

<b>Foothill Regional Medical Center</b>		<b>Manual:</b> Patient Access Policies and Procedures
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<b>Owner:</b> Director of Patient Access		Original Policy Effective Date: 11/01/2012
<b>APPROVALS:</b>	<b>Dates:</b>	Date Revised: 01/01/2025
Policy & Procedure Committee:	10/31/2022	
Medical Staff Committee (is applicable)		
Medical Executive Committee:		Date Reviewed: 10/31/2022
Governing Board:		

## Charity Care

### I. POLICY PURPOSE

To establish a policy for care that is rendered free of charge to individuals who, because of their financial status, are unable to pay for services provided. This policy extends to all patients accepted by Alta Hospitals System.

### II. SCOPE

This policy applies to Patient Access

### III. POLICY

Foothill Regional Medical Center is committed to providing high quality, affordable hospital services to patients that are uninsured/underinsured. This policy establishes the guidelines for each campus to follow to communicate our policy, qualify patients for charity care and properly account for the revenue associated with providing this care.

#### COMPANION POLICIES AND PROCEDURES

This policy is a companion policy and procedure to the Low-Income Financial Assistance (LIFA) P&P and the Self-Pay P&P. Employees should be aware of all three policies to ensure the correct process is followed when serving our patients.

#### DETERMINATION/REVOKABILITY

Charity Care eligibility can be determined, or revoked, at any point in the preadmission, billing or collection process should any significant changes occur in the patient's financial status or third-party coverage. Any disputes on eligibility will be addressed and resolved by the Chief Financial Officer.

### IV. DEFINITIONS:

#### Charity Care

The term "Charity Care" means the providing of care, **free of patient responsibility**, to those patients who qualify under the Charity Care Criteria established by Alta Hospitals System.

#### Discount Payment

The term "Discount Payment" means any charge for care that is reduced but not free, to those patients who qualify under the Self-Pay Discount Criteria.

Additionally, other uninsured patients may be eligible for a discount payment (a.k.a. self-pay

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discount) at a range between 40%-70% of charges. This determination is made by Foothill Regional Medical Center on a case-by-case basis, after evaluating potential insurance options for the patient.

**Charity Care Patient**

A patient whose family income is below or equal to the Charity Care Criteria equal to or less than 250% of the Federal Poverty (FPL) available at: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> or by calling Patient Financial Services at 562-293-3200. Financial Assistance is available to uninsured and underinsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary<sup>1</sup> hospital services.

**V. SCOPE AND RESPONSIBILITIES**

It is the responsibility of the VP of Patient Financial Services and Admitting Director to ensure that appropriate procedures, as described below, are in place to ensure appropriate action is taken.

**VI. PROCEDURES:**

**Notice of Hospitals Charity Care Policy**

The policy will be communicated in a manner consistent with applicable state and federal laws, to any patient who requests assistance in paying their portion of their bill. It is the policy of Foothill Regional Medical Center to assist/direct patients to the appropriate resources for government-sponsored health coverage before applying for Charity Care. A Medi-Cal application (SAWS1) form will be distributed to patients who do not indicate coverage by a third-party payer, or who requests a Charity Care application.

**Financial information required of the patient to determine Charity Care eligibility:**

The information described below assists in that process.

- a. A completed financial assistance application (Mandatory)
- b. Proof of Income:
  - i. Current pay stub **or** most recent income tax return
  - ii. Written verification of wages from employer
  - iii. Copies of unemployment letters
  - iv. Social Security checks
  - v. Disability checks

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<sup>1</sup> Alta Hospitals System determines medical necessity.

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- vi. Signed attestation stating patient is unemployed
- c. Denial of coverage by governmental agency (Medicare, Medi-Cal, CCS, Healthy Families) (Discretionary).

If verification is either impossible or impractical a delegated Manager may complete the information with information received through interviews with those who know the patient’s financial status.

**Determination Process**

Once all required documentation is received, every reasonable effort will be made to make a determination of charity assistance as soon as possible. A letter will be sent to the patient notifying him/her of the determination within 45 days after all documentation is received.

**Collection Requirements**

Patient accounts may not be sent to a collection agency if the patient is attempting to qualify for charity or is attempting in good faith to settle the account by negotiating a payment plan or is making regular partial payments. The account may be assigned to a collection agency so long as the agency agrees to comply with this provision by merely managing the payment plan, negotiating the payment arrangement with the patient, or taking no action pending the outcome of the patient’s application.

Any extended payment plans negotiated with a qualified patient under a discounted fee arrangement must be provided without interest so long as the patient does not default on their payment arrangement.

Any account assigned for collection may not be reported against the patient’s credit record. Additionally, wage garnishments and liens or allowing the sale on real property may not be used by the assignee in collections, as described in SB 2297 and AB 1061.

A health savings account held by the patient or the patient’s family may be considered when negotiating payment plans. Foothill Regional Medical Center may require a patient or guarantor to pay the hospital any amount sent directly to the patient by third-party payors, including from legal settlements, judgements, or awards. Foothill Regional Medical Center may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.

**Discovery of Patient Financial Assistance Eligibility During Collections**

While Foothill Regional Medical Center strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. Foothill Regional Medical Center collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Alta Hospitals System will reverse the account out of bad debt and document the respective discount in charges as charity care.

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### **Charity Write-off Account**

Qualified patients receiving Charity Care will have 100% of their bill written off to the facility's Charity Care Transaction Code.

### **Presumptive Charity**

Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates financial hardship. Foothill Regional Medical Center may presumptively determine that a patient is eligible for charity care or discounted Foothill Regional Medical Center payment based on information other than that provided by the patient or based on a prior eligibility determination. The reason for presumptive eligibility may be reflected in the transaction code used to adjudicate the patient's claim. Additional patient notes may also be included. Examples of exceptions where documentation requirements are waived include, but are not limited to:

- An independent credit-based financial assessment tool indicates indigence.
- An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
  - Patient has an active Medicaid plan
  - Patient is eligible for Medicaid
  - Patients with current active Medicaid coverage will have assistance applied for past dates of service
  - Patient is deceased
- Determination of patient financial assistance eligibility by the Vice President of Revenue Cycle
- Presumptive eligibility tools may not be used for Medicare Fee for Service patients (as required by Centers for Medicare and Medicaid Services' bad debt.

### **Non-Covered/Denied Medicaid or Indigent Care Program Services**

Non-covered and denied services provided to Medicaid or other indigent care program eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:

- Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
- Medicaid-pending accounts
- Medicaid or other indigent care program denials
- Charges related to days exceeding a length-of-stay limit
- claims (including out of state Medicaid claims) with "no payment"
- Any service provided to a Medicaid eligible patient with no coverage and no payment

### **Access to Healthcare During a Public Health Emergency**

Access to Healthcare Crisis must be proclaimed by executive management at Foothill Regional

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Medical Center and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of Foothill Regional Medical Center community during the Access to Healthcare Crisis. During an Access to Healthcare Crisis Foothill Regional Medical Center Hospital may "flex" its patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis)

**Emergency Physician**

An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

**VII. RELATED FORMS (when applicable)**

A.

**VIII. RELATED POLICIES AND PROCEDURES (when applicable)**

**IX. REFERENCES**

A.

**X. POLICY APPROVAL HISTORY**

**Owner**

**Date Approved: 10/31/2022**

A. Director of Patient Access

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## Low Income Financial Assistance

### I. **POLICY PURPOSE**

To establish an Foothill Regional Medical Center policy for care that is rendered at a reduced fee for those who qualify for Low Income Financial Assistance (LIFA).

### II. **SCOPE**

This policy applies to Patient Access

### III. **POLICY**

Foothill Regional Medical Center is committed to providing high quality, affordable healthcare services to patients that are uninsured/underinsured. This policy establishes the guidelines for each campus to follow to communicate our policy, qualify patients for low-income financial assistance and properly account for the revenue associated with providing this care.

#### **COMPANION POLICIES AND PROCEDURES**

This policy is a companion policy and procedure to the Charity Care P&P and the Self-Pay P&P. Employees should be aware of all three policies to ensure the correct process is followed when serving our patients.

#### **DETERMINATION/REVOKABILITY**

Charity Care eligibility can be determined, or revoked, at any point in the preadmission, billing or collection process should any significant changes occur in the patient's financial status or third-party coverage. Any disputes on eligibility will be addressed and resolved by the Chief Financial Officer.

### IV. **DEFINITIONS:**

#### **Low Income Financial Assistance**

The term "Low Income Financial Assistance" means the providing of care at a reduced fee to those patients who qualify under the low income financial assistance criteria established by Alta Hospitals System.

#### **Low Income Financial Assistance Patient**

A patient whose family income is above the Charity Care threshold but equal to or below 400% of the Federal Poverty Level (FPL) available at: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> or by calling Patient Financial Services at 562-293-3200. Or a patient with whose family income is at or below 400% of the Federal Poverty Level with High Medical Costs. High Medical Costs are defined as Annual out-of-pocket medical expenses that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months. Or annual out-of-pocket expense that exceed 10% of the patient's family income, 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. Out of pocket costs and medical expense 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.

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**SCOPE AND RESPONSIBILITIES**

It is the responsibility of the VP of Patient Financial Services and Admitting Director to ensure that appropriate procedures, as described below, are in place to ensure appropriate action is taken.

**V. PROCEDURES:**

**Notice of Hospitals Discount Payment Policy**

The policy will be communicated in a manner consistent with applicable state and federal laws, to any patient who requests assistance in paying their portion of their bill. It is the policy of Foothill Regional Medical Center to assist/direct patients to the appropriate resources for government-sponsored health coverage before applying for LIFA. A Medi-Cal application (SAWS1) form will be distributed to patients who do not indicate coverage by a third-party payer, or who requests a Low-Income Financial Assistance application. Foothill Regional Medical Center does not require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened, or provided, a financial discount. However, Alta Hospitals System may require patients to participate in screening for Medi-Cal eligibility.

**Financial information required of the patient:**

It is the policy of Foothill Regional Medical Center to assist/direct patients to the appropriate resources for government-sponsored health coverage before applying for LIFA. The information described below assists in that process.

1. A completed financial assistance application (Mandatory with limited exceptions as described in the Presumptive Charity section of this policy)
2. Proof of Income:
  - a. Current pay stub
  - b. Written verification of wages from employer
  - c. Copies of unemployment letters
  - d. Social Security checks
  - e. Disability checks
  - f. Signed attestation stating patient is unemployed
  - g. Most recent tax return if no current pay stub
3. Denial of coverage by governmental agency (Medicare, Medi-Cal, CCS, Healthy Families)

(Discretionary)

If verification is either impossible or impractical a delegated Manager may complete the information with information received through interviews with those who know the patient's financial status.

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**Uninsured Adjustments to Accounts**

Qualified patients WITHOUT INSURANCE receiving LIFA will be billed at 100% of the Medicare DRG for inpatient and OPPOS rate for outpatient services provided. The facility’s Low-Income Financial Assistance Transaction Code will be used to adjust the balance remaining.

**Underinsured Adjustments to Accounts**

Qualified patients WITH INSURANCE receiving LIFA will have 100% of their patient responsibility above the Medicare allowed written off to the facility’s Low Income Financial Assistance Transaction Code. Eligibility is determined according to the patient’s family income at or below 400% of the Federal Poverty Level, available at: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> or by calling Patient Financial Services at 562-293-3200.

LIFA for Insured Patients: Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services.

**Determination Process**

Once all required documentation is received, every reasonable effort will be made to make a determination of financial assistance as soon as possible. A letter will be sent to the patient notifying him/her of the determination within 45 days after all documentation is received. The failure to provide information that is reasonable and necessary to make a determination concerning financial assistance may be considered by Alta Hospitals System in making its determination. Financial assistance eligibility shall be determined at any time. Alta Hospitals System shall not impose time limits for applying for charity care or discounted payments, nor deny eligibility based on the timing of a patient’s application.

**Collection Requirements**

Patient accounts may not be sent to a collection agency if the patient is attempting to qualify for financial assistance or is attempting in good faith to settle the account by negotiating a payment plan or is making regular partial payments. The account may be assigned to a collection agency so long as the agency agrees to comply with this provision by merely managing the payment plan, negotiating the payment arrangement with the patient, or taking no action pending the outcome of the patient’s application.

Foothill Regional Medical Center will not report adverse information about a patient’s hospital debt to a consumer credit reporting agency. Per AB 2297 and SB 1061, Alta Hospitals System also recognizes the sale of a patient’s primary residence have been removed, and liens on any real property owned by the patient are prohibited.

Any extended payment plans negotiated with a qualified patient under a discounted fee arrangement must be provided without interest so long as the patient does not default on their payment arrangement.

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Alta Hospitals System 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.

**Emergency Physician**

An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

**Eligibility Procedures**

**Charity and Low Income Financial Assistance Application**

- A notice regarding financial assistance is included in all patient packets.
- A charity application is distributed to all uninsured patients at registration.
- Uninsured patients will be provided an application for Medi-Cal, Healthy Families, or other governmental programs.
- Uninsured patients whose total family income at or below 400% of the federal poverty level will be eligible for charity care or low income financial assistance.
- For purposes of determining eligibility, a patient's family is defined as a patient, 18 years or older, any domestic partner, dependent children of any age; or a patient under the age of 18, parents, caretaker relatives and other children under 21 who are the children or the responsibility of the caretaker relative. Family accounts for the inclusion of parents when the patient is a dependent child who is not a minor.
- A complete application must be submitted (limited exceptions as disclosed in the Presumptive Charity Section of this policy).
- Proof of income is required for validation, if no income patient must sign an attestation of unemployment.

**Guidelines for Reviewing Charity Care and Low Income Financial Assistance Applications:**

- Upon receipt of the application, the application is reviewed by staff at the

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CBO to determine if the application has been completed and the supportive documents are attached.

- The patient will continue to receive statements but will not be sent to a collection agency during the review process.
- If the application is incomplete, the patient is sent a letter requesting the missing information.
- Once the application is complete, the application is forwarded to the CBO Director for determination.
- Once the application is approved, the patient will be sent an approval letter.
- The financial class will be updated, and adjustment form submitted.
- If the application is denied, the patient will be sent a denial letter with explanation.
- The CBO will make every reasonable effort to make the charity/low-income financial assistance determination as soon as possible.

**VI. RELATED FORMS (when applicable)**

A.

**VII. RELATED POLICIES AND PROCEDURES (when applicable)**

A.

**VIII. REFERENCES**

A.

**IX. POLICY APPROVAL HISTORY**

**Owner**  
Director of Patient Access

**Date Approved: 10/31/2022**