Palomar Health Rehabilitation Institute Financial Assistance Policy

PURPOSE

Palomar Health Rehabilitation Institute (PHRI) strives to provide quality patient care and high standards for the communities we serve. This policy demonstrates PHRI's commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between a Health System and a third-party payer, nor is the policy intended to provide discounts to a non-contracted third-party payer or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person or insured.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code (IRC) as well as California Health & Safety Code section 127400 et seq. (AB 774 and AB1503), Hospital Fair Pricing Policies, effective January 1, 2007 and Emergency Physician Fair Pricing Policies, effective January 1, 2011, and January 1, 2015 (SB1276) and Office of Inspector General (OIG), Department of Health and Human Services guidance regarding financial assistance to uninsured and underinsured patients. This policy only applies to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for discounted payment. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance. The financial screening criteria provided for in this policy are based primarily on the Federal Poverty Level (FPL) guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

POLICY

A. This policy is designed to support charity care or discounted payments to patients who qualify.

B. Patients with demonstrated financial need may be eligible for Charity Care or Discounted payment.

C. This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout PHRI. If application of this policy conflicts with payer contracting or coverage requirements consult with PHRI legal counsel.

D. This policy excludes services separately billed physician services

E. This policy will not apply to Financial Assistance Applications if the patient/responsible party provides false information about financial eligibility.

DEFINITIONS

A. Charity Care Patient--A Charity Care Patient is a financially eligible self-pay patient.
B. Charity care" means free care.
C. "Discounted payment" or "discount payment" means any charge for care that is reduced but not free.
D. Emergency Care and Emergency Physician: PHRI does not have an Emergency Department and does not have Emergency Physicians. Patient will not receive an Emergency Department or Emergency Physician Bill.
E. Extraordinary Collection Action (ECA)—A list of collection activities, as defined by the IRS and Treasury, that healthcare organizations may only take against an individual to obtain payment for care after reasonable efforts have been made to determine whether the individual is eligible for financial assistance.

1. Placing a lien on an individual's property.

2. Foreclosing on real property.

3. Attaching or seizing an individual's bank account or other personal property.

4. Commencing a civil action against an individual or write of body

attachment for civil contempt.

5. Causing an individual's arrest.

6. Garnishing wages.

7. Reporting adverse information to a credit agency.

8. Deferring or denying medical necessary care because of nonpayment of a bill for previously provided care under PHRI's Financial Assistance/Charity Care Policy.

9. Requiring a payment before providing medical necessary care because of outstanding bills for previously provided care.

F. Federal Poverty Level (FPL) – Poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services, published at http://aspe.hhs.gov/poverty

G. High Medical Cost Patient--A financially eligible High Medical Cost patient is defined as follows:

1. Not Self-Pay (has third party coverage)

2. Patient's Family income at or below 400 percent of the FPL.

3. Out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) exceed 10 percent of Patient's current family income or family income in the prior 12 months (if documentation provided).

4. Patient does not otherwise receive a discount as a result of third-party coverage for the services to be billed.

H. Medically Necessary Service--A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an

elective treatment.

I. Patient's Family: The patient family shall be determined as follows:

1. Adult Patients: For patients eighteen (18) years of age and older (except for dependent children aged 18-20, addressed below) the patient family includes their spouse, domestic partner, dependent children under twenty-one (21) years of age, and a dependent child of any age if the dependent child is disabled. Children meeting the criteria in this subsection are considered part of the family whether living at home or not.
2. Dependent Child Age 18-20: For patients who are dependent children age eighteen (18) to twenty (20), inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under twenty-one (21) years of age, or any age if disabled.
3. Minor Patients: PHRI does not serve patients under eighteen (18) years of age.
4. Includes spouse or domestic partner; dependent children under 21; and dependent disabled children of any age. For dependent children aged 18–20, "patient's family" is defined per statute.

J. "Reasonable payment plan"- Monthly payments that are not more than 10 percent 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 childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

K. Self-Pay patient--A financially eligible Self-Pay patient is defined as follows:

1. No third-party coverage.

2. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay.

3. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third-party liability as determined and documented by the hospital.

LANGUAGE ASSISTANCE

(All policy and application documents can be provided with translation assistance and or ADA video accommodation through AMN: 844-619-1402 www.stratusvideo.com)

COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

A. Responsibility: Admitting, Patient Financial Services, Billing Office

B. Patients will be provided with written notice with their bill that contains information regarding the hospital's financial assistance policy, including information about eligibility, as well as contact information for a hospital office from which the patient may obtain further information about these policies. At the time of service, notices are to be given to patients that do not appear to have third party coverage, by the Admissions Department. Notices should be provided in English and in languages as determined by PHRIs' geographical area.

C. PHRI Patient Financial Services shall publish policies and train staff regarding the availability of procedures related to patient financial assistance.

D. Notice of our Financial Assistance Policy will be posted in conspicuous places throughout the hospital. Physical posting locations includes Admissions, Billing Office lobby, main entrance, discharge area.

E. The Financial Assistance Policy will be posted on PHRI's website and in 16 languages as determined by PHRI's geographical area upon request. PHRI provides free language assistance and auxiliary aids (braille, large print, audio, accessible electronic formats) upon request.

F. PHRI website footer will include **Help Paying Your Bill** linking to the FAP page; the page will contain **Eligibility**, **How to Apply**, downloadable **application** (English + threshold languages), and **shoppable services / pricing transparency** links.

ELIGIBILITY PROCEDURES

A. Responsibility: Admitting/Registration & Patient Financial Services

B. Every effort will be made to screen all patients identified as uninsured or in need of financial assistance for admission for the ability to pay and/or determine eligibility for payment programs, including those offered through PHRI. Screened patients' financial information will be monitored as appropriate. Screened patients will be provided assistance in assessing patient eligibility for Medi-Cal or any other third party coverage.

C. Patients without third party coverage will be financially screened for eligibility for state and federal governmental programs as well as charity care funding at the time of service or as near to the time of service as possible. If the patient does not indicate coverage by a third- party payer, or requests a discounted payment or charity care, the patient should be provided with information on how to obtain an application for the Medi-Cal program or state funded governmental program before the patient leaves the hospital.

D. High Medical Cost patients with third party coverage will be screened by the Admitting Department or Patient Financial Services to determine whether they qualify as a High Medical Cost patient. Upon patient request for financial assistance, the patient will be informed of the criteria to qualify as a High Medical Cost patient and the need to provide receipts if claiming services rendered at other providers in the past twelve months. It is the patient's decision as to whether they believe that they may be eligible for financial assistance and wish to apply. However, the hospital must ensure that all information pertaining to the Financial Assistance Policy was provided to the patient.

E. The Financial Assistance Application is used to determine a patient's ability to pay for services at PHRI. This form will also be used for review of financial assistance.

F. All uninsured patients will be offered an opportunity to complete a Financial Assistance Application.

G. The Financial Assistants screening will be performed by Patient Financial Services. It is the patient's responsibility to cooperate with the information gathering process.

H. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations.

ELIGIBILITY FOR 100 PERCENT FINANCIAL ASSISTANCE

A. Patients who:

1. Have family incomes at or below 400 percent FPL.

2. Are uninsured, are ineligible for third party assistance or is a high medical cost patient will be extended a 100 percent discount on services rendered.

3. If unable to make contact with a patient, prior to being referred to an outside agency for collection, an Experian review will be completed. If the patient's financial status meets criteria, a discount will be extended.

B. The Financial Assistance Application should be completed for all patients requesting financial assistance.

C. Criteria and process to determine a patient's eligibility for a 100 percent discount are as follows:

1. Patient's Family income is verified not to exceed 400 percent of the FPL with the most recent filed Federal tax return or recent paycheck stubs.

2. High Medical Cost patients with third party coverage who are below 400 percent of the FPL with medical costs in excess of 10 percent of the patient's family annual income will be extended a 100 percent discount payment on services rendered.

3. High Medical Cost patients will be evaluated monthly for eligibility determination, and their status will be valid for the current month or most current service month.

4. Patient Financial Services may -- under unusual circumstances -- extend financial assistance to individuals who would not otherwise qualify for discounts under this policy. When such an award is made, the unusual circumstances justifying the award of charity care will be documented in writing and maintained by Patient Financial Services.

5. Hospitals shall not consider monetary assets in determining eligibility for charity care or discounted payment. Health savings accounts may be considered when negotiating payment plans.

REVIEW PROCESS

A. Responsibility: Admitting/Registration and Patient Financial Services

B. Requirements above will be reviewed and consistently applied throughout PHRI in making a determination on each patient case.

C. Information collected in the Financial Assistance Application may be verified by PHRI.

D. Any patient, or patient's legal representative, who requests a charity care or discount payment under this policy shall make every reasonable effort to provide the hospital with documentation of income and all health benefits coverage. Failure to provide information will result in a denial.

E. Eligibility will be determined based on Patient's Family income.

F. The Financial Assistance Application will be required each time the patient is admitted and is valid for the current admission plus any other outstanding patient liability at PHRI at the time of determination.

G. Patients who are homeless or expire while admitted to PHRI and have no source of funding or responsible party or estate may be eligible for charity care even if a financial assistance application has not been completed. All such cases must be approved by the Patient Financial Services Director or their designees.

H. Patient will be notified in writing of approval or reason for denial of charity care or

discount payment eligibility in languages as determined by PHRI's geographical area pursuant to federal and state laws and regulations.

I. For High Medical Cost patients with third party coverage, it may be necessary to wait until a payer has adjudicated the claim to determine patient financial liability.

J. Documentation is limited to recent tax returns (for year first billed or the prior 12 months) and recent pay stubs (within 6 months before or after first billing or, for preservice, when the application is submitted). If unavailable, hospital may accept other forms of documentation but cannot require them.

PATIENT BILLING AND COLLECTION PRACTICES

A. Responsibility: Patient Financial Services

B. Patients who have not provided proof of coverage by a third party at or before care is provided will receive a statement of charges for services rendered at the hospital. Included in that statement there will be a request to provide the hospital with health insurance or third-party coverage information. An additional statement will be provided on the bill that informs the patient that if they do not have health insurance coverage, the patient may be eligible for Medi-Cal or charity care.

C. Patient's request can be communicated verbally or in writing and a Patient Financial Information Form will be given/mailed to patient/guarantor address. Written correspondence to the patient shall also be in the languages as determined by PHRI's geographical area pursuant to federal and state laws and regulations.

D. If a patient is attempting to qualify for eligibility under the hospital's financial assistance policy and is attempting in good faith to settle the outstanding bill, the hospital shall not send the unpaid bill to any collection agency or other assignee unless that entity has agreed to comply with this policy.

E. Patients are required to report to PHRI any change in their financial information promptly.

F. Information obtained from the tax returns or paystubs collected for the discount

payment or charity care eligibility determinations will not be used for collection activities.

G. For financially eligible Charity Care or discount payment patients, prior to commencing collection activities against a patient, the hospital and its agents will provide a notice containing a statement that non- profit credit counseling may be available and containing a summary of the patient's rights.

H. Bills that are not paid 120 days after the first post-discharge billing statement may be placed with a collection agency under the authority of the PHRI Director of Finance.

I. The patient or the patient's guarantor can apply for help with their bill any time during the collection process.

J. It is the policy of PHRI to not engage in Extraordinary Collection Action (ECA). If in the future PHRI were to change its policy PHRI will comply with the guidelines under 501(r) that states the patient will receive a 30 day written notification of the ECAs PHRI intends to take.

K. PHRI and its agents do not engage in Extraordinary Collection Action and, beginning January 1, 2025, will not report medical debt to credit agencies or place liens on any real property.

L. PHRI or its contracted collection agencies will undertake reasonable collection efforts to collect amounts due from patients. These efforts will include assistance with application for possible government program coverage, evaluation for charity care, offers of no-interest payment plans, and offers of discounts for prompt payment. Neither PHRI nor its contracted collection agencies will impose wage garnishments or liens on primary residences except as provided below. This requirement does not preclude PHRI from pursuing reimbursement from third party liability settlements or other legally responsible parties.

M. Agencies that assist the hospital and may send a statement to the patient must sign a written agreement that it will adhere to the hospital's standards and scope of practices. The agency must also agree to:

1. Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time.

2. Not use wage garnishments, except by order of the court upon noticed motion, supported by a declaration file by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

3. Not place liens on primary residences.

4. Adhere to all requirements as identified in Health & Safety Code Section 127400 et seq.

5. Adhere to all notification requirements of the 501(r)

N. The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. Hospital will refund any amount actually paid in excess of the amount due over $5.00, including interest, within 30 days of determination.

APPEALS/REPORTING PROCEDURES

A. Responsibility: Patient Financial Services

B. In the event of an eligibility dispute or denial, a patient may seek review from PHRI Director of Finance, and the Central Billing Office. The Vice President of Revenue Cycle will review a second level appeal.

C. Eligibility disputes will be reviewed by the Chief Financial Officer (CFO) or Director of

Finance; patients may submit written appeals within 15 business days of denial.

D. The Financial Assistance policy shall be provided to the Department of Health Care Access and Information at least annually on January 1, or with significant revision. If no significant revision has been made by PHRI since the policies and financial information form was previously provided, the Department of Health Care Access and Information will be notified that there has been no significant revision.

RESPONSIBILITY

Questions about the implementation of this policy & financial assistance should be directed to the PHRI Director of Finance at (442) 277-6202.

PHRI reserves the right to make exceptions to this policy on a case-by-case basis.

EXHIBIT 1

Date: _____

Patient Name: _____

Account Number: _____

Dates of Service: _____

_____ Your application for financial assistance has been approved in the amount of _____%. This allowance will be applied to the Hospital charges remaining after all applicable insurance benefits have been paid. This allowance does not apply to your physician's bill or non-covered items such as private room, take home items, etc. The balance remaining, after financial assistance has been applied, must be paid by cash, personal check or money order. Please contact the Patient Accounts Department regarding your choice of payment options.

Your current balance after financial assistance is $: _____.

_____ Your application for financial assistance has been denied. Your level of income is higher than the standard level used to compute our financial assistance allowance.

If you have any questions, please call Marilyn Sharp @ 442-277-6202 8:30 a.m. 4:30 p.m. PST, email, Marilyn.Sharp@palomarhealthrehabinstitute.com, or the hospital at toll-free 442-277-6100 Monday through Friday, 8:30 a.m. to 4:30 p.m. PST.

Sincerely,

Patient Accounts Department; Monday – Friday (8:30 a.m. to 4:30 p.m.)