PALOMAR HEALTH

Procedure : Financial Assistance Full and Discount Payment Charity Care

I. SUMMARY/INTENT:

This procedure defines Palomar Health's (Palomar) procedure for the identification, documentation, and determination of eligibility for Palomar's Financial Assistance Programs. In accordance with its Mission Statement, it is the practice of Palomar, where warranted, to provide a reasonable amount of hospital services without charge to eligible patients who cannot afford to pay for care, or offer reduced payment arrangements for those who qualify. The mission of Palomar is to heal, comfort and promote health in the communities it serves. The vision of Palomar is to be the health system of choice for patients, physicians, and employees – recognized nationally for the highest quality of clinical care and access to comprehensive services.

The vision of Palomar Patient Financial Services – Palomar is a valued community resource; therefore we will perform the following:

- Verify your insurance coverage.
- Provide you with an estimated patient portion of charges as determined by your insurance plan.
  Bill your primary and secondary insurance carriers as provided by you at the time of registration.
  Answer questions from you or your insurance carrier regarding charges incurred.
- Upon request, send you a statement showing insurance payment(s).
- Automatically generate statements for the patient responsibility as indicated by your insurance.
- Educate our community on Assistance Programs and options regarding qualifications for Full Charity Care or Discounted Partial Charity Care. Respect our patients' rights.

II. DEFINITIONS:

A. **Patient**: The person receiving services at a Palomar facility, or the guarantor, who is ultimately responsible for the financial resolution of an account.

B. **Urgent / Emergent**: Compelling immediate action or attention; occurring unexpectedly and requiring urgent action.

C. **EMTALA: Emergency Medical Treatment and Active Labor Act:** Requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status, or ability to pay.

D. Financial Assistance Program: **Financial Assistance:** Either full or partial reduction in charges to patients for emergency or Medically Necessary Health Care Services, in the case of patients who have qualified for Financial Assistance, Medically Indigent, or are Presumptively Eligible as those terms are defined in this policy. Financial Assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles, or both.

E. Charity Care: Free Care

F. **Full Charity Care**: Medically necessary health care services provided for no charge to the patient who does not have or cannot obtain adequate financial resources to pay for his/her health care services and has met the eligibility criteria as described in this policy. Full Charity Care applies to patients qualifying under the Palomar Financial Assistance Program for services not covered by a third party payer, where the patient would otherwise be responsible for paying. If Full Charity Care is granted to a patient, it does not excuse a third party from its obligation to pay for services provided to the patient. Eligibility may be determined prior to or at the time of an admission, during a hospital stay or after a patient is discharged. Each situation is different and shall be evaluated at the time of the application based upon the patient's circumstances.

G. **Discounted Partial Charity Care**: Medically necessary health care services provided at a reduced charge, (any charge for care that is reduced but not free). To the amount Medicare would pay for the same services or less for patients who meet eligibility criteria as described in this policy. This is in contrast to bad debt, which occurs when a patient who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to resolve his/her bill. Discounted Partial Charity Care applies to patients qualifying under the Palomar Financial Assistance Program who have exhausted resources from third party payers prior to applying for this discounted program. If Discounted Partial Charity Care is granted to a patient, it does not excuse a third party or the patient from their respective obligations to pay for services provided to such patient. Eligibility may be determined prior to or at the time of an admission, during a hospital stay or after a patient is discharged. Each situation is different and shall be evaluated at the time of the application based upon the patient's circumstances.

H. **Third Party Payer**: Defined as a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits coverage to a patient.

I. **Federal Poverty Level (FPL)**: The FPL guidelines establish the gross income and family size eligibility criteria for Full Charity Care and Discounted Partial Charity Care status as described in this policy. The FPL guidelines are updated periodically by the United States Department of Health and Human Services.

J. **Eligibility**: Financial Assistance will be given for emergency or Medically Necessary Health Care services to patients who qualify based on information provided via the Application for Financial Assistance or to patients who have been determined to be Presumptively Eligible. In addition, Financial Assistance may be provided in other circumstances on a case-by-case basis as determined by the System Chief Financial

Officer. Financial assistance does not apply to services rendered by any physician, whether rendered on an inpatient or outpatient basis, or to health care providers other than Palomar.

K. **Medically Necessary Health Care Services** : Services or supplies that are determined to be:
   1. Proper and needed for the diagnosis, or treatment of the patient's medical condition;
   2. Are provided for the diagnosis, direct care, and treatment of the patient's medical condition;
   3. Meet the standards of good medical practice in the local area; and
   4. Are not mainly for the convenience of the patient or the patient's doctor.

L. **High Medical Costs**: Defined as Out-of-pocket costs and expenses "mean any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing
   1. Exceed lessor of 10% of the patient's family income in the prior 12 months; or,
   2. Exceed lessor of 10% of the patient's family income in the prior 12 months, 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; or,
   3. A lower level as determined by hospital administration.

PRO**CEDURE: COMPLIANCE - KEY STEPS**: (All patient documents, with the exception of internal documents C and E, are available in English and Spanish.

A. This procedure is to define: a charity care policy statement that explains why the hospital is charitable and how it serves the community's needs. The charity care policy will be a part of fulfilling the hospital's charitable mission.

B. Consistent with our mission, Palomar strives to ensure that the financial capacity of families who need healthcare services does not prevent them from seeking or receiving care. Palomar is committed to serving its community and its needs. Palomar will continually strive to not only provide quality clinical healthcare services; Palomar will continually strive to provide financial counseling healthcare services that will enhance and perpetuate patient health and

the community's ability for continued healthcare services with Federal, State or County healthcare assistance programs.

C. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, ethnicity, socio-economic status, sexual orientation or religious affiliation. Information on the availability of financial assistance will be readily available and accessible to patient families or representatives, and Palomar will be responsive to the patient's/guarantor's needs.

D. The Financial Assistance Program at PH is available to provide discounted or free care to eligible patients for medically necessary inpatient, emergency or outpatient services based upon the guarantor's income, as defined by the FPL.

E. THE GENERAL GUIDELINES FOR POSSIBLE NEED OF FINANCIAL ASSISTANCE:

- Patients who do not have or cannot obtain adequate financial resources to pay for their health care services. Uninsured patients, as well as insured patients for the portion of their bill not covered by insurance, may be eligible.
- Resources from third party payers, local charitable agencies, Victim of Crime, Medi-Cal, Healthy Families, etc. must be exhausted before a Full Charity or Discount Partial Charity adjustment can be applied. Patient/Guarantor is not required to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment. However, the patient/guarantor is required to participate in screening for Medi-Cal eligibility.
- Only hospital services provided by Palomar shall be considered.
- Eligibility determinations shall be based primarily upon income and family size. While expenses and other factors may be considered, these shall not serve as the primary basis for determining eligibility.
- Clinical Determination: The evaluation of the necessity for medical treatment of any patient shall be based upon clinical judgment, regardless of insurance or financial status, in compliance with Palomar's Mission Statement. The clinical judgment of the patient's personal physician or the Emergency Department (ED) staff physician shall be the primary determining criteria for a patient's admission. In cases where an emergency medical condition exists, any evaluation of possible payment alternatives shall occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with all applicable State and Federal laws and regulations.

F. **Presumptively Eligible:** A patient who has not submitted a completed Application for Financial Assistance, but who nonetheless is subject to one or more of the following criteria:

- Homeless
- Deceased with no estate
- Mentally incapacitated with no one to act on his or her behalf

- Medicaid eligible, but not on the date of service or for non-covered services
- Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines
- Incarceration in a penal institution
- Patients referred for services by Community Health Partners (CHP) shall automatically qualify for the same "slide" as allowed by CHP. CHP will provide information regarding its patients when the referral is made.

Palomar will routinely review the foregoing criteria with patients, before asking patients to complete the Application for Financial Assistance. Software programs or automated systems may also be utilized to determine presumptive eligibility. Patients who meet any of the foregoing criteria for presumptive eligibility will be deemed to be eligible for a 100% discount and will not be asked or required to submit an Application for Financial Assistance.

G. Exclusions:
   1. None, all patients may apply.

H. Medically Necessary Health Care Services : Services or supplies that are determined to be:
   1. Emergent/urgent and needed for the diagnosis, or treatment of the patient's medical condition;
   2. Are not mainly for the convenience of the patient or the patient's physician.

I. High Medical Costs: Defined as the patient's annual out of pocket costs incurred by the individual at a Palomar hospital that:
   1. Exceed lessor of 10% of the patient's family income in the prior 12 months; or
   2. Exceed lessor of 10% of the patient's family income in the prior 12 months, 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; or
   3. A lower level as determined by hospital administration.

J. Patient's Family: The following shall be applied to all cases subject to the Palomar Financial Assistance procedure:
   1. For persons 18 years of age and older, spouse, domestic partner as defined in Section 297 of the California Family Code, dependent children of any age, whether living at home or not, and inclusive of parents when the patient is a dependent child who is not a minor.
   2. For persons under 18 years of age, parent or legal guardian is responsible for income verification.

K. Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and, at the time of filing, all of the following requirements are met:
   - Both persons have a common residence.
   - Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
   - The two persons are not related by blood in a way that would prevent
   -

them from being married to each other in this state. Both persons are at least 18 years of age.

- Both persons are capable of consenting to the domestic partnership. Either of the following:
  a. Both persons are members of the same sex.
  b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

L. GENERAL PATIENT RESPONSIBILITIES:

1. To Be Honest: Patients must be honest and forthcoming when providing all information requested by Palomar as part of the financial assistance screening process. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary for financial assistance coverage through any government coverage program or the Palomar Financial Assistance Program. Honesty implies and requires full and complete disclosure of required information and/or documentation.
2. To Actively Participate and Complete Financial Screening: All uninsured patients and those who request financial assistance will be asked to complete a financial evaluation form. Prior to leaving Palomar, the patient should verify what additional information or documentation must be submitted by the patient to Palomar. The patient shares responsibility for understanding and complying with the document filing of PH or other financial assistance programs. Eligibility for discounted payments or charity care shall be determined at any time and eligibility will not be denied based on timing of application.
3. To Pay any or All Required Out-of-Pocket Amounts Due : Patients should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to:
   a. Co-Payments
   b. Deductibles
   c. Deposits
   d. Medi-Cal/Medicaid Share of Cost
   e. Good Faith Estimates

M. To Share Responsibility for Hospital Care: Each patient shares a responsibility for the hospital care they receive. This includes follow-up in obtaining prescriptions or other medical care after discharge. The patient also shares a responsibility to assure that arrangements for settling the patient account have been completed. It is essential that each patient or their family representative cooperates and communicates with PH personnel during and after services are rendered.

N. PATIENT/GUARANTOR RESPONSIBILITIES AS THEY APPLY TO CHARITY APPLICATION PROCESS INCLUDE THE FOLLOWING (BUT ARE NOT LIMITED TO):

1. Providing accurate and complete information in a timely manner so Palomar can process the request for Financial Assistance;
2. Follow through with any federal, state or county assistance program prior to the application for charity;
3. Responsiveness – provide timely follow-up for additional documents or information Palomar requires for the Financial Assistance application process;

4. Full disclosure of the required information;
5. Satisfaction of any patient/guarantor payment obligation;
6. Income verification;
7. Palomar shall request that the patient/guarantor verify the income and provide the documentation requested as set forth in the Financial Assistance Application.

O. **Note**: Tax Returns and W-2's should be provided by the patient for the year prior to date of admission.

P. **Documentation Verifying Income**: Income may be verified through any of the following mechanisms:
1. Tax returns (preferred income verification document)
2. Recent pay stubs/paycheck remittance
3. IRS form W-2
4. Wage and Earnings Statement
5. Social Security income
6. Workers' Compensation or unemployment compensation determination letters
7. Qualification within the preceding six months for governmental assistance program (including food stamps, Medi-Cal, and AFDC)

Q. In the event that the patient/guarantor is unable to provide recent pay stubs:
1. Palomar shall, with the patient's/guarantor's authorization, obtain telephone verification by the patient's/guarantor's employer of the patient's/guarantor's income or accept other documentation of the patient's/guarantor's income.
2. Palomar shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans.
3. Personal bankruptcies may affect a patient's/guarantor's ability to pay all or part of the bill for healthcare services. To help avoid going into bankruptcy, Palomar will work with the patient/guarantor on flexible payment plans.
4. The requested documents to verify income should be made available to Palomar within 14 calendar days. If documentation is not received within the 14 calendar days, an additional 7 calendar day grace period shall be provided. Patient/guarantor may submit copies of the required documents with the Financial Assistance Application.

R. **GENERAL PALOMAR RESPONSIBILITIES**:
1. To treat each and every patient/guarantor associated with our community's healthcare with the utmost dignity, respect and confidentiality.
2. To ensure all applicable associated assistance programs have been reviewed and appropriately screened for patient/guarantor application for program qualification.
3. To provide uninsured patients and those with potentially high medical expenses with a copy of the Notice of Health Care Financial Assistance (Attachment A). The uninsured patients should be directed to applications, as applicable, for Medi-Cal, CMS, or Healthy Families.
4. For patients interested in financial assistance, complete a Financial Assistance

Application for ED, Outpatients or cases identified after admission. All ED non-scheduled outpatients and patients identified after admission shall be handled as indicated below.

5. The Financial Assistance Application process can be initiated by the ED Registration Clerk, Financial Counselor, the patient, Patient Financial Representative (PFR) or Customer Service Representative (CSR).

- If, after a medical screening exam, a patient in the ED is determined to have no financial means to pay, and appears that the patient may not qualify for Medi-Cal or any other service, give the patient the Palomar Application for Financial Assistance (Attachment B). If the patient is homeless or cannot complete the application, offer assistance in completing the form and obtain the patient's signature. If the patient is unable or unwilling to sign, then note this on the form.
- If a patient is currently in-house and it is determined that he/she may not have appropriate coverage or other means necessary to pay for services, the PSR shall give the patient a Financial Assistance Application.

6. Patients scheduled as elective inpatient or scheduled outpatient services shall be subject to the same provisions as described in this procedure with

Patient Access handling all documentation and decision making process as it relates to this procedure and Palomar guidelines for elective or pre-scheduled services. The Patient Financial Representative shall:

- Determine if there are alternative means (i.e., external agency or foundation) to cover the cost of services.

  Make appropriate referrals to the internal Eligibility Firms designed to help patients obtain assistance program coverage, or local county agencies, Healthy Families, Medi-Cal to include any other programs to determine potential eligibility.

7. In the event the patient is denied or is determined to be ineligible for any of these services or it appears this may qualify as a charity case, Patient Services Representative shall notify the patient/guarantor within 14 calendar days of receipt of all documents identified in this procedure as being required to make the determination for qualification or disqualification from the Charity program.
8. The Patient Service Representative will review any and all outstanding patient balances associated with the guarantor information related to the charity application and retrospectively include any and all outstanding balances in the current Application for Debt Relief.
9. Palomar will not discriminate if the account is in this retrospective review.
10. The hospital will retain the current Charity Application on file and its determination for six months. After six months the hospital will anticipate a full re-application process if there is a new patient liability.

S. GENERAL GUIDELINES FOR REVIEWING FINANCIAL ASSISTANCE APPLICATIONS:

1. **Determination**: Is based upon 400% of the established Federal Poverty Guidelines (FPG) as published yearly by the Department of Health and Human Services (DHHS) (http://aspe.hhs.gov/poverty/index.shtml).

This means that a patient has to have an income level less than or equal to 400% of the FPG in order to qualify for either Full Charity Care or the Discount Partial Charity Care programs with High Medical Costs. These guidelines and rates of discount are noted on Attachment C.

Patients or their guarantors who earn 250% or less of the FPG.

Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Full Charity Care: a write-off of 100% of charges.

Patients or their guarantors who earn between 251% and 400% of the current Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Discounted Partial Charity Care.

The billed charges for these patients will be reduced to the highest government payers (Medi-Cal or Medicare) rates.

Patients or their guarantors who earn 451% or more of the Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for the standard self-pay discount as defined in the Palomar Self-Pay Discount Procedure. Palomar will work with the patient/ guarantor on flexible payment plans.

If a patient maintains current eligibility with local and state health programs (e.g. CMS, Medi-Cal, etc.), then the patient will be determined as eligible. Assets Owned: Policy excludes monetary assets when determining patient financial assistance.

T. **GENERAL GUIDELINES FOR THE PROCESSING THE FINANCIAL ASSISTANCE APPLICATION**:

1. Review each completed application upon receipt and determine if all information has been completed or attached, as applicable.
2. Enter notes in the "account comments" section of Palomar's Information System indicating receipt of the request for charity. If incomplete, note the follow-up action, missing items and date.
3. If additional information is required, send the Financial Assistance Request for Information Letter (Attachment D). The patient shall be requested to provide this information within 14 calendar days (plus a 7-calendar day grace period as defined in patient responsibilities to respond with information necessary. If the patient does not return the requested information within 14 calendar days, contact the patient to inquire into the status. Advise the patient that unless Palomar receives the information within 14 calendar days, a decision on their eligibility for financial assistance will be made without the requested information. If the patient does not return the requested information or contact Palomar within the additional 14 calendar day period, the application should be forwarded for review and eligibility

determination. Enter into the "account comments" section of Palomar's information system: "Patient did not return the required financial assistance information."

4. If the Financial Assistance Application is complete, prepare the Financial Assistance Checklist (Attachment E) within 24 hours.
5. Once the packet is complete, forward to the appropriate person as per the following approval schedule:
    - $0 - $20,000 Agency Liaison
    - $20,001 - $50,000 Manager Patient Financial Services
    - $50,001 - $99,000 Director Patient Financial Services
    - $100,000 Vice President Financial Operations

Enter the date the packet was sent into the comment section of Palomar's patient accounting information system.

- If a patient is approved for Financial Assistance, the person approving the Financial Assistance shall enter the appropriate adjustment into the Palomar information system as "approved and write off completed," and complete the Financial Assistance Approval Letter (Attachment F).
- For approved Full Charity Care, the full amount of the bill is to be written off and the account documented.
- For approved Discounted Partial Charity Care, the account should be adjusted to the Medicare reimbursement rate and the remaining balance to be paid by the patient. The patient is eligible for an interest free payment plan on the remaining balance in accordance with the Self-Pay Discount procedure or Extended Payment Plan ~~(Care Payment)~~ procedure.
- If a patient is not approved for Financial Assistance, forward the Financial Assistance Application and the supporting documentation to the Patient Business Services manager for final review.
- If a patient is denied Financial Assistance, send the Financial Assistance Denial Letter (Attachment G).
    - Palomar Health is not required to reimburse a patient if: (1) it has been five years or more since the patient's last payment to hospital/debt buyer, or (2) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.

U. <u>GENERAL GUIDELINES FOR DISPUTE RESOLUTION</u>:

1. The patient's right to appeal any denial for Full Charity Care, Discounted Partial Charity Care and/or Extended Payment plan must be received within 14 calendar days of the denial notification.
2. It is the patient's responsibility to perform a written appeal and thus it should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.
3. This information should be evaluated within 5 calendar days. If the supplemental

information results in the patient qualifying for Financial Assistance, send the Financial Assistance Approval Letter. If the supplemental information does not change the denial determination, send the patient the Financial Assistance Denial Letter (Attachment G) and edit to include the wording related to the denial based upon the additional documents submitted.

V. GENERAL GUIDELINES FOR COLLECTION ON ACCOUNTS OF PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE :

1. All non-Charity Care patients must first have been offered an interest free extended payment plan subject to negotiation and Palomar procedures.
2. Health Savings Accounts held by the patient or the patients' family may be considered when negotiating payment plans.
3. Palomar Health may require a patient or guarantor to pay the hospital any amounts sent directly to the patient by third-party payers, including from legal settlements, judgements, or awards.
4. Palomar Health May waive or reduce Med-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.
5. Palomar and affiliated collection agencies cannot report adverse information to a consumer credit reporting agency or commence civil action against the patient for non-payment at any time prior to 180 days after initial billing. All agencies used by Palomar have been confirmed to be compliant with AB774.
6. Palomar will not send any accounts to agency if the patient is attempting to qualify for Financial Assistance eligibility or attempting in good faith to settle an outstanding bill with Palomar by negotiating a reasonable payment plan or by making regular partial payments or a reasonable amount.
7. Palomar or affiliated agencies will not use wage garnishments or liens on primary residences as a means of collecting on unpaid or underpaid accounts.
8. Unaffiliated agencies will not use:
   - Wage garnishments, except upon order of a court; or
   - Notice or conduct a sale of real property either during the life of the patient or spouse or in some instances a child of the patient that attains the age of majority. Liens on any real property owned by the patient are prohibited.
9. Documentation: Palomar shall maintain detailed records of the numbers of patients and circumstances under which it provides free or reduced cost care under this procedure. Palomar shall also maintain records of the costs incurred in providing free or reduced care to eligible patients.
10. Confidentiality: Palomar shall maintain all information received from patients requesting eligibility under the Financial Assistance procedure

V. EMERGENCY PHYSICIAN:

The treatment administered by an emergency physician at the Hospital's emergency department will be invoiced by the physician responsible for the professional services rendered. Emergency physician services for eligible patients may be eligible for discounts as per state regulations.
For details regarding these discounts, please reach out to the emergency

physician representative directly using the telephone number provided on your doctor's bill.

confidential.

a. Attachment A: Application for Healthcare Financial Assistance
b. Attachment B: Financial Assistance Application
c. Attachment C: Financial Assistance Guideline Determination
d. Attachment F: Financial Assistance Approval Letter
e. Attachment G: Financial Assistance Denial Letter

Source

wed Keywords

Administrator

Next Review Date

Document

Attachments: (REFERENCED BY THIS DOCUMENT)

Owner

Other Documents: (WHICH REFERENCE THIS DOCUMENT)

Collaborators:

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Revenue Cycle 03/25/2011

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