Pioneers Memorial Healthcare District

Title: **Financial Assistance Program (FAP), Charity Care Program**	Policy No. ADM-00312
	Page 1 of 11
Current Author: Cynthia Ramirez Veliz	Effective: 2/2023
Latest Review/Revision Date: May 2024	Manual: Administration

Collaborating Departments: Finance		Keywords: Financial Assistance, Charity Care	
Approval Route: List all required approval			
MARCC 1/16/2024	PSQC	Other:	
Clinical Service _____	MSQC	MEC	BOD 2/2024

Note: *If any of the sections of your final layout are not needed do not delete them, write "not applicable".*

1.0 Purpose:

1.1 To define the criteria used by Pioneers Memorial Healthcare District (PMHD) to evaluate and determine qualification for the Financial Assistance Program (FAP) and Charity Care program. PMHD strives to ensure that the financial capacity of people who need health care services shall not prevent them from seeking or receiving care.

2.0 Scope:

2.1 Patients who receive medically necessary services from PMHD (as defined in California Welfare & Institutions Code §14059.5), including patients, patient families, physicians and hospital staff. This policy does not apply to physician services rendered at PMHD.

In the event that the hospital determines a particular service is not medically necessary, the referring physician and/or the supervising health care provider must sign an attestation indicating the rationale for determining the hospitals service(s) as not medically necessary. Said attestation must be completed prior to the denial of full or partial financial assistance by PMHD.

3.0 Policy:

3.1 Under the patient Financial Assistance Program (FAP), all uninsured patients and those who request financial assistance will be required to complete a Financial Assistance Application (FAA). The FAA is a unified patient application for both full charity care and partial charity care. PMHD shall provide direct assistance to facilitate completion of the FAA.

All hospital documents including the FAA shall be in at least a 12 point san serif font, using straightforward language so that patients may easily read and understand these documents. Documents will be maintained available in any language commonly spoken by five (5%) or more of the service population. All patient notices will be accompanied by a tagline sheet with the following statement provided in English and the top 15 languages spoken by limited English speaking persons in California:

ATTENTION: If you need help in your language, please call 1-800-874-9426, Client ID 201448, where patients obtain more information. Aids and services for people with

disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

3.2 Patients must be honest and forthcoming when providing all information requested by PMHD as part of the financial screening process. The FAA provides patient information necessary for determining patient qualification by the hospital and such information may be used to qualify the patient or family representative for maximum coverage available through government programs. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy include:

3.2.1 Family income based upon federal income tax returns, recent pay stubs, or other relevant information provided by the patient in the absence of said documents; and “Patients family means the following:
For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker.

3.2.2 PMHD FAP relies upon the cooperation of individual patients who may be eligible for full or partial assistance. Patients must make every reasonable effort to provide PMHD with documentation and health insurance coverage information such that PMHD may make a determination of the patient’s qualification for

coverage under the appropriate program. Prior to leaving PMHD, patients should verify what additional information or documentation must be submitted to PMHD.

3.2.3 Patients should expect and are required to pay any or all amounts due at the time of service, including but not limited to, co-payments, deductibles, deposits and Medi-Cal/Medicaid Share of Cost amounts.

3.3 Eligibility alone is not an entitlement to qualification under the PMHD FAP. PMHD must complete a process of application evaluation and determine qualification before full charity or partial charity may be granted.

3.4 PMHD, in its sole discretion, may determine that it has sufficient patient financial information from which to make a financial assistance qualification decision without a completed FAA.

3.5 Financial assistance determination will be made only by approved PMHD personnel according to the following levels of authority:

3.5.1 -Director of Patient Business Office: Accounts less than $10,000

3.5.2 -Chief Financial Officer: Accounts greater than $10,000

4.0 Definitions: Not applicable

5.0 Procedure:

5.1 Qualification for full charity care or partial charity financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay in accordance with Federal Poverty Level (FPL) standards.

5.2 Charity Care Qualification - Eligibility under the PMHD FAP is provided for any patient whose family income is less than 400% of the current federal poverty level, if not covered by a third-party insurance or, if covered by third party insurance which does not result in full payment of the account.

5.3 All open accounts at the time of application will be reviewed for qualification.

5.4 Uninsured Patients - If an uninsured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for full charity care.

5.4.1 If an uninsured patient's family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

5.4.1.1 If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be a percentage of the Medicare amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by

any individual patient shall be on the sliding scale shown in Attachment C.

5.5 Insured Patients - If an insured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, PMHD will accept the amount paid by the third-party insurer and the patient will have no further payment obligation.

5.5.1 If an insured patient's family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

5.5.1.1 For services received by patients covered by a third-party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the Medicare amount (fully loaded Medicare payment rate) of what Medicare would have paid if the patient were a Medicare beneficiary (i.e., if insurance has paid more than the Medicare allowable amount, the patient will owe nothing further, but if the patient's insurance has paid less than the Medicare allowable amount, the patient will pay the difference between the insurance amount paid and the Medicare allowable amount).

5.6 Special Charity Care Circumstances - Patient and patient's families are deemed as automatically eligible for full charity care in the following situations:

5.6.1 Patient is determined by PMHD Registration staff to be homeless and without third party payer coverage.

5.6.2 Deceased patients who do not have any third-party payer coverage, an identifiable estate or for whom no probate hearing is to occur.

5.6.3 Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months. The patient or family representative shall provide a copy of the court order document as part of their application.

5.6.4 Patients seen in the emergency department, for whom PMHD is unable to issue a billing statement, may have the account charges written off (i.e., the patient leaves before billing information is obtained). All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

5.6.5 Patients who are eligible for government sponsored low-income assistance programs (e.g., Medi-Cal/Medicaid, California Children's Services, and any other applicable state or local low-income program) are automatically eligible for full charity care when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other government programs serving the needs of low-income patients (e.g., Child Health and Disability Prevention (CHDP) and some California Children's Services (CCS))

where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance coverage. Under PMHD's FAP, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care.

5.6.6 Any uninsured patient who is classified as a foreign refugee, with documentation from the US Border Patrol, Customs and Immigration Service, and/or other government entity with jurisdiction, may be deemed as eligible for full charity care.

5.6.7 Any uninsured patient whose income is greater than 400% of the current FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients who have higher incomes do not qualify for routine full charity care or discount payment care. However, consideration of a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the patient's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $150,000.00 may be considered for eligibility as a catastrophic medical event**. This does not apply to the Rural Health Clinics**.

5.6.8 Any account returned to PMHD from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

5.6.9 Criteria for Re-Assignment from Bad Debt to Charity Care - All outside collection agencies contracted with PMHD to perform account follow-up and/or bad debt

collection will utilize the following criteria to identify a status change from bad debt to charity care:

5.6.10 Patient accounts must have no applicable insurance (including governmental coverage programs or other third-party payers); and

5.6.11 The patient or family representative must have a credit and/or behavior score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

5.6.12 The patient or family representative has not made a payment within 180 days of assignment to the collection agency; and

5.6.13 The collection agency has determined that the patient/family representative is unable to pay; and/or

5.6.14 The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score.

5.6.15 All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by PMHD Billing Department personnel prior to any re-classification within the hospital accounting system and records.

5.7 Patient Notification - Once a determination of charity care eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

5.7.1 Approval: The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient. Information and directions for any further patient actions will also be provided.

5.7.2 Denial: The reasons for eligibility denial based on the FAA will be explained to the patient. Any outstanding amount owed by the patient will also be identified. Contact information and instructions for payment, including a reasonable payment plan will also be provided.

5.8 Pending: The applicant will be informed as to why the FAA is incomplete. All outstanding information will be identified, and the notice will request that the information be supplied to PMHD by the patient or family representative.

All financial assistance letters will also contain information on the Hospital Bill Complaint Program, including the following statement:

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill

Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

All financial assistance letters will also include the following statement:
Help Paying Your Bill
There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

5.9 Qualified Payment Plans - When a determination of partial charity care has been made by PMHD, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term Qualified Payment Plan.

5.9.1 PMHD shall discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months.

5.9.2 PMHD shall negotiate in good faith with the patient; however, there is no obligation to accept the payment terms offered by the patient. In the event that PMHD and an individual patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, the hospital will use the "Reasonable payment plan" formula as defined in Health & Safety Code Section 127400 (i) as the basis for a payment plan. A "Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. In order to apply the "Reasonable payment plan" formula, PMHD shall collect patient family information on income and "Essential living expenses" in accordance with the statute. PMHD shall use a standardized form to collect such information. Each patient or guarantor seeking to establish a payment plan by applying the "Reasonable payment plan" formula shall submit the family income and expense information as requested, unless the information request is waived by representatives of PMHD.

5.9.3 No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the FAP.

5.9.4 Once a payment plan has been approved by PMHD, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the PMHD Patient Business Office if circumstances change, and payment plan terms cannot be met. However, in the event of a payment plan default, PMHD will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing. Notices of plan default will be sent the patient at least sixty (60) days after the first missed bill and

provide the patient at least thirty (30) days to make a payment before the extended payment plan becomes inoperative. The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative. The patient's financial responsibility shall not exceed the discounted amount previously determined. The patient will receive credit for any payments made before the extended plan became inoperative and the account will become subject to collection.

5.9.5 Dispute Resolution In the event that a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with PMHD. The written appeal 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.

5.9.6 Any or all appeals will be reviewed by the Director of the Patient Business Office. The Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Director shall provide the patient with a written explanation of findings and the determination. If the party making the appeal disagrees with the findings, they make an additional written appeal to the Chief Financial Officer. The decision of the Chief Financial Officer is final. There are no further appeals.

5.10 Public Notice

5.10.1 PMHD shall post notices informing the public of the FAP, the FAA, and the Billing and Collection Policy. Such notices shall be posted in high volume inpatient and outpatient service areas of PMHD, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas, outpatient observation units, or other common patient waiting areas of PMHD. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

5.10.1.1 These notices shall be posted in English and Spanish and are available in other languages as required by Health & Safety Code §127410 (a).

All posted notices shall be in a san serif font, using black text on a white background. Posted notices shall be no smaller than an 11"x17' sheet and written in an easy to read and understand format. Posted notices will be in

English and Spanish and any other language commonly used by five (5%) percent or more of the service population.

Hospital postings will have the following subject headings:

1. "Help Paying Your Bill" with information about the hospital full and partial financial assistance program.
    a. "How to Apply" with contact information for the hospital employee and office where information about financial assistance and an application may be obtained.
    b. "Hospital Bill Complaint Program" followed by the language: If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.
    c. "More Help" followed by: There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.
    d. Information on how a patient with a disability may access the notice in an alternative format, including but not limited to, large print, braille, audio, or other accessible electronic formats.
    e. Information on how to access the notice in another language.

5.10.2 Additionally, the Financial Assistance Policy, the Financial Assistance Application, Public Notice, and the Billing and Collection Policy shall be easily found online at: www.pmhd.org. The webpage is titled "Help Paying Your Bill," and a link is found on (either a footer or header dropdown menu no more than one click away) – HOSPITAL TO SPECIFY BASED ON CHANGES TO CURRENT WEBSITE)
The website shall also include the standard language reference to the Hospital Bill Complaint Program previously stated above in Section 5.

5.10.3 Paper copies of the above referenced documents shall be made available to the public upon reasonable request at no additional cost. PMHD shall respond to such requests in a timely manner.

5.11 Full Charity Care and Partial Charity Care Reporting

5.11.1 PMHD shall report actual Charity Care provided in accordance with this regulatory requirement of the Department of Health Care Access and Information (HCAI) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, PMHD will maintain written documentation regarding its Charity Care criteria, and for individual patients, PMHD will maintain written documentation regarding all Charity Care

determinations. As required by HCAI, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

PMHD will appoint an authorized primary and secondary contact to receive compliance and informational communications from HCAI. Each of these two designated PMHD personnel will register with HCAI and any changes to the primary or secondary contacts will be communicated to HCAI within ten (10) working days.

PMHD will appoint an authorized primary and secondary contact to review and respond to patient complaints. Each of these two designated PMHD personnel will register with HCAI and any changes to the primary or secondary contacts will be communicated to HCAI within ten (10) working days

5.11.2 PMHD shall provide HCAI with a copy of this FAP which includes the full charity care and discount payment policies within a single document. The FAP also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and partial charity care; and 3) the review process for both full charity care and partial charity care. The Billing & Collection policy will also be submitted as it contains elements required under Health & Safety

Code Sections 1274000 et. seq. These documents shall be supplied to HCAI every two years or whenever a significant change is made.

6.0 References:

6.1 California Welfare & Institutions Code §14059.5 - definition of medically necessary Services (referenced in section 2.0)

6.2 Health & Safety Code §127410 (a) – regulation for notices posted (referenced in section 5.9.1.a)

7.0 Attachment List:

7.1 Attachment A - Financial Assistance Program Summary, Public Notice

7.2 Attachment B - Financial Assistance Application

7.3 Attachment C - Sliding Scale Partial Charity Care Schedule

7.4 Attachment BB - Financial Assistance Application – Spanish

7.5 Attachment AA - Financial Assistance Program Summary, Public Notice -Spanish

8.0 Summary of Revisions:

8.1 2.1 Added verbiage for scope.

8.2 3.1.1. Added verbiage on language information.

8.3 3.2.1.1 Revised Family meaning.

8.4 5.6.6 Added verbiage on refugees.

8.5 5.9.4 Added verbiage on plan default notices timeframes.

8.6 5.10.1.1 Added verbiage on posted notices sizes.

8.7 5.10.2 Website information.

8.8 5.11.1 Added verbiage on HCAI communications.