POLICY AND PROCEDURE

TITLE: Financial Assistance Program (FAP) and Discount Policy	
AFFECTED AREA(S)/DEPARTMENT(S): Revenue Cycle	
ORIGINATING DEPARTMENT: Revenue Cycle	
DATE ORIGINAL APPROVED: 01/01/2008	DATE OF LAST APPROVED REVIEW/REVISION: 09/03/2021
VERSION NUMBER (generated by PolicyTech): 4	REGULATORY STANDARD(S):

PURPOSE:

Barton Health seeks to deliver consistently exceptional care while managing its resources responsibly. This allows Barton Health to provide financial assistance to those persons in need. Barton Health has established this policy regarding the Financial Assistance Program (FAP), and Discounts for services rendered by Barton Health.

SCOPE OF SERVICES:

This policy does not create an obligation for Barton Health to pay for patient services rendered by physicians or other medical providers including, but not limited to, anesthesiologists, radiologists and pathologist charges which are not included in the hospital's facility bill.

Barton Health's Charity Care and Discount Policy, also known as the Barton Health FAP and Discount Policy will provide financial assistance in the form of free or discounted fees for service rendered to eligible patients. All open accounts within the first 12 months of initial billing statement shall be considered for Charity Care and/or discounted payment once the FAP application has been approved or denied.

**medically unnecessary services, such as those purely cosmetic in nature are excluded from the hospital's Financial Assistance Programs*

DEFINITIONS:

Amount Generally Billed
The Amount Generally Billed (AGB) is the maximum charge a patient who is eligible for Financial Assistance under this policy is personally responsible for paying, after all deductions

and discounts have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AGB for the Eligible Service(s) provided to a patient. Barton Health calculates the AGB using the "lookback" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. Barton Health uses data based on claims processed by Medicare fee for-service and all private commercial insurers for all medical care over the past year to determine the percentage of gross charges that is typically allowed by these insurers. The AGB percentage is then multiplied by gross charges for emergency and medically necessary care to determine the discount. In 2021, the AGB percentage for inpatient and outpatient services is 32.7% based on calendar year 2020 data.

The discount will be applied to gross charges or balance after insurance once a complete Financial Assistance application has been received and a determination has been made by the Financial Assistance Committee. (Gross Charges X AGB percentage = Amount adjusted to Financial Assistance or Balance after insurance X AGB percentage = Amount adjusted to Financial Assistance)

Applicant
The Applicant is the individual patient or the patient's guarantor, as applicable, who applies for Financial Assistance. A household member, close friend or associate of the patient may also request that the patient be considered for Financial Assistance. A referral may also be initiated by any member of the medical or facility staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, religious sponsors, vendors or others who may be aware of the potential need for Financial Assistance.

Application Period
The Application Period is the later of: (i) 360 days from the patient's discharge from the hospital or the date of the patient's Eligible Service, or (ii) 240 days from the date of the initial post-discharge bill for the Eligible Service.

Bad Debt
Bad debt are charges resulting from services rendered to a patient who is determined to be able but unwilling to pay all or part of the bill. Bad debt is differentiated from charity care by an unwillingness to pay (Bad Debt) versus a demonstrated inability to pay (Financial Assistance).

Catastrophic Medical Expense
Medical expenses that are greater than 40% of the qualified individual's annual income.

Charity Care
Charity Care is full Financial Assistance (i.e., 100% discount) to qualifying patients that relieves the patient and his or her guarantor of their entire financial obligation to pay for Eligible Services. Charity care may be applied to uninsured patients, as well as the patient liability for patients with insurance, this includes charges determined uninsured hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services. Charity Care does not reduce the amount, if any, that a third party may be required to pay for

Eligible Services provided to the patient. Within this Policy, Charity Care is differentiated from discounts or other forms of financial assistance when discussing the amount granted under the Financial Assistance program as a full waiver of the account balance (Charity Care) versus a partial waiver of the account balance (discounts or other forms of financial assistance).

Discounted Care
Discounted Care is partial Financial Assistance to qualifying patients to relieve the patient and his or her guarantor of a portion of their financial obligation to pay for Eligible Services (as defined below). Discounted Care is determined using the patient's income and where it compares to the Federal Poverty Guidelines (FPL). Discounted care includes services to patients with High Medical Costs as discussed in the section "Patient Family Income." Discounted care may be applied to uninsured patients, as well as the patient liability for patients with insurance, this includes charges determined uninsured hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services. Discounted Care does not reduce the amount, if any, that a third party may be required to pay for Eligible Services provided to the patient. Discounts excluded from the Financial Assistance program are usual discounts whose application is not based on an ability to pay.

Eligible Services
Eligible Services include all Emergency Medical Care or non-emergency, Medically Necessary Care delivered by Barton Health within Barton Health-operated hospital facilities including all buildings listed on the license for each hospital. Eligible Services may also include non-covered Medically Necessary Care from any payer provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit, the patient's benefits have been exhausted, balance from restricted coverage, Medicaid-pending accounts, and payer denials. Eligible Services also include services provided to patients as part of any federal, state or local managed indigent care program. Eligible Services excludes elective procedures, physician services, treatments or procedures unless the Financial Assistance Policy's provider list includes the relevant physician or physician group and, if applicable, a description of the services, treatments, or procedures provided by such physician or physician group specifically covered by this Policy.

Emergency Medical Care
Emergency Medical Care means care provided by a hospital facility for:
(a) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(ii) Serious impairment to bodily functions, or
(iii) Serious dysfunction of any bodily organ or part; or
(b) A pregnant woman who is having contractions, when: (i) There is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Physician
An Emergency Physician is a licensed physician or surgeon credentialed by a Barton Health hospital and either employed or contracted (including through a contracted medical group) by the hospital to provide emergency medical care in the emergency department of the hospital. The term "Emergency Physician" does not include a physician specialist who is called into the emergency department or who is on staff or has privileges at the hospital outside of the emergency department.

Essential Living Expenses
Essential Living Expenses are expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Extraordinary Collection Actions (ECAs)

Barton will not engage in ECAs while determining financial assistance eligibility.

ECAs include the following:
(a) Selling an individual's debt to another party except as expressly provided by federal law.
(b) Reporting adverse information about the individual to consumer credit bureaus.
(c) Deferring or denying, or requiring a payment before providing, Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital facility's Financial Assistance Policy.
(d) Certain actions that require a legal or judicial process as specified by federal law, including some liens, foreclosures on real estate, attachments / seizures, commencing a civil action, causing an individual to be subject to a writ of attachment, and garnishing an individual's wages.

ECAs do not include any lien that a hospital is entitled to assert under state law on the proceeds of a judgment, settlement or compromise owed to an individual (or his or her representative) as a result of personal injuries for which a hospital provided care.
Federal Poverty Level (FPL)
The FPL is defined by the poverty guidelines updated periodically in the Federal Register by the HHS under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at: http://aspe.hhs.gov/poverty-guidelines.

Financial Assistance
Charity Care, Discounted Care or other forms of financial assistance, as described in this Policy.
Financial Assistance Policy's Provider List
A listing referenced on the facility's website which details the relevant physician or physician group specifically covered by this Policy.

Gross Charges

Gross Charges (also referred to as "full charges") means the amount listed on the Barton Health hospital facility's chargemaster for each Eligible Service.

Income
Modified Adjusted Gross Income (MAGI), as defined by the IRS.

Medically Necessary Care
Hospital services and supplies and other health care services, to the extent expressly provided for in this Policy, needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted practice standards. Medically Necessary Care does not include care relating to cosmetic procedures that are intended only to improve the aesthetic appeal of a normally functioning body part.

Patient's Family
A Patient's Family includes the patient and:

(a) For persons 18 years of age and older, a spouse, domestic partner, as defined in Section 297 of the California Family Code, and dependent children under 21 years of age, whether living at home or not.
(b) For persons under 18 years of age, a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Patient Family Income
The annual Income earned by the Patient's Family in the 12 months prior to the date on which the Barton Health service was provided.
Patient with High Medical Costs
A patient who has health coverage and who also meets one of the following two criteria:
(a) Annual out-of-pocket costs incurred by the individual at the hospital exceed 10% of the Patient's Family Income (defined below) in the prior 12 months; or
(b) Annual out-of-pocket medical expenses exceed 10% of the Patient's Family Income, if the patient provides documentation of the patient's medical expenses paid by the patient or the Patient's Family in the prior 12 months.

Presumptive Eligibility Determination
Presumptive Eligibility Determination is the process of determining a patient's eligibility for Financial Assistance based upon information other than that provided by the patient, such as qualification in other welfare-based programs, federal, state or local managed indigent care programs, homeless status, or based upon a prior Financial Assistance eligibility determination. (Note that references to "Presumptive Eligibility" in this Policy refer to Presumptive Eligibility for Financial Assistance and do not refer to Medi-Cal Hospital Presumptive Eligibility unless otherwise specified.) In cases whereby Barton does not obtain recent pay stubs or income tax returns (e.g., homeless and undocumented residents), Barton Health may utilize a Presumptive Eligibility Determination process to provide Charity Care or Discounted Care with respect to any category of Financial Assistance. In making a Presumptive Eligibility Determination, Barton Health may rely on information included in publicly available databases and information

provided by third-party vendors who utilize publicly available databases to estimate whether a patient is entitled to Financial Assistance. This screening process is designed to emulate Barton Health's Financial Assistance Application and the information returned through the screening process will constitute adequate documentation when additional information is not available from the patient. The process provides an estimate of the patient's household income and size and analyzes other factors related to the patient's financial need. Barton will notify patients receiving presumptive discounts the basis for the presumptive FAP-eligibility determination and they may apply for more generous assistance (per this FAP).

Presumptive Eligibility for Medi-Cal Insured Patients
A patient who has health coverage under the Medi-Cal or other Medicaid programs is presumed to have an Income below the FPL required for Financial Assistance under this Policy. Financial Assistance may be granted to patients based only on health coverage under the Medi-Cal or other Medicaid programs. Waiver of account balances under this Policy for patients who have health coverage under the Medi-Cal or other Medicaid programs shall never include a waiver of the patient's Share of Cost. As the Share of Cost is considered a condition of coverage, patients will be educated that this amount is not subject to waiver or Financial Assistance.

Reasonable Payment Plan
A Reasonable Payment Plan is an extended payment plan in which the monthly payments are not more than 10% of a Patient's Family Income for a month, after excluding deductions for Essential Living Expenses (as defined above).
Share of Cost
A pre-determined amount of health care expenses that a patient with coverage under the Medi-Cal or other Medicaid programs must incur before he or she qualifies for Medi-Cal benefits. These amounts may not be discounted or written off as part of this Policy.

Service Areas
Barton Health's primary service area encompasses patients residing in area codes 96150, 96151, 96158, 95721, 95735, 96141, 96142, 96155, 89448, 89449, 89413. Barton Health's secondary service areas include patients residing in area codes 96161, 95724, 96145, 96140, 96143, 96146, 96141, 89450, 89451, 89704, 89706, 89701, 89703, 89705, 89411, 89423, 89460, 89410, 96120, 95646, 95720, 93516, 93514

Uninsured Patient
An Uninsured Patient is a patient who does not have health coverage from a health insurer, health care service plan or government-sponsored health care program (e.g., Medicare, Medi-Cal or Medicaid), and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. A patient is considered uninsured when they have insurance, but the insurance does not cover or denies medically necessary services.
Insured Patients with a Carrier Not Under Contract with Barton
Negotiations with insurance carriers involving inferred contractual relationships, for insured patients not under contract with Barton will be conducted by executive management at Barton. Although Barton may agree to the terms of the negotiations with insurance companies, an

inferred contractual relationship is not representative of a patient "under contract" with Barton. All unreimbursed amounts are a form of patient financial assistance - as Barton considers the patient portion uninsured – and are determined as the difference between gross hospital charges and hospital reimbursement. Any care provided to a presumptive or actual case of COVID-19 is provided at an amount no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

APPLYING FOR FINANCIAL ASSISTANCE:

A patient, patient's guarantor or other designated patient representative may apply for Financial Assistance at any time during the Application Period. If the application is filed after the Application Period (defined above) is over, Barton Health may deny the application. However, Barton Health will consider the reasons that the application was not filed during the Application Period and may process the application if it determines that the Applicant acted reasonably even though the application was not filed timely.

Barton Health's standardized application form will be used to document each patient's overall financial status. The Financial Assistance application will be available in the primary languages of the Barton Memorial Hospital service area.

The Barton Health FAP application can be obtained at any Point of Service/Registration area within the hospital or by contacting the hospital's Customer Service department at 530-543-5930, located at 1111 Emerald Bay Road, South Lake Tahoe, California 96150. Barton Health's FAP policy and application can be found on the Barton Health website at https://www.bartonhealth.org/tahoe/financial-aid.aspx and the public California Office of Statewide Health and Planning and Development (OSHPD) web site https://syfphr.oshpd.ca.gov/.

FINANCIAL ASSISTANCE DETERMINATION AND NOTICE:

1. **Documentation, Residency and Filing FAP Application**

Barton Health will consider each applicant's FAP application when completed required documentation and residency requirements are met. Documentation of income for the purpose of determining eligibility for Charity Care is limited to recent pay stubs or income tax returns. A patient must "make every reasonable effort" to provide documentation of income and health benefit coverage. In some cases (e.g., homeless, undocumented resident) Barton Health may utilize presumptive eligibility determinations (as discussed above). Patient's applying for financial assistance must reside in Barton Health's primary and secondary service areas although exceptions to this requirement may be made for special circumstances where the amount of medical costs may be considered catastrophic.

Barton Health's Customer Service Department will assist the patient to qualify for private or public health insurance or sponsorship that may fully or partially cover charges for care rendered by the hospital by providing applications to government programs and access to hospital financial counselor. Programs include private or public health insurance or sponsorship but not

limited to; private health insurance, including coverage offered through the California Health Benefit Exchange (Covered California), Medicare, Medi-Cal, Healthy Families, California Children's Services (CCS), and other state-funded programs designed to provide health coverage.

A patient may continue with the FAP application process for Charity Care while any application for private or public health funding is pending.

Barton Health's Patient Financial Counselor may deny the patient's application if the application is not received within the Application Period or if the necessary documentation is not provided timely under the FAP guidelines.

2. **Notification of Eligibility**
Financial assistance eligibility will be determined as close to the time of service as possible but there is no rigid time limit due to application requirements.

In some cases, a patient eligible for financial assistance may not have been identified prior to initiating external collection action. Barton Health's external agency shall be made aware of this policy and may return the patient account (s) back to the hospital's Customer Service department if eligible. An external collection agency will be required to comply with the hospital's definition of a financially qualified patient, including the hospital's definition of a "reasonable payment plan".

Barton Health has a written policy defining standards and practices for the collection of debt and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables.

Once Charity Care eligibility determination has been made a Barton Health Notification Form will be mailed to the applicant advising of the decision.

3. **Dispute Resolution**
Barton Health may deny a patient's eligibility for Charity Care benefits either because the patient is not financially eligible or because the patient did not provide the documentation that was required to qualify for assistance.

A patient may seek review and appeal the disqualification by notifying the Hospital's Revenue Cycle Director (or designee) the basis of dispute and appeal the initial decision. The Revenue Cycle Director (or designee) shall review the written appeal by the patient and inform the patient of a decision in writing within thirty (30) days of receipt of patient's written appeal notice.

Appeal letters may be dropped off at Barton Health's Customer Service Department located at 1111 Emerald Bay Road in South Lake Tahoe or mailed to;
Barton Healthcare System
Revenue Cycle Director
P.O. Box 9578
South Lake Tahoe, CA 96158

FINANCIAL ASSISTANCE PROGRAMS AVAILABLE TO THE FINANCIAL QUALIFIED PATIENT

A. **Full Charity Care**: Financial Qualified Patients are eligible for full Charity Care upon a demonstration of meeting the income eligibility requirements to be a Financial Qualified Patient. Full Charity Care is free care for Barton Health undiscounted charges for covered services.

To be financially qualified for full Charity Care, patient/guarantor must complete an application and provide all required documents, a patient/guarantor does not have a source of payment for any portion of their medical expenses. Payment sources include, without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability carriers.

B. **Extended Payment Plan:** To the extent that a Financial Qualified Patient does not qualify for full charity care, e.g., by failing to submit timely a FAP application, the Financial Qualified Patient may be offered an interest free extended payment plan for any balance remaining. The Extended Payment Plan will be negotiated between Barton Memorial Hospital's Customer Service Department and the patient.

If an agreement between the Customer Service Department and the patient cannot agree on terms for a reasonable payment plan, monthly payments will be set up that will not exceed ten percent of the patient's family income for a month, excluding deductions for essential living expenses.

Once an extended payment plan has been established, Barton Memorial Hospital may consider the payment plan null and void if the patient fails to make all consecutive payments due during a 90-day period. Prior to terminating the extended payment plan, the Customer Service department will:

1. Attempt to contact patient by telephone.
2. If no response, Barton Memorial Hospital will send one final statement -and then the extended payment plan may be terminated and inform patient of the opportunity to renegotiate the payment plan if requested by the patient.

The notice and phone call will be made to the last known phone number and address of patient. The patient will have 30 days from Barton Memorial Hospital's notice and telephone call to respond to stop termination of the current extended payment plan.

C. **Emergency Physician Fair Pricing Policy**: Barton Memorial Hospital Emergency

Department Physicians have a discount payment policy the hospital will make available to the patient/guarantor upon request. These Emergency Physician Fair Pricing Policy/Policies will coincide with the hospital's current Federal Poverty Level. For further information on the Barton Memorial Hospital's Emergency Physician Fair Pricing Policy, the Patient may ask for the Emergency Physician Fair Pricing hand out or by contacting:

- Intermedix (Emergency Physician billing company) at 800-225-0953
- Barton Memorial Hospital's Customer Service Department at 530-543-5930

DISCOUNTS AVAILABLE

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Discounted Medical Care:
Barton Memorial Hospital offers partial financial assistance to qualified self-pay patients to relieve the patient and his or her guarantor of a portion of their financial obligation to pay for Eligible Services.

Uninsured Discount:
Barton Memorial Hospital will apply a 30% discount to all uninsured patient liability.

ADDITIONAL IMPORTANT COMMUNICATION OF FINANCIAL ASSISTANCE AVAILABILITY

1. **Written Notice to Patients**: Notices on information of Barton Memorial Hospital's Financial Charity Care Discount policies will include eligibility and contact information and where additional information may be requested. Notices will include information on the Emergency Physician discounts that are available. Notices will be available at time of preadmission, registration, upon request, and at the time of discharge from service. Notices will be available in the primary languages of the Barton Memorial Hospital Service area to all patients receiving services including inpatient, ancillary, emergency, outpatient, surgical and recurring services such as physical therapy and infusion therapy.

2. **Written Hospital Estimates:** Upon request, Barton Memorial Hospital will provide a written estimate of the amount the hospital will require from the patient to pay for services/supplies that are expected to be provided. The estimate request requirement applies to all patients without health coverage, regardless if patient meets criteria for full Discounted Care benefits. Estimates may be obtained by contacting Barton Memorial Hospital's Authorization Department at (530) 543-5715 during normal business office hours.

**Emergency services are exempt from the written estimate requirement.*

3. **Posted Notices:** Notices of the hospital's policy for financially qualified and self-pay patients will be posted in the Barton Memorial Hospital's Emergency Department, the Customer Service department, admitting locations and outpatient ancillary departments that furnish services

directly to patients.

4. **Providing Applications:** Barton Memorial Hospital will provide applications for Medi-Cal, Healthy Families, and coverage through the California Health Benefit Exchange (Covered California) or any other available State and County funding health coverage programs. The applications will be provided to the patient who does not indicate coverage by a third-party payer, or who requests financial assistance. The applications shall be provided prior to discharge for inpatients and patients receiving emergency or outpatient care.

5. **Information to Patients without Third-Party Coverage:** Barton Memorial Hospital will include a summary statement of the Financial Assistance Program in the statement that includes charges for services rendered and is sent to the patient.

6. **Access to Healthcare Crisis:** An Access to Healthcare Crisis must be proclaimed by Barton Health leadership, approved by the board of directors and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of the hospital's community during the Access to Healthcare Crisis. During an Access to Healthcare Crisis Barton Health may "flex" it's patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

7. **Patient Confidentiality**: All patient financial information obtained for the purpose of determining eligibility for Barton Memorial Hospital's Financial Assistance Program will not be used in the collection of debt process.

All patient financial information obtained for the Financial Assistance Program and Discount Policy will be secured under the Privacy and HIPAA requirements. Disclosure of such information shall be limited to staff that is involved with the Financial Assistance Program and Discount Policy. Unauthorized disclosure of a patient's confidential financial information is strictly prohibited and will result in disciplinary action.

REFERENCES

Title 22, California Code of Regulation Division 5

California Health & Safety Code Sections 127400-127462

California Hospital Association – Financial Assistance Policies

IRC Section 501(r) Final Regulations

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