COALINGA REGIONAL MEDICAL CENTER FINANCIAL ASSISTANCE POLICY

Department: Patient Financial Services
Category: Policies
Subject: Financial Assistance Program
Effective Date: January 1, 2024

POLICY:

Overview: Coalinga Regional Medical Center (CRMC) is committed to providing medical care to all patients, regardless of their financial circumstances. In recognition of financial hardships, CRMC offers a Financial Assistance Program to reduce or eliminate medical bills for patients who meet specific eligibility criteria.

Program Description: The Financial Assistance Program is designed to provide relief from medical expenses for eligible individuals who are uninsured, underinsured, or experiencing high medical costs relative to their income. The program covers medically necessary services provided by CRMC, ensuring that no patient faces an undue financial burden for essential healthcare.

Eligibility Criteria: Eligibility for financial assistance is based on the patient's family income, insurance status, and medical costs, as outlined below:

Charity Care:

a. Eligibility criteria:

   i. Patients whose family income is at or below 400% of the Federal Poverty Level (FPL);
   ii. No third-party payor; and,
   iii. Limited assets not including those listed below.

b. Both patient income and monetary assets of the patient will be considered but shall not include:

   i. Retirement or deferred compensation plans qualified under the internal Revenue Code (i.e. 401k, IRA);
   ii. Non-qualified deferred compensation plans;
   iii. The patient's first $10,000 of assets or more than 50% of monetary assets over the first $10,000.

Discount Payment:

a. Eligibility Criteria:

   i. Uninsured patients or insured patients with high medical costs whose income is at or below 400% of the Federal Poverty Level (FPL)

b. Extended payment plan to allow payment of the discounted price overtime

i. The hospital and the patient will negotiate the terms of the payment plan and take into consideration the patient's family income and essential living expenses.

ii. If the two parties cannot agree on the plan, the hospital will create a reasonable payment plan, where monthly payments are not more than 10% of the patient's family income and essential living expenses.

The granting of charity care or discounted payments shall not be based on an individualized determination of financial need and will NOT take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Eligible persons may have payments adjusted on a sliding fee scale, in accordance with financial needs, as determined in reference to the FPL in effect at the time of the determination. The basis for the amounts charged for qualified persons is as follows:

- Patients whose family income is at or below 400% of the FPL may receive free care.
- Patients whose family income is at or below 400% of the FPL but no more than 600% of the FPL are eligible to receive services at discounted rates.
- Patients whose family income exceeds 600% of the FPL may be eligible to receive discounted rates on a case-by-case basis, based on their specific circumstances, such as catastrophic illness.
- Any expected payments from those eligible patients would not exceed the payments that would be expected from Medicare or Medi-Cal, whichever is greater. If there is no established payment for the service under Medicare or Medi-Cal, the hospital may establish an appropriate discount payment.

Special Circumstances:

a. Patients who have filed for bankruptcy or are deceased with no remaining estate are automatically eligible for full financial assistance.

b. Patients facing extraordinary financial hardships, such as job loss, may also qualify for assistance.

c. Emergency Room Physicians are required by law to provide discounts to patients who are uninsured or whose family income is at or below 400% of FPL.

PROCEDURE:

I. Pre-Admission

a. The hospital will make reasonable efforts to obtain from the patient or the patient's representative, information about whether private or public health insurance may fully or partially cover the charges for services provided by the hospital to the patient including, but not limited to:

i. Private health insurance (including insurance offered through the state health benefit exchange)
ii. Medicare
iii. Medi-Cal or other state funded health coverage programs

b. The hospital will provide all persons without insurance with a written estimate of the amount the hospital will require patients to pay for the health care services provided.

II. Patient Admission

a. Upon admission (within 3 days of admission) the patient or the representative will be provided with written documents about the financial assistance policy (i.e. discounted payment and charity care) of the hospital which will include but is not limited to:

i. A statement indicating that if the patient lacks or has inadequate insurance and meets certain low- and moderate- income requirements that the patient may qualify for discounted payments or charity care.
ii. A telephone number from which the patient may obtain information about discounted payments or charity care and how to apply for that assistance.

b. If the patient is not competent or able to receive the notice during the admission process, the notice will be provided at the latest during the discharge process or via United States Postal Mail within 72 hours of providing the services, and include:

i. Eligibility criteria contact information for the hospital administrator where they may obtain additional information about the hospital policies.
ii. The Internet address for Health Consumer Alliance (https://healthconsumer.org).

c. In addition, the hospital's policy regarding discounted payment and charity services will be posted in location(s) that are visible to the public, such as admissions office and hospital lobby in addition to the hospital's Internet website.

d. These notices will be made available in at least English and Spanish to meet the primary languages spoken in the community. For any patient who is unable to understand the information in written formats available, the information will be provided by reading the information to the patient utilizing language or auditory interpreter services.

e. Patients admitted to the hospital that do not have coverage by third-party payer or those that request a discounted price or charity care will receive an application and assistance in completing the application for the Medi-Cal program or other state- or county- health funded health coverage program.

III. Application Process

a. Patients seeking financial assistance must complete the Financial Assistance Evaluation Application, or the Discount Payment Application available through CRMC's Patient Financial Services Department. The following steps outline the process:

b. Submission:

i. Applications can be submitted before, during, or after receiving care.
ii. Supporting documentation must accompany the application.

c. For purposes of determining eligibility for Discount and Charity Care, documentation of income shall be limited to:

i. Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed.
ii. Three months' pay stubs from within the 6 months before or after the patient is first billed (or in preservice when the Application is submitted)

d. Timeline:

i. Once the application is received, patients have three weeks (21 days) to submit all required documentation.

CRMC's Patient Financial Services Department reviews all applications. Eligibility is based on income, family size, and medical expenses. Patients will receive a written determination within 30 days of submitting a completed application.

Note: information obtained through the financial application process will **NOT** be used in the collection activities.

Assistance: The Patient Financial Services Department is available to assist patients with completing the application, including providing translations as needed.

Validity: Approved applications are valid for 180 days. Patients may reapply or update their application if their financial situation changes.

Appeal Process: Patients may appeal a denied application by submitting a written appeal to the Patient Financial Services Department within 30 days of the decision.

Appeals will be reviewed by the Director of Revenue Cycle, with a final determination made within 30 days of the appeal.

IV. Debt collections for eligible patients

a. If payment has not been received in full by 180 days, Patient Financial Services shall enforce its cash collection program. CRMC shall not allow an account to have adverse information reported to a credit- reporting agency or commence civil action against a patient for non-payment at any time prior to 180 days after billing. If a patient has a pending appeal for coverage of services, CRMC shall not allow an account to have adverse information reported to a credit-reporting agency or commence civil action against the patient for non-payment at any time prior to 180 days after the patient appeal is completed.