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EFFECTIVE DATE:

The effective date of this policy on Financial Assistance Program for Sierra View Medical Center (Charity Care) is January 1, 2025

PURPOSE:

Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to all persons within Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed in meeting the health care needs of all persons in the community. SVMC is committed to providing access to Financial Assistance programs on medically necessary services when patients are uninsured, underinsured, or may need help paying their hospital bill. These programs include government sponsored coverage programs, charity care, and discounted care. The purpose of this policy is to establish eligibility guidelines and within for the Financial Assistance Program (FAP) available at Sierra View Medical Center and to outline the process for detaining eligibility.

AFFECTED AREAS/PERSONNEL: *FINANCIAL COUNSELORS, PATIENT ACCESS & PATIENT FINANCIAL SERVICES*

DEFINITIONS:

1. **Charity Care** defined as health care services provided at no charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for the care, who qualify free care under the eligibility guidelines specified in this policy.
2. **Discounted Care** defined as health care services provided with a partial discount or reduced charge to patients who do not have adequate financial resources or other means to pay for care; who qualify for a discounted payment under the eligibility guidelines specified in this policy.
3. **Essential Living Expenses** for the purpose of this policy, expenses for all of the following; as applicable to the applicant. Mortgage/rent payment and maintenance, food, house supplies, utilities, telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including auto instalment payments, auto insurance, gas and repairs), laundry and other extraordinary expenses.
4. **Family** defined as follows:

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A. For persons 18 year of age and older, the patient's family includes the patient's spouse, domestic partner, dependents children under 21 years of age, whether living at home or not, and dependent children of any age, if the child(ren) is disabled.

B. For patients under 18 years of age, or patients who are 18-20 years of age and are a dependent child, the family includes the patient's parent, caretaker relatives, other children under 21 years of age of the parent or caretaker relative, dependent children of the patient's parents or caretaker relatives if those children are disabled.

5. Financially Qualified Patients are eligible for assistance under this policy in the following category:

A. Self-Pay Patient are patients who do not have third party insurance, Medi-Cal, Medicare, or other payment source who do not have a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined by Sierra View Medical Center.

B. Under-insured Patient are patients with high medical cost who have insurance or health coverage but have a remaining patient responsibility balance that they are unable to pay. Patient responsibility balance include deductibles, coinsurance, that constitute high medical costs.

C. Exhausted Benefits where patients with insurance whose benefit limit under insurance have been exhausted prior to admission or whose insurance has denied stays, denied days of care, or refused payment for medically necessary services.

D. Patients who are eligible for Medi-Cal, Medicare, California Children's Services and any other applicable state or local low-income programs who do not receive coverage or payment for all services or for the entire stay.

6. High Medical Cost are defined as annual out-of-pocket medical costs incurred at Sierra View Medical Center that are not reimbursed by insurance or a health coverage program, such as

A. Medicare copays

B. Medi-Cal cost sharing

C. The high medical costs incurred by the patient that exceed 10 percent of the Patient's Family Income in the prior 12 months, or annual out-of-pocket medical expenses incurred in the prior twelve (12) months that exceed 10% of the Patient's Family income.

7. Federal Poverty Level is define as the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority.

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POLICY:

In accordance with Sierra View Medical Center’s mission and values, we strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. Charity care will not be abridged on the basis of age, sex, race, creed, disability, national origin, sexual orientation, gender identity, or financial status. The Financial Assistance Policy will apply to all patients who receive medically necessary services at SVMC. SVMC recognize that the need for financial assistance is a sensitive and deeply personal issue for recipients. SVMC values’ guide staff training and the selection of personnel who implements this policy are committed in maintaining confidentiality of information and individual dignity for all who seek charity care.

Financial assistance is based on income and family size as defined by Federal Poverty Income Guidelines. SVMC provides all patients a written notice about the availability of our charity care and discount care policy, including information about eligibility and contact information to the financial counseling department. This notice also includes how to find our shoppable services and the contact information to the Consumer Alliance; an organization that helps patients understand the billing and payment process, as well as provides information regarding Covered California and Medi-Cal presumptive eligibility. Any member of the medical staff, any employee, the patient, patient family, community advocate or any other responsible party may request financial assistance from SVMC.

Financial Assistance Program is comprised of Charity Care (free care) and Discounted Care. Charity care is available for medically necessary care; charity is not generally available for non-medically necessary, specialized, high-cost services (i.e. experimental, elective etc.). Exceptions maybe made with certain cases with administrations approval. SVMC will actively assist patients in pursuing alternative source of payment from third parties. Those individual of families who qualify for alternative programs and services within the community but refuse to take advantage of them, will not be covered by this policy. SVMC will make reasonable efforts presumptively determine financial assistance eligibility based on prior eligibility charity care or the use of third party to identify charity care.

Charity Care

A full write-off of all balances due from a patient, whether the patient is insured, underinsured or self-pay, shall be granted to those financially qualified patients whose family income is up to 200% of the most recent Federal Poverty Guidelines.

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SVMC presumes qualified for charity care any patient who can provide proof that they are eligible for or in a public benefits program such as CalWORKS, CalFresh, SSI/SSP, Medicare Savings Program, WIC, or general assistance/general relief.

Discounted Care

Discounted Care will be granted to financially qualified patients earning between 201% and 400% of the Federal Poverty Level based on the most recent Federal Poverty Guidelines. For these patients, expected payment for services will be limited to the amount SVMC would have received from Medicare.

In determining what if any payment is due from a patient with insurance, the expected payment amount will be compared to the amount paid by their third-party insurance. If the amount paid by the third-party insurance is greater than the expected payment, no payment will be sought from the patient. If the expected payment is greater than the payment received from the third-party insurance, and the patient has a remaining patient responsibility amount, the difference in payment will be sought from the patient subject to a determination of eligibility for financial assistance.

How to Apply

All patients will be notified of the Financial Assistance Policy and how to access the Financial Assistance Application. Patients may request financial assistance application in person by visiting SVMC at 465 W. Putnam Ave in Porterville California 93257, over the phone by calling Financial Counselors at (559) 788-6002 or (559) 788-6143, email by sending written request to financialcounseling@sierra-view.com, or download the application from Sierra View website at <https://www.sierra-view.com/patients-visitors/billing>. Documentation required to determine eligibility is included on the application.

The application will be available in English and Spanish, and any other language deemed necessary available in Registration or Patient Accounting area. For patient who speak a language other the English or Spanish, or who need other accessibility accommodations, SVMC will provide appropriate language accommodations free of charge.

SVMC determines eligibility for financially qualified patients in accordance with this policy and applicable state and federal laws. A patient, or patient's legal representative, who requests financial assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. SVMC may consider the failure to provide this information in making its determination. The information provided for the application will only be

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used in reaching a determination of Financial Assistance and will not be used for collection activities.

Financial assistance application only applies to charges or services provided by SVMC. Emergency and other non-employed physicians providing emergency services in SVMC are required to provide discounts to financially qualified patients whose family incomes are at or below 400 percent of the Federal Poverty Guidelines. At the patient's request, SVMC will advise patients to apply for charity care to the physician's billing company upon the patient's receipt of a bill for services from that billing company. This statement shall not be construed to impose any additional responsibilities upon SVMC.

A patient's status or claims with respect to worker's compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care, may be taken into consideration when evaluating the patient's eligibility for charity care or discount payments.

Governmental Assistance

The SVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for charity care or discount care assistance. SVMC makes all reasonable effort to determine whether medical care may be fully or partially paid for under other private or public health insurance. Consideration include coverage offered through private health insurance, Medi-Cal, Medicare, California Children's Services, the California Health Benefit Exchange (Covered California) or other county-funded programs. SVMC will provide application of program when patient is identified as potentially eligible for Medi-Cal or any other coverage.

An application is provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care. A patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount care. Any patient who requests financial assistance will be asked to complete a financial assistance application.

Eligibility Guidelines

SVMC used the following to determine financially qualified recipients and the amount of charity extended 1) Patient Income, 2) Patient Family Size and 3) The Federal Poverty Guidelines as established by Health and Human Services are used to determine the annual income guidelines and limits. This will require the patient, guarantor or representative to submit:

1. A true, accurate, and complete confidential Financial Assistance application.
2. Acceptable income verification, such as recent payroll stubs, tax returns, or other items or verifications. If the patient is unemployed or does not receive payroll

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stubs; a written statement of need must be provided, by the patient or the patient's representative, attesting to their income and employment status as part of their application.

3. Other sources of payment for services rendered; to aid in determining charity care in relation to the amount due after applying all other resourced of payment.

Charity Eligibility Period

Charity care may be determined at any time SVMC is in receipt of the financial assistance application with all necessary documentation and information. While it is preferred that patient be screened for charity care prior to third-party collections, they be screened at any time. Once Financial Assistance is granted, services in the six-month period following the approval will also remain eligible for charity care or discount charity. However, if over the course of six-months period the patient's family income or insurance status changes to such an extent that the patient may be ineligible for free or discount care, the patient has an obligation to report those changes to SVMC. Once ineligible a new charity care application is required. A new charity care application is necessary after the six-month eligibility period has expired. There is no limit on the number of times a person may request financial assistance.

Charity Care Determination Time Requirements

Every effort is made to determine a patient's eligibility for charity care as soon as possible. While it is desirable to determine the amount of charity care for which the patient is eligible as close to the time of service as possible, there is no limit on the time when an application or the eligibility determination is made. A determination will be postponed while insurance or other sources of payment are still pending. The timeframe to make a decision on an application will be extended if the patient has a pending appeal for coverage of the services, until a final determination of that appeal is made. The patient shall make a reasonable effort to communicate with SVMC about the progress of any pending appeals. For purposes of this section, "pending appeal" includes any of the following:

1. A grievance or appeal against a health plan
2. An independent medical review
3. A fair hearing for a review of Medi-Cal eligibility or claims
4. An appeal regarding Medicare coverage consistent with federal law and regulations

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The timeframe to make a decision on an application may also be extended if a patient is attempting to qualify for coverage under any third-party insurance, Medi-Cal, or Medicare, or if the patient has a pending claim with respect to workers' compensation, automobile insurance, or other insurance, including potential payments from pending litigation or third-party liens related to the incident of care.

Discount Care Payment Plans

In the event a Financially Qualified Patient still has a remaining balance after payment has been received from third-party payers and an application for financial assistance has been processed, expected payment for services will be limited to the amount SVMC would have received from Medicare.

The hospital and the patient shall negotiate the terms of the payment plan and take into consideration the patient's household income, essential living expenses, and the availability of a health savings account of the patient or the patient's family. If the hospital and the patient cannot agree on the payment plan, the hospital shall create a payment plan where monthly payments will not be more than 10 percent of a patient's household income for a month, excluding deductions for essential living expenses.

If a patient defaults in making regular payments, Sierra View Medical Center makes reasonable efforts to contact the patient by phone and in email/writing, giving notice that the extended payment plan may become invalid. An attempt at renegotiating the payment plan will be done at the request of the patient or their guarantor. SVMC initiates collection efforts only after reasonable efforts to contact the patient have failed and after 90 days of non-payment. SVMC does not report adverse information to a credit-reporting bureau.

Who Grants Charity Care

Sierra View Medical Center personnel according to the following levels of authority approve financial assistance:

Financial Counselor: Accounts less than \$5,000

Patient Financial Services Manager: Accounts less than \$10,000

Director of Revenue Cycle: Accounts less than \$25,000

Chief Financial Officer: Accounts greater than \$25,000

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Once a determination is made, a notification letter will be sent to each applicant advising him or her of the decision. SVMC keeps financial assistance records for ten years and are ready available.

Special Circumstances

SVMC may grant charity care in special circumstance to those who would not otherwise qualify for assistance under this policy. SVMC will document the reason charity care was extended and why the patient did not meet. Presumptive charity is approved due to but not limited to the following:

1. Social Diagnosis (i.e. homeless, etc.)
2. Bankruptcy
3. Deceased with no known an estate
4. When collection agency assignment would not result in resolution of the account
5. Collection agency determines the account(s) as uncollectible in accordance with SVMC financial assistance policy

Other Eligible Circumstances

SVMC deems those patients that are eligible for government sponsored low-income assistance program (e.g., Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low income program) to be indigent. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g., CHDP, and CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care. All Service Authorization Request (SAR) denied due to attending physician is not CCS paneled under the California Children Services (CCS) program will qualify for charity care.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by

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insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

1. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

On rare occasions, a patient's individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their SVMC bill. In these situations, with the approval of management, part or all of their cost of care may be written off as charity care.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital within thirty days of notification of denial. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all-additional relevant documentation to support the patient's claim should be attached to the written appeal.

The review process shall consist of this level of management:

1. First Level: Patient Financial Services Manager
2. Second Level: Director of Revenue Cycle

Public Notice/Posting

SVMC shall post notices informing the public of the Charity Care and Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas, observation units, where patient may pay their bill or other common outpatient areas of the hospital.

Notice posted include English and Spanish (LEP) plain language statement indicating SVMC has a financial assistance policy, for low-income uninsured or underinsured patient who may not be able to pay their bill. The policy provides charity care or discount care write-off or payment plan in a manner consistent with all the applicable federal and state laws and regulations. How to contact Financial Counseling department for more information about the financial assistance policy and how to request or find the financial assistance application. Where to find financial assistance information on SVMC website. The internet address for the Health Consumer Alliance (<https://healthconsumer.org/>), an organization that helps patients understand the billing

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and payment process, as well as provides information regarding Covered California and Medi-Cal presumptive eligibility. For patient who speak a language other the English or Spanish, or who need other accessibility accommodations, SVMC will provide appropriate language accommodations free of charge by contacting Financial Counseling department.

SVMC provides this same written notice upon admission or discharge to every patient. If the patient leaves the facility without receiving the written notice, SVMC will email or mail the notice within 72 hours of providing services.

Collection Guidelines

SVMC will make reasonable attempts to obtain insurance information. SVMC statements includes language telling the patient that he or she may be eligible for coverage offered through the California Health Benefit Exchange and other state or county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children’s Services, and the phone number to the Financial Counseling Department. Calls to obtain insurance information or set up a payment plan with patients may be made.

If a patient indicates they are unable to pay, the patient will be referred to a Financial Counselor to assist them with applying for health coverage, to include the California Health Benefit Exchange and other state-or-county-funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children’s Services along with the SVMC Financial Assistance program. Accounts with not be sent to collections agency if the patient is in the process of applying for financial assistance. If the patient does not comply with requests for information or refuses to provide SVMC with information, the account can be sent for collections no sooner than 180 days after initial billing. Prior to sending the account to collections, a notice (goodbye letter) along with a charity application, name of the collection agency whom the account will be referred to, along with information on how to receive help will also be included in the final notice to the patient.

External Collection Agencies

Collection agencies are responsible for complying with all state and federal laws pertaining to fair collection of debit, SVMC financial assistance policy and SVMC collection policy.

An account placed with an outside collection agency can be considered for charity care at any time in accordance with SVMC financial assistance policy. When, during the

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collection process, a patient asserts they cannot afford to pay the debt, has failed to make previously agreed upon extended payments, or is otherwise identified by the collection agency as meeting SVMC charity care eligibility criteria, the collection agency will refer the account to SVMC to screen for charity care eligibility. All accounts returned from a collection agency, the financial counselor department will undertake reasonable efforts to gather eligibility information from the patient. If, after such reasonable efforts, the patient fails or refuses to provide required information, the account will be referred back to the collection agency.

If the patient complies and granted charity, SVMC will evaluate the patient's financial status over the previous eight months to determine eligibility for financial assistance. SVMC will refund financial qualified patients for the amount actually paid over \$5.00, if any, in excess of the amount due for debt related to care received from SVMC. Interest will apply for refunds beyond 30 days. An evaluation of any payments made during the previous eight months, when the patient would have been financially eligible for charity, will be conducted identify any possible overpayment in excess of the amount due prior. If the patient is eligible for discounted care, any outstanding balance the patient owes will be reduced according to the discounted care. Any payments the patient made while eligible for discounted care will be applied to any amount due from the patient; any amount the patient paid in excess of the discounted care amount due in that month shall be reimbursed. Payments made for debt related to care received from SVMC at a time when the patient was not eligible for Financial Assistance shall not be reimbursed.

REFERENCES:

- Code of Federal Regulations Title 26 section 1-501
- California Health and Safety Codes Section 127420, 124345, 124345, 127400, 127405, 127410, 127420, 127425, 127426 & 127452
- Assembly Bill 774.
- Assembly Bill 297.
- Assembly Bill 1020
- Assembly Bill 297
- Senate Bill 1061
- Senate Bill 1276