PURPOSE

As declared in our mission statement, Community Hospital of the Monterey Peninsula ("Community Hospital") is committed to caring for all who come through our doors, regardless of ability to pay, to the fullest extent allowed by law and available resources. This policy is intended to provide the framework for our Sponsored Care Program and Discount Payment Program.

POLICY

In addition to the information outlined in this policy, patients should be aware that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility. Patients may visit the Health Consumer Alliance website for more details: https://healthconsumer.org. Patients may also access Community Hospital's list of shoppable services at https://www.montagehealth.org/patient-family-resources/Billing-Insurance-Financial Assistance/cost-care-estimates.

A. Uninsured patients and patients with high medical costs whose income is below 400 percent of the federal poverty level are eligible to apply for financial assistance for medically necessary hospital and hospital-based physician services provided by Community Hospital of the Monterey Peninsula. Qualifying applicants will be granted the highest award for which they are eligible.

    1. Sponsored Care – This program may give a patient a discount of up to 100 percent on the services she or he received. To qualify, the patient's gross family income must not exceed 300 percent of the federal poverty level. Patients must provide information and documentation about their family members' income and about any health benefits coverage they have.

    2. Discount Payment Program—This program may give a patient a discount to reduce the amount she or he owes. To qualify, the patient's gross family income must not exceed 301- 400 percent of the federal poverty level. Patients must provide information and documentation about their family members' income and any health benefits coverage they have.

B. Applications from patients whose income is above 400 percent of the federal poverty level will also be thoroughly reviewed, and awards will be granted on a case-by-case basis.

C. Emergency department physicians who provide emergency medical services at Community Hospital are required to provide discounts to uninsured patients and patients with high medical costs whose income is at or below 400 percent of the federal poverty level.

D. Current and prospective patients may apply for the Sponsored Care Program or the Discount Payment Program. Information about these programs is available at all patient intake and treatment locations within Community Hospital facilities and

is provided to each patient presenting for services. An application for the Sponsored Care and Discount Payment program will be provided to all patients who request one. Additionally, enrollment counselors are available to provide information and applications for Medi- Cal, Medicare, California Health Benefit Exchange, and other available government programs. A pre-screening interview may be done with patients to ensure that they meet the basic eligibility criteria.

E. The criteria Community Hospital will follow in verifying a patient's eligibility for financial assistance programs are described in this policy. Monetary assets will not be considered in determining eligibility for financial assistance, in accordance with HCAI regulations. Upon approval, financial assistance is provided through one of two programs: (1) the Sponsored Care Program; or (2) the Discount Payment Program. These programs may cover all or part of the cost of services provided, depending on the patient's eligibility, income, and. The Sponsored Care and Discount Payment programs are intended for patients who's personal or family financial ability to meet hospital expenses is absent or demonstrably restricted. The minimum requirement for both programs is stated below based upon the patient's combined family income as a percentage of the applicable federal poverty level (FPL) as published annually in the Federal Register (http://aspe.hhs.gov/poverty). Given Community service area demographics, available resources, and mission to meet the healthcare needs of its community, financial assistance is available for patients with income levels up to 400 percent of the FPL for the patient's family size. Community Hospital's Sponsored Care and Discount Payment programs are intended to fully comply with the Hospital Fair Pricing Policies Act and Section 501(r) of the Internal Revenue Code. This policy is intended to be stated as clearly and simply as possible for the benefit of our patients.

Financial Assistance may be applied to uninsured patients, as well as any medical care not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost-sharing. Policy AD-1029 outlines Montage Health's process for determining eligibility for this program.

Non-covered and denied services provided to Medicaid-eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability. All charges related to services not covered, including denials, are considered charity care. Examples may include, but are not limited to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)

- Medicaid-pending accounts
- Medicaid or other indigent care program denials
- Charges related to days exceeding the length-of-stay limit
- Medicaid claims (including out-of-state Medicaid claims) with "no payment""
- Any service provided to a Medicaid-eligible patient with no coverage and no payment

Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at Community Hospital. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.

F. Discovery of Patient Financial Assistance Eligibility during Collections. While Community Hospital strives to determine patient financial assistance as close to the time of service as possible, in some cases, further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified before initiating external collection action. The collection agencies shall be made aware of this possibility and are requested to refer back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Community Hospital will reverse the account out of bad debt and document the respective discount in charges as charity care.

G. Negotiations with insurance carriers involving inferred contractual relationships for insured patients not under contract with Community Hospital will be conducted by executive management. Although Community Hospital may agree to the terms of the negotiations with insurance companies, an inferred contractual relationship is not representative of a patient "under contract" with the hospital. Community Hospital considers any reimbursement of less than 20% of cost to be charitable event. Any care provided to a presumptive or actual case of COVID-19 is provided at an amount no greater than what the patient would have otherwise been required to pay if provider. All unreimbursed amounts are a form of patient financial assistance and are determined as the difference between gross hospital charges and hospital reimbursement.

Applying for Assistance

A. Requests for financial assistance may be made verbally or in writing at any point before, during, or after the provision of care. Financial assistance applications

are provided to all patients in the primary language of 5 percent or more of the primary community serviced by the hospital.

B. Applications for Sponsored Care or Discount Payment program must be submitted to the Service department prior to service or to the Patient Business Services or Patient Access department during and/or after receiving services by using the Application for Sponsored Care or Discount Payment Program. Incomplete applications will remain on file and may be completed at any time. Community Hospital will not impose arbitrary deadlines for submission of documentation and will make reasonable efforts to assist patients in completing their applications. In addition to a completed application, a letter explaining the patient's circumstances and/or a letter from the person(s) providing living assistance to the patient may be requested.

   • See Eligibility Criteria below.

   A patient (or a patient's legal representative) who requests Sponsored Care or Discount Payment, must make every reasonable effort to provide documentation of income and health benefits coverage. Community Hospital will accept other reasonable evidence of income or financial status if standard documentation is not available. Uninsured patients, who are eligible for a government- sponsored health benefit plan, or health benefit coverage through the California Health Benefit Exchange with a government subsidy, will be informed of those programs and encouraged to apply, but application to such programs is not a requirement for receiving Sponsored Care or Discount Payment assistance This also applies to patients who are at or below 138 percent of the federal poverty level, who are eligible for modified adjusted gross income Medi-Cal. Hospital enrollment counselors will be available to assist patients with the application process for government-sponsored health benefit plans, health benefit coverage through the California Health Benefit Exchange, Medi-Cal, Medicare, and other available programs. Applying for these programs will be encouraged but will not be a requirement for Sponsored Care When patients do not cooperate with the enrollment counselors, Community Hospital will make reasonable effort, through letters and telephone calls, to encourage patients to cooperate prior to its review and decision regarding Sponsored Care and/or Discount Payment eligibility.

   Applications may be denied and the associated account(s) referred to a collection agency if documentation sufficient to determine eligibility is not provided. However, Community Hospital will not initiate adverse credit reporting or civil action for nonpayment until at least 180 days after the initial billing. Patient debt will not be sold unless all HCAI conditions are met.

C. If a patient applies or has a pending application for another health coverage program at the same time they apply for the hospital Sponsored Care or Discount

Payment Program, the pending status of either application shall not prevent or delay the review of or action on the other.

D. This policy applies only to emergency and medically necessary services provided by Community Hospital. Services provided at a hospital facility by private healthcare providers, such as personal physicians and ambulance conveyance, are not covered by the Sponsored Care and Discount Payment programs. Community Hospital maintains a list of providers delivering emergency or other medically necessary care covered by the Sponsored Care and Discount Payment programs. The list is available on the hospital's website at: www.chomp.org. These programs are available only for emergency and medically necessary services provided by Community Hospital that are not covered by any other government programs or funding sources, including third-party insurance coverage for which an individual applicant is eligible. See the list of non-covered services below.

E. All medically necessary Services are eligible for Sponsored care and discount payment programs. Services performed within the hospital are presumed medically necessary unless an attestation is provided indicating otherwise. Attestations will be signed by the referring provider or supervising healthcare provider for services in questions. Attestation will be obtained before denying a patient's eligibility for Sponsored Care or discount payment programs for all services in question for non-medical necessity. Below are some examples of possible non-covered services:

   A. All healthcare services not billed by Community Hospital, such as non-hospital-based physician services and ambulance transportation

   B. Non-medically necessary bariatric surgery

   C. Non-medically necessary cosmetic services

   D. Services which, in the opinion of competent hospital staff, are provided only as a stop- gap when a patient is staying at the hospital, or at Westland House, for the convenience of the family and/or physician

   E. Non-medically indicated care

   F. Durable medical equipment

   G. Oxygen and oxygen supplies, except when pre-approved

   H. Any service or product considered to be experimental

   I. Services or products unapproved for patient use by the FDA

   J. Services or products that would effectively place the hospital in the position of having to provide such services or products for extended periods of time, including when the patient is not a patient of Community Hospital.

Discount Payment Program

A. Community Hospital is committed to providing qualifying uninsured patients and insured patients with any expenses for medical care that are not reimbursed by insurance or health coverage program, such as Medicare copays or Medi-Cal cost sharing, as defined below, with a discount that exceeds that provided to participants in the Medicare program. Among government-sponsored health benefit programs, Medicare provides the highest reimbursement rates and is accepted by Community Hospital. No individual who qualifies for the Discount Payment Program will be charged more than the amount generally billed ("AGB") by Community Hospital to individuals who have insurance covering such emergencies and/or medically necessary care. Community Hospital calculates the AGB using the prospective Medicare method described in 26 C.F.R. § 1.501(r)-5(b)(4). All patients who qualify for the Discount Payment Program will also be eligible for a zero-interest extended payment plan on the remaining balance. The hospital limits expected payment for services it provides to a patient at or below 400 percent of the federal poverty level, eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive providing the services from Medicare and Medi-Cal, whichever is greater.

B. The total gross charge for services and the discount to be applied will be shown on the award letter. These discounts apply to any expenses not covered or reimbursed by the insurance or health coverage program.

C. Demonstrating Eligibility

1. Uninsured and underinsured patients are required to provide according to 22 CCR 96051.7 (b):
    - Recent tax returns: from the year the poatient was first billed or the prior 12 months
    - Recent stubs (within 6 months before or after the billed date or application submission
    - Other reasonable documentation that reflects the patient's financial situation

D. Payment plan

1. Patients who qualify for the Discount Payment Program will also be eligible for an interest-free payment plan. In situations where an agreement cannot be reached, a minimum monthly payment amount should not exceed 10 percent of the patient's family's monthly income (after essential living expenses). Any payment plan that remains unpaid for 90 consecutive days will be declared delinquent and may be advanced

for collection activity after attempts have been made to renegotiate the terms of the defaulted payment plan. See Procedure for Financial Assistance Program, Sponsored Care and Discount Payment Program AD- 1029.

Sponsored Care (free care of charity care)

A. Community Hospital is committed to providing qualifying patients , as defined below, with a 100 percent discount on the amount determined to be due from the patient. This discount applies expenses for medical care that are not reimbursed by insurance or health coverage program, such as Medicare copays or Medi-Cal cost sharing.

B. Requests for financial assistance may be made verbally or in writing at any point before, during, or after the provision of care.

C. Demonstrating Eligibility
    1. Patients are required to provide according to 2CCR 96051.7 (b):
        - Recent tax returns: from the year the patient was first billed or the prior 12 months
        - Recent pay stubs (within 6 months before or after the billing date or application submission
        - Other reasonable documentation that reflects the patient's financial situation

D. Presumptive Charity Care

Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates hardship. Examples of these exceptions where documentation requirements are waived include but are not limited to: enrollment in public assistance programs such as CalFresh, CalWORKs, WIC, General Assistance, or other means-tested programs; homelessness; or prior eligibility for financial assistance within the past 6 months.

- An independent credit-based financial assessment tool indicates indigence.
- An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
    - Patients have an active Medicaid plan
    - Patients are eligible for Medicaid or patients with current active Medicaid coverage will have assistance applied for past dates of service
    - Patients are deceased without a surviving spouse and/ or estate

- Determination of patient financial assistance eligibility.

Presumptive eligibility tools may not be used for the following:

- Patients who have not provided the Coordination of Benefits as requested by their insurance.
- Another form of medical payment that claim processing has not yet been completed such as a cost share plan.
- Patient service resulted in a Third-Party payor or any legal settlements, judgments or awards to be issue

Dispute/Appeal process

If the patient/guarantor appeals the original decision, additional supporting documentation must be submitted along with the written request for review to Patient Business Services, within 30 days of the original approval/denial date. These steps are to be followed:

1. . Refer to request to customer service supervisor for initial review.
2. If Supervisor review leads to a change I original determination, the application can be processed with additional documentation.
3. If the original determination is to be upheld, the supervisor will refer to the director for further review and determine a response to the patient.

Special Circumstances

Uninsured patients and patients with income that exceeds 400 percent but is less than 500 percent of the applicable federal poverty level will be awarded a 25 percent discount on total patient balance and will also be eligible for a zero-interest extended payment plan for the remaining balance.

Payments in excess of the amount due after discount

In the event the Community Hospital collects payments from a patient who subsequently qualifies for the Sponsored Care or Discount Payment Policy, Community Hospital will refund any excess previously paid by the patient, together with interest thereon at the current rate (refer to refund procedure) per annum from the date Community Hospital received the overpayment. This does not apply to overpayments of less than $5. Community Hospital will refund the patient within 30 days. Refunds will not be eligible for the following, unless otherwise required by law or regulation:

- It has been five years or more since the patient's last payment to the hospital..

Policy maintenance and reporting

This policy document is to be reviewed annually for consistency with all applicable laws and available resources. Additionally, this information must be submitted to California Department of Health Care Access and Information every other year on January 1, or whenever a significant change is made. To make the Sponsored Care and Discount Payment policies available to the community, the hospital will publish the policy and application on its website and include application information in its initial billing statements.

Practice

See procedure document, Sponsored Care and Discount Payment Program AD-1029.

Definitions

The following terms have the following meanings:

A. Federal poverty level means the poverty guidelines specific to income and family size, which are updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

B. Underinsured means having health insurance that does not cover all the medical expenses and may face high out-of-pocket costs, deductibles, or co-payments that can lead to financial hardship.

C. Patient's family means the following:

1. For persons 18 years of age and older, family includes dependent children of any age and accounts for the inclusion of parents when the patient is a dependent child who is not a minor defined in Section 297 of the Family Code.

2. Family includes parents, caretaker relatives, and other children of the parent or caretaker relative.

D. Hospital-based physicians mean doctors who provide services at Community Hospital and are billed under Community Hospital's Provider Identification Number (PIN). These include Emergency department physicians, radiologists, pathologists, cardiologists, radiation oncologists, and psychiatrists.

Access to Healthcare During a Public Health Emergency

Executive leadership must proclaim an Access to Healthcare Crisis; an Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of Community Hospital's community during the Access to Healthcare Crisis. During an Access to Healthcare Crisis, Community Hospital may "flex" its patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as an addendum if an Access to Healthcare Crisis is proclaimed. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

CONTENTS	DESCRIPTION
Submitted by:	Director, Revenue Cycle
Next review date:	January 2026
Effective date:	January 2022
Applicable to:	Patient Business Services Staff, Patient Access Staff, Social Services Staff, Radiology Staff, Rehabilitation and Wound Staff, Diabetes and Nutrition Staff, Cardiology Staff, Ohana Staff.
Approved by:	Patient Business Services, Patient Access, Social Services, Radiology, Rehabilitation and Wound, Diabetes and Nutrition, Cardiology, Ohana President's Administrative Committee (PAC), The Board.
Reviewed by:	Patient Access, Patient Business Services, Social Services, Radiology, Rehabilitation and Wound, Diabetes and Nutrition, Cardiology, Ohana. PAC, The Board
Replaces:	
References:	Patient Business Services Procedure: Sponsored Care and Discount Payment Program, Federal poverty level defined in the Federal Register (http://aspe.hhs.gov/poverty).
Key Words:	Low income, federal poverty level, family income, charity care, financial assistance eligibility criteria and application, enrollment counselor.
Distribution:	CHOMP Intranet Policies and Procedures; Patient Business Services Staff. Patient Access Staff, Social Services Staff, Radiology Staff, Rehabilitation and Wound Staff, Diabetes and Nutrition Staff, Cardiology Staff, Ohana Staff.
Additional information:	
Related policies or programs:	Procedure for Financial Assistance Program, Sponsored Care and Discount Payment Program AD-1029 and AD-1031 General Administrative Policy – Collection Policy