Financial assistance policy

Encompass Health Rehabilitation Hospital of Murrieta
35470 Whitewood Road
Murrieta, CA 92563
951.246.6500
ehc.rehab/MurrietaFA

Purpose

This policy outlines the circumstances under which the hospital will provide free or discounted emergency or other medically necessary care to eligible patients who are unable to pay for their care, as determined by the hospital in accordance with the eligibility criteria and other terms specified in this policy. Patients are expected to cooperate with the hospital's procedures for obtaining Financial Assistance, securing insurance or other forms of payment, and contributing to the cost of their care based on their ability to pay.

This policy applies to emergency or medically necessary care provided by the hospital. This policy does not apply to care delivered by physicians or other healthcare providers who bill "privately" (separate from the hospital). (See Attachment A for additional information about physicians and other healthcare providers providing care within the hospital.)

This policy does not apply to care that is not emergency or medically necessary care, including elective services or items that are solely for the comfort or convenience of a patient.

Financial Assistance does not apply to amounts that are covered by insurance, governmental programs or other funding sources (which may include, but are not limited to, workers' compensation, automobile or other liability insurance, crime victims' compensation funds, and litigation recoveries). To be eligible for Financial Assistance, a patient is expected to apply for and comply with all processes related to seeking assistance from other insurers and/or third-party sources of payment (including all applicable governmental programs) as requested by hospital staff. Patients who are noncompliant or uncooperative in attempting to obtain insurance coverage, qualification under governmental programs, or payment from third-party sources will not be eligible for Financial Assistance.

A patient will be ineligible for Financial Assistance if the patient, or his or her representative, provides false information or falsified documentation of household size, income, assets, or other pertinent information.

Definitions

Covered Services – emergency or medically necessary care provided by the hospital. Covered Services do not include services that are not emergency or medically necessary care, or care that is provided by physicians or other healthcare providers who bill "privately."

Emergency or medically necessary care – services that are necessary and appropriate to sustain life or to prevent serious deterioration in the health of the patient from injury or disease. Medically necessary will be determined by the treating physician.

Family – includes spouse/domestic partner, children, and any other persons treated as "dependents" for federal income tax purposes.

Financial Assistance – reduction of an eligible patient's account balance for Covered Services under the terms of this policy.

Patient – the individual receiving medical treatment and/or, in the case of an unemancipated minor or other dependent, the parent, legal guardian or other person (guarantor) who is financially responsible for the patient.

Uninsured – a patient who does not have health insurance coverage, is unable to obtain affordable coverage, and is ineligible for government healthcare programs or other third-party payment sources.

Underinsured – a patient who is not uninsured, but whose out-of-pocket medical expenses exceed his or her financial ability to pay.

Policy

Subject to the terms of this policy, Financial Assistance is provided to eligible patients who are uninsured or underinsured.

Eligibility for Financial Assistance, and the amount of Financial Assistance that will be provided, are based on an individualized assessment by the hospital of a patient's financial need, generally determined by measuring the patient's gross family income against the Federal Poverty Guidelines as specified in the Financial Assistance Discount Guidelines in Attachment B, provided that the patient does not have other financial resources that could be used to pay for his or her care. The Financial Assistance Discount Guidelines are adjusted annually to reflect changes in the Federal Poverty Guidelines.

Patients are presumed to be eligible for financial assistance, without completing an application, in the following circumstances:

1. Homelessness
2. Deceased with no estate
3. Mental incapacitation with no one to act on patient's behalf
4. Recent Medicaid coverage, i.e. coverage within three (3) months of admission or discharge.

Presumptive financial assistance will be the most generous assistance available under the Financial Assistance Policy.

A patient determined to be eligible for Financial Assistance will not be billed more than the amount generally billed for emergency or other medically necessary care by hospital to individuals who have insurance covering such care. (See Attachment B for additional information about the "amount generally billed" limitation.)

If a patient is underinsured and is determined to be eligible for Financial Assistance, discounts will only apply to the balance due from the patient after insurance payments and other third-party payment sources have been applied to the account.

For purposes of this policy, “income” includes, but is not limited to, revenue from the following sources (before taxes):

- Wages
- Tips
- Payments from Social Security
- Retirement benefit payments
- Unemployment compensation
- Worker’s compensation
- Veterans’ benefits
- Public assistance
- Alimony
- Child support
- Pensions
- Regular insurance or annuity payments
- Investment income

For purposes of this policy, “other financial resources” includes, but is not limited to the following:

- Savings
- Checking account
- Medical savings account, healthcare savings account and/or flexible spending account
- Trust fund
- Retirement accounts
- Investment assets
- Other liquid assets
- Equity value of real estate, other than the patient’s primary residence
- Benefits from charity organizations
- Pending litigation

To apply for Financial Assistance, a complete Financial Assistance Application is required. A complete Financial Assistance Application is inclusive of, but not limited to, disclosure of household size, employment information, income, assets and other financial resources, outstanding financial obligations, and supporting documents (such as recent tax returns, bank statements and pay stubs), as detailed in the Financial Assistance Application and the associated instructions. If documentation proving household income is not available, patients may call the hospital finance department at the phone number listed above to discuss other evidence demonstrating eligibility. Undocumented residents (non-U.S. citizens living as residents in the U.S.) and patients who are without a home address may apply for Financial Assistance. Failure to provide the required information and documentation in a timely manner may result in ineligibility for Financial Assistance.

Complete Financial Assistance Applications should be submitted to the hospital at the address listed above. A hospital finance representative will review the application for completeness. Financial Assistance determinations must be approved by the Facility Controller, and in certain circumstances, by the hospital CEO. The hospital will notify patients in writing of the decision on their eligibility under this policy.

Copies of this policy, a plain language summary of this policy, the Financial Assistance Application, and the associated instructions are available free of charge upon request by writing to the address above. These documents can be found in the admitting/registration areas of the hospital and may also be downloaded at hospital’s website.

All patients will be offered a plain language summary of the Financial Assistance Policy during discharge or intake.

Billing statements will contain a written conspicuous notice informing patients about the availability of financial assistance, a telephone number where they may receive more information, as well as website address where the Financial Assistance Policy, application and plain language summary may be found.

Further information about this Financial Assistance Policy and assistance with the application process are available by calling Hospital Phone Number, or in person during normal business hours or by appointment from a hospital finance representative.

When a patient does not qualify for Financial Assistance under this policy but has special circumstances, other discounts may be available that are not part of this Financial Assistance Policy. In these situations, hospital staff will review all available information (including documentation of income, liquid and illiquid assets, and other resources, amount of outstanding medical bills and other financial obligations) and make a case-by-case determination of the patient's eligibility for other potential discounts.

Once a patient has been discharged and the patient's balance due has been determined, the Billing Office will mail the patient monthly account statements and make phone calls in an attempt to collect the outstanding balance. If no payment has been received for 120 days, the account may be sent to a third-party collection agency.

The hospital, and any third parties acting on its behalf, do not engage in extraordinary collection actions such as lawsuits, liens, foreclosures, wage garnishment or reporting adverse information to credit agencies.

For additional information, please see the Billing and Collections Policy, which may be downloaded from hospital website. Copies are also available upon request, free of charge, by mail and in admitting/registration areas of the Hospital.

Nondiscrimination & emergency medical care

Hospital does not have a dedicated emergency department. The hospital will appraise emergencies, provide initial treatment, and refer or transfer an individual to another hospital/facility, when appropriate, without discrimination and without regard to whether the individual is eligible for Financial Assistance.

Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that an individual pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with hospital's appraisal and provision, without discrimination, of such initial treatment.

Attachment B – 2024 Financial Assistance Discount Guidelines

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2024 Family Income as a Percent of Federal Poverty Guidelines

Discount provided		**100% discount**	**75% discount**	**50% discount**
Family size	Federal poverty guidelines*	Income less than or equal to 200% of FPG	Income of 201% - 300% of FPG	Income of 301% - 400% of FPG
1	$14,580	$0 - $29,160	$29,161 - $43,740	$43,741 - $58,320
2	$19,720	$0 - $39,440	$39,441 - $59,160	$59,161 - $78,880
3	$24,860	$0 - $49,720	$49,721 - $74,580	$74,581 - $99,440
4	$30,000	$0 - $60,000	$60,001 - $90,000	$90,001 - $120,000
5	$35,140	$0 - $70,280	$70,281 - $105,420	$105,421 - $140,560
6	$40,280	$0 - $80,560	$80,561 - $120,840	$120,841 - $161,120
7	$45,420	$0 - $90,840	$90,841 - $136,260	$136,261 - $181,680
8	$50,560	$0 - $101,120	$101,121 - $151,680	$151,681 - $202,240

* For family units with more than 8 persons, add $5,140 for each additional person.

Amounts charged to a patient eligible for Financial Assistance under this policy will be based on the applicable discount stated in the table above multiplied by the gross charges otherwise billable to the patient, subject to the “AGB” limitation described below.

In accordance with Internal Revenue Code section 501(r), a patient eligible for Financial Assistance under this policy will not be charged more than the amount generally billed to individuals who have insurance covering such care (“AGB”).

Facility has initially elected to calculate AGB under the “prospective Medicare method” described in applicable Treasury Regulations, using the billing and coding process the Facility would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount the Facility determines would be the total amount Medicare would allow for the care (including both the amounts that would be reimbursed by Medicare and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles).