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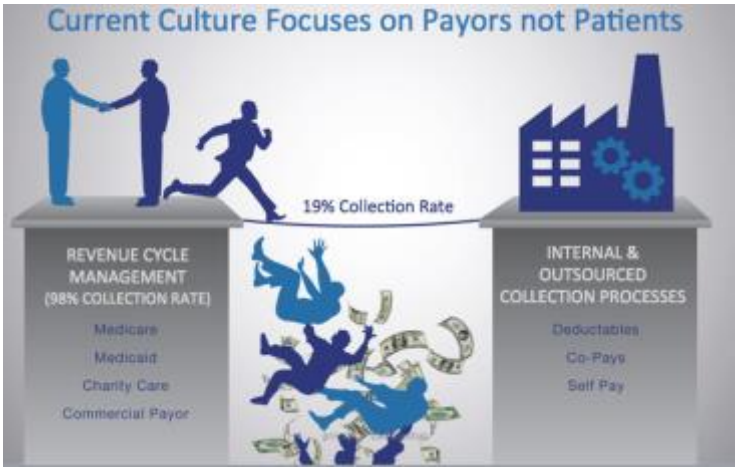
Financial Assistance Grant Program

Providing Compassionate, Compliant Financial Assistance

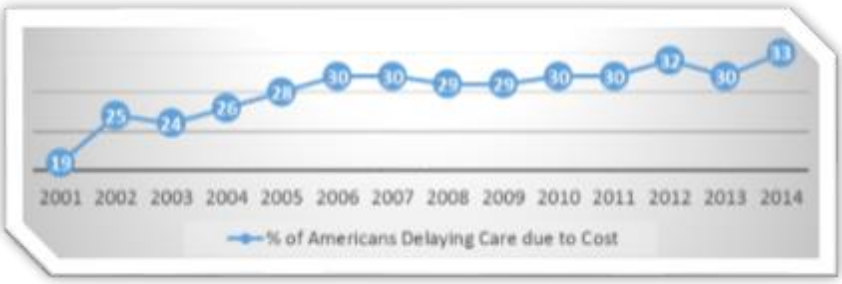
Overview:

With the passage of the Affordable Care Act, the creation of the Consumer Financial Protection Bureau (CFPB), along with the continued effort of individual corporations to cut insurance premium costs, the marketplace has seen a massive shift in the financial responsibility and compliance burdens for Healthcare cost, resulting in a spike in the level of patient out-of-pocket medical expenses. This year patient out-of-pocket medical expenses will exceed $400 billion with a national collection rate of only 19%, which evidences the fact that there is a significant community need for financial assistance for patients who do not qualify for charity care or other financial assistance programs. This is a crisis for both consumers and healthcare providers.



The Problem:

- **Patients delay needed care** because they can't afford the out-of-pocket expenses.
- **Patients delaying treatment** due to cost has a negative impact on **Provider Revenue**
- **The Common Practice** of offering non-standardized payment plans violates Federal Consumer Protection Laws and erodes patient confidence in the integrity and transparency of Provider pricing.

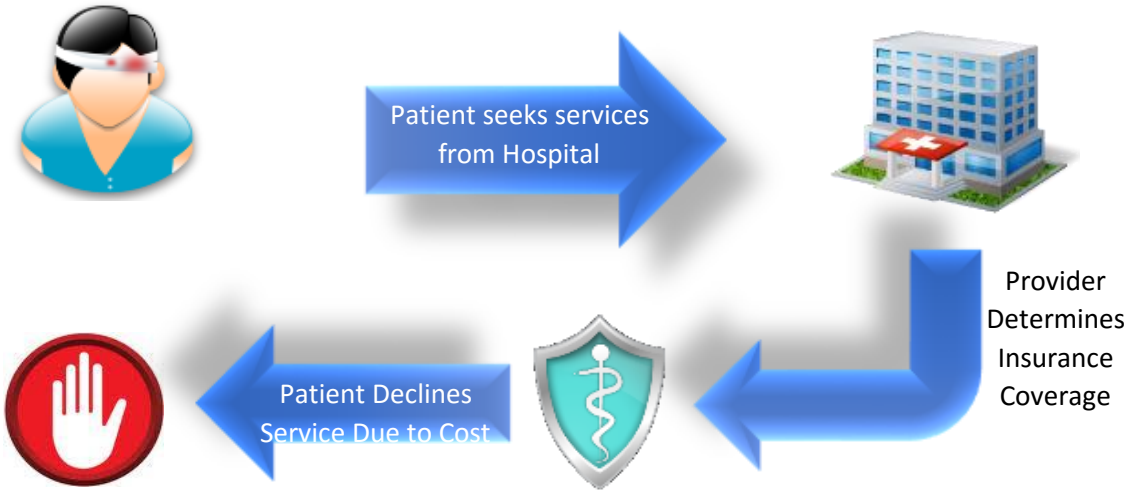


The Challenge:

- In an attempt to "capture whatever we can" related to patient balances, financial counselors at many Providers offer patients inimitable payment options, discounts and repayment time periods. Although the Providers are trying to be flexible to individual and situational patient needs, in aggregate, many patients with the same financial liability will receive different offers from their peers and **Consumer Fairness best practices are violated**.
- Providers need to be **compliant with Federal Consumer Protection Laws**, including the Equal Credit Opportunity Act (ECOA), the Truth in Lending Act (TILA), and the Electronic Funds Transfer Act. Notably, these compliance requirements exist even if scenarios where the Provider does not charge interest on payment plans. When initiating (and modifying) payment plans, many providers are not providing patients the proper paperwork and regulatory disclosures.
- Waiving or discounting patient deductibles and/or co-pays violates contracts with Commercial Payors and Public Financial Assistance Programs.
- Providers are also challenged by:
  - Drastic ***spike in bad debt*** associated with patient deductibles, co-pays, and self-pay balances.
  - Expanded collection strategies are having a **negative effect on patient satisfaction,** which negatively affects reimbursements and the brand image of the Provider.
  - **Excessive cost of** managing and collecting **small balance accounts**

The Current Process:

As we noted above patents are delaying, or even refusing, services due to high out of pocket balances owed. Recent studies show that more than 1 out of every 3 Americans are delaying needed care due to cost. The current process can be summarized by the following:



Total Procedure Cost	$50,000
Insurance Coverage	$45,000
Patient Balance Due	$5,000

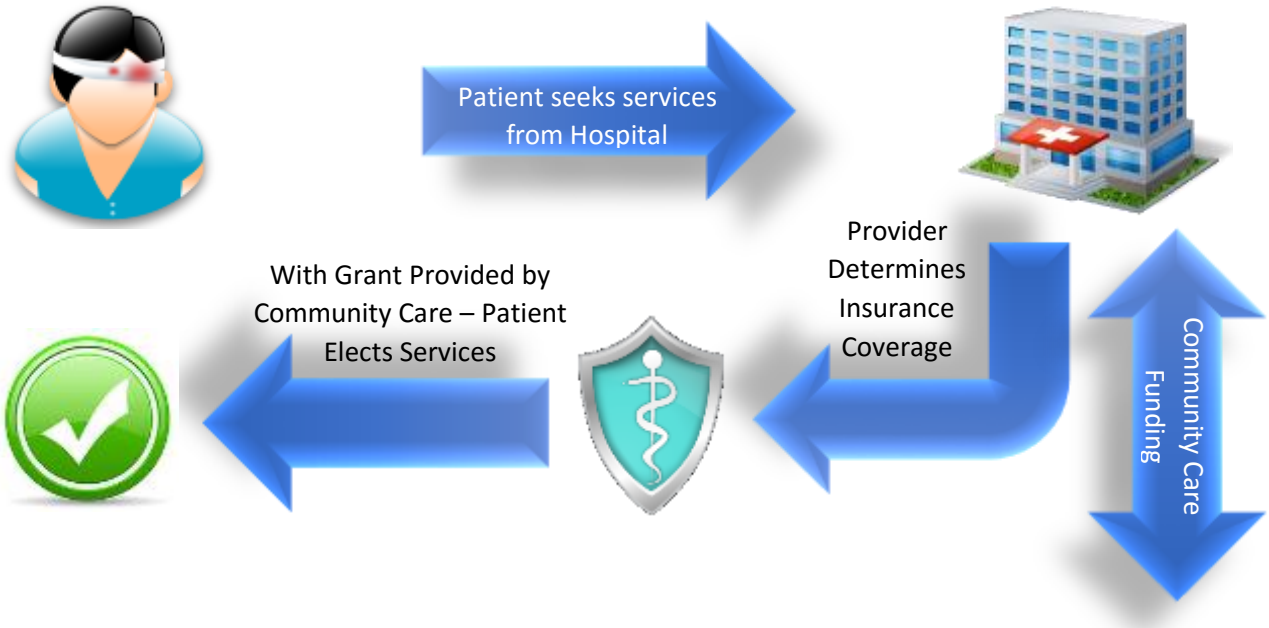
The results of this broken process are clear:

- ✓ Patients are <u>not</u> receiving needed care,
- ✓ Significant <u>lost revenue</u> for the provider,
- ✓ Providers administering treatment in an inequitable fashion,
- ✓ Poor community relationships between Provider and population served.

The Solution:

The Community Care Foundation provides procedure-based or match-payment based financial assistance grants for 5-90% of patient out-of-pocket expenses to consumers who don't qualify for charity care but are struggling to pay their out-of-pocket medical expenses, including elective procedures and premiums for continued health coverage. The Community Care Foundation has partnered with FinPay to adhere to federal and state regulatory requirements. When combined with FinPay's compliant approach and high-touch customer service payment platform Providers will significantly reduce, or even eliminate many of these challenges. The Community Care Foundation's partnership with FinPay provides automation of grant applications, payments, and compliance requirements related to federal inducement & anti-kickback laws (See Exhibit A)

The Community Care Process works as follows:



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Total Procedure Cost	$50,000
Insurance Coverage	$45,000
Patient Balance Due	$500
Community Care Grant	$4,500

The benefits of the Community Care Foundation process are clear:

- ✓ Patients receive needed care,
- ✓ Patients can continue to afford their healthcare Insurance premiums,
- ✓ Provider can minimize procedure cancellations due to cost,
- ✓ Providers will deliver transparent and standardized pricing to consumers in compliance with IRC 501(r) and Federal Consumer Protection Laws while effectively still allowing flexibility for Providers to offer patients with third-party financial assistance.
- ✓ Patients will receive an engaging financial experience that mirrors the high quality clinical experience delivered by their Provider,

Conclusion:

The ***Community Care Foundation Program*** enables patients to get the care they need when they need it. Community Care compliments and enhances a Provider's existing Charity Care and other Financial Assistance Programs. Community Care Grants are automatically applied to patient accounts through the FinPay compliant Platform. Community Care Grant qualifications are determined in accordance with customized Community Care Program guidelines (similar to how charity care funds are applied to low-income patient accounts).

Providers who participate in The Community Care Foundation Programs, which include the Patient Education and Payment Platform, are immediately compliant with current Federal Consumer Protection Laws relating to patient payments. The Community Care Foundation actively tracks consumer finance and healthcare laws and regularly updates our policies and procedures with an eye toward compliance with applicable federal and state laws.

The result is **transparency, integrity and equality in pricing for all patients** while enabling the Provider to offer patients flexible payment alternatives and Grants that are compliant with Federal Law and Commercial Payor contracts. Lastly, there is a tremendous public relations benefit that The Community Care Program contributes to a Provider's Brand image in their community.

Exhibit A

Regulatory Summary

The Community Care Foundation ("CCF") is a Pennsylvania nonprofit corporation that is seeking federal tax-exempt status under IRC Section 501(c)(3).[1] The Foundation's charitable purposes will include administering a financial assistance grant program designed to fund up to 90% of out-of-pocket healthcare balances owed by patients who do not qualify for traditional charity care or financial assistance (or for whom charity care/financial assistance is insufficient) but who, based on objective measures of income, assets and other means/ability to pay, are unable to pay certain out-of-pocket expenses (as described above) for medically necessary healthcare services. The Foundation's primary focus will be on patients who opt out of needed care due to cost; however, patients with scheduled inpatient or outpatient procedures may also qualify. In addition to meeting income and asset thresholds/criteria, eligible patients will be required to be residents of the Southeastern Pennsylvania/New Jersey/Delaware region**,** and have qualifying out-of-pocket healthcare expenses.

The patient will also be required to meet certain other eligibility conditions (e.g., completion of Medicaid/other financial assistance applications, completion of financial education and counseling, ability to make the minimum down payment, and enrollment in an automated payment program for any balance remaining after the grant and down payment are applied, etc.). CCF uses a payment platform to maintain transaction histories for all grants issued to ensure that Foundation funds are only used for permissible purposes and to ensure compliance with all regulatory standards. CCF plans to solicit donations from a wide range of potential donors, including hospitals and other providers which may benefit from grants provided by CCF.

CCF has an exclusive partnership with FinPay to provide needed services to, and functions on behalf of CCF, including but not limited to certain management, personnel, compliance, and administrative services, including financial counseling services by FinPay payment specialists to grant applicants, automated payment software and support services, grant/payment processing and related services in connection with CCF's grant programs. These services are designed to ensure the grants are used for proper charitable purposes and to assist patients in meeting their financial obligations. FinPay will also monitor all grant transactions in order to comply with regulatory requirements. All grantees will be required to establish a FinPay account so that the Foundation can validate that the grants are used for qualified healthcare expenses. All grantees will have complete "freedom of choice" to have their health care services provided by a provider of their choice, whether or not that provider has made a donation to the Foundation or has a contract with FinPay. Upon approval of a grant, the Foundation will transfer the grant funds to the grantee's FinPay account and FinPay will then, at the appropriate time, transmit the necessary payment to the hospital or provider performing the services, including the grant funds and any required down payment from the patient. However, the provider will not be informed that the funds were provided by a grant from the Foundation and the provider will be unaware of whether the FinPay payment is being paid in whole or in part by the patient, a grant or otherwise.

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[1] CCF plans to submit its Form 1023 application to the IRS for exemption from federal income tax. While it is difficult to predict, the IRS may take from 6 to 12 months to complete its review of the application. During the period while the application is pending, CCF will generally be permitted to carry on activities as if tax-exempt (i.e., it will file IRS Form 990 tax returns and not have to pay taxes on exempt function income).

More specifically, when CCF grant recipients choose to receive care from providers that have existing contracts with FinPay ("In-Network Providers"), grant payments will be processed in the same way that all other FinPay transactions (i.e., which do not involve CCF grant funds) are processed for such In-Network Providers' patients with no indication as to whether the payments coming from FinPay accounts are comprised of patient funds, CCF grant funds or both. Fees for processing such FinPay account transfers (whether or not including grant funds) will be paid by the In-Network Providers to FinPay pursuant to their contracts with FinPay. FinPay will be responsible for processing, and will be compensated for processing, all patient payments for such In-Network Providers regardless of whether CCF grant funds are involved and will receive the same fees regardless of whether the transfer includes CCF grant funds.

When CCF grant recipients choose to receive care from providers that do not have existing contracts with FinPay ("Out of Network Providers"), FinPay will contact such Out of Network Providers informing them that a patient would like to transfer funds to that provider from his/her FinPay account. The Out of Network Provider will be asked to undertake certain steps (e.g., establishing a merchant account with FinPay as it would for any commercial credit card company) to allow the transfer of such funds from the FinPay account. FinPay will not indicate to the Out of Network Providers whether the payments coming from FinPay accounts are comprised of patient funds, CCF grant funds or both, and we understand that there will be many other situations not involving CCF grant funds where FinPay will contact and set up a transfer with an Out of Network Provider in the exact same manner (i.e., the fact that FinPay contacts an Out of Network Provider will not necessarily indicate to that provider that the funds being transferred include CCF grant funds).

FinPay Platform Background

FinPay, in conjunction with certain of its affiliates, contracts with hospitals and other healthcare providers to provide patient financial management solutions, including various financial services to increase the patients' propensity to pay for the clinical services provided to them. FinPay does so by focusing on increasing the revenue capture rate of patient co-insurance, co-payments, deductibles and other out-of-pocket expenses related to those services. FinPay's services include (i) the use of data analytics to identify common denominators of patients who may pose a higher financial risk to providers, (ii) development of financial clearance policies and processes for developing solutions for these high-risk patients, (iii) provision of on-site payment specialists to provide financial education & counseling and managing expectations on billing & claims to assist patients in understanding and meeting their financial obligations, as well as the availability of various grant programs to which they may apply, (iv) provision of more payment options (e.g., single payment, installment plan, credit/debit cards, bank/ACH transfers, and medical loans through a network of community banks), and (v) provision of a secure, cloud-based, automated platform to process those payments and pay the provider. FinPay's platform will therefore be used to provide the patient financial management solutions outlined above, and then will serve as the conduit for transfer of payment for that portion of each patient's payments through its automated system. FinPay's platform also has integrated compliance tools that assist its hospital/ provider clients to be compliant with federal and state consumer protection laws, Internal Revenue Code ("IRC") and other regulatory agencies.

Legal Requirements/ Guidelines.

Under the federal Anti-Kickback Statute and the Civil Monetary Penalties Law (as described in more detail below),[2] a hospital or other healthcare provider is generally prohibited from routinely waiving the payment of co-insurance, co-payments or deductibles by patients. The purpose of this restriction is to reduce the risk of inducing beneficiaries to over-utilize health care services covered under those government programs.[3] A hospital/ provider is also prohibited from doing indirectly what it cannot do directly.[4] Therefore, it is critical that the arrangements outlined above do not violate this proscription or other applicable laws. In general, the Anti-Kickback Statute,[5] which is a criminal statute that includes significant penalties, including imprisonment, prohibits the payment of any "remuneration" to induce or in return for patient referrals or other business generated by the parties. The Civil Monetary Penalties Law[6] prohibits offering certain remuneration/ inducements to patients to receive care from a particular provider.[7] The outline below is based primarily on guidance from various advisory opinions issued by the OIG with respect to similar arrangements, and in particular, OIG Advisory Opinion #07-06 (re: the HealthWell Foundation), and OIG Advisory Opinions #15-06 and #15-14, as well as IRS guidelines.

I. Community Care Foundation Structure

A. Organizational Structure

1. Nonprofit corporation organized under state law (Pennsylvania)

2. No members/shareholders; governed by self-perpetuating board of directors (or FinPay serves as sole corporate member of Foundation; appoints majority independent board)

3. Seek tax-exemption under Section 501(c)(3) of the IRC and non-private foundation status as a publically supported public charity

B. Basic 501(c)(3) Organizational/Operational Requirements

1. Organized and operated *exclusively* to further charitable/tax-exempt purposes under Section 501(c)(3) (i.e., must not be organized or operated for the benefit of any private interests/purposes)

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[2] Sections 1128B(b) and 1128A(a)(5) of the Social Security Act, respectively (42 U.S.C. §1320a-7b(b) and 42 U.S.C. § 1320a–7a(a)(5)).

[3] Many commercial health insurance contracts also prohibit routine waiver of co-insurance, co-payments and deductibles.

[4] For example, the Anti-Kickback Statute applies broadly to any type of direct/indirect remuneration intended to reward or induce referrals in connection with services reimbursed under federal healthcare programs.

[5] Section 1128B(b) of the Social Security Act (42 U.S.C. §1320a-7b(b)).

[6] Section 1128A(a)(5) of the Social Security Act (42 U.S.C. § 1320a–7a(a)(5)).

[7] Except as specifically referenced above, we have not addressed compliance with any other state or federal laws, including, without limitation, any consumer credit protection statutes or regulations.

2. No part of net earnings may inure to the benefit of any private individual or entity (e.g., no dividends/distributions to members, owners, shareholders, etc.)

3. Limitation/prohibition on lobbying activities and campaign activities

4. Upon dissolution, remaining assets must continue to be used exclusively for charitable purposes (typically distributed to another 501(c)(3) organization)

C. Other 501(c)(3) Standards/ OIG Standards

1. Independent Board of Directors

- At least a majority of directors are independent (i.e., have no direct or indirect financial or employment relationship with Foundation, FinPay or affiliates, or any donor)

- No direct or indirect healthcare donor representation on board of directors or on other decision-making bodies

- Handles all policy-making functions for the Foundation

2. Independent Officers

- Officers do not have financial or employment relationship with FinPay

- Certain officers may be designated to serve as members of the governing board *ex officio* (e.g., Foundation CEO)

- Compensation paid to officers must be *reasonable* and consistent with *fair market value*

3. Conflict of Interest Policy

- No improper donor or FinPay influence/control over Foundation or Program matters (e.g., selection of grantees, determination of eligibility criteria, charitable objectives, etc.)

- Board members required to disclose potential conflicts of interest annually

- Any board/committee members or other decision-makers must be recused from voting/discussion on matters with respect to which they have a conflict of interest

4. Charitable Beneficiary Class (for Grant-making)

- Must define sufficiently broad "charitable class" of potential charitable recipients as to benefit public, and not private, interests

- Beneficiaries may be limited to residents in a certain geographic area, who have certain healthcare needs, who do not have sufficient means to pay, etc.

D. Third-Party Management/Personnel and Administrative Services Agreements[8]

1. Services provided must be *commercially reasonable* and compensation paid to third-parties must be consistent with *fair market value* of services provided[9]

2. Compensation should be fixed/objective and must not allow any sharing of Foundation net income/profits

3. Agreement between CCF and third-party service providers must be negotiated, terminated, renewed, overseen etc. by Foundation board (with recusal of any conflicted directors) or other independent/disinterested body (i.e., unrelated to any donor)

4. Management and other personnel/operations must be segregated from third-party business operations (per OIG Advisory Opinion – HealthWell Foundation):

   - Ethical wall to maintain third-party segregation (i.e., confidentiality agreements, separate project teams/management/personnel, separate office space, separate IT systems and data/files, staff training, etc.)[10]

   - Prohibition on third-party employees/agents soliciting donations to Foundation from healthcare donors (i.e., can solicit from other donors)[11]

   - Prohibition on third-party employees/agents proposing, developing or deciding upon eligibility criteria[12]

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[8] CCF may hire its own personnel or use a partner other than FinPay.

[9] To the extent possible, the Management Agreement should be structured to fall within the Personnel and Management Contracts Safe Harbor under the Anti-Kickback Statute. (See: 42 C.F.R. Section 1001.952(d).) Confirmation of fair market value compensation by an independent valuation firm is strongly recommended (although not required). Services under this contract could include, for example, processing grant applications, providing education and counseling services to grantees, ensuring grants are used for eligible purposes and that required down payments are made, maintaining electronic records of grant distributions and bundled payments, grantees are enrolled in automated payment programs for residual balances, and all documentation and reports are compliant with legal requirements.

[10] Based on this OIG guideline, for example, CCF's agreement with FinPay could require FinPay to assign counselors to CCF's office to provide the required counseling services on behalf of CCF to grant applicants. However, FinPay payment specialists providing patient counseling services for its hospital clients should not be the same specialists providing counseling services to CCF grant applicants. Also, such counseling should not be provided to grant applicants at the location of a FinPay client or donor in order to maintain complete independence of CCF and its grant application process from the FinPay clients or donors to avoid any inference of a connection.

[11] This would not necessarily prohibit FinPay representatives from informing its healthcare provider clients of the availability of the grant program (which availability would otherwise be widely publicized in the community) as long as such representatives do not solicit donations or provide any advantage to such providers' patients in obtaining grants.

- Prohibition on Foundation tying, conditioning or connecting donations with third-party's commercial business operations

- Appointment of independent Compliance Auditor to oversee/audit above safeguards and report to Foundation board

- Annual engagement of independent review organization to conduct independent audit of the above safeguards

- Compensation paid to Foundation staff must be *reasonable* and consistent with *fair market value* and not take into account any business generated for third-parties or donors

II. Program Design/Administration

A. Objective, Uniform, Verifiable Eligibility Criteria

1. Eligibility for assistance based solely on documented financial need/inability to pay and other reasonable criteria (i.e., no consideration of healthcare provider identity, donors, referral sources, etc.)

2. Criteria must be verifiable and applied objectively and consistently (e.g., in a CCF charity care/eligibility policy)

3. All eligible patients receive assistance on a first-come, first-served basis to the extent funding is available

B. Community Outreach/Notice

1. CCF must make grant availability known to broader community in the geographic area served

2. Must implement measures designed to reasonably publicize grant availability to members of the charitable class (e.g., website, brochures, advertisements, mailings, contact with and materials provided to providers, patients and community organizations/patient advocacy groups, etc.) given reasonable budgetary constraints[13]

C. Foundation Independence from Healthcare Provider Donors

1. Donors may contribute effectively to support financially needy patients generally, including federal healthcare program beneficiaries, by contributing to independent, *bone fide* charitable assistance programs

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[12] This safeguard would not necessarily preclude third parties from advising CCF on payment processing or other service matters.

[13] Measures must be taken to ensure that the grant program is widely known and not a private grant program available primarily through promotion by third parties to its clients/potential clients.

2. Donors not permitted to exert any direct or indirect control or influence over Foundation, Program, grantee selection, eligibility criteria, allocation of funds, etc. [14]

3. No donor earmarks permitted for a particular treatment, procedure, service, disease/ condition, etc. that are unique to or only available from that specific donor (i.e., which might benefit a particular provider's patients)[15]

4. Foundation engages in broad charitable solicitations (i.e., not just from healthcare providers whose patients may receive grants)

5. No advantage/priority given to donors or patients of donors in the grant application and approval process

6. No reports or data provided to donors showing relationship between donated amounts and frequency of use of donors' services or business generated for donors[16]

7. No individual grantee/patient information provided to any donor[17]

8. Grants paid as to not identify to donor/provider that funds are coming from Foundation grants[18]

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[14] We believe it would be prudent not to permit provider/ donors to assist patients in the grant application process in order to avoid any question that the provider/donors could track grant funds. These patients could be referred to FinPay payment specialist for required counseling.

[15] CCF may establish one or more disease funds in accordance with broadly defined disease states based on widely recognized clinical standards (*See*: OIG Advisory Opinion #15-06). Donors could earmark contributions to a particular disease fund, but not with any greater specificity (e.g., not for patients requiring certain treatments). The OIG also approved a foundation providing support to help financially needy patients obtain an MRI for the diagnosis or evaluation of a specific disease (*See*: OIG Advisory Opinion #15-14). In each case, the key is that a donor's earmarking does not result in the proposed arrangement serving as a disguised conduit for financial assistance to patients obtaining the services, procedures, drugs or devices from that donor. (*See*: OIG Advisory Opinion #15-06, p. 8)

[16] CCF may provide aggregate data to donors, such as number of applications and grants awarded, but not information that would enable a donor to correlate the amount of frequency of donations with the grants to patients in the donor's facilities.

[17] Each of the OIG Advisory Opinions cited above (i.e., OIG Advisory Opinions #07-06, #15-06 and #15-14) reference a specific safeguard whereby the charitable organization has a policy of not providing donors with any individual patient information/data as to prevent donors from correlating the amount or frequency of donations with the number, volume or medical condition of patients that might utilize such donor's healthcare products/services. This safeguard helps to preserve the legitimacy of, and intent behind, the donors' contributions as charitable in nature instead of in return for/as an inducement for patients to receive services from such donor. The use of the FinPay platform will provide compliance with these opinions.

FinPay processing/payment of grant funds for patients to providers is only permissible if FinPay does not disclose that funds are pursuant to a grant from CCF or the provider would not otherwise be able to discern this information (e.g., FinPay processes and makes payments under its contract with the provider for patient payments, including those who do not have grants). Even if the provider does not have a current contract with FinPay but is approached by FinPay to receive payment of CCF grant funds as processed by FinPay, the provider will not be made aware, directly or indirectly, as to whether such funds are from CCF grants, the patient or otherwise.

9. Broad eligibility criteria (i.e., not limited to specific diseases/conditions or services such that only one or a few providers are available)

D. No Improper Influence/Steering of Grant Recipients/Patients

1. Patients must have already consulted with physician or other healthcare provider and determined course of treatment prior to grant application

2. Patients must be notified that they are free to choose any provider and/or switch providers

3. Foundation must not refer, recommend or arrange for use of any particular provider, product, plan, etc.

4. Healthcare donors not identified, promoted or recommended to patients[19]

E. Independence from third party Business Operations

1. No assistance, grants or other benefits provided by CCF should be conditioned on or tied to any third party business relationships (i.e., grants must not be used to help generate any business for third parties or its clients)

2. CCF's grant payment process must not require or promote engagement of third parties by patient recipient or healthcare provider

3. No advantage/priority given to actual or potential third party clients (or patients of clients) in grant application or approval process

4. Third parties must not market or promote to potential hospital/provider clients that CCF grants will be available if they contract with third parties or donate to the Foundation[20]

5. Foundation must not market, endorse, advertise or promote third party business operations to any donors, patients, service providers, potential customers, etc.[21]

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[18] None of the Advisory Opinions included payment to a third party for payment to the provider, although this is not precluded by these opinions. As we understand, any third party processing of payments must provide additional protections since it may serve to prevent the provider from tracking whether payments are coming from the patient or CCF grants.

[19] This safeguard also likely prohibits listing certain donors on CCF's website. In OIG Advisory Opinion #15-14, the charitable organization published the names of certain pharmaceutical donors but only those whose services/pharmaceuticals did not qualify for assistance under the grant program.

[20] This safeguard does not necessarily preclude objective disclosure of the general third party/CCF relationship by any third party so long as such does not suggest/imply that contracting with a third party will provide any advantage in obtaining CCF grant funds.

[21] This safeguard does not necessarily preclude objective disclosure of the general third party/CCF relationship by CCF so long as such does not serve to promote, advertise or market a third parties services to potential clients.

Summary.

The Foundation may be formed as a charitable organization to provide financial assistance grants to patients in need who meet its eligibility criteria, including federal healthcare program beneficiaries, and hospitals and other providers may donate to the Foundation as part of our national health care system's safety net, provided that (i) the Foundation is organized and operated as outlined above as an independent, *bone fide* charitable organization free from influence from any donors or other interested third parties, including third parties, and its application for tax-exempt status (Form 1023) under Section 501(c)(3) of the IRC is approved by the IRS; and (ii) neither the donations nor the grants are provided to circumvent the proscriptions against waiving co-insurance, co-payments or deductibles under federal law.