Barstow Community Hospital
Charity Care Payment Policy

EFFECTIVE DATE:

The effective date of this Charity Care 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 Charity Care 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 Charity Care, 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 Charity Care 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 Charity Care.

DEFINITIONS:

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

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

Charity Care: Free care.

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) an 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.

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.

Out-of-Pocket Medical Expenses: 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 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.

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.

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

Charity Care is available to any Financially Qualified Patient, meaning a patient whose family income is at or below 400 percent of the Federal Poverty Level **and** who:

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

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.

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 Charity Care by contacting our Director of Admitting at 760-957-3133. Patients may also access the Application directly by contacting the Director of Admitting at 760-957-3133.

B. Application Process and Eligibility Determinations

Eligibility for Charity Care will be determined in accordance with the following procedures:

1. The Application is for internal use only.
2. Services performed within the Hospital are presumed to be medically necessary unless the Hospital provides an attestation, before the Hospital denies a patient eligibility for the Charity Care program, that the Hospital services at issue were not medically necessary.
3. 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.
4. 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.
5. The Hospital must determine a patient's eligibility for Charity Care 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 Charity Care. The Hospital may not impose time limits for applying for Charity Care, or deny eligibility based on the timing of a patient's application.
6. The documentation requirements are listed on the Application. The patient must make every reasonable effort to furnish the Hospital with documentation of income. 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.
7. The Hospital may waive or reduce Medi-Cal and Medicare cost sharing amounts as part of its Charity Care 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.

8. Patients covered by out of state Medicaid where the Hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the Hospital to become a provider, will be eligible for Charity Care upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. No other documents will be required in order to approve the Application. The patient will not be required to make a formal financial assistance/charity application. The Hospital may submit the application and verification of Medicaid coverage as proof of qualification.
9. The Application will be sent to the Business Office for financial determination by the Financial Counselor or Business Office Manager.
10. If the Financial Counselor determines through the Application and documented support that the patient qualifies for Charity Care, they will give the completed and approved Application to the Business Office Director for approval authorization, prior to write off.
11. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account, if any.
12. Once approved for financial assistance/charity care, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account.
13. 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.
14. The Business Office Director, Assistant Business Office Manager, or Patient Access Manager is responsible for reviewing every Application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval. All fields on the Application must be completed properly. Drawing lines through fields such as income is not appropriate. If the income is zero, zeros must be entered.
15. Medicaid patients who receive covered IP and ER services that meet Medicare medical necessity but have exhausted state benefit limits (IE limited IP days or limited annual ER visits, for example), or have limited Medicaid coverage, such as family planning, will not be required to provide any supporting documents providing verification of Medicaid coverage for the service dates completed.
16. The CFO may waive the documentation requirements and approve a case for Charity Care at their sole discretion based on their belief the patient does/should qualify for Charity Care. Waiver of the documentation requirements should be noted in the comments section on the patient's account, printed out, and attached to the Application.
17. 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 the approved

Application will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, and Business Office Manager 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 Quorum Health Corporation financial policy for approving adjustments.

18. 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.
19. A review for eligibility for Charity Care will include any other outstanding accounts for the patient that may also be eligible for financial assistance.
20. In the event of a dispute regarding the patient's eligibility for Charity Care, the patient may seek review from the Director of Admitting, 760-957-3133 or the Business Office Manager.
21. 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. Charity Care Determinations

Each Application will be individually reviewed, and eligible patients will be provided Charity Care financial assistance. The determination for Charity Care 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.

D. Presumptive Eligibility for Charity Care

1. There may be circumstances under which a patient's qualification for Charity Care may be established without completing the formal Application and/or providing the necessary and required documents for approval. 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. This information will enable the Hospital to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.
2. Presumptive eligibility for Charity Care may be determined on the basis of individual life circumstances that may include:
    a. Homelessness or receipt of care from a clinic serving those experiencing homelessness;
    b. Participation in Women, Infants and Children (WIC) programs;
    c. Eligibility for food stamps;

d. Eligibility for school lunch programs;

e. Living in low-income or subsidized housing; and/or

f. Patient is deceased with no estate or deceased and cannot identify patients name or address.

E. Availability of Charity Care 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 Charity Care 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 Charity Care. 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 Charity Care on the Hospital's website and including a link to the Policy itself on the Hospital's website.

Last Revised Date: October 30, 2024