Charity Care and Discount Payment Policy

I. Scope:

The purpose of this policy is to outline the circumstances under which charity care and payment discounts may be provided to qualifying low-income patients for medically necessary services provided.

II. Purpose:

Temecula Valley Hospital (TVH) recognizes that there are individuals in need of medical services who are unable to pay for such services. It is the intent of TVH to assist such patients with the settlement of their portion of the medical bill by properly screening for Charity Care or Discounted Payment eligibility if unable to pay the bill and to make services available at no cost or a reduced cost to individuals who meet the eligibility requirements.

Patients qualifying for Financial Assistance have an annual Family Income that is at or below 400% of Federal Poverty Level (FPL) and who have (i) received medically necessary services from the Hospital, (ii) are uninsured or underinsured; and (iii) have completed required documentation substantiating their income levels as set out herein.

This policy is to be used by the Hospital's Admissions Coordinators/Financial Counselors to screen, educate and counsel patients presenting to the facility requesting/requiring charity assistance and or discounts as appropriate. Co-payments, deductibles, coinsurance, and other amounts owed by a patient may be reduced in the limited circumstances identified in this Policy, in accordance with another policy addressing billing and collection of patient accounts, or as otherwise approved by the Hospital's CFO/CEO in consultation with Hospital's legal counsel.

TVH will comply with federal and state laws and regulations relating to emergency medical services and charity care.

TVH will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary TVH services.

In extenuating circumstances, the hospital may at its discretion approve charity care outside of the scope of this policy.

This policy is to be interpreted and implemented so as to be in full compliance with the Hospital Fair Pricing Act (Health and Safety Code Section 127400 et. seq.), the Hospital Fair Billing Program (22 Cal. Code of Regs. Section 96051 et seq.), and other laws and regulations governing the collection of amounts due from patients. All collection agencies working on behalf of TVH shall comply with Health and Safety Code Section 127400 et. seq. as amended and applicable TVH policies regarding collection agencies, including this policy.

III. Definitions:

"Charity Care" means free care, and refers to full financial assistance to qualifying Self-Pay Patients that relieves them of their financial obligation for medically necessary health care services.

"Discount(ed) Payment" or "Partial Discount" means any charge for care that is reduced but not free, and refers to partial financial assistance to qualifying patients that relieves them of their financial obligation in part for medically necessary health care services.

"Family Income" means the annual earnings of all members of the Patient Family as shown by recent pay stubs or income tax returns. "Recent income tax returns" are tax returns that document Family Income for the year in which the Patient was first billed or 12 months prior to when the Patient was first billed. "Recent paystubs" are paystubs within a 6-month period before or after the Patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

"Federal Poverty Level (FPL)" means the poverty guidelines based on income and family size as updated periodically in the Federal Register by the U.S. Department of Health and Human Services, published at Poverty Guidelines | ASPE.

"Financial Assistance" is a general term and includes patients who qualify for Charity Care or High Medical Cost Charity Care.

"Guarantor" means a person who has legal financial responsibility for the patient's health care services.

"High Medical Cost Charity Care" refers to a write-off of a High Medical Cost Patient's remaining financial responsibility after payment is made by a third-party source of payment for Medically Necessary Services (e.g. not a Self-Pay Patient), that relieves them of their financial obligation for Medically Necessary Services.

"A High Medical Cost Patient" means a person (i) whose Family Incomes does not exceed four hundred percent (400%) of the Federal Poverty Level; and (ii) whose out-of-pocket costs exceed the following:

- Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent (10%) of the patient's current family income or family income in the prior 12 months; or
- Annual out-of-pocket expenses that exceed 10 percent 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.
- Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal

cost sharing.

"Hospital Bill Complaint Program" means the state program which reviews hospital decisions about whether patients qualify for help in paying the Patient's Responsibility for healthcare services rendered. If a patient believes financial assistance was wrongly denied, then the patient may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

"Medically Necessary Service" means a medical service or treatment that is necessary to treat or diagnose a medical condition, the omission of which could adversely affect the patient's condition, illness or injury, and is not an elective or cosmetic surgery or treatment.

"Patient Family" means either of the following:

- For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the California Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not; or

- For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

"Reasonable Payment Plan" means monthly payments that are not more than ten percent (10%) of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, 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.

"Self-Pay Discount" is a discount provided to patients who do not qualify for Charity Care, a Partial Discount, or a High Medical Cost Charity Care and who do not have a third-party insurance carrier or whose insurance does not cover the service provided or who have exhausted their benefits.

"Self-Pay Patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, 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.

IV. Procedures:

Hospital shall provide Financial Assistance in the form of Charity Care and High Medical Cost Charity Care to qualified patients who have satisfied the eligibility criteria set forth in this

Policy. Hospital will further help patients in seeking assistance from any other available programs including the Federal and State-funded California Children's Health Insurance Program (CHIP), county programs, or grant programs, depending upon their specific circumstances. Patients are **not** required to apply for government program assistance in order to be eligible for Financial Assistance from TVH pursuant to this Policy. All patients, regardless of their ability to pay, will be treated fairly and with respect before, during, and after the delivery of healthcare.

This Policy relies upon the cooperation of individual applicant's accurate and timely submission of the financial screening information set forth in the procedures below. Financial Assistance is not to be considered a substitute for personal responsibility. Patients are expected to contribute to the cost of their care based on their individual ability to pay. Falsification of information about financial eligibility may result in the denial of an application for Financial Assistance.

Hospital shall provide emergency services to all individuals based solely on the individual's medical need in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and California law. There shall be no delay in providing a medical screening and stabilization services in order to inquire about an individual's insurance status or payment method.

An emergency physician who provides emergency medical services in a Hospital location that provides emergency care is also required by law to provide discounts to Self-Pay Patients or High Medical Cost Patients who are at or below 400% of the federal poverty level.

Patients with demonstrated financial need may be eligible for Financial Assistance if they complete an application and meet the eligibility requirements for Charity Care or High Medical Cost Charity Care as defined in this Policy. Patients who do not complete an application may be presumptively determined to be eligible for Financial Assistance using information provided by sources other than the patient or other individual seeking financial assistance in certain circumstances, as set forth in the Presumptive Eligibility procedures below. A patient who is presumptively determined to be eligible for Financial Assistance shall be eligible for the most generous available discount or charity care. Financial Assistance may be denied when the patient or other responsible party does not meet the requirements of this Policy.

Patients who indicate a financial inability to pay a bill for Medically Necessary Care shall be evaluated for Charity Care, High Medical Cost Charity Care, and/or coverage by a federal, state, or county program as applicable. The granting of Charity Care or High Medical Cost Charity Care shall be based on an individualized determination of Family Income, and shall not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, Health PAC, Victims of Crime, California Children Services, or an Affordable Care Act benefit plan. Hospital shall assist patients in exploring appropriate alternative sources of payment and coverage from public and private payment programs and to also assist patients in applying for such programs. However, if a patient applies, or has a pending application, for another health coverage program at the same time the patient applies for Charity Care or High Medical Cost Charity

Care, neither application shall preclude eligibility for the other program.

Annual Family Income of the applicant will be determined using recent income tax returns and/or recent pay stubs, as of the time the Medically Necessary Services were provided, or at the time of application for Charity Care and/or Financial Assistance. Financial Assistance applications are accepted at any time post-service by USPS mail to the mailing address or the fax number provided on the Financial Assistance application. The Financial Assistance Application may also be returned in-person to the Hospital. The patient will be required to submit the following information:

- Completed Financial Assistance application.
- Recent pay stubs as defined in this policy.
- Copy of recent Federal Income Tax Return (Form 1040) for the members of the Patient Family.

Application Process:

TVH shall display information about its charity care policy at appropriate access areas. A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for Financial Assistance, an application will be provided with instructions on how to apply. As part of this screening process TVH will assist the patient or the guarantor with determining whether they have exhausted or are not eligible for any third-party payment sources, provided that applying for government program eligibility is not a requirement for receiving Financial Assistance:

Where it is reasonable for TVH to conclude that the guarantor is an indigent person (homeless), then a prima-facie determination of eligibility may be made and, in these cases, TVH may not require an application or supporting documentation.

A patient (guarantor) is eligible to apply for charity care at any time upon submitting sufficient documentation to TVH to support a Financial Assistance determination.

Based upon documentation provided with the Financial Assistance application, TVH will determine if additional information is required, or whether a Financial Assistance determination can be made.

The failure of a guarantor to reasonably complete appropriate Financial Assistance application procedures shall be sufficient grounds for TVH to initiate collection efforts.

An initial determination of sponsorship status and potential eligibility for Financial Assistance will be completed as closely as possible to the date of service.

TVH will notify the patient (guarantor) of a final determination within fifteen (15) business days of receiving the necessary documentation.

The patient (guarantor) has the right to appeal the determination of ineligibility for Financial Assistance by providing relevant additional documentation to TVH's Central Billing Office within thirty (30) days of receipt of the notice of denial. The appeal shall be considered by the business manager, chief financial officer, or their designee.

All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the patient (guarantor). The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant.

Eligibility:

For Charity Care shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

- Presumptive Charity: There may be circumstances under which a patient's qualification for Charity Care may be established without completing the formal Financial Assistance application and/or providing the necessary and required documents for approval as set forth above. The Hospital may utilize other sources of information to make an individual assessment of financial need to determine whether the patient is eligible for Charity Care and approval. This information will enable the Hospital to make an informed decision on the financial need utilizing the best estimates available in the absence of information provided directly by the patient. Presumptive eligibility for Charity Care may be determined on the basis of individual life circumstances that may include:
    - Patient was granted Financial Assistance within the last 180 days.
    - Homelessness or receipt of care from a clinic serving those experiencing homelessness;
    - Participation in Women, Infants and Children (WIC) programs;
    - Eligibility for food stamps;
    - Eligibility for school lunch programs;
    - Living in low-income or subsidized housing; or
    - Patient is deceased with no estate or deceased and cannot identify patient's name or address.
- Self-Pay Charity Eligibility: A Self-Pay Patient with a Family Income at or below 400% of the FPL.
- High Medical Cost Patient Charity Care Eligibility: A High Medical Cost Patient with a Family Income at or below 400% FPL and either:

- annual Out-Of-Pocket (OOP) expenses incurred by the patient at this hospital that exceed the lesser of 10 percent of the patient's current Family Income or Family Income in the prior 12 months; or

- annual OOP expenses incurred with other healthcare providers that exceed 10 percent 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.

Financial Assistance:

For services rendered to patients on or after January 1, 2025, the Hospital shall offer the following (services rendered prior to January 1, 2025 shall be subject to the Financial Assistance Policy in effect at the time):

Charity Care - Self-Pay Patients with a verified Family Income at or below 400% of the most recent FPL will receive a full write-off of all charges for Medically Necessary Services.

High Medical Cost Patient Charity Care - High Medical Cost Patients with a verified Family Income at or below Four Hundred Percent (400%) of the most recent FPL will receive a full write-off of the patient's responsibility for Medically Necessary Services.

Partial Discount - Self-Pay Patients with a verified Family Income between 401% and 500% of the most recent FPL will receive an additional uninsured discount of all Self-Pay charges for Medically Necessary Services. For these patients, expected payment for services will be limited to the amount the Hospital would have received from Medicare.

Self-Pay Discount - Self-Pay Patients with gross incomes exceeding 500% of the FPL will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is less.

Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with the Hospital Fair Pricing Act, the Hospital Fair Billing Program, and the Federal PPACA (Patient Protection and Affordable Care Act) as follows:

- Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and all patient access areas.

- A Notice of Collection Practices shall be provided to all patients (guarantors) during registration and included in the final billing statement.

- This policy shall be widely publicized throughout the TVH including not limited to the TVH website and otherwise be made available upon request.

- Financial Questionnaires shall be available in all registration/ patient access areas.

- TVH staff including Admitting/Registration and Financial Counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third-party coverage, including private health insurance (Covered California Health Exchange), Medicare, Medicaid, and other state programs and assist patients in applying for coverage when appropriate.

Self-Pay bills shall include the following:

- Statement of Charges

- A request that the patient inform the hospital if the patient has insurance coverage and that if the patient does not have coverage that they may be eligible for Medicare, Healthy Families, Medicaid, insurance through the California Health Exchange, other state or county programs and charity.

- A statement indicating how the patient may obtain an application or apply for the aforementioned programs along with a referral to the local consumer assistance office at a local legal services office.

  Note: If the patient or patient's representative indicates the patient has no third-party coverage and requests a discounted rate or charity, the patient shall be provided with an application for the Medicaid program, Healthy Families program or other applicable state or county program.

- Information on the hospital’s financial assistance and charity program applications including a statement that if the patient lacks or has inadequate insurance and meets certain low-income requirements they may qualify for discounted payment or charity care. A telephone number for additional information on the hospitals discount payment and charity program should accompany this statement.

Patient eligibility with no application. Instances where a Financial Assistance Application is not required per charity definitions.

Treatment Authorization Request (TAR) denials, Medicaid non-covered services, and untimely Medicaid billing write-offs will be recorded with their respective adjustment codes. Medicare/Medicaid accounts are written off to a respective adjustment code to be captured for Medicare Bad Debt reimbursement.

Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.

For Medicare/Medicaid adjustments, that portion not claimed as Medicare bad debt reimbursement will be reclassified as charity.

A patient may be verified as homeless at any time during the revenue cycle. The Charity Care eligible portion of the account will be adjusted using adjustment code 88870852 — "Charity Discount."

TVH facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to pay and can submit the account for charity approval under the following circumstances:

- Self-Pay Patients with gross incomes at or below 400% of Federal Poverty Guidelines (FPG). The entire balance will be deemed charity.

- Self-Pay Patients with gross incomes in excess of 400% but less than 500% of FPG, may qualify for a Partial Discount. The liability for this income group in all cases will never be more than the expected reimbursement from Medicare.

- Self-Pay Patients with gross incomes in excess of 500% of the FPL, the patient's liability will be the self-pay discount rate in effect at time of service.

- High Medical Cost Patients with incomes less than 400% of the FPL and healthcare expenses exceeding 10% of annual income during the past 12 months will be eligible for full charity.

Patient Eligibility as established by financial need per Financial Questionnaire.

All TVH employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and must refer the patients for financial counseling.

Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family. In these instances, a Financial Questionnaire can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.

The Financial Questionnaire must be accompanied by proof of income in the form of either recent income tax returns or recent pay stubs, both as defined above. If none of these documents can be provided, TVH can consider any of the following documents:

- If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay.

- If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.

Patients may request a Financial Assistance Application by calling the Central Billing Office,

writing to the mailing address on their patient billing statement, or downloading the form from the TVH websites.

Patients completing Financial Questionnaire are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Questionnaire.

Financial Assistance Application Review/Approval Process:

For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any Central Billing Office employee. Standard transaction approval levels will apply.

A Financial Questionnaire must be reviewed by a financial counselor. If gross income is at or below 400% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income is required). If the gross income is more than 400% but less than 500% of FPL, an assessment for qualification of Partial Discount based on income will be made by the financial counselor with write-offs subject to standard approval levels.

Financial Questionnaire shall be reviewed and approved, denied or returned to the patient with a request for additional information within fifteen (15) business days of receipt.

Collection agency requests for charity or Financial Questionnaire received from a collections agency shall be reviewed by Central Business Office (CBO). The CBO shall follow the review process described in (b) above in determining ability to pay and approving Charity Care, High Medical Cost Charity Care, or Partial Discount.

If charity is approved, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor, including interest. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained, and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

Notification of charity determination:

For homeless charity write-offs, no notification is necessary.

In all instances where a Financial Questionnaire was submitted, the person approving the application shall submit a written determination of no charity, Partial Discount or full charity to the person who submitted the applications on behalf of the patient within fifteen (15) days of final determination of the completed application.

In the event Partial Discount or no charity is approved, the notification letter will advise that the patient may appeal the determination.

Appeals should be in writing to:

Temecula Valley Hospital
Attn: Patient Access Services
31700 Temecula Parkway
Temecula, CA 92592

The Central Billing Office shall respond to all charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be restarted to afford the patient ample opportunity to make payment, per the provisions of applicable state law.

If Partial Discount is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. Patients shall have the opportunity to negotiate an interest-free Payment Plan that would allow the Patient to pay their balance over time. If TVH and the Patient are not able to agree on the terms of a payment plan, the default Payment Plan shall be monthly payments that are not more than 10 percent (10%) of a Patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, 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.

The extended Payment Plan may be declared no longer operative after the Patient's or Guarantor's failure to make all consecutive payments due during a 90-day period starting with the first day that the Patient misses a payment. Before declaring the hospital extended Payment Plan no longer operative, TVH shall make a reasonable attempt to contact the Patient or Guarantor by telephone and to give notice in writing at least sixty (60) calendar days after the first missed payment that the extended Payment Plan may become inoperative, and of the opportunity to renegotiate the extended Payment Plan. Prior to the hospital extended Payment Plan being declared inoperative, TVH shall attempt to renegotiate the terms of the defaulted extended Payment Plan, if requested by the Patient or Guarantor. The Patient shall be given at least thirty (30) calendar days, starting from the date the written notice of the missed payment was sent, to make a payment before the extended Payment Plan is declared inoperative. For purposes of this, the notice and telephone call to the Patient or Guarantor may be made to their last known telephone number and address. If a Payment Plan is declared inoperative, and the Patient has qualified for Financial Assistance, TVH and any collection agency shall limit the amount it seeks from the Patient or Guarantor to the amount the Patient was responsible to pay after any discounts.

If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of the Hospital Fair Pricing Act and the Hospital Fair Billing Program, including not garnishing wages or placing a lien on a principal residence.

Processing of charity write-off:

If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.

The 100% charity discount percentage is then applied to the account, using existing adjustment codes.

A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to Partial Discount and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund within 30 days of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Overpayments of less than $5 are not required to be refunded. Should a Partial Discount account need to be referred to an outside agency for collection, the account will be flagged as a Partial Discount recipient so that the agency can assure that:

It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and

It will not report the delinquency to a credit-reporting agency until 180 days after the date of service, or 180 days after the patient received partial charity approval.

Refunds to Patients:

If TVH determines that a Patient qualifies for assistance under this Policy, and has paid TVH more than the amount that should be due from that Patient, TVH shall refund the amount paid to TVH in excess of the amount due including interest at the rate provided in the Code of Civil Procedure Section 685.010 from the date of TVH's receipt of the overpayment. Notwithstanding the foregoing, if the amount overpaid by the Patient is $5.00 or less, TVH shall not refund the overpayment or pay interest.