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| Plumas DISTRICT HOSPITAL | **TITLE: Discount Payment Policy and Procedure** |
| | **DEPARTMENT/COMMITTEE: Patient Financial Services** |
| | **Effective Date: December 20, 2024** |

**Policy Purpose:**

Plumas District Hospital (PDH) is committed to providing outstanding compassionate care with exceptional customer service. This policy demonstrates PDH's commitment to our mission and vision by helping to meet the needs of low income patients in our community who are uninsured, underinsured or have high medical costs. The purpose of this policy is to define the eligibility criteria for discounted payment of services and to provide administrative and accounting guidelines for the identification, classification and reporting of patient accounts eligible for discount payment.

PDH is committed to compliance with the Hospital Fair Pricing Policies Act and ensuring that patients with high medical costs who are at or below 400% of the federal poverty level are eligible to apply for participation in the Discount Payment Policy program. Providing patients with opportunities for financial assistance coverage for healthcare services is also an essential part of fulfilling the PDH mission and vision.

**Definitions:**

**Charity Care Patient:** A patient who:

1. Is a Self-Pay Patient; and
2. Has Family Income at or below 400% of the Federal Poverty Level.

**Family Income** is the annual earnings of all members of the Patient Family from the prior twelve (12) months or prior tax year as shown by the recent pay stubs or income tax returns, before taxes, deductions, and child support. This includes income from employment, investments, real estate, and businesses.

**Federal Poverty Level** means the current 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.

**High Medical Cost Patient**: A patient who:

1. Is not a Self-Pay Patient (i.e., the patient has a third-party source of payment); and
2. Has Family Income at or below 400% of the Federal Poverty Level; and
3. Has out-of-pocket medical expenses in the prior twelve (12) months (whether

incurred at PDH or at other medical providers) that exceeds the lesser of 10% of the patient's current family income or family income in the prior twelve (12) months.

**Patient Family**: For patients eighteen (18) years of age and older, the Patient Family includes the patient's spouse, domestic partner, and dependent children under twenty-one (21) years of age, whether living at home or not. For patients under eighteen (18) years of age, the Patient Family includes the patient's parent(s) or caretaker relative(s), and other children under twenty-one (21) years of age of the parent(s) or caretaker relative(s).

**Self-Pay Patient**: A patient who has no third-party source of payment for healthcare services. Self-Pay Patients include without limitation: (a) patients who qualify for a government program but receive services that are not covered under the program; and (b) patients whose benefits have exhausted prior to or during the provision of services.

**Policy:**

This policy applies to all patients receiving hospital (not clinic) services who meet the criteria of a Charity Care Patient or a High Medical Cost Patient, as defined in this policy. A sliding fee schedule based on the most recent Federal Poverty Level Guidelines will be used to determine the qualifying income levels of applicants. Guidelines are subject to change annually based on the Federal Poverty Level Guidelines.

Discounted care will be offered if the patient's Family Income is between 175% and 400% of the most recent Federal Poverty Level Guidelines. For example, patients determined to be eligible for discounted care in 2024 will receive the discounts set forth in **Attachment A**, below. Patients who do not meet the criteria for discounted care under this policy may be referred to the Charity Care or Prompt Payment Policy.

**Eligibility Procedures and PDH's Review Processes:**

1. **Enrollment Process:**

   a. An informal determination of Discount Payment Policy eligibility will be determined by the Patient Financial Counselor, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor; however, the recommendation of the Patient Financial Counselor is not required in choosing to fill out the Financial Assistance Application.

   b. Upon submission of the application packet for consideration by the Patient Financial Counselor, all properly submitted applications will be reviewed and a determination made within 10 business days.

   c. All applications must be filled out completely and accurately with one of the following required documentation attached, to be considered:

i. Current W-2 withholding form or Income Tax statement form from the previous year, or

ii. Pay stubs from the previous three months.

d. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.

e. A letter of either approval or denial will be submitted to each applicant. The letter will contain: the percent discount; adjusted balance (if more than one account, each will be combined into one account for accounting and billing/statement purposes); and the required monthly payment due each month. Also included in the envelope will be a payment schedule and a discount card.

f. If a patient disagrees with the eligibility determination, they may submit a written dispute to the PDH Revenue Cycle Director. The correspondence should include the reasons for the disagreement and any supporting documentation.

g. For patients deemed eligible under this policy, the maximum payment for services provided by PDH will not exceed the greater of the amounts PDH would, in good faith, expect to receive from Medicare or Medi-Cal for the same services. Eligible patients are responsible for paying no more than this reimbursement rate.

i. Applicants will need to reapply at the end of each calendar year for continued eligibility, or as needed with updated information/changes to guarantor accounts.

2. **Discount Payment Account Billing Process, Terms and Settlement:**

a. All accounts will be billed upon discharge or upon satisfaction of all third party payers, and approved discounts.

b. Participants are requested to remain current on their outstanding balances. In order to remain current, participants must pay the balance due by 30 days of statement date. If unable to meet these requirements, prior arrangements must be made with the Billing Office / Patient Financial Counselor.

c. If participant information changes, the participant shall submit changes to the Billing Office / Patient Financial Counselor to update their applications or to complete/submit a new application.

d. If participant does not pay within 15 days past due, without prior arrangements with the Billing Office / Patient Financial Counselor (e.g., a payment plan, discussed in Section 3 below), he/she will be removed from the program.

e. Upon removal from the program, a 6-month grace period will be enforced where all amounts will be due and the patient will not be eligible for the program. Accounts on the program will have the discounted amount removed, original balance reinstated minus any payments (subject to Section 1(g) above), and prepared for collections. These accounts will not be considered a part of the new application once the participant is eligible for the program again.

f. A new application on new accounts may be submitted after the grace period for consideration.

g. Accounts that are removed from the program and that still contain a positive balance after the 6-month grace period will be forwarded to an outside collection agency who will, at their discretion, notify credit reporting bureaus. Under no circumstances will an account be reported to a credit reporting bureau under 150 days from the first bill date.

3. **Payment Plan:** In cases where the patient is approved for discounted care and still owes a bill under the program:

a. Patients can be offered an extended payment plan. Extended payment plans will be interest-free.

b. If PDH (or its contracted designee) and the patient are unable to agree on the terms of a payment plan, the default payment plan shall by a monthly payment of not more than ten percent (10%) of the patient's Family Income after excluding essential living expenses. "Essential living expenses" means 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 child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

c. A payment plan may be declared inoperative after the patient's failure to make all consecutive payments due during a ninety (90)-day period. Before declaring a payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by telephone and to give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. For the purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

d. When an extended payment plan is declared inoperative by a hospital, the patient's financial responsibility shall not exceed the greater of the amounts PDH would, in good faith, expect to receive from Medicare or Medi-Cal for the same services (as set forth in Section 1(g) above). In addition, the patient shall receive credit for any payments previously made under the extended payment plan.

4. **Participant Accounts Maintenance:** A folder (electronic) for each Charity Care applicant will be created, and will include the following items:

   a. All accounts will be reviewed monthly for fee adjustments, monthly payments and co-payments.

   b. Notices will be sent for all accounts which are non-compliant.

   c. Collections efforts may be pursued for accounts that are not paid by 15 days past the due date of the statement sent after discounts have been applied .

   d. In the folder for each application the following items are required:

      i. Patient information and application

      ii. A copy of every correspondence between PDH and the participant

      iii. Detailed bills on all accounts to be included in the application

      iv. Adjustment form with adjustments taken on accounts

      v. Any additional notations and pertinent information

      vi. Charity Care and Financial Discount Calculation Worksheet

**References:**

Pursuant to California Health and Safety Code (H&S Code) Section 127405, PDH has established eligibility levels for financial assistance and charity care at less than 400 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. PDH is a rural hospital as defined in H&S Code Section 124840.

The processes and procedures described above are designed to comply with the Hospital Fair Pricing Policies Act (H&S Code Sections 127400 through 127446). Questions regarding the Hospital Fair Pricing Policies Act can be addressed by the Patient Financial Counselor(s) or by California's Department of Health Care Access and Information (HCAI) website, at:

https://hcai.ca.gov/affordability/hospital-fair-billing-program/

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

**Attachment A:**

| PDH Discount Payment Policy Program | | | | |
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| **2024 US Poverty Level (USPL) Guidelines** | | | | |
| **Numbers in Household** | **Up to 175% USPL** | **Between 176% & 225% USPL** | **Between 226% & 400% USPL** | **Above 400% USPL** |
| | **Discount 50%** | **Discount 40%** | **Discount 30%** | **Discount NONE** |
| **1** | $0.00 - $26,355 | $26,356 - $33,885 | $33,886 - $60,240 | $60,241 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **2** | $0.00 - $35,770 | $35,771 - $45,990 | $45,991 - $81,761 | $81,762 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **3** | $0.00 - $45,185 | $45,186 - $58,095 | $58,096 - $103,280 | $103,281 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **4** | $0.00 - $54,600 | $54,601 - $70,200 | $70,201 - $124,800 | $124,801 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **5** | $0.00 - $64,015 | $64,016 - $82,305 | $82,306 - $146,320 | $146,321 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **6** | $0.00 - $73,430 | $73,431 - $94,410 | $94,411 - $167,840 | $167,841 and up |
| | *Net Income Net Income* | | *Net Income* | *and over* |
| **7** | $0.00 - $82,845 | $82,846 - $106,515 | $106,516 - $189,360 | $189,361 and up |
| | *Net Income* | *Net Income* | *Net Income* | *and over* |
| **8** | $0.00 - $92,260 | $92,261 - $118,620 | $118,621 - $210,880 | $210,881 and up |
| | *Net Income* | *Net Income* | *et Income* | *and over* |
| **For each additional person over 8 in household, add $2,690** | | | | |