Department of Health Services Finance Policy	
Document Title Financial Assistance Programs and Charity Care Policy	**POLICY NUMBER** 515 **VERSION NUMBER** 6
REVENUE CYCLE ☐ 1 year ☐ 2 years ☒ 3 years **EFFECTIVE DATE:** 06/01/2025 **LAST REVIEW DATE:** 01/01/2025 **NEXT REVIEW DATE:** 02/01/2028	**ATTACHMENTS** ☐ YES ☒ NO

PURPOSE

The purpose of this policy is to describe the Financial Assistance Programs (FAPs) and to establish requirements and guidelines for financial screening of patients who may qualify for the Department of Health Services (DHS) FAPs.

POLICY STATEMENT

DHS maintains FAPs that address both charity care and discount programs to pay for the medical services received at DHS facilities for patients who are uninsured, underinsured, or have healthcare coverage (third-party payer) with out-of-pocket medical expenses, for whom it would be a financial hardship to fully pay. Applications for FAPs may be taken at any point the patient engages with a DHS facility, including when patients have upcoming services, already received services, or have received a bill (during any point in the billing cycle).

These FAPs include the Ability to Pay (ATP) Program, Discount Payment Program (DPP), Sensitive Services Discount Payment Program (SSDPP), and an interest-free Extended Payment Program (EPP). In addition to these programs, PFS staff will provide information to patients about Covered California (CA) and how to apply if they might be eligible.

DHS will make information about FAPs readily available to patients and will communicate this information with patients who may be eligible at various points of contact. Any patient who indicates the financial inability to pay a bill will be screened and evaluated for a government-funded program and/or FAPs, depending on potential eligibility.

DEFINITIONS

Charity Care: Free care provided to patients unable to pay for all or part of a bill for medical services provided by DHS based on limited income or financial hardship.

APPROVED BY: Allan Wecker	**DATE:** 06/01/2025
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Discounted Care: Reduced cost of care provided to patients who receive medical services at DHS, based primarily on limited income or financial hardship.

Financial Assistance Programs (FAPs): These are sometimes referred to as charity care and discounted care and are equivalent to the Reduced Cost Plan/No-Cost Plan and the Ability to Pay Plan referenced in County Code 2.76.350 and as required by Health & Safety Code Sections 127400 et seq.

High Medical Costs**:** Any out-of-pocket costs incurred by the patient for the medical services received at DHS that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

Government-Funded Health Care Programs: This refers to federal or state-funded programs such as Medi-Cal (Medicaid) and Medicare, as well as Family PACT, California Children Services (CCS), Cancer Detection Program, etc.

LA County Patient: Patients who reside in Los Angeles (LA) County. This may also include patients who are in the process of transitioning to LA County residency and intend to reside in LA County or unhoused patients who usually reside in and spend most of their time in LA County.

Out-of-County Patient: Patients who reside outside of Los Angeles County.

Patient Financial Services (PFS) staff: DHS employees at DHS facilities who initiate and process Medi-Cal applications and other financial assistance applications.

Third Party Payer: An organization that pays for medical services on behalf of a patient, through either public healthcare coverage (such as Medi-Cal or Medicare, which are government funded) or private insurance (such as employer-based coverage or through Covered California, etc.).

Uninsured: Patients who do not have healthcare coverage to cover the medical services received.

Underinsured: Patients who do not have adequate healthcare coverage to cover the services being provided. This includes patients with private or public healthcare coverage from a third-party payer with out-of-pocket medical expenses, including cost sharing and deductibles, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for the services being provided.

Liability: The amount the patient should pay for the services received based on a financial need assessment, sometimes referred to as the patient's responsibility for payment.

PROCEDURES

Ability to Pay (ATP) Program

The ATP program is the FAP for LA County patients that offers both free (charity) care and discounted care.

A. Covered Services/Benefits:

The ATP Program covers all medically necessary services provided at DHS facilities, including:

- Inpatient, Outpatient, and Emergency Services
- Laboratory and Diagnostic Tests
- Medications
- Durable Medical Equipment (DME) and Supplies

B. Eligibility Criteria:

- Patients who are uninsured, underinsured, or have healthcare coverage (third party payer) with high medical costs as defined above.
- Charity care is available for persons with income up to 200% of FPL; however, ATP has no upper income cap for eligibility for discounted care, but liability increases on a sliding scale above 200% FPL. Eligibility is based on a patient's recent household size and monthly gross income (i.e., employment-based earnings, disability/unemployment insurance benefits, rental income, etc.) to ensure appropriate reduced cost of care is applied. Recent income verification may be required, (i.e., paystubs and/or income tax returns). Declaration of income is initially acceptable; income verification is not required at the time of application but maybe requested up to 6 months after the application approval at the discretion of DHS.
- Resources/assets (i.e., bank accounts, real property, etc.) are not counted in the determination.
- Patients must be screened for potential Medi-Cal eligibility using the Medi-Cal Linkage Referral Checklist and cooperate in the application process, if potentially eligible for free (charity) care.
    - If a patient has previously applied for Medi-Cal and was found ineligible, then the patient does not need to reapply for Medi-Cal in order to apply or reapply for ATP. The exception would be if there has been changes to the Medi-Cal program or the patient has had a change in circumstance (e.g., income, household size, assets) that would impact potential eligibility for Medi-Cal.

C. ATP Liability/Cost:

The amount that a patient may need to pay will vary depending on household size and income. The ATP Inpatient and Outpatient Services Liability Charts are updated annually using the Federal Poverty Levels (FPLs) in the Federal Register released by the U.S. Department of Health and Human Services.

- Outpatient ATP liability is per month for the services rendered regardless of the number of visits in the month.
- Inpatient ATP liability is per admission regardless of the length of stay.
- If the household income is at or below 200% FPL, then the liability amount is $0 for inpatient/outpatient services.
- If the household income is above 200% FPL, then there is a liability amount for inpatient/outpatient services. The amount of liability increases respective to the income level. The higher the income level, the higher the liability amount.

D. Duration of the ATP Services Application and Agreement:

The ATP Application and Agreement is effective for one (1) year from the first day of the month of application for all inpatient and outpatient services received during a period of twelve (12) months. Patients can reapply for ATP annually, when their current agreement is coming to an end.

- ATP applications can be made retroactively with no time limitation. A retroactive application is based on the date of service and will use the current FPL and patient information (e.g., recent income and household size).

E. Presumptive Eligibility for Ability to Pay (Auto ATP):

- Patients who have Restricted (Limited Scope) Medi-Cal with no share of cost (SOC) and are LA County patients are presumptively eligible for ATP and the ATP program will

automatically be applied to any visits (encounters) for medically necessary services that are not covered by Medi-Cal.
- Patients who are presumptively eligible will be covered by ATP without having to complete and sign an ATP Services Agreement.

F. Terms and Conditions:

The Terms and Conditions along with the ATP Services Agreement will be provided to the patient for their records. The Terms and Conditions provides detailed information about the services covered, eligibility, length of eligibility, ATP liability amount, third party liability, and appeals process.

Discount Payment Program (DPP)

The DPP is the FAP that offers discounted care for Out-of-County patients.

DPP offers a deduction (discount) from the payment obligations for medical services received at DHS.

A. Covered Services/Benefits:

The DPP Program covers all medically necessary services provided at DHS facilities only, including:
- Inpatient, Outpatient, and Emergency Services
- Laboratory and Diagnostic Tests
- Medications
- Durable Medical Equipment (DME) and Supplies

B. Eligibility Criteria:

- Patients who are uninsured or underinsured who receive services at a DHS facility.
- Recent household size and monthly gross income is less than or equal to 400% of the Federal Poverty Level (FPL) to reduce their cost of care.
- Income verification (i.e., paystubs, and/or income tax returns) is required.
- Resources/assets (i.e., bank accounts, real property, etc.) are not counted in the determination.
- Patients must be screened for potential Medi-Cal eligibility using the Medi-Cal Linkage Referral Checklist, if potentially eligible.

C. DPP Liability/Cost:

- The patient's liability amount shall not be greater than the amount the facility would receive from the Medi-Cal program for the same service to a Medi-Cal eligible patient. If the amount the facility would receive from the Medi-Cal program exceeds charges, the patient's liability amount shall not be greater than 95% of the patient's charges.
- The Medi-Cal reimbursement rate is used for each facility for the corresponding date of service.
    - Inpatient admission services liability amount is calculated per day for each inpatient admission.
    - Outpatient services liability amount is calculated for each outpatient visit during the DPP Agreement period.

D. Duration of the DPP Services Agreement:

- Each inpatient admission requires a separate DPP Application and Agreement form.

- Outpatient services require a new DPP Application and Agreement form for an annual period (12 months); a single agreement may be made for all outpatient services received during a single 12-month period.
    - DPP applications can be made retroactively with no time limitation. A retroactive application is based on the date of service and will use the corresponding FPL and patient information (e.g., recent income and family size) in existence at that time.

Sensitive Services Discount Payment Program (SSDPP)

A. Covered Services/Benefits:

- SSDPP covers United States residents that live outside of Los Angeles (LA) County for inpatient and outpatient sensitive services at a low cost or no cost.

B. Eligibility Criteria:

- Applicant/patient should have United States residency (outside of LA County)[1].
- Recent household size and monthly gross income must be less than or equal to 400% FPL. Declaration of income is acceptable; income verification is not required at the time of application.
- Resources (property) will not be counted.
- Applicant/patient should provide identity verification and address verification.

C. SSDPP Liability/Cost:

Each SSDPP agreement liability may vary depending on household size and income.

- Income sliding scale for SSDPP is equivalent to the ATP sliding scale up to 400% FPL.

D. Duration of the SSDPP Services Application and Agreement:

The SSDPP Application and Agreement form can be completed in-person or telephonically with a patient/responsible relative under penalty of perjury. The SSDPP Application and Agreement shall cover one (1) inpatient admission, or any outpatient services received during a period of twelve (12) months. Each additional inpatient admission requires a separate SSDPP Agreement form.

- SSDPP applications can be made retroactively with no time limitation. A retroactive application is based on the date of service and will use the current FPL and patient information (e.g., recent income and family size).

How to Apply

Patients can apply for a FAP in-person or telephonically by visiting or calling one of our LA Health Services facility and speaking to our staff. PFS staff will complete the application with the patient or their responsible relative, determine the patient's financial liability, if any, and present the Application and Agreement for signature. The patient or their responsible relative must attest to the accuracy of the information that they provide under penalty of perjury. This is done verbally if application is taken telephonically. Such completed applications are then mailed to the patient. As noted above, the DPP program requires income verification at the time of application; the other programs do not. However, verification may be requested later, so patients are advised to retain their documentation (i.e. pay stubs

[1] LA County patients are eligible for the ATP Program.

or income tax returns). The SSDPP program requires identity verification as well as address verification at the time of application.

Extended Payment Program (EPP)

Interest free EPP is available to patients with a financial liability that request additional time to pay their liability, including patients who have been granted a discount through any of these financial assistance programs. The following points shall guide the negotiation with the patient.

- EPP typically extends up to 18 months but may be extended further.
- Monthly payments should not be more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
- Any patient who asks about a payment plan and who has not already applied for other DHS financial assistance should be informed of the FAPs and screened for eligibility.

In the event that the terms of a reasonable payment plan are not reached, DHS will determine monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.

Posting of Information

Notices regarding the availability of FAPs to low-income and uninsured patients will be posted in visible locations throughout each County facility including at least Admitting/Registration, Billing Inquiry, Emergency Department, other outpatient settings such as waiting rooms, observation units, and the DHS website. Every posted notice regarding FAPs will contain brief instructions on how to apply, including a telephone number for more information. Copies of this information should be available to patients, upon request. Posters will contain information on how to access information about the FAP in required threshold languages and in ADA-compliant formats.

Appeal Process

Patients who wish to appeal their financial assistance eligibility determination may submit their request in writing to the DHS financial screening staff. DHS staff will provide patients the corresponding appeal instructions and/or form. The appeal form will be reviewed/approved by the manager over the eligibility process. A written response from the manager will be provided to the patient within ten (10) working days.

AUTHORITY

California Welfare & Institutions Code Section 16953(b)
California Health & Safety Code 127400 et seq.
Los Angeles County Code 2.76.350

REFERENCES

DHS Policies:
370.1 Patient Identity Verification
370.2 Patient Address Verification
516 Coverage Verification and Financial Screening Requirements
530 Charging & Collection of Medical Services Rendered