Southwest HEALTHCARE
PALMDALE REGIONAL MEDICAL CENTER

POLICY AND PROCEDURE

Title: California Charity Care Procedure

Location: Palmdale Regional Medical Center	**Policy Number:**	**Page: 1 of 11**
Department of Document Owner: ADMITTING		
Original Effective Date: 1/1/2022	**Last Review Date: 1/1/2025**	**Last Revision Date: 3/31/2025**
Section: Department Specific / Patient Access Services		

Scope:
The purpose of this policy is to outline the circumstances under which charity care and payment discounts may be provided to qualifying low-income patients for medically necessary services provided.

Purpose:
Palmdale Regional Medical Center (PRMC) recognizes that there are individuals in need of medical services who are unable to pay for such services. It is the intent of PRMC to assist such patients with the settlement of their portion of the medical bill by properly screening for Charity Care or Discounted Payment eligibility if unable to pay the bill and to make services available at no cost or a reduced cost to individuals who meet the eligibility requirements.

Qualifying patients have an annual income that falls within 0-400% of Federal Poverty Level (FPL) and who have (i) received medically necessary services from the Hospital, (ii) are uninsured or underinsured; and (iii) have completed required documentation substantiating their income levels as set out herein.

This policy is to be used by the Hospital's Admissions Coordinators/Financial Counselors to screen, educate and counsel patients presenting to the facility requesting/requiring charity assistance and or discounts as appropriate. Co-payments, deductibles, coinsurance, and other amounts owed by a patient may be reduced in the limited circumstances identified in this Policy, in accordance with another policy addressing billing and collection of patient accounts, or as otherwise approved by the Hospital's CFO/CEO in consultation with Hospital's legal counsel.

1. PRMC will comply with federal and state laws and regulations relating to emergency medical services and charity care.
2. PRMC will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary PRMC services.
3. In extenuating circumstances, the hospital may at its discretion approve charity care outside of the scope of this policy.
4. This policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 et. seq., effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008, Assembly Bill 1503 effective January 1, 2011, SB 1276 effective 01/01/2015, Assembly Bill 1020 effective January 1, 2022, Assembly Bill 2297 effective 1/1/2025, Senate Bill 1061 effective 1/1/2025. All collection agencies working on behalf of PRMC shall comply with Health and Safety Code Section 127400 et. seq. as amended

and applicable PRMC policies regarding collection agencies.

Definitions:

- "Charity Care" refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary health care services (full charity).

- "Discount Payment" refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary health care services (partial charity).

- **"**Family Income" means the annual earnings of all members of the Patient Family from the prior twelve (12) months or prior tax year as shown by the recent pay stubs or income tax returns.

- "Federal Poverty Level (FPL)" means the poverty guidelines based on income and family size as updated periodically in the Federal Register by the U.S. Department of Health and Human Services, published at http://aspe.hhs.gov/poverty.

- "Financial Assistance" is a general term and includes patients who qualify for Charity Care Discounts or High Medical Cost Discounts.

- "Guarantor" means a person other than the patient who is legally responsible for payment of the patient's bill.

- "High Medical Cost Discount" refers to a High Medical Cost Patient's remaining financial responsibility after payment is made by a third-party source of payment for Medically Necessary Services (e.g. not a Self-Pay Patient), to relieve them of their financial obligation for Medically Necessary Services.

- **"**High Medical Cost Patient" means a patient who has: (i) a third-party source of payment for Medically Necessary Services (e.g. not a Self-Pay Patient); (ii) a family income at or below 400% FPL; and either (iii) annual Out-Of-Pocket (OOP) expenses incurred by the patient at this hospital that exceed the lesser of 10 percent of the patient's total Family Income in the prior 12 months or (iv) annual OOP expenses incurred with other healthcare providers that exceed 10 percent of the patient' Family Income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patients family in the prior 12 months.

- "Hospital Bill Complaint Program" means the state program which reviews hospital decisions about whether patients qualify for help in paying the Patient's Responsibility for healthcare services rendered. If a patient believes financial assistance was wrongly denied, then the patient may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

- **"**Medically Necessary Service" means a medical service or treatment that is necessary to treat or diagnose a medical condition, the omission of which could adversely affect the patient's condition, illness or injury, and is not an elective or cosmetic surgery or treatment.

- **"**Patient Family" means either of the following:

    - for patients who are eighteen (18) years of age and older, Patient Family means the patient's spouse, domestic partner, dependent children under twenty-one (21) years of age (whether living at home or not), and dependent children who are disabled (regardless of age); or
    - for patients under eighteen (18) years of age, Patient Family means the patient's parent(s) or caretaker relative(s), other children under twenty-one (21) years of age of the parent(s) or caretaker relative(s), or other dependent children of the parent(s) or caretaker relative(s) who are disabled (regardless of age).

- "Out-Of-Pocket (OOP)" expenses or costs means any amounts owed for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing, and are the responsibility of the patient.

- "Reasonable Payment Plan" means an extended interest free payment plan that is negotiated between the Hospital and the patient/guarantor for any OOP amounts owed. The payment plan will take into account the patient's income, essential living expenses, assets, the amount owed, and any prior payments. Monthly payments will not be greater than 10 percent of a patient's Family Income for a month, excluding deductions for essential living expenses. Essential living expenses include any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

- "Self-Pay Discount" is a discount provided to patients who do not qualify for a Charity Care Full Discount, a Charity Care Partial Discount, or a High Medical Cost Discount and who do not have a third-party insurance carrier or whose insurance does not cover the service provided or who have exhausted their benefits.

- "Self-Pay Patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

Procedures:

1. Hospital shall provide Financial Assistance in the form of Charity Care Discounts and High Medical Cost Discounts to qualified patients who have satisfied the eligibility

criteria set forth in this Policy. Hospital will further help patients in seeking assistance from any other available programs including the Federal and State-funded California Children's Health Insurance Program (CHIP), county programs, or grant programs, depending upon their specific circumstances. Patients who are not eligible for assistance from another program may be eligible for Financial Assistance from the Hospital pursuant to this Policy. All patients, regardless of their ability to pay, will be treated fairly and with respect before, during, and after the delivery of healthcare.

2. This Policy relies upon the cooperation of individual applicants' accurate and timely submission of the financial screening information set forth in the procedures below. Financial Assistance is not to be considered a substitute for personal responsibility. Patients are expected to contribute to the cost of their care based on their individual ability to pay. Falsification of information about financial eligibility may result in the denial of an application for Financial Assistance. The Hospital may require a patient or other responsible party to make reasonable efforts to apply for and receive government-sponsored assistance for which they may be eligible as a condition for receipt of a Charity Care Discount under this policy.

3. Hospital shall provide emergency services to all individuals based solely on the individual's medical need in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and California law. There shall be no delay in providing a medical screening and stabilization services in order to inquire about an individual's insurance status or payment method.

4. An emergency physician who provides emergency medical services in a Hospital location that provides emergency care is also required by law to provide discounts to Self-Pay Patients or High Medical Cost Patients who are at or below 400% of the federal poverty level.

5. Patients with demonstrated financial need may be eligible for Financial Assistance if they complete an application and meet the eligibility requirements for a Charity Care Discount or a High Medical Cost Discount as defined below. Patients who do not complete an application may be presumptively determined to be eligible for Financial Assistance using information provided by sources other than the patient or other individual seeking financial assistance in certain circumstances, as set forth in the Presumptive Eligibility procedures below. A patient who is presumptively determined to be eligible for Financial Assistance shall be eligible for the most generous available discount. Financial Assistance may be denied when the patient or other responsible party does not meet the requirements of this Policy.

6. Patients who indicate a financial inability to pay a bill for a Medically Necessary Care shall be evaluated for Charity Care Discounts, High Medical Cost Discounts, or coverage by a federal, state, or county program as applicable. The granting of a Charity Care Discount or a High Medical Cost Discount 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. Hospital 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 a patient applies, or has a pending application, for another health coverage program at the same time the patient applies for a Charity Care Discount or a High Medical Cost Discount, neither application shall preclude eligibility for the other program.

7. Annual Family Income of the applicant will be determined as of the time the Medically Necessary Services were provided, or at the time of application for Charity Care and/or Financial Assistance. Financial Assistance applications are accepted at any time post-service by USPS mail to the mailing address or the fax number provided on the Financial Assistance application. The Financial Assistance Application may also be returned in-person to the Hospital. The patient will be required to submit the following information:
    - Completed Financial Assistance and Charity Care application;
    - Recent pay stubs from within the 6 months before or after the patient is first billed (or in preservice when Application is submitted);
    - Copy of Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed.

8. Application Process. PRMC shall display information about its charity care policy at appropriate access areas. A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for charity care, an application will be provided with instructions on how to apply. As part of this screening process PRMC will review whether the guarantor has exhausted or is not eligible for any third-party payment sources:
    a. Where the guarantor's determined an indigent person (homeless) is obvious to PRMC, then a prima-facie determination of eligibility may be made and, in these cases, PRMC may not require an application or supporting documentation.
    b. A patient (guarantor) who may be eligible to apply for charity care after the initial screening will be given fourteen (14) days to provide sufficient documentation to PRMC to support a charity determination.
    c. Based upon documentation provided with the charity application, PRMC will determine if additional information is required, or whether a charity determination can be made.
    d. The failure of a guarantor to reasonably complete appropriate application procedures shall be sufficient grounds for PRMC to initiate collection efforts.
    e. An initial determination of sponsorship status and potential eligibility for charity care will be completed as closely as possible to the date of service.
    f. PRMC will notify the patient (guarantor) of a final determination within fifteen (15) business days of receiving the necessary documentation.

g. The patient (guarantor) has the right to appeal the determination of ineligibility for charity care by providing relevant additional documentation to PRMC within thirty (30) days of receipt of the notice of denial.
h. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the patient (guarantor) and the Department of Health in accordance with state law. The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant.

9. Eligibility for Charity Care shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

a. Presumptive Charity: 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 as set forth above. The Hospital 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 the Hospital to make an informed decision on the financial need 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:
   - Patient was granted Financial Assistance within the last 180 days.
   - 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; or
   - Patient is deceased with no estate or deceased and cannot identify patient's name or address.

b. Self-Pay Charity Eligibility: A Self-Pay Patient with a Family Income at or below 400% FPL.

c. High Cost Charity Eligibility: A High Cost Medical Patient with a Family Income at or below 400% FPL and either:

   i. annual Out-Of-Pocket (OOP) expenses incurred by the patient at this hospital that exceed the lesser of 10 percent of the patient's total Family Income in the prior 12 months; or

   ii. annual OOP expenses incurred with other healthcare providers that exceed 10 percent of the patient' Family Income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patients family in the prior 12 months.

10. **Financial Assistance:** For services rendered to patients on or after January 1, 2025, the Hospital shall offer the following (services rendered prior to January 1, 2025 shall be subject to the Financial Assistance Policy in effect at the time):

    a. *Charity Care Full Discount* – Self-Pay Patients with a verified Family Income at or below 400% of the most recent FPL will receive a full write-off of all charges for Medically Necessary Services.

    b. *High Medical Cost Discount* – High Medical Cost Patients with a verified Family Income at or below Four Hundred Percent (400%) of the most recent FPL will receive a full write-off of the patient's responsibility for Medically Necessary Services.

    c. *Charity Care Partial Discount* - Self-Pay Patients with a verified Family Income between 401% and 500% of the most recent FPL will receive a partial charity write-off of all Self-Pay charges for Medically Necessary Services. For these patients, expected payment for services will be limited to the amount the Hospital would have received from Medicare.

    d. *Self-Pay Discount* - Self-Pay Patients with gross incomes exceeding 500% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is less.

11. Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774, AB 1020, AB 2297, SB 350, SB 1061, SB 1276 and the Federal PPACA (Patient Protection and Affordable Care Act):
    - Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and all patient access areas.
    - A Notice of Collection Practices shall be provided to all patients (guarantors) during registration and included in the final billing statement.
    - This policy shall be widely publicized throughout the PRMC including not limited to the PRMC website and otherwise be made available upon request.
    - Financial Questionnaires shall be available in all registration/ patient access areas.
    - PRMC staff including Admitting/Registration and Financial Counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third-party coverage, including private health insurance (Covered California Health Exchange), Medicare, Medicaid, and other state programs and assist patients in applying for coverage when appropriate.
    - Self-Pay bills shall include the following:
      A. Statement of Charges
      B. A request that the patient inform the hospital if the patient has insurance coverage and that if the patient does not have coverage that they may be eligible for Medicare, Healthy Families, Medicaid, insurance through the California Health Exchange, other state or county programs and charity.

C. A statement indicating how the patient may obtain an application or apply for the aforementioned programs along with a referral to the local consumer assistance office at a local legal services office.
    i. Note: If the patient or patient's representative indicates the patient has no third-party coverage and requests a discounted rate or charity, the patient shall be provided with an application for the Medicaid program, Healthy Families program or other applicable state or county program.
D. Information on the hospital's financial assistance and charity program applications including a statement that if the patient lacks or has inadequate insurance and meets certain low-income requirements they may qualify for discounted payment or charity care. A telephone number for additional information on the hospitals discount payment and charity program should accompany this statement.
E. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.
F. Patient eligibility with no application. Instances where a Financial Assistance Application is not required per charity definitions:

- Treatment Authorization Request (TAR) denials, Medicaid non-covered services, and untimely Medicaid billing write-offs wilt be recorded with their respective adjustment codes. Medicare/Medicaid accounts are written off to a respective adjustment code to be captured for Medicare Bad Debt reimbursement.
- Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.
- For Medicare/Medicaid adjustments, that portion not claimed as Medicare bad debt reimbursement wilt be reclassified as charity.
- A patient may be verified as homeless at any time during the revenue cycle. The Charity Care eligible portion of the account will be adjusted using adjustment code 88870852 — "Charity Discount".

12. PRMC facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to pay and can submit the account for charity approval under the following circumstances:
    - Self-Pay Patients with gross incomes at or below 400% of Federal Poverty Guidelines. The entire balance will be deemed charity.
    - Self-Pay Patients with gross incomes in excess of 400% but less than 500% of FPG, and limited assets, may qualify for partial charity. The liability for this income group in all cases will never be more than the expected reimbursement from Medicare.
    - Self-Pay Patients with gross incomes in excess of 500% of FPG, the patient's liability will be the self-pay discount rate in effect at time of service.

- High Medical Cost Patients with incomes less than 400% of FPG and healthcare expenses exceeding 10% of annual income during the past 12 months will be eligible for full charity.
- Patient Eligibility as established by financial need per Financial Questionnaire.
- All PRMC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and must refer the patients for financial counseling.
- Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family.
    - In these instances, a Financial Questionnaire can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.
- The Financial Questionnaire must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:
    - If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay.
    - If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.
    - Patients may request a Financial Assistance Application by calling the CBO, writing to the mailing address on their patient billing statement, or downloading the form from the PRMC websites.
    - Patients completing Financial Questionnaire are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Questionnaire.
- Financial Assistance Application Review/Approval Process:
    - For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any CBO employee. Standard transaction approval levels will apply.
    - A Financial Questionnaire must be reviewed by a financial counselor. If gross income is at or below 400% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income is required). If the gross income is more than 400% but less than 500% of FPG, an assessment for qualification of partial charity based on income will be made by the financial counselor with write-offs subject to standard approval levels.
    - Financial Questionnaire shall be reviewed and approved, denied or returned to the patient with a request for additional information within fifteen (15) business days of receipt.

- Collection agency requests for charity or Financial Questionnaire received from a collections agency shall be reviewed by Central Business Office (CBO). The CBO shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no charity.
- If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained, and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

- Notification of charity determination:
  - For homeless charity write-offs, no notification is necessary.
  - In all instances where a Financial Questionnaire was submitted, the person approving the application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the applications on behalf of the patient within fifteen (15) days of final determination of the completed application.
  - In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination.
  - Appeals should be in writing to:

    Palmdale Regional Medical Center
    Attn: Patient Access Services
    38600 Medical Center Drive
    Palmdale, CA 93551
  - The CBO shall respond to all charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be restarted to afford the patient ample opportunity to make payment, per the provisions of applicable state law.
  - If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774, AB 1020, AB 2297, SB 350, SB 1061, and SB 1276, including not garnishing wages or placing a lien on a principal residence.

- Processing of charity write-off:

  A. If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges

against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.

B. The 100% charity discount percentage is then applied to the account, using existing adjustment codes.

C. A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:

   i. It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and

   ii. It will not report the delinquency to a credit-reporting agency until 180 days after the date of service, or 180 days after the patient received partial charity approval.