Subject:	**Financial Assistance Policy**	**Formulated:**	**11/2012**
Manual:	**Patient Financial Services**	**Reviewed:**	**04/2013, 02/2014, 11/2014, 04/2020, 12/2021**
Alvarado Hospital Medical Center		**Revised:**	**04/2013, 02/2014, 11/2014, 04/2020 12/2021**

I. Policy:

Each for-profit hospital owned by Prime Healthcare Services, Inc. (each, a "Hospital"), offers a financial assistance program for those patients who meet the eligibility tests described below. The intent of this Financial Assistance Policy (the "Policy") is to satisfy applicable federal and state laws and regulations; all provisions should be interpreted accordingly.

II. Applicability of the Policy:

This Policy only covers services furnished by the Hospital. Members of the medical staff who are not employees of the Hospital may, separate and apart from the Hospital, implement their own financial assistance programs. For example, emergency physicians are required by law to provide discounts to uninsured patients with high medical costs who are at or below four hundred percent (400%) of the Federal Poverty Level. The Hospital is not responsible for the administration of any financial assistance program offered by the Hospital's non-employed medical staff physicians or such physicians' billing practices.

III. Procedure:

1. Eligibility for Financial Assistance

A. Self-Pay Patients

A patient qualifies for **charity care** as described in Section (III)2 below if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medicaid as determined and documented by the hospital; (2) the patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital; (3) the income of the Patient's Family does not exceed four hundred (400%) of the current Federal Poverty Level; **and** (4) the patient has monetary assets of less than ten thousand dollars ($10,000.00) determined as set forth below.

A patient qualifies for the **discounted payment program** if all of the following conditions are met: (1) the income of the Patient's Family does not exceed four hundred fifty percent (450%) of the current Federal Poverty Level; **and** (2) the patient has monetary assets of less than ten thousand dollars ($10,000.00) determined as set forth below.

B. Insured Patients

A patient who has third party coverage or whose injury is a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for charity care, but may qualify for the discounted payment program if (i) he or she has a Family income at or below four hundred percent (400%) of the Federal Poverty Level; and (ii) has out-of-pocket medical expenses that exceed the lesser of: (a) ten percent (10%) of the patient's family income in the prior twelve (12) months (whether incurred or paid in or out of any hospital) or (b) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's current Family Income.

C. Other Circumstances

The Director of the Hospital's Patient Financial Services, (PFS) Department shall also have the discretion to extend charity care or the discounted payment program to patients under the following circumstances:

(i) The patient qualifies for limited benefits under the state's Medicaid program, *i.e.*, limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital. This includes non-covered services related to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (*i.e.*, patients that may only have pregnancy or emergency benefits, but receive other care from the Hospital);
- Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for charity care;
- Medicaid or other indigent care program denials;
- Charges related to days exceeding a length of stay limit; and
- Any other remaining liability for insurance payments.

(ii) The patient qualifies for a county-level medically indigent services program but no payment is received by the Hospital.

(iii) Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the Hospital's PFS Director has reason to believe that the patient would qualify for charity care or the discounted payment program, *i.e.*, homeless.

(iv) A third party collection agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that charity care or the discounted payment program be offered.

(v) Other circumstances of charity care shall be documented in the patient's record indicated either by transaction type or in the patient's notes.

D. Determination of Income and Assets

Documentation of income of the patient's Family shall be limited to recent pay stubs or income tax returns. "Family" for this purpose means: (1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker, relatives, and other children under 21 years of age of the parent or caretaker relative.

In determining a patient's monetary assets, the Hospital shall not consider retirement or deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, the first ten thousand dollars ($10,000.00) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000.00).

E. Federal Poverty Levels

The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient's family or household. The Federal Poverty Levels as of 2021 are as follows:

SOURCE: Federal Register, Vol. 86, No. 19, February 1, 2021, pp. 7732 - 7734

2021 Poverty Guidelines for the 48 Contiguous States and the District of Columbia (These figures are updated and republished annually; see https://aspe.hhs.gov/poverty-guidelines)		
Persons in Family/Household	400% of Poverty Guideline	450% of Poverty Guideline
1	$51,520	$57,960
2	$69,680	$78,390
3	$87,840	$98,820
4	$106,000	$119,250
5	$124,160	$139,680
6	$142,320	$160,110
7	$160,480	$180,540
8	$178,640	$200,970
For families/households with more than 8 persons, see https://aspe.hhs.gov/poverty-guidelines.		

2. Charity Care and Discounted Payment Program

Financial assistance may be granted in the form of full charity care or discounted care, depending upon the patient's level of eligibility as defined in this Policy.

The patient balances for those patients who qualify for **charity care**, as determined by the Hospital, shall be reduced to a sum equal to zero dollars ($0) with the remaining balance eliminated and classified as charity care.

The patient balances for those patients who qualify for the **discounted payment program** will be reduced; any discount will be applied against the gross charges for hospital services provided. The payment obligation of a patient eligible for the discounted payment program will be determined on a case-by-case basis but will not exceed 100% of the greater of the amount the Hospital would expect to receive for providing services from Medicare or Medicaid, whichever is greater (the "Discounted Payment Maximum"). An eligible patient with insurance will be obligated to pay an amount equal to the difference between what the Hospital receives from the insurance carrier and the

Discounted Payment Maximum. If the amount paid by insurance exceeds the Discounted Payment Maximum, the patient will have no further payment obligation.

The discounted payment program shall also include an interest-free extended payment plan to allow payment of the discounted price over time. The Hospital and the patient shall negotiate the terms of an extended payment plan, taking into consideration the patient's Family income and essential living expenses.

3. Application Process

Any patient who requests financial assistance will be asked to complete a financial assistance application. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. A patient is expected to submit the financial assistance application promptly following care, but no later than hundred eighty (180) days following the date of the first post-discharge statement. As stated above in "Other Circumstances," the Director of the Hospital's Patient Financial Services may authenticate charity care when the Hospital has reason to believe that the patient would qualify for charity care or the discounted payment program, *i.e.*, homeless.

The financial assistance application requests patient information necessary for determining patient eligibility under this Policy, including patient or family income and patient's family size. The Hospital will not request any additional information from the patient other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they so choose. Qualification for financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

4. Resolution of Disputes

Any disputes regarding a patient's eligibility for financial assistance shall be directed and resolved by the Hospital's Chief Financial Officer.

5. Publication of Policy

In order to ensure that patients are aware of the existence of this Policy, the Hospital shall take the following measures:

- Notice of the availability of financial assistance shall be clearly and conspicuously posted in locations that are visible to the patients in the following areas: (1) Emergency Department; (2) Billing Office; (3) Admissions Office; and (4) other outpatient settings including observation units; and (5) prominently displayed on the hospital's internet website, with a link to the policy itself.
- Every patient who is seen at the Hospital, whether admitted or not, shall receive the notice attached hereto as Exhibit A. The notice shall be provided at the time of service, discharge, or when the patient leaves the facility. If the patient leaves the facility without receiving notice, the Hospital shall mail the notice to the patient within 72 hours of providing service. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

- Each bill that is sent to a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge must include the notice attached hereto as Exhibit B. The notice shall be provided in non-English languages spoken by a substantial number of the patients served by the Hospital.

6. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to a patient including private health insurance, coverage offered through the federal health insurance marketplace, Medicare, Medicaid, and/or other government-funded programs designed to provide health coverage.

If a patient does not indicate that he/she has coverage by a third party payor or requests financial assistance, Hospital staff shall provide the patient with a notice in the form attached as Exhibit B that includes the following: (a) a statement of charges for services rendered by the Hospital, (b) a request that the patient inform the Hospital if the patient has private or public health insurance coverage or other coverage, (c) a statement that if the patient does not have health insurance coverage, the patient may be eligible for coverage under the state's Medicaid program or other governmental programs; (4) a statement indicating how the patient may obtain applications for the state's Medicaid program or other governmental programs (and as appropriate, the Hospital will provide such applications to the patient); and (5) information regarding the Hospital's financial assistance program. The Hospital shall also provide the patient with a referral to a local consumer legal aid assistance program.

7. Collection Activities

The Hospital may use the services of one or more external collection agencies for the collection of patient debt. No debt shall be advanced for collection until the Director of the Hospital Patient Financial Services or his/her designee has reviewed the account and approved the advancement of the debt to collection. The Hospital shall obtain a written agreement from each such collection agency that the agency will comply with the requirements of this Policy and applicable state law (including the California Health and Safety Code, for facilities located in California).

Any collection agency utilized by the Hospital shall comply with any payment plan entered into between the Hospital and the patient. If a patient applies for financial assistance, any collections actions will be suspended pending the decision on the patient's financial assistance application. If during collections, it is discovered the patient qualifies in whole, or in part, for charity care or a self-pay discount, collection efforts will cease, and the respective balance will be written off to charity care or as a self-pay discount. Neither the Hospital nor any collection agency utilized by the Hospital shall (i) use wage garnishments or liens on primary residences to collect unpaid medical bills or (ii) report adverse information to a consumer credit reporting agency or commence civil action against a patient for nonpayment at any time prior to 180 days after the initial billing.

The Hospital will send a notice to the patient before commencing any collection actions, which specifies the following: (i) collection activities the Hospital or contracted collection agency may take, (ii) the date after which such actions may be taken, (iii) that financial assistance is available for eligible patients, (iv) the dates of service of the bill that are being assigned to collections; (v) the name of the entity the bill is being assigned or sold to; (vi) information on how the patient can obtain an itemized bill from the hospital; (vii) the name and plan type of the health coverage for the patient on record with the hospital at the time of services, or a statement that the hospital does not have that information; (viii) an application for the hospital's charity care and financial assistance; and (ix) the date the patient was originally sent a notice of financial assistance application, the date or dates the patient was sent a financial assistance application, and if applicable, the date a decision was made. A template for this notice is attached hereto as Exhibit C.

For accounting purposes, any account that qualifies for bad debt under the Hospital's internal policy, but is not deemed as bad debt (resulting from revenue recognition accounting standards), will be considered and reported as patient financial assistance as a reduction to Hospital revenue.

Exhibit A
[Notice to be provided to all patients]

Summary of Financial Assistance

Eligible patients who have household family income below 450% of the current Federal Poverty Level and meet certain low- and moderate-income requirements may qualify for free care or partially discounted care and extended payment plan options from Alvarado Hospital Medical Center. Emergency Department physicians and other physicians who are not employees of the hospital may also separately offer financial assistance.

For further information or a financial assistance application, please contact us at (619) 229-3060.

Completed applications should be delivered to:
Alvarado Hospital Medical Center
Attn: Patient Financial Services
6655 Alvarado Road
San Diego, CA 92120

Additional Resources: The Health Consumer Alliance ("HCA") is a resource available to patients to help patients understand the billing and payment process, as well as Covered California and Medi-Cal Presumptive Eligibility. HCA offers free assistance over-the-phone or in-person. For more information, visit the Health Consumer Alliance website at https://healthconsumer.org.

Shoppable Services: To review this Hospital's list of shoppable services in accordance with Title 45 section 180.60 of the Code of Federal Regulations, please visit: https://www.alvaradohospital.com/patients-visitors/billing-financial-assistance/.

Exhibit B

[Notice to be included in post-discharge billing statements to patients who have not provided proof of insurance]

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medicaid, state-funded health coverage programs, or other similar programs. If you do have such coverage, please contact our office at (619) 229-3060 as soon as possible so the information can be obtained and the appropriate entity billed.

If you do not have health insurance coverage, you may be eligible for Medicare, Medicaid, coverage offered through the federal health insurance marketplace, state- or county-funded health coverage, or the Hospital's charity care or discounted payment program. For more information about how to apply for these programs, please contact our office so we can answer your questions and provide you with applications for these programs.

Exhibit C

[Hospital Notice to Send to Patient Prior to Assigning or Selling Debt to Collection Agency]
Include financial assistance application with this notice

Name: **[PATIENT NAME]**
Dates of Service: [DATES OF SERVICE]
Health Insurance on File: [INCLUDE NAME AND PLAN TYPE, IF NONE INCLUDE "HOSPITAL DOES NOT HAVE THAT INFORMATON."]
Date Patient Originally Sent Notice of Financial Assistance: [DATE]
Date Patient Originally Sent Financial Assistance Application: [DATE]
Date Decision on Financial Application Rendered (if applicable): [DATE OR "N/A"]

Our records indicate that you have outstanding patient balances due related to the above dates of services. Patients seeking discounted or free care must fill out and submit the Financial Assistance application, which is included with this notice. No patient eligible for financial assistance will be charged more for emergency or medically necessary care than amounts generally billed to individuals who have insurance covering such care. For more information, to obtain an itemized bill for the services provided to you on the above dates of service, or for assistance with the application process, please contact the Hospital at (619) 229-3060 or you may visit https://www.alvaradohospital.com or 6655 Alvarado Road, San Diego, CA 92120.

Despite our efforts to contact you, the patient balance remains unpaid. The Hospital is assigning the outstanding balance due to **[NAME OF COLLECTION AGENCY].**

Enclosure: Financial Assistance Application