Barstow Community Hospital
Discounted Payment Policy

EFFECTIVE DATE:

The effective date of this Discounted Payment Policy ("Policy") is April 29, 2016.

PURPOSE:

1. Barstow Community Hospital ("Barstow" or 'Hospital") is committed to serving the High Desert area and its residents with inpatient and outpatient services, as well as medical, surgical, and emergency care.
2. The purpose of this Policy is to define the eligibility criteria for patients seeking financial assistance in the form of Discounted Payments to meet the costs of their Medically Necessary Care at Barstow.
3. With this Policy, Barstow seeks to outline the process for determining eligibility and applying for Discounted Payments, to effectively communicate these criteria and processes to patients in need, and to ensure that all policies are accurately and consistently applied.
4. All patients, regardless of ability to pay, will be treated equitably, and with dignity, respect and compassion. The availability and granting of Discounted Payments will be based on an individualized determination of family income, and will not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.
5. This Policy is established in compliance with the requirements set forth in California Health & Safety Code §§ 127400 *et seq.*

SCOPE:

This Policy applies to all staff at Barstow and governs their interactions with patients seeking Discounted Payments.

DEFINITIONS:

For the purpose of this Policy, the terms below are defined as follows:

Application: "Hospital Discounted Payment and Charity Care Application."

Charity Care: Free care.

Discounted Payment: Any charge for care that is reduced but not free.

Emergency Physician: A licensed physician or surgeon who is credentialed by the Hospital and either employed or contracted by the Hospital to provide emergency medical services in the emergency department of the Hospital. An "emergency physician" does not include a physician specialist who is called into the emergency department of the Hospital or who is on staff or has privileges at the Hospital outside of the emergency department.

Essential Living Expenses: 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.

Federal Poverty Level (FPL): The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.

Financially Qualified Patient: A patient who is both of the following: (1) a Uninsured/Self-pay Patient or a Patient with High Medical Costs; **and** (2) a patient who has a family income that does not exceed 400% of the federal poverty level.

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

Out-of-Pocket: 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.

Medically Necessary Care: Any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers the life, cause suffering or pain, results in illness or infirmity, threaten to cause or aggravate handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures.

Monetary Assets. Assets that are convertible to cash. This does not include retirement or deferred compensation plans qualified under the Internal Revenue Code, nonqualified deferred compensation plans, or assets below the maximum community spouse resource allowance under Section 1396r-5(d) of Title 42 of the United States Code.

Patient's Family: For patients 18 years of age and older, Patient's Family is defined as their spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, Patient's Family is defined as their parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

Patient with High Medical Costs: A patient whose family income is at or below 400% of the FPL. High Medical Costs means: (1) patient's annual out-of-pocket medical expenses at the Hospital, which are not reimbursed by any insurance or health coverage program, exceeds 10% of the patient's current family income or the family income in the prior 12 months, whichever is less; **or** (2) patient's annual out-of-pocket medical expenses at any facility, which are not reimbursed by any insurance or health coverage program, exceeds 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; **or** (3) a lower level determined by the Hospital in accordance with this Policy.

Reasonable Payment Plan: Monthly payments that are not more than 10% of a Patient's Family income for a month, excluding deductions for essential living expenses.

Self-Pay or Uninsured Patient: A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, and whose injury is not a compensable injury for Worker's Compensation, automobile insurance, or other insurance (third-party liability) as determined and documented by the Hospital. Self-pay patients may include Charity Care patients.

PROCEDURE

A. Eligibility

All Self-Pay or Uninsured Patients qualify for a 40% discount of their medical costs for services provided at Hospital.

Financially Qualified Patient, meaning a patient whose family income is at or below 400% of the Federal Poverty Level, **and** who:

1. Is an Uninsured Patient/Self-Pay Patient **or**
2. Has High Medical Costs,

are eligible for Charity Care. ***See*** **Charity Care Policy.**

The Hospital utilizes a single, unified patient Application for financial assistance. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. A patient who applies only for a Discounted Payment may receive less assistance than a patient who also applies for Charity Care.

Any patient who requests financial assistance, indicates that they may be a Financially Qualified Patient, or indicates a financial inability to pay for Medically Necessary Care will be provided an Application. The Hospital staff may access copies of the Application to provide to patients potentially eligible for Discounted Payments by contacting our Director of Admitting at 760-957-3133. Patients may also access the Application directly by contacting Director of Admitting at 760-957-3133.

B. Application Process and Eligibility Determinations

Eligibility for Discounted Payments will be determined in accordance with the following procedures:

1. The Application is for internal use only.
2. Upon admission to the Hospital, all uninsured patients and patients with a non-discounted insurance will be provided information in writing regarding the availability of Discounted Payments, as well as the availability of a financial counselor who can screen the patient for coverage eligibility under Medicare,

Medi-Cal, and other third-party payors. The patient will be asked to sign an acknowledgement of receipt of such written information. The original signed acknowledgement will be maintained in the patient medical record and the patient will be provide with a copy.

3. All uninsured patients and patients with a non-documented insurance will also be provided a brochure that explains the Hospital Discounted Payment Policy and Charity Care Program. Patients who are interested will be provided with an Application form to fill out during the registration or financial counseling process.
4. Services performed within the Hospital are presumed to be medically necessary unless, before the Hospital denies a patient eligibility for the Discounted Payment program, the Hospital provides an attestation signed by the referring provider supervising provider stating that the Hospital services at issue were not medically necessary.
5. The Hospital will not require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, a Discounted Payment. When screening for eligibility for a Discounted Payment, the Hospital may require the patient to participate in a screening for Medi-Cal eligibility.
6. The Hospital staff will access a copy the Application and provide it to the requesting or otherwise eligible patient. The Application is available in the primary languages of the service area. For applicants who speak other languages, the Hospital will provide interpreter assistance for applicants to complete the form.
7. The patient will be required to complete the Application and provide supporting documentation, which will be considered in the Hospital's determination of eligibility:
    a. A recent tax return, meaning a tax return which documents a patient's income for the year in which a patient was first billed or 12 months prior to when the patient was first billed; and/or
    b. Recent paystubs, meaning pay stubs that are within a 6-month period before a patient is first billed by the Hospital, or in the case of preservices, when the Application is submitted, or a letter from the employer.

    The Hospital may accept other forms of documentation of income, but must not require other forms. The Hospital may presumptively determine that a patient is eligible for a Discounted Payment based on information other than that provided by the patient or based on a prior eligibility determination. The Hospital may not consider a patient's Monetary Assets in determining eligibility under this Policy.
8. The Hospital 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 the Hospital'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 Hospital may require the patient or Guarantor to reimburse the Hospital for the related health services rendered up to the amount reasonably awarded for that purpose.

9. The Hospital must determine a patient's eligibility for Discounted Payments at any time the Hospital is in receipt of the patient's income tax return and pay stubs, or presumptively determines that a patient is eligible for Discounted Payments. The Hospital may not impose time limits for applying for Discounted Payments, or deny eligibility based on the timing of a patient's application.
10. The documentation requirements are listed on the Application. The patient must make every reasonable effort to furnish the Hospital with documentation of income and health benefits coverage. If a patient fails to provide information that is reasonable and necessary for the Hospital to make a determination of eligibility, the Hospital may consider that failure in making its determination of eligibility. The patient must also attest in writing that the information they are furnishing to the Hospital is accurate.
11. When a patient appears to qualify for Discounted Payments, the Application will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager.
12. If the Financial Counselor determines that the patient qualifies for Discounted Payments, they will give the completed and approved Application to the Business Office Manager for approval authorization prior to write off.
13. Once an account is approved for Discounted Payments, the Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.
14. Once approved for Discounted Payments, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self-pay and a letter sent to the patient for the remaining balance. The letter will indicate that the discount has been credited to the patient account.
15. If the Application is incomplete, it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.
16. Patients must be provided with interest free monthly payment arrangements that are agreed upon by both parties.
17. The CFO may waive the documentation requirements and approve a case for financial assistance/charity care at their sole discretion based on their belief the patient does/should qualify for charity. The amount or percentage of charity care discount will be left to the CFO's discretion. Waiver of the documentation requirements should be noted in the comments section on the patient's account,

as well as the percent or dollar amount approved for charity adjustment, printed out and attached to the Application.

18. Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved Application will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review and approval of the write-off by signing the bottom of the Application. The signature requirements will be based on the QHC financial policy for approving adjustments.
19. Information regarding the amount of charity care provided by the Hospital, based on the Hospital's fiscal years will be aggregated and included in the annual report filed with the State. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits.
20. The Hospital may waive or reduce Medi-Cal and Medicare cost sharing amounts as part of its Discounted Payments program. In waiving or reducing Medicare cost sharing amounts, the Hospital may consider the patient's Monetary Assets to the extent required for the Hospital to be reimbursed under the Medicare program for Medicare bad debt without seeking to collect cost sharing amounts from the patient as required by federal law.
21. A review for eligibility for Discounted Payments will include any other outstanding accounts for the patient that may also be eligible for the financial assistance.
22. In the event of a dispute regarding the patient's eligibility for a Discounted Payment, the patient may seek review from the Director of Admitting, 760-957-3133 or the Business Office Manager.
23. Patients who wish to appeal the denial of assistance under this Policy must include an explanation of the reason the Application should be reconsidered. The Business Office Manager will review any additional information. If the information would still result in a denial, Business Office Manager will submit the Application to the CFO who will make a final determination. The CFO's decision is final.

C. Discounted Payment Determinations

Each Application will be individually reviewed, and eligible patients will be allowed to pay a Discounted Payment. The determination for Discounted Payments for which a patient may be eligible should be confirmed as close to the time of service as possible. The Hospital will make every effort to provide a determination of eligibility within 30 days of receiving all requested information and documentation from the patient.

Patients who qualify for a Discounted Payment will not be charged an out-of-pocket amount in excess of 10% of their prior 12 months income.

A determination that a patient has the ability to pay the remainder of their bill does not prevent a reassessment of the patient's ability to pay at a later date if there is a change in the patient's financial status.

D. Availability of Discounted Payment Information

1. During preadmission or registration (or as soon thereafter as practicable and after stabilization of the patient's emergency medical condition in the case of emergency services), the Hospital will provide all patients with information regarding financial assistance which also includes a plain language summary of the Discounted Payment Policy.

2. The Hospital will also provide patients with contact information for a Hospital employee or office from which the patient may obtain further information about Discounted Payments. The information provided will be in the primary language of the Hospital's service area and in a manner consistent with all applicable federal and state laws and regulations.

3. The Hospital will prominently post information about Discounted Payments on the Hospital's website and including a link to the policy itself on the Hospital's website.

E. Discounted Payments for Emergency Care

An emergency physician who provides emergency medical services in the Hospital must provide discounts to Uninsured Patients/Self-Pay Patients or Financially Qualified Patients with High Medical Costs. This requirement does not impose any additional responsibilities upon the Hospital.

F. Extended Payment Plan Available

1. Patients who are eligible for a Discounted Payment are also eligible for an interest free, extended payment plan to allow payment of the discounted price over time. The Hospital and the patient must negotiate the terms of the payment plan. In doing so, the Hospital must take into consideration the patient's family income and Essential Living Expenses. The Hospital may consider the availability of a patient's health savings account held by the patient or the patient's family. If the Hospital and the patient cannot agree on the terms of the payment plan, the Hospital must create a Reasonable Payment Plan using the formula described in Cal. Health & Safety 127400(i).

2. The Hospital may declare the extended payment plan no longer operative after the patient's failure to make all consecutive payments due during a 90–day period beginning on the first billing statement's due date missed by the patient.

3. Prior to declaring the extended payment plan no longer operative, the Hospital will give notice to the patient in writing that the extended payment plan may become inoperative. This notice must be sent at least 60 calendar days after the first missed bill and provide the patient with at least 30 calendar days to make a payment before the extended payment plan becomes inoperative.
4. Once the extended payment plan becomes inoperative, the patient is responsible for the discounted amount previously determined to be eligible for and shall receive credit for any payments previously made under the extended payment.

Last Revised Date: December 16, 2024