POLICY AND PROCEDURE

TITLE: Financial Assistance Program (FAP) and Discount Policy	
AFFECTED AREA(S)/DEPARTMENT(S): Revenue Cycle	
ORIGINATING DEPARTMENT: NV - Physician Billing	
DATE ORIGINAL APPROVED: 01/01/2008	DATE OF LAST APPROVED REVIEW/REVISION: 11/21/2024
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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 2024 the AGB percentage for inpatient and outpatient services is 29.10% based on calendar year 2023 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.

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 may also include high medical costs such as expenses that are not covered by insurance or health coverage program, such as Medicare copays and Medi-Cal cost sharing**.** 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 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.

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: https://aspe.hhs.gov/topics/poverty-economic-mobility/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 of covered Providers is maintained in a document separate from the FAP. The public can readily obtain this list free of charge online at www.bartonhealth.org under the heading of Patients & Family, Billing/Financial Assistance, Financial Aid, "Providers covered by Barton Health Financial Assistance Program". This document can also be obtained on paper by contacting Customer Service, Financial Counselor, or Barton Hospitals Front Office.

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 are considered Medically Necessary Care unless either the referring provider or the supervising provider attests that the hospital services at issue were not medically necessary. The attestation must be signed by the provider. The attestation must be obtained before a hospital can deny patient eligibility.

Supervising health care provider means the primary physician or, if there is no primary physician in the patient's record, the health care provider who had primary responsibility for a patient's health care. Generally, 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 20 years of age, a parent, caretaker relatives, and other children under
21 years of age of the parent or caretaker relative.
(c) Disabled family members over the age of 18.

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 whose Patient's Family Income does not exceed 400% FPL 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
The process by which Barton Health may grant circumstantial eligibility based on an objective, good faith determination of financial need, taking into account the individual patient's circumstances, the local cost of living, a patient's income, a patient's family size, and/or the scope and extent of patient's medical bills, based on reasonable methods to determine financial need. (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.) The Chief Executive Officer, the Chief Financial Officer, or his/her/their designees shall be authorized to approve patients for circumstantial eligibility for charity or discounted care, and must ensure documentation of the basis upon which circumstantial eligibility was granted. 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 of the basis for the presumptive FAP-eligibility determination and they may apply for more generous assistance (per this FAP).

Patients deemed presumptively eligible for financial assistance may be documented as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to Charity Care, self-pay discounts, non-covered services and payer denials.

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 may include a waiver of the patient's Share of Cost.

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.

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.

PROVIDERS COVERED AND NON-COVERED UNDER THIS POLICY:

Providers in the following groups have agreed to offer charity care discounts consistent with this policy when delivering emergency or other medically necessary care at Barton Health:

- Barton Medical Foundation
- Tahoe Carson Valley Medical Group
- Lake Tahoe Orthopedic Institute
- Tahoe Orthopedic and Sports Medicine

Providers not covered under this policy are providers in the following medical groups:

- South Lake Tahoe Anesthesia Group

- Sierra Nevada Medical Imaging
- Tahoe Emergency Physicians
- Any other provider not on the covered provider list above

APPLYING FOR FINANCIAL ASSISTANCE:

A patient, patient's guarantor or other designated patient representative may apply for Financial Assistance.

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.

Patients who qualify for financial assistance will have:

● An annual family income that is less than or equal to 400% of the FPL, as determined by guidelines published annually by the U.S. Department of Health and Human Services;
● Met with a Barton Financial Counselor to explore eligibility for other programs, such as: Workers' Comp, Medi-Cal, and Victims of Crime; and
● Completed a Financial Assistance Program application and provided supporting documentation to verify income.

- Supporting documentation to verify income includes the following;
  ● Copy of income tax return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when patient was first billed.
  ● Copy of two (2) most recent pay stubs for applicant and spouse or domestic partner. Paystubs must be from within the 6-month period before or after patient is first billed (or in preservice when application is submitted).
  ● A letter explaining the need for financial assistance.

The Barton Health FAP Policy and application is available free of charge.
Request a copy:

- In person at any Point of Service/Registration area within the hospital
- By contacting the hospital's Customer Service department at 530-543-5930 or the Patient Financial Counselor at 530-543-6086
- By mailing in a written request to Barton Health Attn: Financial Counselor 2170 South Ave. South Lake Tahoe, CA 96150
- Via e-mail to: financialassistance@bartonhealth.org
- On the Barton Health website at https://www.bartonhealth.org/tahoe/financial-aid.aspx or the public Department of Health Care Access and Information (HCAI) web site https://hcai.ca.gov/affordability/hospital-fair-billing-program/hospital-policies/.

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 from within a 6 month period before or after patient is first billed (or in preservice when application is submitted) or income tax returns from the year the patient was first billed or 12 months prior to when patient was first billed. 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).

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.

If an application for Financial Assistance is received but is incomplete, a letter will be sent to the patient outlining what is missing from the application. If the additional information is not received within a reasonable time frame, Barton will send a denial letter to the patient stating that the application was not complete and the missing information was not received.

Barton Health's Patient Financial Counselor may deny the patient's application 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 to the Financial Counselor located at 2170 South Ave 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

For Financially Qualified Patients, Barton Health will limit the expected payment for services to the amount of payment Barton Health would expect to receive from Medicare or Medi-Cal, whichever is greater. If there is no established payment for a service under Medicare or Medi-Cal, Barton Health will establish an appropriate discounted payment.

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.

1. Qualifying patients with a household income equal to or less than 249% of the Federal Poverty Level (FPL) receive 100% discount (free care) for Barton Health undiscounted charges for covered services.

B. **Discounted Care**: Qualifying patients with a household income equal to or less than 400% of the FPL receive the following sliding scale discounts for Barton Health

undiscounted charges for covered services.

1. Household income between 250% - 299% of FPL receive a 75% discount on the Amount Generally Billed (AGB) for Barton Health covered services.
2. Household income between 300% - 349% of FPL receive a 50% discount on the Amount Generally Billed (AGB) for Barton Health covered services.
3. Household income between 350% - 400% of FPL receive a 25% discount on the Amount Generally Billed (AGB) for Barton Health covered services.

The AGB is determined net of any payments received by a health insurer, health care service plan or government-sponsored health care program (e.g., Medicare, Medi-Cal or Medicaid).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.

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 Financial Assistance Policy. 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:

- 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.

Hospital Bill Complaint Program
The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more

information and to file a complaint.
Contact us if you have any questions or concerns about billing or the collection process.

REFERENCES

Title 22, California Code of Regulation Division 7

California Health & Safety Code Sections 127400-127462

California Hospital Association – Financial Assistance Policies

IRC Section 501(r) Final Regulations