ANAHEIM GLOBAL MEDICAL CENTER CHAPMAN GLOBAL MEDICAL CENTER HEMET GLOBAL MEDICAL CENTER MENIFEE GLOBAL MEDICAL CENTER ORANGE COUNTY GLOBAL MEDICAL CENTER SOUTH COAST GLOBAL MEDICAL CENTER VICTOR VALLEY GLOBAL MEDICAL CENTER POLICY AND PROCEDURE			
Title:	**CHARITY CARE/DISCOUNT CARE POLICY**		
Manual:	**BUSINESS OFFICE PROCEDURE MANUAL**	**Policy No.:**	02.06.02
Original Date: 3/08/2005	**Revised Date:** 08/07/2017, 12/8/2022, 02/02/2023, 12/30/2024	**Reviewed Date:** 4/01/2015	

PURPOSE:

The purpose of this Policy is to define the criteria that will be used by the Facilities above (each a "Facility") to comply with the requirements of the California Hospital Fair Pricing Policies Act.

SCOPE:

This policy applies to the cost of services for medically necessary services provided by the Facility to patients who meet the requirements for charity care or discounted payment. Unless otherwise specified, this policy does not apply to services provided by physicians or other medical providers, including, without limitation, emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a patient's bill from the Facility. This policy does not create an obligation for the Facility to pay for such physicians' or other medical providers' services. In California, an emergency physician who provides emergency services in a hospital is required to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

DEFINITIONS:

Charity Care: Charity care is defined as medically necessary inpatient or outpatient hospital services provided at no cost to a patient who (1) is an Uninsured Patient or a Patient with High Medical Costs, (2) has an income equal to or less that 200% of the current applicable federal poverty guideline ("FPG") and (3) has established qualification in accordance with requirements contained in this policy.

Discount Payment: A discount payment is defined as any charge for care that is reduced but not free that results from any medically necessary inpatient or outpatient hospital service provided to a patient who: (1) desires assistance with paying their hospital bill, (2) is Uninsured or is a Patient

with High Medical Costs, (3) has an income from 201% to 400% of the applicable FPG; and (4) who has established qualification in accordance with requirements contained in this policy.

Federal Poverty Guidelines ("FPG"): The Federal Poverty Guidelines are guidelines issued and updated periodically by the United States Department of Health and Human Services that establish the gross income eligibility criteria (based on family size) for Charity Care and Discount Payment status as described in this policy.

Good Faith Estimate: An amount quoted by Facility Registration staff that represents a reasonable approximation of the actual price to be paid for services received by the patient at the Facility. If a Good Faith Estimate is reasonably required, Registration staff will make their best reasonable efforts to develop and quote a Good Faith Estimate, however, registration staff may not be able to fully predict the actual medical services that will subsequently be ordered by the patient's attending, treating or consulting physician(s).

Medically Necessary Services: Financial assistance under this policy shall only apply to medically necessary services which are services or supplies determined to be proper and needed for the diagnosis, direct care or treatment of the medical condition and meet the standards of good medical practice in the medical community. Financial assistance is excluded under this policy for services that are not medically necessary including, but not limited to, unique services where medically efficacious alternative therapies are available. Examples of excluded services include, but are not limited to, the following: cosmetic and/or plastic surgery services or other services that are primarily for patient comfort and/or patient convenience.

Patient with High Medical Costs: A patient is considered to have high medical costs if he or she has (1) a family income equal to or less than 400% of the applicable FPG and (2) meets one of the following criteria:

(a) Annual out-of-pocket medical expenses incurred by the individual at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months, or

(b) Annual out-of-pocket medical expenses that 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.

"Out of pocket medical expenses" mean 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.

Patient's Family: A patient's family means the following:

1. For persons 18 years of age and older, a patient's family means a spouse, domestic partner (as defined in Section 297 of the Family Code) or dependent children under 21 years of age, or any age if disabled, whether living at home or not.

a. Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
   (1) Both persons have a common residence.
   (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
   (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
   (4) Both persons are at least 18 years of age.
   (5) Either of the following:
      (A) Both persons are members of the same sex; or
      (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
   (6) Both persons are capable of consenting to the domestic partnership.

2. For persons under 18 years of age, or for a dependent child 18 to 20 years of age, a Patient's family means parents, caretaker relatives and other dependent children under 21 years of age, or any age if disabled, of a parent or caretaker relative.

Qualified Payment Plan: A payment plan established for a patient who has qualified for a Discount Payment through this Policy is classified as a Qualified Payment Plan. A Qualified Payment Plan shall have no interest charges applied to any or all balances due from the patient/guarantor. In the event that the Facility and the patient/guarantor cannot reach agreement on terms for a Qualified Payment Plan, the Facility shall use the formula described in Health & Safety Code Section 127400(i) to establish terms for a "reasonable payment plan," as defined in the statute.

Uninsured Patient: An Uninsured Patient is 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 Facility.

POLICY:

I. Charity Care/Discount Payment Qualification: If a patient qualifies pursuant to this policy, financial assistance in the form of Charity Care or a Discount Payment may be granted to the patient. If a person requests charity care or a discount payment and fails to provide information that is reasonable and necessary for the Facility to make a

determination, the Facility may consider that failure in making its determination. Financial assistance may be denied when the patient/responsible person does not meet the qualification requirements under this policy.

The Facility will make every reasonable effort to make a patient's qualification determination as soon as possible. The Facility will not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 180 days after initial billing.

II. Application Requirement: All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the Financial Assistance Application. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary to make a determination of the patient's qualification for financial assistance coverage through any government coverage program or this policy. The patient should expect and is required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to, copayments and deductibles.

III. Process and Procedure.

A. Eligibility. A patient is eligible for financial assistance if (1) the patient's family income is equal to or less than 400% of the applicable FPG and (2) the patient is either an Uninsured Patient or a Patient with High Medical Costs. Notwithstanding the foregoing, the Facility may, in its sole discretion, choose to offer financial assistance to patients whose family income is greater than 400% of the applicable FPG

Eligibility alone is not an entitlement to financial assistance. The patient must complete the Financial Assistance Application and provide all required documentation and the Facility must complete a process of applicant evaluation and determine qualification before charity care or a discount payment may be extended to the patient.

The Facility may require a patient to participate in screening to see if the patient is eligible for Medi-Cal before the patient is screened for or provided a Discount Payment or Charity Care but shall not require the patient to actually apply for Medicare, Medi-Cal or other coverage before the patient is screened for or provided a Discount Payment or Charity Care.

B. Other Insurance Options. Uninsured Patients will also be (1) offered information, assistance and referral to government-sponsored programs for which they may be eligible and (2) provided information regarding insurance coverage through Covered California. Uninsured Patients will also be provided with contact information for local consumer legal assistance center which may assist the uninsured patient with obtaining health benefits coverage.

C. Completion of a Financial Assistance Application.

1. The Financial Assistance Application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. The Facility will not deny eligibility for financial assistance based on the timing of a patient's application.

2. The Financial Assistance Application provides:
   a. Information necessary for the Facility to determine if the patient has income sufficient to pay for services.
   b. Documentation useful in determining qualification for financial assistance; and
   c. An audit trail documenting the Facility's commitment to providing financial assistance.

3. In certain circumstances, a completed Financial Assistance Application may not be required if the Facility, in its sole discretion, determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

4. If a patient applies or has a pending application for another health coverage program at the same time he or she applies for financial assistance under this policy, neither application shall prevent the patient for establishing eligibility under the other program.

D. Determination Based On Ability to Pay. Qualification for Charity Care or a Discount Payment shall be determined solely based on the patient's and/or patient family representative's ability to pay. Qualification shall not be based in any way on age, gender, sexual orientation, gender identity, ethnicity, national origin, veteran status, disability or religion. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the Facility retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

E. Eligibility for Charity Care or Discount Payment. For the purposes of determining a patient's eligibility for a Discount Payment, the Facility shall consider family size and documentation of family income in the form of federal income tax returns and/or recent pay stubs. If a patient desires to provide other forms of documentation of income, the Facility may decide, in its sole discretion, whether to consider such other documentation in its determination of eligibility.

F. Catastrophic Medical Event. Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance as determined in the Facility's sole discretion. The determination of a catastrophic medical event shall be based upon the amount of the patient's family income and assets as reported at the time of occurrence. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.

G. Pricing Guidelines. If a patient qualifies for a Discount Payment, the Facility shall limit the expected payment for medically necessary services rendered to the amount the Facility would expect, in good faith, to receive for providing the services from Medicare, Medi-Cal or health plan in effect for Medi-Cal patients, whichever is greater. If the Facility provides a service for which there is not established payment by a government-sponsored program, the Facility shall establish an appropriate discount payment.

The Facility may require a patient or guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for that facility's services.

If the patient receives a legal settlement, judgment, or award under a liable third party action that includes payment for health care services or medical care related to the injury, the Facility may require the patient or guarantor to reimburse the Facility for the related health care services rendered up to the amount reasonably awarded for that purpose.

H. Qualified Payment Plans.

1. When the Facility has determined a patient is qualified for a Discount Payment, the patient shall have the option to pay any or all outstanding amounts due in one lump sum payment or through a scheduled term Qualified Payment Plan. The Facility will discuss payment plan options with each qualified patient that requests to make payments pursuant to a Qualified Payment Plan. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms taking into consideration the patient's family income, essential living expenses and availability of a health savings account held by the patient or the patient's family, if one exists.

2. Reasonable Payment Plan. If a qualified patient or guarantor and the Facility cannot agree on the terms of a Qualified Payment Plan, the Facility will use the "reasonable payment plan" formula as defined in Health & Safety Code Section 127400(i) as the basis for a payment plan. A "reasonable payment plan" means monthly payments that are not more than 10% of patient's family income for a month, excluding deductions for essential living expenses, defined by Health & Safety Code Section 127400(i) as 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. .

In order to apply the "reasonable payment plan" formula, the Facility shall collect patient family information on income and "essential living expenses" in accordance with the statute. Each patient or guarantor seeking to establish a payment plan by applying the "reasonable payment plan" formula shall submit the family income and expense information as requested in the Facility's standardized form, unless the information request is waived by the Facility.

3. No Interest. No interest will be charged to Qualified Payment Plan accounts for the duration of any plan arranged under the provisions of this policy.

4. Payment Default. After a Qualified Payment Plan has been approved by the Facility, any failure to pay all consecutive payments during a 90 day period due may constitute a payment plan default. It is the patient or guarantor's responsibility to contact the Facility's Central Business Office if circumstances change and payment plan terms cannot be met. However, in the event of payment plan default, the Facility will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing indicating that the Qualified Payment Plan may become inoperative. Before the Qualified Payment Plan is declared inoperative, the hospital, collection agency, debt buyer, or assignee shall attempt to renegotiate the terms of the defaulted Qualified Payment Plan, if requested by the patient. The hospital, collection agency, debt buyer, or assignee shall not commence a civil action against the patient or responsible party for nonpayment before the time the Qualified Payment Plan is declared to be no longer operative. For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a Qualified Payment Plan, this section does not limit or alter the obligation of the patient to make payments on the obligation owing to the Facility pursuant to any contract or applicable statute from the date that the Qualified Payment Plan is declared no longer operative.

IV. Appeals. If the patient disagrees with the decision on the application, he/she has the right to dispute and appeal concerning the patient's qualification. A patient may seek review from the Corporate Central Business Office Director and/or Chief Financial Officer for further review.

V. Emergency Physicians. An emergency physician who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to Uninsured Patients or Patients with High Medical Costs who are at or below

400% of the applicable FPG. An "emergency physician" is a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. This statement shall not be construed to impose any additional responsibilities upon the Facility.