SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL	**Page 1 of 11**

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PURPOSE:

Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify, in accordance with the requirements of this Financial Assistance Policy.

This Financial Assistance Policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), AB 72 (Balance billing), January 1, 2022 AB 1020 and AB 532 guidance, and United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") guidance regarding financial assistance to uninsured and underinsured patients, Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for charity care. The financial screening criteria in this policy are based primarily on the Federal Poverty Level ("FPL") guidelines updated periodically by HHS in the Federal Register.

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

DEFINITIONS:

1. Charity Care: Full Charity Care is defined as a full charitable deduction (100% discount) for those with an income under 200% or less of the Federal Poverty Level
2. Partial Charity Care Payment: For those with an income of 201% - 400% of the Federal Poverty Level. A partial charitable deduction for all eligible amounts owed to Sierra View Medical Center.
3. High Medical Cost: Annual out-of-pocket costs at the hospital that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months.
4. Reasonable Payment Plan: A default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached. SB 1276 defines the plan as monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.
5. Good Faith Estimate (GFE): A cost estimation for the items and services furnished by SVMC and convening providers
6. Independent Dispute Resolution (IDR): a process in which providers, emergency facilities and health plans can use to resolve payment disputes for certain out-of-network items and services.
7. Provider Dispute Resolution (PDR): a process a patient can initiate if a patient receives a bill that is substantially in excess of the GFE (defined as bill is >$400 in excess of the GFE) and is done within one hundred and twenty calendar days (120) of receiving a bill.

POLICY:

Sierra View Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. The Financial Assistance Policy will apply to all patients who receive

services at SVMC. SVMC provides all patients a written notice about the availability of our discount payment and charity 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. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

In accordance with Sierra View Medical Center's mission and values, all patients will receive medically necessary healthcare in compliance with federal law, regardless of the patient's ability to pay for services. The hospital will also provide qualified patients with financial assistance to help cover the costs of services and reduce patients' personal financial responsibilities

Full Charity Care Defined

Full Charity Care is defined as a full charitable deduction (100% discount) for all eligible amounts owed to Sierra View Medical Center. The applicants must have a qualifying income of 200% or less of the Federal Poverty Level. Any necessary[1] inpatient or outpatient hospital service provided to a patient who is either unable to pay for care and who has established qualification in accordance with requirements contained in the SVMC Financial Assistance Policy and by requesting assistance in a timely-manner, defined as request being made for financial assistance one year from date of service or date of denial or payment from insurance company.

Partial Charity Care Defined

Partial Charity Care is defined as a partial charitable deduction for all eligible amounts owed to Sierra View Medical Center. The applicants must have 1) qualifying income between 201% to 400% (or not to exceed 400%) of the Federal Poverty Level, 2) applicant with a high medical cost to include any necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured.

Depending upon individual patient eligibility, financial assistance may be granted for full charity care or discount partial charity care. SVMC may exclude patients who would be eligible to apply but who do not apply or otherwise comply with the hospital's reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care. SVMC definition of reasonable process for qualifying for Full Charity Care and Discount Partial Charity Care is to complete the charity application and submit all financial documents and supporting documentation within one year from the date of service or one year from the insurance payment or denial.

Full and Discount Partial Eligibility: General Process and Responsibilities

The SVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, SVMC will use a financial assistance application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial

assistance application. Uninsured and underinsured patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients with a qualifying income of 400% or less of the current Federal Poverty Level who experience high medical costs, including patients with a third-party insurance coverage may also be eligible for financial assistance. In addition, SVMC will provide contact information to a local consumer assistance center, Central California Legal Services, located within Tulare County, and for patients residing outside Tulare County, we will provide the Health Consumer Alliance contact information. Patients presenting with these types of situations will be required to follow the same application process and approval will be reviewed on a case-by-case basis. 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 payment program. Any patient who requests financial assistance will be asked to complete a financial assistance application.
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.

Eligibility is defined for any patient whose family[2] income is 400% or less of the current Federal Poverty Level. Request for Financial Assistance Program can't be for services related to an injury compensable for the purpose of workers' compensation, automobile insurance or other insurance as determined and documented by the hospital and/or unable to pay for their care, based upon determination of financial need in accordance with this policy.

Patients' income and other financial criteria are the basis for determining the amount of the hospital-sponsored financial assistance patients receive. While both uninsured and insured patients are eligible for financial assistance from Sierra View Medical Center, patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-Cal and the Healthy Families program) for which they may be eligible. Patients will be given the opportunity to explore these resources before receiving charity care.

Patients at Sierra View Medical Center who are unable to pay their balances and are in need of financial assistance will be screened without bias toward their gender, ethnicity and religion or employment status. Patients will be objectively assessed by a qualified hospital staff member through the review and assessment of pertinent patients' information. For the purposes of this objective screening process, patients will be required to submit relevant documentation such as the following:

- Applications are located on the SVMC website, the patient portal or by contacting the financial counseling department
- All W-2 earnings or previous tax returns or most recent previous 2 months pay stubs and withholding statements
- Pension or Social Security income statements
- All statements of financial obligation
- Government-sponsored program denial or approval letter with effective date

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- Hardship letter, if applicable

Financial assistance will be provided to eligible uninsured and insured patients in the form of discounts of patients' personal financial responsibilities. The following framework, based upon the federal poverty guidelines that consider patients' income and number of dependents, will be utilized to objectively and consistently determine the percentage discount that eligible patients receive:

Financial Assistance Guidelines

Percent of Federal Poverty Guidelines	Charity Care Discount Percentage
200% or below	100%
Percent of Federal Poverty Level	**Partial Charity Care Discount Percentage**
201 – 266%	75%
267 – 332%	50%
333 – 400%	25%
401% or above	0%

- Partial Charity Care Discount Percentage will be applied to the Medicare rate in effect at the time of service.

For example, an individual with two other family members and an annual income of $18,000 is at less than 200% of the federal poverty guidelines and would receive a 100% discount on their bill.

For example, an individual with two other family members and an annual income of $43,000 is between 251 – 300% % of the federal poverty guidelines they would only pay 50% of the Medicare rate in effect at the time of service.

All financial assistance provided to patients, whether covering all or part of their balances, will be documented by SVMC in order to ensure objectivity in the charity care dispersed, and to provide records able to meet all internal and external requirements for providing assistance to patients in need.

In order to communicate its charity care policy to all patients, SVMC billing statements will include the phone number(s) of SVMC Financial Counselors that patients may call for financial assistance information. In addition, a copy of the application will be sent to every patient before assigning to collections. Contact information along with phone numbers with information on how to receive Charity Care and Financial Assistance will also be prominentlydisplayed in all hospital registration areas including observations units if applicable. A notice of the hospital's policy will also be available on the hospital internet website.

Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Financial Counselors.

SVMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:

Patient Financial Services Manager: Accounts less than $10,000
Administrative Director of Revenue Cycle: Accounts less than $25,000
Chief Financial Officer: Accounts greater than $25,000

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

- No insurance or a valid denial under any government coverage program or other third party insurer;
- Limited insurance benefits paid by third party payer
- Family income based upon tax returns or recent pay stubs (2 month)
- Family size, per tax returns
- Monetary assets as provided for under law
- Hardship letter, if applicable

Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

When Financial Assistance is granted, the patient and dependents will remain eligible for 6 months from the month of service. Accounts within the 6 month span can automatically be applied to charity, but on the 7th month and forward, the guarantor/patient will need to complete another Financial Assistance application. Medi-Cal/Medicaid share of cost (SOC) amounts are not eligible for financial assistance. The SOC amounts are set by the State, the State require patients to pay the SOC as a condition of receiving Medi-cal/Medicaid.

Patients at or below 400% of the Federal Poverty Guidelines who do not qualify for 100% discount will pay a percentage of the Medicare rate in effect at the time of service.. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided by SVMC.

Financial Assistance Exclusions/Disqualification

The following are circumstances in which Financial Assistance is not available under this policy:

a) Uninsured or Self-Pay patient seeks Complex/Specialized Services: Generally, Uninsured Patients who seek Complex/Specialized services (e.g. experimental or investigational procedures), and seek to

receive Financial Assistance for such services must receive administrative approval from the individual responsible for finance at the Hospital (or designee) prior to the provision of such services in order to be eligible for Financial Assistance. The uninsured or self-pay patient and/or ordering doctor will need to provide diagnosis and procedure code(s) and SVMC will provide the uninsured or self-pay patient a good faith estimate (GFE). If the patient elects to continue services we will initiate financial clearance which must have administrative approval. Elective services that are normally exclusions from coverage under health plan coverage agreements (e.g., cosmetic procedures) are not eligible for Financial Assistance.

b) Patient declines covered services: An Insured Patient who elects to seek services that are not covered under the patient's benefit agreement (such as an HMO patient who seeks out-of-network services.)

c) Insured Patient does not cooperate with third-party payer: An Insured Patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance.

d) Payer pays patient directly: If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance for the services.

e) Information falsification: Hospitals may refuse to award Financial Assistance to patients who falsify information regarding Family Income, household size or other information in their eligibility application.

f) Third party recoveries: If the patient receives a financial settlement or judgment from a third-party tortfeasor that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances, and is not eligible for Financial Assistance.

Payment Plans

When a determination of discount partial charity has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled reasonable payment plan.

The hospital and patient will work together to negotiate the terms of a payment plan. In the event the hospital and the patient cannot agree on a payment plan, SVMC will abide by the payment plan formula, defined in AB1276. SVMC will take into consideration the patient's family income and essential living expenses when determining a payment plan. The patient is responsible for providing SVMC copies of their essential living expenses. If an agreement cannot be reached with the patient, SVMC must institute a reasonable payment plan, with monthly payments not to exceed 10% of a patient's family income for a month after deductions of essential living expenses. "Essential living expenses" are defined 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 expenses, and other extraordinary expenses. If the reasonable payment formula results in a payment of less than $10 a month, the subsequent extended payment plan shall be $10 per month.

Patients who wish to renegotiate the terms of a defaulted extended payment plan are able to enter into another extended payment plan with payments in the amount of either the reasonable payment formula or

$10 per month and if the patient fails to make all consecutive payments due during a 90-day period, that extended payment plan is considered inoperative.

No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Special Circumstances

In extenuating circumstances, SVMC may at its discretion approve financial assistance outside of the scope of this policy.

Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, and when collection agency assignment would not result in resolution of the account. The accounts eligible for charity due to homelessness are identified by the current ICD-10 per CMS guidelines. No application will be required for these circumstances.

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program.

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 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.

Any patient whose income exceeds 400% of the Federal Poverty Guidelines and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high

incomes, do not qualify for routine full charity care or discount partial charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.

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- The California law, AB 72, which took effect in July 2017 and the No Surprise Act effective January 2022 protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services and non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. In addition, the No Surprise Act provides uninsured or self pay patients with protections as well.

- SVMC utilizes the services of contracted physicians. These physicians are not employed by the district but provide services to the SVMC patient population. These physicians may not be an in-network provider. The No Surprise Act prevents the hospital and convening providers from balance billing.

SVMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at the hospital. In the event that a patient or guarantor does not respond or communicate with SVMC to resolve an open account, SVMC may forward the account to its collection agency after 180 days has elapsed and after providing the patient a financial assistance application.

Collection Guidelines

SVMC will make reasonable attempts to obtain insurance information. If no insurance was provided at the time of service, patient will receive statements, which 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.

SVMC will assign unresolved financial obligations to a debt collection agency after: 180 days if the patient has failed to comply with an established payment plan or non-payment on an account where the

patient guarantor is not in process of completing an eligibility application for a government-sponsored insurance program or applying for charity care and/or financial assistance. A final notice with a charity care and financial assistance application, the 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 bill. Patients with pending appeal for coverage of services will not be forwarded to a third party collection agency until a final determination of that appeal is made. If the appeal is unfavorable and the patient is responsible for the outstanding obligation, the patient will be afforded the opportunity to qualify for charity care or discount payment arrangements as prescribed above. Patient guarantors must keep SVMC Financial Counselors updated on the coverage appeal.

Certain account categories returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care, provided that the patient cooperates with the Charity Care/Financial Assistance Guidelines outlined in this policy. The following types of claims categories will be reviewed for possible charity:

1) Self-Pay or Underinsuredaccounts
2) Any account where the guarantor expressed the inability to pay the accounts

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

Collection Agencies will return all accounts that meet the following guidelines; 1) Deemed patient is unable to pay, 2) Patient provides 3rd party coverage, 3) Patient requests Financial Assistance, 4) Not able to reach a reasonable payment plan.

Collection agencies have the responsibility to be familiar with SVMC's policy for Financial Assistance and Charity Care and as such will be responsible for ensuring patients who meet guidelines are returned to SVMC.

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.

Any or all appeals will be reviewed by the hospital's Administrative Director of Revenue Cycle. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the patient will be notified of findings and determination within thirty days of appeal notification.

In the event that the patient believes a dispute remains after consideration of the appeal by the Administrative Director of Revenue Cycle, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and

documentation, as well as the findings of the Administrative Director of Revenue Cycle. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient within thirty days of appeal notification. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Public Notice

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, or other common outpatient areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. The information notice is also available onthe Sierra View Medical Center website. Patients can access the Charity Care and Financial Assistance Policy and download the application and return via email, in person, or by mail.

These notices shall be posted in English and Spanish and any other primary languages that are representative of 5% or greater of patients in the hospital's service area.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

Good Faith Requirements

SVMC arranges for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, SVMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the Sierra View Medical Center financial assistance.

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- Senate Bill 1276 (2020). Retrieved from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB1276.

- No Surprise Billing (CMS) Title XXVII of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021

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