

ADMINISTRATIVE MANUAL Charity Care (Financial Assistance Policy)	Implemented 02/2007 Revised: 12/29/2023 Reviewed: 12/2023 Responsibility: Business Office
	Reference: California Health and Safety Code, IRS §127400-127446; IRC§501(r)

POLICY:

Fairchild Medical Center’s mission statement, “To provide health care services of exceptional quality to all who need us,” reflects Fairchild Medical Center’s social accountability to the community we serve. Providing charity care (financial assistance) to our patients, along with other community benefit services, is important evidence of Fairchild Medical Center’s mission fulfillment. It is imperative that the determination, reporting, and tracking of charity care are in concert with our not-for-profit mission and community obligation.

Discounted payment and/or charity care will be based on the individual’s ability to pay as defined by the Federal Poverty Income Guidelines and the attached sliding scale. No one will be denied access to services due to the inability to pay. Confidentiality of information and individual dignity will be maintained for all who seek charitable services. The handling of personal health information will meet all HIPAA requirements.

PURPOSE:

The purpose of this policy is to define the eligibility criteria for charity care services and to provide administrative and accounting guidelines for the identification, classification, and reporting of patient accounts as charity care.

DEFINITIONS:

Charity Care: A patient is eligible for Charity Care consideration based on meeting the income eligibility criteria as established by the Federal Poverty Income Guidelines Sliding Scale. Charity Care will be defined as “free care,” and “discounted payment” will be defined as any charge for care that is reduced but not free.

Charity care and discounts provided by this policy are generally not available for elective services otherwise classified as non-covered or not medically necessary. However, in certain cases an exception may be made. These exceptions require approval from Administration.

Specialized, high-cost services requiring charity care are also subject to the review of Administration prior to the provision of the service.

Uninsured: Individuals who do not have third-party coverage from a health insurer, health care services plan, Medicare, Medi-Cal, limited worker's compensation/auto insurance, and whose family income is at or below 400 percent of the federal poverty level.

Underinsured: A patient who has limited insurance coverage that does not provide coverage for the medically necessary care provided or the maximum liability under the insurance coverage.

Family Income: Income is generally the total yearly gross income of the patient's family unit.

- For adults, it is the sum of the total yearly gross income of the patient, their spouse, domestic partner, and potentially dependent children under 21.
- For minors, it includes the income of the patient, their parent(s), caretaker relatives, and other children under 21 of the parent or caretaker relative.

Federal Poverty Level: The United States Congress has the authority to set the dollar amount of income it considers poverty according to family size. The Federal Poverty Level (FPL) is routinely updated and published in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Medically Necessary Care: Medically necessary care is defined as "health care services or supplies that are needed to diagnose and treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

Income: Income is defined as a family's annual earnings and cash benefits from all sources before taxes. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earnings rates.

Self-Pay: Is a patient who is uninsured and who is at or below 400% of the FPL. A patient without third-party coverage from a health insurer, health care service plan, Medicare, Medi-Cal, and whose injury is not a compensable injury for purpose of worker's compensation, automobile insurance, or other insurance.

High Medical Costs: High Medical Costs refer to any medical care that is not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing. High medical costs apply to insured patients whose income is at or below 400 percent of the Federal Poverty Level and who have incurred annual out of pocket medical expenses – whether at the hospital or elsewhere – that exceed 10 percent of the patient's family income in the prior 12 months.

Essential Living Expenses: Essential Living Expenses include, but are not limited to:

- Rent or house payments and maintenance.
- Food and household supplies
- Utilities, telephone, and transportation/auto expenses
- Medical and dental payments, insurance, and child or spousal support

Procedure:

1. Who may Qualify for Charity Care or Discounted Payments (HSC127405(a)(1)(A); IRC§501(r):

- a. Self-pay patients
- b. Patients experiencing a sudden loss of income.
- c. Patients facing extraordinary circumstances.
- d. Insured Patients with limited coverage
- e. Insured patients who have exhausted their benefits
- f. Insured patients with high medical costs
- g. Insured patients with high-deductible plans

2. Eligibility Criteria:

a. Charity Care/Discounted Payment Application (See Financial Assistance Application)

- (1) A patient who indicates an inability to pay for a medically necessary service shall be evaluated for charity care or discounted payment assistance.
- (2) Fairchild Medical Center's Financial Assistance Application Form will be used to document each patient's overall financial situation.
- (3) A notification letter will be sent to each applicant once a determination is made, informing them of the facility's decision.
- (4) Employment status, potential payments from pending litigation, and any third-party liens related to the incident of care may be considered when determining eligibility.
- (5) The amount and frequency of hospital bills may also be considered.
- (6) All data used in making an eligibility determination should be verified to the extent practical based on the amount involved.
- (7) The hospital will use the look-back method for calculating amounts generally billed.

- b. Eligibility for Charity Care Discount or Discounted Payments for Patients with no Third-Party Coverage (Self Pay).
- (1) Patients with no third-party coverage whose family income is less than or equal to 200% of the FPL may qualify for free care.
 - (2) Patients with no third-party coverage with family incomes between 201% and 400% of FPL are eligible for a discounted payment.
 - (3) Eligibility will be determined by a review of patient's income. Income will be verified with current tax returns that document the patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed or current paycheck stubs. Additional information may be requested after a review of the tax return.
 - (4) Eligibility Period: The eligibility period is one year from the date of the initial eligibility determination, unless over the course of that year the patient's family income or insurance status changes to such an extent that the patient becomes ineligible.
 - (5) Patient to complete Fairchild Medical Center's Financial Assistance Application requesting a charity discount or discounted payment. Applications are available online at [fairchildmed.org/financial assistance](http://fairchildmed.org/financial%20assistance), or by contacting a Financial Counselor at (530) 841-8537.
 - (6) Criteria to be used to determine a patient's eligibility for a Discounted Payment:
 - a. Patient's income must be between 201% and 400% of FPL with current tax returns that document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed or current paycheck stubs.
 - b. A sliding-fee schedule approach will be used to determine the discounted payment depending on patient/family size and income. This may result in a different discounted payment for the same service depending on the patient's income level.
 - (7) Patients may also be offered an Extended Payment Plan. The terms of the plan will be negotiated by the patient and Fairchild Medical Center's Financial Counselors and will take into consideration the patient's family income and essential living expenses. The monthly payment limit shall be an amount that is not more than 10% of the patient's family income for the month, excluding deductions for "essential living expenses".

c. Eligibility for Discounted Payments for High Medical Costs Patients with Third Party Coverage.

- (1) High Medical Cost patients with third party coverage whose family incomes are between 201% and 400% of the Federal Poverty Level (FPL) are eligible for a discounted payment. High medical costs are defined as out-of-pocket medical expenses equal to or greater than 10% of the patient's annual family income in the last twelve months.
- (2) Patient to complete Fairchild Medical Center's Financial Assistance Application requesting a charity discount or discounted payment.
- (3) Patient to provide proof of payment of medical costs. Fairchild Medical Center reserves the right to verify payments.
- (4) Criteria to be used to determine a patient's eligibility for Discounted Payment for High Medical Costs:
 - a. Patient/Family income must be verified and must fall between 201% and 400% of the FPL. Income is verified using the patient's current filed federal tax return for the year in which the patient was first billed or for the 12 months prior, or by using current paycheck stubs.
 - b. Patients may also be offered an Extended Payment Plan. The terms of the plan will take into consideration the patient's family income and essential living expenses. The monthly payment limit shall be a payment that is not more than 10 percent of the patient's family income for the month excluding deductions for "essential living expenses".
 - c. A sliding fee schedule approach will be used to determine the discounted payment depending on patient/family size and income. This may result in a different discounted payment for the same service depending on the patient's income level.

d. Eligibility for 100% Charity Care (Free Care)

To qualify for 100% Free Care, the patient must meet the expense qualification as described below:

- (1) Expense Qualification: The patient's Allowable Medical Expenses must exceed 10 percent of his or her Family Income determined:

- a. The Hospital will multiply the Family Income as determined (see Definition of Income) by 10%
- b. The Hospital will determine the patient's Allowable Medical Expenses.
- c. The Hospital will compare 10% of the Family Income (Definition of Income) to the total amount of the patient's Allowable Medical Expenses. Based on this comparison, the hospital will establish the appropriate discount amount using the guidelines provided in Exhibit A (Charity Discount Matrix).

(2) If the patient qualifies for Charity Care (Free Care) and the discounted payment, the hospital will apply the greater of the two discounts.

(3) Eligibility Period: The eligibility period is one year from the date of the initial eligibility determination, unless over the course of that year the patient's family income or insurance status changes to such an extent that the patient becomes ineligible.

(4) If the patient receives a discount because of third-party coverage, the patient is not eligible for an additional discount.

e. Emergency Room Physicians

Under section 127450, emergency physicians that provide emergency medical services in a hospital that provides emergency care will provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

f. Homeless Patients

Homelessness is considered a "presumptive eligibility" factor, meaning that the patient experiencing homelessness may automatically qualify for charity care without having to go through the application process. If a patient is known to be homeless, Fairchild may waive the requirement for a completed financial assistance application or proof of income, as the patient's situation already indicates an inability to pay for services. Patients determined to be eligible due to "presumptive eligibility" are eligible for the highest level of discount, which is typically Charity Care (Free Care) for emergency and medically necessary services.

g. Collection Agency

If a collection agency identifies a patient meeting the hospital's charity care eligibility Criteria, the patient's account may be considered for charity care. Collection agency

Accounts meeting charity care criteria shall be returned to the hospital billing office and reviewed for charity care eligibility. If an account is returned and the patient is deemed to be eligible for financial assistance, the patient will not be charged more than the amount of payment the hospital would expect in good faith to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

h. Special Circumstances

- (1) Deceased patients who pass away while admitted with no known estate or funding source, may be deemed eligible for charity care without a full, traditional application. A copy of the Death Certificate or obituary will be used to verify a patient's death.
- (2) Presumptive Eligibility: If a patient does not submit an application or documentation of income, Fairchild Medical Center may presumptively determine that a patient is eligible for charity care or discounted payment based on other information, such as a prior eligibility determination.
- (3) High Medical Costs: Patients with income above the standard limit but with annual out-of-pocket medical expenses at the hospital exceeding 10% of their family income in the prior 12 months may qualify for discounted rates.
- (4) Discretionary Assistance: Fairchild Medical Center may grant discounted or charity care at their discretion for patients facing catastrophic medical expenses or based on an assessment of the patient's individual financial situation, including unique income, assets, and expenses.
- (5) For rare occasions, a patient's individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their hospital bill. In these situations, with the approval of Administration, and per the Bad Debt Write-Off Authorization policy, part, or all of their cost of care may be written off as charity care. There must be complete documentation of why the decision was made to do so and why the patient did not meet the regular criteria.
 - a. Medi-Cal Denied Patient Days and Non-Covered Services: Medi-Cal patients are eligible for charity care write-offs related to denied stays, denied days of care, and non-covered services. These Treatment Authorization Requests (TARs) denials and any lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity.

I Governmental Assistance

- (1) The Hospital may assist patients in determining if they are eligible for any governmental or other assistance program, including applying for Presumptive Eligibility (PE) through California's Medi-Cal program. PE ends on the last day of the following month in which an individual was determined to be eligible for PE. Patients must follow up with the local division of Health and Social Services office and submit a completed application for benefits to be continued beyond this date. Applying for Governmental Assistance is not a requirement for Charity Care or discounted payments.
- (2) Patients eligible for programs such as Medi-Cal or SB612, but whose eligibility status is not established for the period during which the medical services were rendered, may be granted charity care for those services.

j. Application Process

- (1) An application for charity care or discounted payments can be determined at any time the hospital is in receipt of the information regarding the patient's income and financial situation. A patient has 30 days to return complete information, or the application is considered inactive. In some cases, eligibility is readily apparent, and a determination can be made before, on, or soon after the date of service. In other cases, it may take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information.
- (2) Patients may obtain a copy of the Financial Assistance Policy, the plain language summary, and the financial assistance application on our website www.fairchildmed.org/financial assistance or by calling (530) 841-8537 and speaking with one of our Financial Counselors.
- (3) The application process may take place prior to service, at the time of service (during admission or discharge), or after the billing process. In all cases the patient must make their desire to apply for financial assistance known to the Financial Counselors.
- (4) The application process includes completing the Financial Assistance Application and providing all supporting documentation required in the application.
- (5) The completed application should be received by Fairchild Medical Center during the application period. Applications can be mailed to Fairchild Medical Center at 444 Bruce Street, Yreka, California, 96097.

- (6) If the application is returned incomplete, the patient will be contacted by phone and/or letter requiring the missing information. Application will not be processed until all information has been received. If the patient fails to complete the application process, the application for financial assistance may be denied.
- (7) Submitting false information on the Financial Assistance Application may also result in a denial of financial assistance, in which case all collection efforts may be resumed.
- (8) Every effort should be made to determine a patient's eligibility for charity care or discounted payments. In some cases, a patient eligible for charity care or discounted payment may not have been identified prior to initiating external collection action. Accordingly, each collection agency under contract with the hospital should be made aware of the policy on charity care. This will allow the agency to report amounts that they have determined to be uncollectible due to their inability to pay in accordance with the facilities charity care or discounted eligibility guidelines.

3. Notice of Determination

A written notice by the Financial Counselor of the charity or discounted payment determination will be mailed to the address on file for the patient within 7 days of the determination being made. The notice shall be issued prior to, or in conjunction with, any billing statement sent to the patient. The notice will include:

- A clear statement of the eligibility determination, whether it was approved or denied.
- A clear explanation of the reduced bill
- If denied, a reason for the denial
- Instructions on how to appeal the decision
- Information on the Hospital Bill Complain Program

4. Appeal of Determination

If the patient is denied charity or disputes the level of charity discount or discounted payment given, the patient has 30 days to provide a written appeal from the date of notice of determination. This written appeal shall be addressed to the Business Office Manager who has 10 business days to respond to the patient's written appeal. The appeal process involves review by the Chief Financial Office and/or Chief Executive Officer. The hospital's decision on this appeal is final and will be communicated in writing to the patient. (HSC 127405(a)(1)(A); IRC§501(r))

5. Recordkeeping

Records relating to potential charity care patients must be readily obtained. Business Office records relating to charity care or discounted payments will be kept for five years. In addition, notes relating to charity applications and approval, or denial should be entered on the patient's account.

6. Public Notice and Posting (HSC 127410(b), IRC§501(r))

A notification addressing the availability of financial assistance will be posted in all registration areas, and a copy of the written notice shall be provided at the time of service if the patient is conscious and able to receive a written notice at that time. If the patient cannot receive the written notice at the time of service, the notice shall be provided during the discharge process. If the patient is not admitted, the written notice shall be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital shall mail the notice to the patient within 72 hours of providing services.

Notice of the hospital's policy for financially qualified and self-pay patients will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all the following:

- (a) Emergency department
- (b) Admissions office
- (c) Other outpatient settings

7. Collection Efforts of Eligible Patients

- a. Patients who qualify for charity receive 100% discount for the qualifying period, but patients who qualify for discount payments will receive a percentage discount. The remaining balance is needed to satisfy the patient's financial obligations.
 - b. No-interest extended payment plans will be negotiated in good faith with patients receiving discounted payments to meet their financial obligations. If the patient does not negotiate a payment plan, any remaining balance may be subject to placement with a collection agency if necessary.
- (1) Once a payment plan is established, if no payments are made on the no-interest extended payment plan for 90 days, reasonable efforts to contact the patient in writing and by phone must be made and documented. The written notice must contain contact information about whom to contact and an opportunity to re-negotiate another no-interest extended payment plan.

(2) Reporting to the consumer credit reporting agency and/or civil action may only begin after reasonable efforts have been made to re-establish the extended payment plan to meet the patient's financial obligations.

FORMS:

Charity Discount Matrix (Exhibit A)

Financial Assistance Application (Exhibit B)

Providers Covered (Exhibit C)

Amounts Generally Billed (Exhibit D)