PURPOSE

Barlow Respiratory Hospital (the "Hospital"), in keeping with its mission and values, provides its services without charge to eligible patients who cannot afford to pay for care. This policy provides guidelines to identify patients who potentially qualify for charity care and procedures for the processing of individual patient accounts.

PERSONS AFFECTED

Admitting
Business Services
Finance
Administration
Social Service
Case Managers
Physicians

POLICY

This Charity Care Policy is intended to comply with all applicable federal and California laws regulating charity care provided by the Hospital, including without limitation, Article 3 of Chapter 2 of Part 2 of Division 107 of the California Health and Safety Code, commencing with Section 127400. Patients who qualify for charity care will not be charged for the medical services that they receive.

DEFINITIONS

"***Family income***" means the patient's income, together with the income of the following: (1) for patients 18 years and older: the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for patients under 18 years old: the patient's parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

"***Federal poverty level***" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

"***Patient with high medical costs***" means a person who does not receive a discounted rate from the Hospital as a result of his or her third-party coverage, when either of the following apply: (1) annual out-of-pocket costs incurred by the patient, at the Hospital, exceed 10% of the patient's ***family income*** in the prior 12 months, or (2) annual out-of-pocket medical expenses incurred by the patient, anywhere, 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.

"***Self–pay patient***" means 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 Hospital.

RESPONSIBILITIES

Business Services is responsible for initial screening, which may include performing financial screening and means testing on patients to determine qualification for charity care. Admitting, Social Service, Case Managers, and physicians may request that charity determination be initiated.

POLICY STATEMENT/PROCEDURE

Amount of Charity Care

Patients who are eligible for charity care will not be charged for the medical services that they receive.

Eligibility Determination

A charity care patient is a patient whose ***family income*** does not exceed 200 percent of the ***federal poverty level***, and who is: (1) a ***self-pay patient***, or (2) a ***patient with high medical costs***.

Generally, the determination that a patient stay is considered eligible for charity care will be made upon admission or as soon as possible thereafter. However, in some cases the designation as charity care may be made after rendering services, and in some circumstances even after rendering of the bill. All services at Barlow are available as charity care.

The Financial Assistance Approval Form (see attached) shall be completed for all charity care requests and be submitted to the Director of Business Services for review. Generally, only the following may be considered in determining eligibility for charity care.

- ***Family income***, as evidenced by recent pay stubs or income tax returns;
- Whether the patient is a ***self-pay patient***; and
- Whether the patient is a ***patient with high medical costs***, as evidenced by appropriate documentation.

In no circumstances shall the following be considered in determining eligibility for charity care:

- Retirement or deferred-compensation plans qualified under the Internal Revenue Code.
- Nonqualified deferred-compensation plans.
- The first ten thousand dollars ($10,000) of a patient's monetary assets.
- Fifty percent (50%) of a patient's monetary assets over the first ten thousand dollars ($10,000).

Financial information may be verified by a third party service. In unusual circumstances (for example, there is reason to believe the patient has substantial assets despite a low family income), the Hospital may require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value. Information obtained in determining eligibility for charity care shall not be used for collections activities.

Approval of financial assistance will be denied if Medi-Cal or other health and welfare eligibility application is refused by the patient or if the patient is uncooperative or delays the process. Generally, the patient will be given 30 days to complete the necessary paperwork to apply for financial assistance, including providing supporting documents. In addition, assignment to Hospital of all insurance payments, including liability settlements, is required, within the guidelines of the Hospital Lien Act.

Final Approval and Notification of Charity Care Eligibility Decision

Charity care must be approved by either the Chief Executive Officer ("CEO") or Chief Financial Officer and documented on the Financial Assistance Approval Form. At the time a decision is made for the approval or denial of an account for charity, a letter should be sent to the patient or responsible party as notification of the decision made. The letter should be written and should include the following information:

- Patient name
- Account number(s)
- Current outstanding balance of the account(s)
- Dollar amount or number of days stay granted for charity (which generally will be all amounts)
- Any balance which will be due on the account (if only a portion of the account is to be written off to charity, for example, amounts incurred after the patient has reached a lifetime limit under his or her insurance policy)
- Detail of arrangements to pay for any remaining balance on the account after the charity write off is made (for example, amounts incurred before reaching a lifetime limit)
- Appeal process if request for financial assistance was denied.

The letter should be signed by the CEO.

A Charity Care Committee shall be established and consist of the CEO, Medical Director, Executive Director of Strategic Planning, and a Board member. The duties of the Committee are to:

- Review appeals of denials of financial assistance, including the following documentation:
    - Appeal letter to the Committee from the patient or party with financial responsibility requesting reevaluation.
    - Supporting documents that may provide inability to pay that were not part of the initial consideration.
- Make recommendations to the CEO or CFO for final approval.

Notice of Policy

All potentially eligible patients are encouraged to apply for assistance through the State, County or other programs. The Hospital shall provide patients with a clear and conspicuous written notice that shall contain information about the availability of the Hospital's Charity Care Policy and Discounts for Medical Services Provided Policy, as well as contact information for the Business Services Department (213.250.4200, Ext. 3302 or 3306), from which the person may obtain further information about such policies. Such notice shall also be provided to patients who may be billed for that care, but who were not admitted. This written notice shall be provided in English, and in any language that is spoken by more than 5% of the Hospital's patients.

Clear and conspicuous notice of the Charity Care Policy and Discounts for Medical Services Provided Policy shall be posted in locations visible to the public, including:

- The main lobby at Barlow Main
- The patient financial counseling room at Barlow Main
- The visitor waiting room at BRH@VPH
- Admissions office
- The hallway outside of the nursing station at BRH@PIH

If the Hospital bills a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge, as part of that billing, the Hospital shall provide the patient with notice that includes all of the following:

- A statement of charges for services rendered by the hospital.
- A request that the patient inform the Hospital if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or other coverage.
- A statement that if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Childrens' Services Program, or charity care.
- A statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program and that the Hospital will provide these applications. If the patient does not indicate coverage by a third party, or requests a discounted price or charity care, then the Hospital shall provide an application for the Medi-Cal program to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving outpatient care.
- Information regarding the charity care application, including a statement that if the patient lacks, or has inadequate, insurance, and meets certain low-and moderate-income requirements, the patient may qualify for discounted payment or charity care, and the contact information for the Business Services Department (213.250.4200, Ext. 3302 or 3306), from which the person may obtain further information about such policies, , and how to apply for such assistance.

Other

Normal charging procedures will be followed by the Hospital for recording services provided to charity care patients.

Collection activity by the Hospital will cease when (i) the patient is declared eligible for charity care or (ii) the patient is attempting to qualify under the Hospital's Charity Care Policy and is attempting in good faith to settle an outstanding bill by negotiating a reasonably payment plan or by making regular partial payments of a reasonable amount (unless any collection agency to which such patient's bill has been forwarded has agreed to comply with the provisions of Article 3 of Chapter 2 of Part 2 of Division 107 of the California Health and Safety Code, commencing with Section 127400).

The completed Financial Assistance Approval Form will be filed in Business Services.

The amount of charity care provided will be reported separately in the monthly financial statements.

APPROVED BY:

_____

Name/Title/Date

_____

Name/Title/Date

_____

Name/Title/Date

PURPOSE

To establish guidelines for providing discounts off charges for medical care provided by Barlow Respiratory Hospital.

PERSONS AFFECTED

Medical Staff
Administration
Barlow Respiratory Hospital, Barlow Research Center, and Barlow Foundation Employees
Admitting
Ambulatory Care
Business Services

POLICY

General

This discount policy ("Policy") is intended to comply with all applicable federal and California laws regulating discounts provided by Barlow Respiratory Hospital (the "Hospital"), including without limitation, Article 3 of Chapter 2 of Part 2 of Division 107 of the California Health and Safety Code, commencing with Section 127400.

Definitions

"***Family income***" means the patient's income, together with the income of the following: (1) for patients 18 years and older: the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for patients under 18 years old: the patient's parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

"***Federal poverty level***" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

"***Financially qualified patient***" means a patient whose ***family income*** does not exceed 350 percent of the ***federal poverty level,*** and who is: (1) a ***self-pay patient***, or (2) a ***patient with high medical costs***.

"***Patient with high medical costs***" means a person who does not receive a discounted rate from the Hospital as a result of his or her third-party coverage, when either of the following apply: (1) annual out-of-pocket costs incurred by the patient, at the Hospital, exceed 10% of the patient's ***family income*** in the prior 12 months, or (2) annual out-of-pocket medical expenses incurred by the patient, anywhere, 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.

"***Self–pay patient***" means 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 Hospital.

Patient Discounts

Coinsurance and Copayments: Non-Federal Health Program, Insured Patients

In certain circumstances, Admitting negotiates contract terms with insurance companies that waive patient coinsurance and copayment responsibilities. Except as otherwise provided in this Policy, these amounts may be waived only under such circumstances.

Coinsurance and Copayments: Federal Healthcare Program Patients

Business Services may offer a federal healthcare program patient a discount of up to 30% off the Hospital's standard charges after services have been rendered, which discount shall be applied to the patient's coinsurance or copayment amount, as applicable. This discount is not a "standing" or "routine" discount, and is to be offered on a case by case basis toward a patient's coinsurance or copayment amounts during the collection process after services have been rendered, depending on the facts and circumstances and in the exercise of the Hospital's commercially reasonable judgment.

If the discount relates to Hospital inpatient services, then the following four requirements should be met:

1. The coinsurance or copayment amounts reduced must be (i) owed to the Hospital, (ii) for inpatient hospital services, and (iii) reimbursed under the Medicare Part A prospective payment system;

2. The Hospital must not later claim the amount reduced as bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction onto Medicare, a state health care program, other payors or individuals;

3. The Hospital must offer to reduce the coinsurance or copayment amounts without regard to (i) the reason for admission, (ii) the length of stay of the patient, or (iii) the diagnostic related group for which the claim for Medicare reimbursement is filed; and

4. The Hospital's offer to reduce or waive the coinsurance or copayment amounts must not be made as part of a price reduction agreement between the Hospital and a third-party payor, unless the agreement is with the furnisher of a Medicare SELECT policy (but not a Medigap policy).

If the discount does not relate to Hospital services reimbursed under Medicare Part A, the discount may be provided if the following three requirements are met:

1. The waiver is not advertised;

2. The waiver is not routinely offered; and

3. Either the waiver is made following an individualized, good-faith assessment of financial need, or the waiver is made after reasonable efforts have failed to collect the copayment or coinsurance directly from the patient.

*Discounts to **Financially Qualified Patients***

Any patient who the Hospital determines to be a ***Financially Qualified Patient***, in accordance with (and as defined in) this Policy, shall be eligible for and receive a discount off the Hospital's charges.

Application for Discounted Payment or Charity Care. Any patient (or patient's legal representative) requesting a discount, charity care or other financial assistance from the Hospital shall complete and submit to the Hospital an Application for Discounted Payment or Charity Care (the "Application"). In submitting the Application, the patient (or patient's legal representative) shall make every reasonable effort to provide the Hospital with supporting documentation of the patient's ***family income*** and the patient's health benefits coverage. For these purposes, documentation of ***family income*** shall be limited to recent pay stubs or income tax returns.

Determining Eligibility. The Hospital shall review each patient's Application, together with supporting documentation and other relevant information available to the Hospital, to determine whether that patient is a ***Financially Qualified Patient***, as defined in this Policy, and hence eligible for discounts. The Hospital shall make all reasonable efforts to obtain, from the patient or patient's representative, information about whether a third-party payor may fully or partially cover the charges. If the patient or patient's representative fails to provide information that is reasonable and necessary for the Hospital to make a determination regarding the patient's eligibility for discounts under this Policy, the Hospital may consider that failure in making its determination. If a patient or patient's representative disputes the Hospital's initial determination of the patient's eligibility for discounts under this Policy, then the patient or patient's representative may seek review by the Director of Business Services. The Hospital may determine a patient's eligibility for discounts hereunder any time the Hospital is in receipt of information reasonable and necessary for the Hospital to make such a determination.

Amount of Discount. Anyone determined by the Hospital to be a ***Financially Qualified Patient*** shall receive a discount off the Hospital's charges, such that the discounted price for the Hospital's services shall be equal to the amount of payment the Hospital would receive, for providing such services, from Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program of health benefits in which the Hospital participates, whichever amount is greatest. If the Hospital provides a service for which there is no established payment by any government-sponsored program of health benefits in which the Hospital participates, the Hospital shall establish an appropriate discounted payment.

Deposit. Upon admission, any ***self-pay patient*** shall be required to make an initial deposit of $20,000. A separate financial agreement specifying the terms of the ***self-pay patient***'s arrangements is required to be prepared by Business Services and signed by the ***self-pay patient*** or ***self-pay patient***'s representative. Promptly after discharge, the Hospital shall reimburse the ***self-pay patient*** any amount paid in excess of the amount due under this Policy, including any amount remaining on deposit.

Installment Payments. Any ***Financially Qualified Patient*** who receive discounts under this Policy may also pay the discounted price in periodic installments, in accordance with an extended payment plan negotiated between the ***Financially Qualified Patient*** and the Hospital. The Hospital shall not charge interest under any such extended payment plan.

Notices. The Hospital shall provide all patients with a written notice containing information about the availability of the Hospital's discount policy, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. This written notice shall be provided in English, and in languages other than English.

Notice of the Hospital's policy for ***financially qualified patients*** shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to the billing office and admissions office.

If the Hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, then as a part of that billing, the Hospital shall provide the patient with a clear and conspicuous notice that includes all of the following: (1) a statement of charges for services rendered by the Hospital; (2) a request that the patient inform the Hospital if the patient has health insurance coverage, including Medicare, Healthy Families, Medi-Cal, or other coverage; (3) a statement that if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program, or charity care; (4) a statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program and that the hospital will provide these applications (if the patient does not indicate coverage by a third-party payer, or requests a discounted price or charity care, then the Hospital shall provide an application for the Medi-Cal program, the Healthy Families Program or other governmental program to the patient, prior to discharge if the patient has been admitted, or to patients receiving outpatient care); (5) information regarding the Application for Discounted Payment or Charity Care, including the following: (a) a statement that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care, (b) the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount policy, and (c) how to apply for that assistance.

Approval of All Discounts

All discounts must be approved by the Director of Business Services, and any discounts exceeding $250 also require approval from either the CFO or CEO.

Employee and Physician Discounts

Employee Discounts

As a perquisite of employment, all full-time and part-time Barlow Respiratory Hospital, Barlow Research Center, and Barlow Foundation employees and their spouses, parents, and children, are provided a discount of 20% off the Hospital's standard charges for any inpatient and outpatient services provided to them at the Hospital. Per diem and temporary employees are not eligible for this benefit. Eligible employees and their family members who are eligible for a federal health program (e.g., Medicare) will not receive this discount for outpatient services.

Physician Professional Courtesy Discounts

As also referenced in policy CC #76, Business Courtesies to Potential Referral Sources, professional courtesy discounts are available to all retired physicians and physicians on the Hospital's medical staff and their immediate family members for health care services of the type routinely offered by the Hospital, provided, however, that if the physician (or immediate family member) is a Federal health program beneficiary, then professional courtesy discounts are available *only* upon a good faith showing of financial need.

The professional courtesy discount is 10% off the Hospital's standard charges for any inpatient or outpatient services provided at the Hospital.

Procedures for Applying Employee and Physician Discounts

The employee and physician discounts described above apply to the patient's financial responsibility for the bill, after insurance coverage.

Admitting and Ambulatory Care shall notify Business Services when services are rendered to an eligible employee, physician, or immediate family member so that Business Services can ensure that the discount is properly applied.

Business Services shall maintain a log of all discounts given, including appropriate approvals as required by this policy (see sample log attached), and shall verify that the insurer has been notified in writing if the discount involves any whole or partial reduction of any coinsurance obligation. Business Services shall note all discounts given in the patient account notes.

Pharmacy Purchases

As a convenience to our employees, retired physicians and physicians on the Hospital's medical staff, and their immediate family members, the Hospital provides prescription and non-prescription drugs for the personal use of our employees, physicians and/or their dependants if the drugs are usually and customarily "in stock" in the Hospital pharmacy. The Hospital will dispense the prescription and non-prescription drugs within the normal pharmacy standards and practices.

The Hospital will provide these prescription and non-prescription drugs at the Hospital's cost plus required government tax plus a 2% markup for administration of the program. Employees and physicians will pay the Hospital for these purchases with cash or check.

Annual Flu Shots

An annual flu shot is provided free of charge to all full-time and part-time employees, and physicians on the medical staff in good standing.

APPROVED BY:

_____

Name/Title/Date

_____

Name/Title/Date

_____

Name/Title/Date