| Community Healthcare Partner, Inc.<br><br>**POLICY AND PROCEDURE** | Subject: Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy | Item No.<br>8530-200<br><br>Page 1 of 8 |
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| Supersedes: NEW<br>Revised/Effective: 06/13, 8/22 | Scope: Hospital Wide | |
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| Administrative Approval: | | Date: |

Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy is a "resource of last resort" for patients who fail to qualify for adequate health insurance, Federal, State or Local medical assistance programs, grants, and other forms of aid for services provided at Colorado River Medical Center (CRMC).

**I. POLICY:**

It is the policy of CRMC to provide general acute and outpatient care throughout all areas of the Hospital for all patients regardless of their ability to pay. Financial assistance is extended in accordance with AB774 and the mission and values of the hospital, ensuring a demonstrative public benefit to the community.

Consideration is given to any patient based upon financial resources. Screening and processing is conducted without concern for residency, gender, ethnic origin or employment status. Annual income is the primary factor in determining eligibility.

Uninsured patients or their guarantor (responsible party) earning between 201% and 275% of the Federal Poverty Guideline are eligible for an AB774 Discount. The related patient accounts will be written down in accordance to the CRMC Sliding Fee Scale based on guarantors income and family size. Uninsured patients or their guarantor (responsible party) earning 200% of the Federal Poverty Guideline or less will be granted Charity Care.

Uninsured individuals earning above 275% of the Federal Poverty Guideline whose bill creates an undue financial hardship will be considered for discounts on a case by case basis. (See III.5.D.)

Any patient dissatisfied with CRMC's decision regarding AB774 Discount or Charity Care determination will be able to appeal that decision by submitting concerns in writing to CRMC's Compliance Committee.

**II. DEFINITIONS:**

**Annual Income:** Annual gross income as reported on the most recently filed income tax return of all members of the family household.

**Family Household:** Defined by the inclusion of the applicant, the applicant's spouse (if any) and the applicants dependent(s), (if any).

**Self Pay:** Patient without insurance coverage or other payer source.

**Financial Class-1:** Patient financial status pending review for Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy.

**Financial Counselor:** A hospital employee specially trained to assist patients, guarantors, and families to reach an acceptable resolution to identified financial limitations.

**Case Management:** A process managed by a licensed nurse to monitor level of care issues, act as a liaison between patient, physician, other providers of medical and social services and insurance payers. Additionally, case managers are instrumental in the process of discharge planning to insure a smooth transition to home or next level of care.

## III. UNDERINSURED/UNINSURED PATIENT DISCOUNT/SLIDING FEE AND CHARITY CARE POLICY CRITERIA

1. Types of Services Covered:

   A. All general acute care hospital service.
   B. Cosmetic surgeries and skilled nursing services are not covered.

2. There is no requirement for residency in order to be considered for assistance.

3. All homeless and uninsured patients are automatically screened for assistance.

4. Insurance Issues:

   A. Medi-Cal Share of Cost recipients does not qualify for Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy. These patients have a predetermined financial responsibility that has been predetermined by Medi-Cal.

   B. Inpatient days denied by Medi-Cal as not medically necessary become eligible for Charity Care write-off in the denial is upheld following CRMC appeal. The Medi-Cal denied day is adjusted for purposes of stating the "uncollectible" as the charity in preference to inflating the Medi-Cal contractual allowance.

   C. Patients with Medicare and commercial HMO/PPO coverage are eligible for Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy. If these patients have large out of pocket expenses they will be considered and approved for Sliding Fee and/or Charity Assistance if they meet all financial requirements. No discount will be applied to the remaining portion of the patient's claim after their primary and any secondary insurance payments and contractual adjustments are applied.

5. Financial Status Criteria.

   A. The Financial Assessment Worksheet (Exhibit C) is used to calculate income, where appropriate, 50% of monetary assets after the first $10,000.

   B. Patients/families whose yearly gross income is between 200% of the Federal Poverty Limit Guidelines (see attached Exhibit A).

      Eligible Amount: 100% write off to Charity Care

   C. Patients/families whose yearly gross income is between 201% and 275% of the Federal Poverty Limit Guidelines (see attached Exhibit A).

      Eligible Amount: Based on Sliding Fee Schedule according to income and family size.

   D. Patients/families whose yearly gross income is above 275% of the Federal Poverty Limit Guidelines and whose documentation verifies financial hardship. (see attached Exhibit A)

      Eligible Amount: Charges/balance after all third party payments and discounts have been applied up to a cap equaling 10% of gross annual income plus eligible monetary assets. Monetary assets. Excluding primary residence and qualified retirement plans, will be calculated at 50% of the monetary assets after the first $10,000. Qualified retirement plans to be excluded are; 401K Plans, 403B Plans and IRA's.

   E. Calculation of annual income includes verification of the prior year's tax return.

      1. Income tax documents must be used is indicated to assist in verifying income.

      2. If not working, the latest unemployment check of social worker's attesting of homeless can be considered.

**III. PROCEDURE**

1. Identification

   A. Candidates for the Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Discount Policy can be indentified at any point along the patient revenue cycle process. Every effort shall be made to identify eligibility during the service period.

      1. Pre-Registration

      2. Point of Service

3. Discharge

4. Follow-up after discharge

B. Every patient will be presented, at time of service, with notice regarding the Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy. Every patient will be offered Medi-Cal and or Medicaid applications. Patients will be asked to sign an acknowledgement attesting that notice of program and offer of application has transpired.

C. A follow-up notice regarding the Underinsured/Uninsured Patient Discount/Sliding Fee and Charity Care Policy will be included with first billing for services.

D. Referral for Consideration

1. Initial referrals may be directed to any business office employee, a Financial Counselor of the Social Services department.

2. The Patient/family/guarantor is instructed regarding the application process.

3. Arrangements are made for an in-depth interview.

4. The Patient/family/guarantor is instructed to bring the following documents to the interview:

a) Identification ,
b) Last filed income tax returns, and
c) Verification of members of the family unit under consideration

E. A summary of the encounter is documented in the appropriate system according to the hospital department.

1. Registration personnel document notes pertaining to the situation in the Hospital Patient Accounting System currently CPSI.

2. Business office personnel document in the Hospital Patient Accounting System CPSI.

3. Social Service personnel document on the patient chart summaries on their encounters and enter information into the Patient Accounting System CPSI.

4. Patient attestation regarding receipt of notice and offer of applications filed in patient medical record.

2. Screening

A. The appropriate Financial Counselor reviews the initial referral information and arranges for the initial interview. When possible, this should be completed during the period of service.

B. The Patient/family/guarantor receives clarification of the program and information regarding the documentation required for the review.

3. Financial Assistance Interview by PFS Manager

A. The program is fully described and the Patient/family/guarantor is given the opportunity to ask questions and receive clarification about the process and requirements.

B. A review of insurance, lack thereof, and identification of any other potential payer source is conducted.

C. Clarification of and documentation of income and family unit information is verified.

D. Calculation of the annual income is performed.

E. Review of other supportive documentation, as indicated.

F. Other information as indicated on the Disclosure Form is documented/reviewed; and it is required that the form is signed by the responsible party or assigned representative.

G. Arrangements may be made for subsequent interviews, if necessary, in order to obtain all necessary information.

H. Copies of all documents are retained for hospital record keeping purposes.

4. Financial Assistance Application Approval Process

A. PFS Manager may approve up to $5,000.

B. The Chief Executive Officer approves all amounts and accounts greater than $5,000.

5. Pending Applications

A. Consideration is given for the fact that the patient and family are in a stressful financial situation and may not be able to present all necessary information at the first meeting.

B. Financial Counselors follow-up to obtain necessary information by phone, by sending letters asking for needed documents, or by personal visit.

C. After three documented contacts have been attempted and the 150th day is exceeded, the application is documented as denied and closed, and the account is transferred to Bad Debt.

D. The collection agent for CRMC will follow AB774 regulations regarding collection practices.

6. Approved Application

A. Patient/family/guarantor is notified immediately, in person, if the patient is a hospital in-patient at the time of approval.

B. A letter explaining the determination and fully describing any necessary arrangements is mailed to the address submitted during the application.

C. The Patient/family/guarantor will be asked to sign a contractual agreement regarding any extended payment arrangements related to the amount determined to be patient responsibility.

7. Denied Applications

A. Patient/family/guarantor is notified immediately, in person, if the patient is a hospital in-patient at the time of decision.

B. A letter explaining the determination and fully describing any necessary arrangements is mailed to the address submitted during the application; included in this letter is a description of the decision appeal process.

C. An individual who is referred to Financial Counseling as a potential recipient of financial assistance who refuses to sign the Disclosure statement or provide required information will be denied automatically.

D. Any impacted party may appeal a denial decision by submitting their concerns in writing to CRMC's Compliance Committee.

E. The patients financial class reverts to Self Pay and the account is processed as a Self-Pay receivable per protocol

8. Monthly Reports

A. A monthly report will be prepared in the Business Office providing the total Charity applications approved with the amounts written off.

B. A monthly report will be prepared in the Business Office providing the total of discount applications approved with the amounts discounted.

**EXHIBITS:**

A. Federal Poverty Limit Guidelines for Sliding Fee
B. Patient Disclosure Report
C. Patient Charity Care Application

## UNINSURED PATIENTS

**POLICY**

In compliance with Assembly Bill 774, CRMC will publish its policy for uninsured patients by clearly and conspicuously posting notices in locations that are visible to the public, including, but not limited to, all of the following:

(1) Emergency department;
(2) Billing/cashier office;
(3) Patient Registration;
(4) Other outpatient settings.

Additionally, uninsured patients will be provided with the Letter to the Uninsured. In compliance with SB 1276, the letter will educate patients about availability of coverage through government programs, including the Exchange, be accompanied by a Medi-Cal application, and will provide a referral number to a local consumer assistance center housed at legal services offices.

AB 1503 requires Emergency Room physicians to limit expected payment from eligible patients that are uninsured or have high medical costs who are at or below 350% of the federal poverty level.

In compliance with Bad Debt Policy 85300.0098, accounts will not be approved for legal action until AFTER 150 days after the initial billing. In addition, in compliance with Internal Revenue Service rules, the hospital or its collection agency(s) will not exercise any Extraordinary Collection Activities (ECAs) including reporting to credit agencies, against an individual whose eligibility has not been determined before 120 days. after the first post discharge billing statement. CRMC will not garnish wages. It will however permit liens on homes or other real estate for the purpose of securing repayment at sale or refinancing when income exceeds 400% of FPL. Under certain circumstances when income does not exceed 400% FPL, CRMC may file a lien on a primary residence for a hospital bill that will not be exercised during the life of the patient or his/her spouse, or during the period a child of the parent is a minor, and/or as otherwise outlined by state law.

**PROCEDURE**

1. Prior to or at registration/admission *(or after an Emergency Department patient has been medically screened and stabilized)* educate the uninsured patient about the Self Pay Discount Program and provide the letter to the uninsured. Allow the patient to apply for Hospital Presumptive Eligibility. If he/she declines or does not qualify:

   1.1 Estimate the patient's total charges based on the discount rates.
   1.2 Request the patient's estimated liability.
   1.3 Set up payment arrangements for any amount that cannot be collected at the time of service or prior to discharge. Work with the patient to negotiate the terms of the payment plan. If the hospital and the patient cannot agree on the payment plan, use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan.
   1.3.1 Income does not include retirement or deferred compensation plans.

1.3.2 Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.

1.3.2.1 "Essential living expenses" means, for purposes of this subdivision, 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 childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses."

1.3.2.2 For example, if income is $3,000 per month and essential expenses are $2000, PIH Health Hospital would need to agree to $100 payments (3000-2000=1000*.10=100).

Payment plans can be considered inoperative after the patient's failure to pay consecutive payments during a 90-day period and after sending written notice and placing a call to the patient. The hospital will attempt to renegotiate the payment plan.

2. Most Self Pay Discount adjustments (65% of charges) will automatically be written off to transaction code 99017. For those services that do not adjust automatically, Patient Accounting Staff will submit adjustment 99017 for posting to the patient account.

3. Statements will automatically reflect the discounted rates. In addition, they will include information required under SB 1276 and under IRS rules.

4. Any accounts referred to bad debt will reflect the discounted rate.

5. Hospital collection agencies will not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial post discharge billing