is posted on the Freeman Health System website and copies of this policy can be obtained at admitting areas and the business office.

ELIGIBILITY:

The Freeman Health System typically bases eligibility on income, and residency.

Income: Financial assistance is typically granted to eligible insured and uninsured patients with income not exceeding 250% of Federal Poverty Level.

- Insured patient balances due to:
 - Coinsurance, copay, and deductible.
 - Where there is no contractual obligation with payer.
 - Charges where insured patients have exhausted benefits and are otherwise responsible for remaining amounts.
 - Patients eligible for Medicaid or other indigent care programs where service is non-covered.
 - Patients eligible for Medicaid or other indigent care programs where charges have exceeded the approved length of stay.
- Self-pay discount given to uninsured patients that meet guidelines for financial assistance under: (Financial Assistance, Presumptive eligibility based predictive model or Presumptive eligibility based on life circumstances) will be applied to charges approved for patient under financial assistance.

Residency: To be eligible for financial assistance, the applicant must be permanently residing in the Freeman Health System primary or secondary service area (See Exhibit A#). There may be exceptions to this residency requirement in the event that an out-of-area resident is being treated for a life-threatening injury or condition.

US Citizenship/Immigration Status: Financial assistance is available to non-citizen immigrants legally residing in the Freeman Health System service area. Non-citizen applicants will be asked to provide an Alien Resident Card or a United States Citizen Identification Card in order to be considered for eligibility. Immigrants in the United States with a status of visitor, student or any person who has a “temporary” or “pending” status will not qualify for financial assistance.

ELIGIBLE SERVICES:

1. Emergency medical care provided in an emergency setting.
2. Medically necessary care which is reasonably calculated to prevent, diagnosis, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:
 - Endanger life;
 - Cause suffering or pain;
 - Result in illness or infirmity;
 - Threaten to cause or aggravate a handicap; or
 - Cause physical deformity or malfunction.
3. Medical services provided in a non-emergency setting for needs that may threaten life.
4. The following Health Essentials services:
 - a. Oxygen therapy
 - b. c-pap and bi-pap
 - c. Group 2 and Group 3 wheel chairs
 - d. Invasive and non-invasive ventilators
5. McDonald County ambulance services.
6. The services of Freeman Health System physicians provided in the Freeman Health System facilities covered under this policy.
7. Service provided by Ozark Center physicians, in-patients at Freeman Health System Hospitals.
8. The services of contracted emergency department physicians, not employed by Freeman Health System.

For a complete list of providers that are covered by this policy, as well as those not covered under this policy, (See Exhibit B#).

Exclusions:

Services not eligible for financial assistance include:

1. A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.
2. Experimental services or services which are generally regarded by medical profession as unacceptable treatment are not medically necessary.
3. Health Essentials services are excluded, with the exception of the specific service listed above as eligible services.
4. Air ambulance services provided to or from non-Freeman Health System facilities, or non-Freeman Health System ambulance services.
5. Services that are elective, experimental, cosmetic, or packaged price procedures.
6. Service provided by Ozark Center physicians at Ozark Center out-patient facilities.
7. Services provided in Freeman Health System facilities by non-Freeman Health System providers. Patients are urged contact these providers directly to inquire into their assistance policies

Financial assistance is not offered for insured patients for any amount due after insurance if the patient fails to get the required referrals or insurance approvals, or is seeking or has received out-of-network care for non-emergent services. Financial assistance is offered to insured patients providing that insurance contract allows it. Patients possessing tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account will be expected to utilize account funds prior to being granted financial assistance.

EMERGENCY MEDICAL POLICY:

Freeman Health System will provide emergency care in accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations. No patient will be screened for financial assistance or payment information prior to receiving medical treatment in emergency situations. Emergency care will be provided at an equal level to all patients, regardless of ability to pay. Collection actions that discourage people from seeking emergency medical care, such as requiring upfront payments or permitting debt collection activities that interfere with provision of emergency medical care, are prohibited under this policy.

FINANCIAL ASSISTANCE:

Financial assistance may be provided to patients, or their guarantors, who meet the income, asset, and residency guidelines under this policy.

Free Care: The full cost of care for eligible services provided at Freeman Health System are waived and covered for the patient, or guarantor, if the following guidelines are met:

1. The applicant meets eligibility criteria and has annual household income that does not exceed 100% of the Federal Poverty Level, and;
2. Other coverage and payment sources have been examined and applications submitted for private coverage, including but not limited to: HSA, HRA, public medical assistance programs, and other forms of financial assistance offered by third parties.

Free Care with Fixed Co-payment: The cost of care for eligible services provided at Freeman Health System are waived, with the exception of fixed co-payment (See Exhibit C), if the following guidelines are met:

1. The applicant meets eligibility criteria and has annual household income in excess of 100% Federal Poverty Level but no exceeding 200% of the Federal Poverty Level, and;
2. Other coverage and payment sources have been examined and applications submitted for private coverage, public medical assistance programs, and other forms of financial assistance offered by third parties.

The free care fixed co-payment will be an amount as described in Exhibit C. Patients with insurance will pay the free care fixed co-payment, in addition to any co-payment required by their insurance plan for the specific visit.

Partial Discounted Care: The cost of care for eligible services provided at Freeman Health System are discounted for the patient, or guarantor, if the following guidelines are met:

1. The applicant meets eligibility criteria and has annual household income in excess of 200% Federal Poverty Level but not exceeding 250% of the Federal Poverty Level, and
2. Other coverage and payment sources have been examined and applications submitted for private coverage, including but not limited to: HSA, HRA, public medical assistance programs, and other forms of financial assistance offered by third parties.

Under the partial discount, patients will pay the amount as described in Exhibit C. Patients with insurance will be required to also pay any co-payment required by their insurance plan for the specific visit.

Catastrophic Assistance: Freeman Health System may provide financial assistance for eligible patients, or their guarantors, with household income greater than 250% of the federal poverty level when Freeman Health System medical bills exceed 30% of household income. Patients, or their guarantors, meeting the threshold for catastrophic eligibility will have their Freeman Health System charges reduced to an amount equal to 30% of family income.

COBRA Premium Assistance: Patients, or guarantors, with annual household income not exceeding 250% Federal Poverty Level may qualify for COBRA premium assistance. Patients, or guarantors, are expected to apply for programs and other funding sources identified by Freeman Health System, including COBRA coverage, which extends health insurance coverage benefits for a limited time once employment end. If COBRA coverage is possible and the patient does not receive Medicare or Medicaid, an eligible patient, or patient guarantor, may provide a COBRA premium notice and Freeman Health System may pay this cost for a limited time while the patient or guarantor obtains other health insurance coverage. Patients that qualify for premium assistance should already have coverage established and will not be bound to Freeman Health System for their healthcare needs. Premium assistance review is bound to the policy guidelines of 90 days.

Out-Patient Pharmacy Assistance: This program is for patients being discharged from the hospital as an in-patient or from emergency department, urgent care clinic, or the Stephens Unit who need medication to continue treating a condition diagnosed by Freeman Health System physician. Medications prescribed by a primary care physician in a clinic/office setting are excluded.

This benefit may also be available under situations for established patients of Freeman Clinics requiring medications to save lives or sustain life. This may include outpatient oral cancer drugs and associated medications. This benefit cannot be combined with other available benefits such as Drug Manufacturing Grants and or Financial Aid. Patients not eligible for this benefit may be considered for assistance equal to our 340B cost for drug. Drugs eligible for Financial Assistance benefit must be filled at our Freeman West Hospital Quick Med location, any pricing for 340B will be established at the time of the prescription being filled by pharmacy.

Out-patient pharmacy benefits are limited to two occurrences in a 12 month period. There is a maximum benefit of \$250.00 per episode, not to be combined by individuals who qualify. Requests for assistance must be made at time of prescription drop-off at Freeman Health System Hospital Pharmacy location with application completed.

Pharmacy assistance will be available only for prescription medications that are part of the Freeman Health System drug formulary and in accordance with formulary requirements. Certain medications may be excluded from coverage of benefits such as prescription cough suppressants. This program will cover non-name brand medications. In the event the prescribed medication is not available in the form of a "generic" brand,

the pharmacist will use discretion for determination of coverage.

Pharmacist will review prescriptions and patient history for approval. Benefits for pain relieving medications will be reviewed to determine if treatment is a result of an acute injury or accident. Benzodiazepines may be dispensed with maximum quantity 20 pills provided for patients of outpatient status. (Inpatient discharges may not be subject to quantity limitations)

Freeman Pharmacist reserves the right to deny prescriptions based need and availability.

Pharmacy benefits are applicable only after all other prescription benefits have been exhausted. (I.e. Corporate pharmaceutical assistance program benefits). Patients receiving benefits through VA facilities may qualify for assistance with prescription medications for the minimum dose needed until further treatment through a VA facility is available.

APPLICATION AND DOCUMENTATION:

Applications for financial assistance must be submitted within 240 days from the date of the first post-discharge statement. Applicants will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. When applying for assistance, an applicant must cooperate with Freeman Health System to explore available third party coverage. Assistance will be provided to patients in applying for Medicaid or other programs. All available health insurance or grant resources must be exhausted before consideration for financial assistance.

Patients choosing not to cooperate in applying for programs may be denied financial assistance. During this screening process, a financial assistance application will be completed. If the applicant is found ineligible for Medicaid or other coverage, a financial assistance eligibility determination will be made. ~~A patient may apply for patient responsibilities deemed after payment from the identified payer(s).~~ If the patient does not meet state Medicaid criteria, it is not necessary to process an application through that program.

APPLICANTS MUST PROVIDE THE FOLLOWING DOCUMENTS WITH THEIR APPLICATION:

1. Proof of identity (driver's license, or other photo ID with patients address)
2. Proof of annual income (copies of the previous year's income tax return)

Where the patient/guarantor indicates they do not file federal tax returns, Freeman Health System may request that the patient/guarantor complete IRS form 4506-T (Request for Transcript of Tax Return), found on-line at www.irs.gov/pub/irs-pdf/f4506t.pdf. The patient/guarantor should complete lines 1-5 after the Health System has completed lines 6-9. Health System will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9 Health System will enter prior year and prior 3 years.

3. Proof of current income (copy of employers check stub(s) for all employers where

employee worked in current year.

4. Acceptable explanations or considerations such as recent loss of employment must be supported through documentation such as termination letter or a letter from prior employer stating that the patient/guarantor is no longer employed as of specified date.

The application may be reopened and reconsidered for FA once the required information is received, and within 120 days post assignment to third party collection agencies.

The facility receiving the completed application will review them to ensure that required documents are present and all information is verified. Applications will be reviewed by the Financial Assistance Coordinator or Director of Patient Financial Services with determination noted.

No applicant will be denied assistance based on failure to provide information or documentation not described in this policy or on the application.

If an application is incomplete, the applicant will be notified by mail that more information is needed to complete the application process. It will be the responsibility of the patient, or guarantor, to complete the application and provide supporting documents to constitute a complete application. An incomplete application will be returned to the patient via mail and in some cases a Freeman Health System representative may contact the applicant by phone to obtain the required information, noting such contact in comments. Applications that remain incomplete after 30 days of request for information may be denied, without supporting information that would have led to delay; (such as but not limited to major illness of self or dependent, death in family etc.)

If an applicant denied assistance has experienced a change of income or status after the decision, an updated application may be submitted for review.

Applicants found ineligible for financial assistance may dispute the decision in writing by providing information as to the reason for the dispute and any helpful information to describe the basis for the dispute or appeal. A dispute or appeal letter must be received within 30 days of the date of the determination letter.

Financial assistance applications and required documentation are to be submitted to the following office:

Patient Account Department
Freeman Health System
3320 S. McClelland Blvd
Joplin, Missouri 64804-3599

TIME FRAME FOR ELIGIBILITY DETERMINATION:

A determination of eligibility will be made within 15 working days after the receipt of a complete application including all information necessary to make a determination.

Once the eligibility determination has been made, the results will be documented in the

comments section on the patient's account and the completed and approved application will be filed on the system shared drive. Patients will receive written notification of the eligibility determination.

PRESUMPTIVE ELIGIBILITY BASED ON LIFE CIRCUMSTANCES:

Some patients are presumed to be eligible for financial assistance based on their life circumstances. Presumptive financial assistance may be granted based on information obtained from sources other than the patient or patient guarantor.

In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Patients that are proven to be homeless and unable to provide verifications to complete the financial assistance application.
- Patients who are incarcerated and unable to provide verifications to complete the financial assistance application.
- Patients that receive benefits under the Women, Infants and Children's (WIC) program. Applicant must provide the WIC program eligibility statement.
- Patients that receive Supplemental Nutritional Assistance Program (SNAP) benefits (formerly known as Food Stamps). Applicant must provide the SNAP (food stamp) eligibility statement.
- Patients that have eligibility for State Medicaid program's which meet Freeman FPG guidelines, but for which there is no program reimbursement due to but not limited to: (restrictions/exclusions, out of state provider enrollment).

Such patients may be approved with management consideration.

These patients will not need to complete the financial assistance application and presumptive eligibility will be used to grant them a full free care discount of 100% providing patients meet residency and immigration requirements.

PRESUMPTIVE ELIGIBILITY BASED ON PREDICTIVE MODEL:

Freeman Health System understands that there are certain patients for whom the financial assistance application process may present a challenge. Under these circumstances other sources of information may be used to make an individual assessment of financial need. This information will allow for an informed decision on the financial need of these non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

Freeman Health System will use a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income. This electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals under the typical financial

assistance application process.

When this electronic technology is utilized, it will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows screen all patients to be screened for assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

When eligibility is granted using electronic enrollment screening as the basis for presumptive eligibility, a 100% discount will be granted for eligible services.

Patient accounts granted presumptive eligibility using this method will be provided free care for any remaining balance due for eligible services for retrospective dates of service only. Refunds for payments made by patients on the specific account(s) prior to electronic screening will be granted only if the patient completes an application and is found eligible for assistance and a refund. Accounts granted presumptive eligibility will be classified as financial assistance. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their electronic eligibility qualification, and will not be included in the hospital's bad debt expense.

No patient will be denied assistance based on this method. If a patient does not qualify under the electronic enrollment process, the patient may apply for assistance by submitting and application through the typical process.

QUALIFICATION PERIOD:

If a patient is determined eligible, financial assistance will be granted for accounts incurred within 240 day of the first post-discharge statement and will remain in effect for 3 months. There is an exception for outpatient recurring dialysis, and recurring rentals; for these patients assistance will be approved for one year.

AMOUNTS GENERALLY BILLED:

Freeman Health System will use a look-back method for determining the amount generally billed (AGB). Under this method, a percentage discount is calculated annually on allowed claims for emergency and other medically necessary care provided to patients covered by Medicare fee-for-service and all private insurers. Patient responsibilities are included in this allowed amount.

The AGB percentage will be calculated for each hospital and updated annually. Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under this financial assistance policy. Questions concerning the calculation of the amount generally billed should be directed to the Decision Support Department, accessed by calling (417) 347-1111.

OBTAINING FINANCIAL ASSISTANCE INFORMATION:

The financial assistance application, financial assistance policy and financial assistance plain language summary free of charge.

Website:

Please visit the Freeman Health System for a copy of the financial assistance application, financial assistance policy and the financial assistance plain language summary.

Phone:

Please call the Patient Accounts Department at (417) 347-6686 or toll-free at 888-707-4500 to request a copy of the financial assistance application, financial assistance policy and/or financial assistance plain language summary. It will be mailed free of charge.

In Person:

Information on financial assistance is available in hospital registration and admission areas and in physician offices. Please visit our Patient Accounts Department to obtain a copy of the financial assistance application, financial assistance policy and/or financial assistance plain language summary.

If you need help completing the financial assistance application, please call the Patient Accounts Department or arrange an appointment with one of our staff representatives.

Information on financial assistance and the notice posted in the hospital is translated into Spanish and will be translated and in any language that is the primary language spoken by 1,000, or 5% — whichever is fewer — of patients likely to be encountered by Freeman Health System hospitals.

RECORD RETENTION:

Patients Financial Assistance applications will be retained on file for 7 years. Applications will be available for Freeman Health Providers allowing cross access to reduce duplicate efforts and to assure standard practices across the health system.

REPORTING OF FINANCIAL ASSISTANCE:

Information regarding the amount of Financial Assistance provided by the health system, based on the health system's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits.

RELATED POLICIES:

Information on the Freeman Health System Billing and Collection Policy is available on the Freeman Health System website or may be obtained or by contacting Patient Accounts Department at (417) 347-8247 or toll-free at 888-707-4500.

POLICY REVIEW AND APPROVAL:

The below individuals have read and approved this policy:

12/3/2020 Health System CEO Date

12/3/2020 Health System CFO Date

The Freeman Health System Governance Board has reviewed and approved of this financial assistance policy. This policy is subject to periodic review.

12/3/2020 Health System Governance Board Date