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PURPOSE

Monrovia Memorial Hospital (MMH) strives to provide quality patient care for the communities we serve. This policy demonstrates MMH's commitment to our mission and vision by helping to meet the needs of the low-income, uninsured, and the underinsured patients in our community.

The purpose of this policy is to provide patients with information on the availability of Charity Care at MMH, to outline the process for determining eligibility, and to establish guidelines and standards that MMH will follow with respect to the collection of patient debt, including patients who are eligible for Charity Care. This policy addresses financial assistance (Charity Care) at MMH.

POLICY

MMH will operate in a manner such that no patient shall be denied service due to an individual's inability to pay. Consistent with this commitment, it is the policy of MMH to provide Charity Care to qualified low-income uninsured or underinsured patients to whom we provide services in our community. This policy will be administered in a manner consistent with state and federal laws and regulations.

As required by law, MMH shall provide patients with information regarding Charity Care and other programs during the patient intake process. It is imperative that the notification of availability, determination, reporting and tracking of financial assistance is in concert with our mission and our community obligations. Patients that are eligible for financial assistance are not charged more than the Amounts Generally Billed (AGB) for Medically Necessary Care.

MMH's Charity Care program is not a substitute for personal responsibility. Patients are expected to cooperate with MMH's procedures for obtaining Charity Care and other payment sources to contribute to the cost of their care based on their ability to pay.

DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Amounts Generally Billed (AGB): The maximum charge a patient who is eligible for Charity Care is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No

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patient eligible for Charity Care will be charged more than the AGB using the “lookback” method by multiplying the “Gross Charges” for any Medically Necessary Care that is provided by AGB percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in federal law. “Gross Charges” for these purposes means the amount listed on each Hospital Facility’s chargemaster for each Medically Necessary Care service.

Application Period: The time provided to patients by MMH to complete the Charity Care application. It expires on the later of (i) 365 days from the patient’s discharge from an MMH facility or the date of the patient’s medically necessary care, or (ii) 240 days from the date of the initial post-discharge bill for the Medically Necessary Care received at an MMH facility.

Family Income: Determined consistent with the IRS definition of Modified Adjusted Gross Income for the patient and all members of the Patient’s Family.

Federal Poverty Level (FPL): FPL means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.

Charity Care: Includes full charity care and high medical cost charity care (as outlined in section A. Eligibility Criteria).

Financially Qualified Patient: A patient who is a Self-Pay Patient or is a High Medical Cost Patient, and who has a Family Income that does not exceed 400 percent of the federal poverty level.

High Medical Costs: A patient who is not Self-Pay; has a family income at or below 400 percent of the FPL; and has total out-of-pocket medical expenses in the prior 12 months that exceed 10 percent of the patient’s Family Income.

Medically Necessary Care: Any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers the life, cause suffering or pain, results in illness or infirmity, threaten to cause or aggravate handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures.

Patient’s Family: For patients 18 years of age and older, Patient’s Family is defined as their spouse, domestic partner, and dependent children under 21 years of age, whether living at home

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or not. For persons under 18 years of age, Patient's Family includes a parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

Uninsured patient: An individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for Medically Necessary Care covered by this policy.

Uninsured Patient: A patient who has no third-party source of payment for any portion of their medical expenses, including but not limited to, commercial or other health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, or third-party liability. For the purpose of this policy an "uninsured patient" may include a "self-pay" patient and/or a patient whose benefits under all potential sources of payment have been exhausted prior to admission.

Self-Pay Discount: Describes the situation where the hospital has determined that the patient does not qualify for Charity Care but is eligible for a Self-Pay Discount and is expected to pay only a part of the bill. The Self-Pay Discount is described more fully in the MMH policy, "Selfpay and Prompt Pay Discount Policy".

A. Self-Pay Patient: A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, and whose injury is not a compensable injury for Worker's Compensation, automobile insurance, or other insurance (third-party liability) as determined and documented by hospital.

PROCEDURE

A. Eligibility

Eligibility for Charity Care will be considered for those individuals who are unable to pay for their care and are uninsured and ineligible for any government health care program or for those patients that have High Medical Costs. The granting of Charity Care shall be based on an individualized determination of Family Income, and shall not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.

In determining whether a patient qualifies for Charity Care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, Health PAC, Victims of Crime, California Children Services, or an Affordable Care Act benefit plan.

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MMH shall assist patients in exploring appropriate alternative sources of payment and coverage from public and private payment programs and to also assist patients in applying for such programs. However, if the patient applies, or has a pending application for another health coverage program at the same time that he or she applies for Charity Care or discount payment program, neither application shall preclude eligibility for the other program.

Eligibility for Charity Care will be determined in accordance with the following procedures. The patient will be required to submit the following information:

Completed Financial Assistance and Charity Care application.

Proof of income tax return and monetary assets, or subsequent month bank statements or most recent payroll stub or Federal Income Contributions Act (FICA) earnings summary from the Social Security Administration.

a. Eligibility Criteria

Financial Assistance Category	Patient Eligibility Criteria	Available Discount
Full Charity Care	Patient is an Uninsured Patient with a Family Income at or below 400% of the most recent FPL.	Full write-off of all charges for Medically Necessary Care.
High Medical Cost Charity Care (for insured Patients)	Patient is an Insured Patient with a Family Income at or below 400% of the most recent FPL and Medical expenses for themselves or their family (incurred at MMH or other providers in the past 12 months) exceed 10% of the patient's Family.	A write-off of the Patient Responsibility amount for Medically Necessary Services.

b. Income and Monetary Assets of Patient

In determining eligibility under this policy, MMH may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified

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under the internal revenue code or nonqualified deferred compensation plans. Furthermore, the first ten thousand (\$10,000.00) of a patient's monetary assets shall not be counted in determining eligibility, nor shall fifty percent (50%) of a patient's monetary assets over the first ten thousand dollars (\$10,000.00) be counted in determining eligibility. Assets are cash, checking accounts, savings accounts, money market funds, certificates of deposits, real estate property, etc.

- c. Charity Presumptive Eligibility application or comply with requests for documentation in the application process. As a result, there may be circumstances under which a patient's qualification for Charity Care may be established without completing the formal Financial Assistance application and/or providing the necessary and required documents for approval. MMH may utilize other sources of information to make an individual assessment of financial need to determine whether the patient is eligible for Charity Care and approval. This information will enable MMH to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient. Presumptive eligibility for Charity Care may be determined on the basis of individual life circumstances that may include:
 - Homelessness or receipt of care from a clinic serving those experiencing homelessness.
 - Participation in Women, Infants and Children (WIC) programs
 - Eligibility for food stamps
 - Eligibility for school lunch programs
 - Living in low-income or subsidized housing and
 - Patient is deceased with no estate or deceased and cannot identify patients name or address.
- d. Contracting with Other Organizations to Determine Eligibility MMH may from time-to-time contract with other organizations that specialize in assisting patients and their families with qualifying for charity or other sources of funding or insurance enrollment. Organizations/Contractors are required to abide by the policies set forth by MMH. Patients are given information regarding the availability of assistance from these other organizations and are encouraged to cooperate with the qualifying process. Patients are not expected to incur any costs when utilizing these services.

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e. Eligibility Period:

Once the determination is made that the patient is eligible for Charity Care, patients will be eligible for a period of one year after the determination is made. After one year, patients must re-apply for Charity Care. If at any time information relevant to the eligibility of the patient changes, it is the patient's responsibility to notify MMH of the updated information.

A review will include any other outstanding accounts for the patient that may also be eligible for the financial assistance approval timeframe.

B. APPLICATION PROCESS

1. A financially qualified or high-cost medical patient who indicates the financial inability to pay a bill for a Medically Necessary Care shall be evaluated for Charity Care and any other federal, state, or county program.
2. The MMH standardized application form, shown as the "Financial Assistance and Charity Care Application" (see Attachment A), will be used to document each patient's overall financial situation. This application is available in the primary languages of the service area. For applicants who speak other languages, MMH will provide interpreter assistance for applicants to complete the form. This form is for internal use only.
3. Patients should complete the application for Charity Care as soon as possible after receiving Medically Necessary Care at an MMH hospital facility. Patients will receive a charity application as part of the first billing statement. Failure to complete and return the application within 240 days of the date the Hospital first sent a post-discharge bill to the patient may result in the denial of Charity Care.
4. The patient must make every reasonable effort to furnish the hospital with documentation of income. The documentation requirements are listed on the charity budget form and the Charity Care application form.
5. The patient must attest in writing that the information they are furnishing to the hospital is accurate.

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6. A financially qualified or high-cost medical patient may also obtain a Charity Care application on our website or by calling our Customer Service Team or our Financial Counselors.

C. SPECIAL CIRCUMSTANCES

Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance criteria set forth above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of MMH undiscounted charges for Medically Necessary Care, with the approval of MMH CEO. MMH must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non-exhaustive list of situations that may qualify for Special Circumstances Charity Care.

1. Deceased. Deceased patients without insurance, an estate, or third-party coverage.
2. Bankruptcy. Patients who are in bankruptcy (filed but an open case) or completed bankruptcy in the past three (3) months.
3. Homeless Patients. Emergency room patients without a payment source if they do not have a job, mailing address, residence, including temporary residence, or insurance. However, all other county, state, or government programs must be considered as part of enrollment screening. Consideration must also be given to classifying emergency- room-only patients who do not provide adequate information as to their financial status.
4. Medi-Cal. Medi-Cal Denied Patient Days and Non-Covered Services: Medi-Cal/CCS and other State of California programs patients are eligible for Charity Care write-offs related to denied stays in limited circumstances (e.g., when the admission/services were Medically Necessary Care as determined by the treating physician or the patient was not safe to discharge and there is no administrative day payment). The Treatment Authorization Request (TAR) will record the reason for the denial. However, patients may not receive financial assistance for the Medi-Cal Share of Cost.

D. CHARITY CARE DETERMINATION

The determination for Charity Care and other government programs for which a patient may be eligible should be confirmed as close to the time of service as possible, in some cases, eligibility is readily apparent and a determination can be made before, on, or

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soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. At any time, if a patient sends confirming information and the application that demonstrates qualification for Financial Assistance, then full or partial charity care will be indicated. MMH will make every effort to provide a determination of eligibility within 30 days of receiving all requested information and documentation from the patient.

If the patient doesn't qualify or does not submit requested documents, the patient will be billed in accordance with Debt Collection Policy. The patient's unpaid balance will never be turned over to collections.

1. Disputes:

A patient may seek review of any decision by the Hospital to deny Charity Care by notifying the Director of Patient Financial Services or the Director of Patient Access. Patients may dispute verbally or in writing. The Director will review the patient's dispute as soon as possible and inform the patient of any decision in writing.

2. Uninsured discounts and Extended Payment Plans

MMH patients who do not have third-party insurance and are not eligible for a government program will receive a discount off MMH charges. The uninsured discount percentage for Hospital and Professional billing is 75% from total charges.

MMH offer uninsured patients and insured patients with a patient responsibility portion the option to enter into an agreement to pay their patient responsibility portion and any other amounts due over time. MMH will also offer extended payment plans for those patients who indicate an inability to pay a patient responsibility amount in a single installment.

All payment plans shall be interest-free. MMH will negotiate an extended payment plan to allow payments over time that is agreed upon between MMH and the patient based on the patient's family income and essential living expenses. If MMH and the patient are unable to agree on the terms of the payment plan, MMH shall extend a payment plan option under which the patient may make a monthly payment of not more than 5% of the patient's monthly family income after excluding essential living expenses.

"Essential living expenses" means expenses for any of the following: rent, 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. The extended payment plan may be declared no longer operative after the patient's failure to make all

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consecutive payments during a 90-day period. Before declaring the payment plan no longer operative, MMH or the contracted collection agency shall make a reasonable attempt to contact the patient by phone and to give notice in writing that the extended payment plan may become inoperative, and that the patient has the opportunity to renegotiated payment plan. After a payment plan is declared inoperative, MMH or the contracted collection agency may commence collection activities.

3. Charity Care Exclusions:

The following services are ineligible for the application of Charity Care under this Policy:

- a. Medi-Cal Patients with Share of Cost: Medi-Cal patients who are responsible to pay share of cost are not eligible to apply for Charity Care under this Policy to reduce the amount of share of cost owed.
- b. Cosmetic Procedures: Elective procedure that is normally an exclusion from coverage under a health plan such as cosmetic procedures.
- c. Physician Services: Services that are not billed by MMH.
- d. Payer Pays Patient Directly: If a patient receives a payment for services directly from a payer.
- e. Insured patient does not cooperate with third-party payer: An insured patient who is insured by a third-part payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the thirdparty payer's liability.
- f. Services which are already bundled and discounted.

4. Reimbursing Overcharges:

If the hospital erroneously collected the patient portion, from a patient who qualifies for charity care, the patient will be reimbursed the principle. This clause shall not apply if the overpayment is \$5 or less. In this case, the hospital shall furnish credit equal to the amount of \$5 or under for a period of 60 days.

A. AVAILABILITY OF CHARITY CARE INFORMATION

1. Pre-Admission or Registration: During preadmission or registration (or soon thereafter as practicable and after stabilization of the patient's emergency medical condition in the case of emergency services), MMH shall provide all patients with information regarding financial assistance which also includes a plain language summary of the Charity Care Policy. MMH shall also provide patients with contact information for an MMH employee or office from which the patient may obtain further information about charity care and discount payments. The information

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provided shall be in the primary language of MMH service area and in a manner consistent with all applicable federal and state laws and regulations.¹

2. Financial Counselors: patients who may be uninsured patients shall be interviewed and screened by a Financial Counselor who shall visit with the patients in person at the Hospital. Financial Counselors shall give such patients a Charity Care application and screen the patient for other government programs.
3. Posting and Other Notices
Information about Charity Care shall be provided as follows:
 - a. By posting in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, including, without limitation, in the emergency department, billing office, admitting office, and other hospital outpatient service settings including observation units.
 - b. By prominently posting information about Charity Care on MMH's website and including a link to the policy itself on MMH's website.
 - c. By including information about financial assistance in bills that are sent to Uninsured Patients. This information shall include an i) application for charity care and financial assistance, ii) the phone number for patients to call with questions about financial assistance, and iii) the website address where patients can obtain additional information about financial assistance including the Charity Care Policy and a plain language summary of the Policy. MMH will include the name of the collection agency in the final patient statement sent to any patients whose accounts are being referred to such an agency.

AUTHORITIES AND OTHER RESPONSIBILITIES

A. Authority

Authority for decision making with regard to this Policy and the progression to formal debt collection is granted to the Director for Patient Accounting and Patient Access Services and/or an individual with such authority at a higher level or rank in MMH including the Vice President of Revenue Cycle, the Chief Financial Officer and other personnel granted this authority for coverage when the Director or designee is not available.

B. Roles and Responsibilities

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1. Policies and Procedures:

Additional policies and procedures may be adopted to address the various responsibilities in the determination of charity care. This includes documentation of any contact with the patient, provision of information, and assistance to the patient making the determination of charity care eligibility and notifying the patient.

2. Record Keeping:

Records relating to potential charity care patients must be readily accessible. MMH must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied, and the reasons for denial.

In addition, notes relating to Charity Care application and approval, or denial should be entered on the patient's account.

MISCELLANEOUS

1. Submission to the Department of Health Care Access and Information (HCAI): Beginning January 1, 2023, and biennially thereafter, or when significant changes have been made to this policy, MMH will submit this policy to HCAI. Submission of the policy shall be consistent with the manner prescribed by HCAI.
2. Accounting for Charity Care:
To allow MMH to track and monitor the amount and type of charity care being granted, the hospital will account for the charity care write-offs and record all transactions as an "administrative write-off."

REFERENCES

1. Internal Revenue Code section 501 (r)
2. California Health and Safety Code Section 127400 through 12740

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