PARALLON
HCA Healthcare

DEPARTMENT: Operations Support	**POLICY DESCRIPTION:** Financial Assistance Policy for Uninsured California Patients
PAGE: 1 of 17	**REPLACES POLICY DATED:** 09/15/2016, 11/01/2017, 07/01/2020, 11/04/2021
APPROVED: 01/23/2024	**EFFECTIVE DATE:** 01/01/2022
ANNUAL REVIEW DATE: 01/23/2024	**REFERENCE NUMBER:** PARA.PP.OPS.015CA

SCOPE:

An uninsured discount is available to the following California patient accounts:

1) All Self Pay or uninsured patient accounts, excluding elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients;
2) Accounts where insurance benefits have been exhausted or terminated;
3) Medicare outpatient self-administered drugs;
4) All "Insured Patients with High Medical Cost" will be eligible for an Uninsured Discount per the details provided below; and
5) Uninsured Patients whose family income exceeds 400% of the Federal Poverty Level are eligible for a managed-care PPO like Uninsured discount.

NOTE: A client-specific discount policy may need to be developed for Parallon clients with hospitals in California based on the client's charity and discount policies. Use the reference number identifying the client as defined in the Policy and Procedure Development policy PARA.PP.GEN.001. (Example: PARA.PP.OPS.015CAL for LifePoint).

PURPOSE:

To define the process, for selecting the appropriate Self Pay IPLAN, providing patients with information regarding available discounts, and processing discounts for patients assigned one of the Uninsured Discount IPLANS. All steps taken will be in compliance with California legislation effective 1/1/2007 – AB 774, Senate Bill No. 350 effective 1/1/08, AB 1503 effective 1/1/11, and Senate Bill No. 1276, effective 1/1/2015.

POLICY:

A. Definitions

Patients with High Medical Costs – patients that incur out-of-pocket costs exceeding 10% of their family income in the prior 12 months excluding Essential Living Expenses and, for purposes of the uninsured discount, whose family income is between 201% and 400% of the Federal Poverty Level. Patients are eligible for this designation even if they receive a discounted rate as a result of third-party coverage. The 10% threshold may be documented in 2 ways 1) the out-of-pocket costs are incurred at the hospital; or 2) the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

"Essential Living Expenses" – any of the following expenses: 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."

Patient's Family (for purposes of determining "family income") – For persons 18 years or 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, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

"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.

B. Eligible Patients[1]

All Self Pay patient accounts and all insured Patients with High Medical Costs accounts will be eligible for an uninsured discount, with the exception of elective cosmetic procedures; facility designated self-pay flat rate procedures, scheduled/discounted procedures for International patients and, accounts eligible for the charity discount. Uninsured discounts will also be applied to accounts where insurance benefits have been exhausted or terminated. Medicare outpatient self-administered drugs will also receive the uninsured discount. Accounts will be assigned one of the following Uninsured Discount IPLANS.

IPLAN	IPLAN Description	LOG ID	Ins Series	Pat Series	IP Proc Code	OP Proc Code
099-40	Uninsured Discount Plan	UINS	110	208	920970	920980
099-41	Uninsured Discount Plan – Burn Unit	UINB	110	208	920971	920981
099-42	Uninsured Discount Plan – Transplant	UINT	110	208	920972	920982
099-44	Uninsured State Specific	UINC	110	208	920973	920983
099-47	Uninsured Discount Plan – Patient Non-Compliance	UINS	110	208	920970	920980
099-49	Uninsured – Partially Exhausted Benefits	N/A	110	208	920970	920980
N/A	Uninsured – Medicare Self - Administered Drugs	N/A	N/A	N/A	N/A	957983

[1] An emergency physician who provides emergency medical services is also required by law to provide discounts to uninsured and under insured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

The discount amounts will be provided to each facility in a formal rate schedule document. The patient will receive the Uninsured Discount unless the patient qualifies for a Charity Discount as outlined in the existing PARA.PP.OPS.016CA Charity Financial Assistance Policy for Uninsured and Underinsured California Patients.

C. Discount criteria:

Uninsured patients and insured Patients with High Medical Costs will first be reviewed for Government Program Eligibility and Charity criteria. Uninsured Patients, as well as insured Patients with High Medical Costs, whose family income is between 201% and 400% of the Federal Poverty Level are eligible for a discounted charity write off. In no event will such patients be pursued for payment beyond the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi Cal, Healthy Families, or "any other government-sponsored health program of health benefits" in which the hospital participates, whichever is greater.

Uninsured Patients whose family income exceeds 400% of the Federal Poverty Level are eligible for a managed-care PPO like Uninsured discount.

D. Documentation of Income:

To support a patient's income relative to the Federal Poverty Level, documentation in the form of recent pay stubs or income tax returns is required. Patients must make a reasonable effort to provide hospital with documentation of income and health benefits coverage. If the patient fails to complete a Financial Assistance Application, the hospital could consider the patient to be above 400% of the Federal Poverty Level.

No supporting documentation provided by the patient as part of the Financial Assistance Application for the Uninsured Discount shall be used for collections activities.

E. Patient Notification at the Time of Registration:

If it is determined the patient is uninsured or an insured Patient with High Medical Costs at the time of registration, the patient/responsible party will be presented with an Uninsured Patient Information document that provides information on the Uninsured Discount Policy and other available discounts and payment options. This document will outline the process for uninsured discounts and inform the patient of additional account resolution options (i.e. monthly payments). The patient/responsible party will be asked to sign and date the document. The document will then be scanned into the imaging system and be placed in the imaging Patient Folder document type, as a validation that information regarding discounts has been communicated to all uninsured patients and insured Patients with High Medical Costs.

F. Patient Access Responsibilities at the Time of Registration:

Patient Access will be responsible for assigning the Uninsured IPLAN using the selections above and for presenting the Uninsured Patient Information Document to the patient/responsible party. Patient Access will explain the process as documented, answering questions related to the document and obtaining a signature from the patient/responsible party documenting that the information regarding available discounts was provided.

All requests for payment will be based on estimated total charges less the appropriate uninsured discount based on the income criteria listed above.

Patient Access will be responsible for requesting from the patient/responsible party the expected patient liability amount by using a facility specific deposit schedule which has been updated to reflect the Uninsured Discount.

Patient Access will be responsible for asking the patient/responsible party for payment in full or, at the request of the patient with High Medical Costs, shall negotiate monthly payment arrangements on the patient liability amount. If the patient/responsible party and Patient Access employee cannot agree on a payment plan, the Patient Access employee shall establish a "Reasonable Payment Plan" as defined herein, taking into consideration the patient's monthly family income less Essential Living Expenses. Once the payment plan is negotiated, the account will be administered and monitored by CSO.

G. Inpatient and Outpatient self pay patients who are able to make payment in full or monthly payment arrangements.

- Assign the appropriate Uninsured Discount IPLAN if the family income is known. If the family income is not known, use the 099-40 unless this is a Burn Unit or Transplant patient.
- The Uninsured Discount IPLAN should reflect proration of 100% of the total charges for the patient.
- A facility/SSC specific prompt pay discount may be applied in addition to the Uninsured Discount as set forth in the PARA.PP.GEN.043 Discount Policy for Patients.
- The facility and the patient shall negotiate interest free, payment plans if the patient cannot pay for the entire encounter in full, taking into consideration the patient's family income and Essential Living Expenses. If the facility and patient cannot agree on an extended payment plan, the payment plan shall meet the requirements of a Reasonable Payment Plan as defined herein.

H. Inpatient self pay patients or insured Patients with High Medical Costs who are not able to make payment in full or monthly payment arrangements, including a Reasonable Payment Plan, and Outpatient self pay patients will be considered for Medi-Cal eligibility.

- Assign the facility designated Pending Medi-Cal IPLAN as the primary payor.
  - The Pending Medi-Cal IPLAN should reflect proration of 100% of the total charges for the patient.
- Assign the Pending Charity IPLAN (099-50) as the secondary payor.
  - Present the patient with a Financial Assistance Application for Charity consideration.
- Assign the appropriate Uninsured Discount IPLAN as the tertiary payor if the family income is known. If the family income is not known, use the 099-40 IPLAN unless this is a Burn Unit or Transplant patient.

I. Outpatient self pay patients or insured Patients with High Medical Costs who are not able to make payment in full or monthly payment arrangements, including a Reasonable Payment Plan and do not meet the Medi-Cal eligibility threshold.

- Assign the Pending Charity IPLAN (099-50) as the primary payor.
  - The Pending Charity IPLAN should reflect proration of 100% of the total charges for the patient.
  - Present the patient with a Financial Assistance Application for Charity consideration.
- Assign the appropriate Uninsured Discount IPLAN as the secondary payor, if the family income is known. If the family income is not known, use the IPLAN 099-40 unless this is a Burn Unit or Transplant patient.

J. All Inpatient and Outpatient self pay patients registered for elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients.

- Assign the facility/SSC designated IPLAN for the discounted/flat rate procedure.

The default of Self Pay IPLAN 000-00, due to the absence of an IPLAN, should be avoided once this policy is implemented. All accounts that are not assigned an IPLAN and systematically assigned Self Pay 000-00 should be reviewed and moved to the appropriate IPLAN. All accounts excluding Client/Industrial accounts must be registered with an appropriate IPLAN for the third party payor, Medi-Cal Pending, Charity Pending, elective cosmetic/facility designated flat rate plan or an

Uninsured Discount Plan. A Business Objects script has been developed to assist in identifying accounts without an IPLAN assignment.

K. IPLAN Assignment if the Patient has Insurance:

If at any time it is determined that the patient is covered by a health plan, the Uninsured Discount IPLAN should be removed; except that where the patient meets the definition of an insured Patient with High Medical Costs. The Uninsured Discount IPLAN is limited to patients who have no third party payor source of payment. The IPLAN assignment of the third party payor should be assigned to the account in place of the Uninsured Discount IPLAN.

L. Retroactive consideration for Medi-Cal eligibility or Charity Discount:

Uninsured Discount Plan patients that retroactively are considered for Medi-Cal eligibility or Charity discounts will have the appropriate Pending Medi-Cal eligibility and Pending Charity IPLANS assigned as outlined in the Patient Access process above. The Uninsured Discount will be reversed until determination of Medi-Cal eligibility and Charity can be ruled out. If a patient applies, or has a pending application, for Medi-Cal or other health coverage at the same time as he/she applies for a discount payment program, the pending Medi-Cal or other health coverage application shall not prevent the patient from applying for discounted care.

M. Insurance Denials for no coverage including pre-existing:

Accounts where the insurance remits a denial of coverage including pre-existing conditions and there is no other insurance coverage on file will be considered self-pay accounts. The IPLAN for the insurance denial should be removed and the Pending Medi-Cal IPLAN added as primary (if the account meets local screening guidelines), Pending Charity IPLAN assigned as secondary and the Uninsured Discount IPLAN assigned as tertiary. A Financial Assistance Application will need to be forwarded to the patient/responsible party.

N. Patient Statements:

Statements should not be sent out until the uninsured discount has been posted. Letters to a Self Pay patient/responsible party should not include the account balance until the Uninsured Discount has been posted. If you use letters in your Medicaid Pending or Charity Pending process, you will need to remove the account balance reflected on them. If the facility bills a patient who has not provided proof of coverage by a third party at the time care is provided or upon discharge, as part of that billing, the facility shall provide the patient with clear and conspicuous notice of: 1) the charges; 2) request that the patient inform the facility if patient has health insurance, including Medicare, Healthy Families, Medi-Cal or other coverage, including coverage under the California

Health Benefit Exchange; 3) a statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state or county-funded health coverage or charity care; 4) a statement indicating how the patient can obtain applications for the above coverage and that the facility will provide these applications; 5) a referral to a local consumer assistance center housed a legal services office

O. Patient Default on Extended Payment Plans:

An extended monthly payment plan may be declared inoperative if the patient fails to make three consecutive payments in a 90 day period; provided that, the facility, or its collection agent, shall make a reasonable attempt to contact the patient by telephone and, give notice in writing, that the extended payment plan may become inoperative due to non-payment, and that the patient has an option to renegotiate the extended payment plan. The facility, or its collection agent, shall renegotiate the extended payment plan if the patient so requests. The notice and telephone call may be made to the last know telephone number and address of the patient. No adverse information may be reported to a consumer credit reporting agency and no civil action may be commenced against the patient until the payment plan is declared no longer operative.

P. Late Charges:

Accounts with the Uninsured Discount IPLAN as the primary payor should not have late charges posted. If late credits are posted to the account, the Uninsured Discount should be recalculated to reflect the correct patient liability. The Bill Code master file on Patient Accounting should be modified to reflect no posting of late charges. Late charges after the Late Charge Days have elapsed should be NPST (not posted) from the Late Charge Report.

Q. Patient Dispute Process:

In the event a patient wishes to appeal a dispute regarding eligibility for this policy, patient may seek review from the Patient Access Director, Hospital Chief Financial Officer or SSC Executive in accordance with the Charity Review Appeal Process, PARA.PP.OPS. 020.

R. Patient Overpayments:

If any amount is paid by the patient and is subsequently determined to be in excess of the patient's liability, the patient will be refunded monies overpaid on the associated account, plus 10% interest beginning on the date the payment by the patient was received by the hospital within thirty days. Hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00).

S. Insurance Denials for Partially Exhausted Benefits:

Accounts where a denial is applied due to partially exhausted benefits, the Uninsured – Partially Exhausted Benefits IPLAN (099-49) should be applied to the secondary position, after the payor with partially exhausted benefits. A manual p-line must be performed to adjust the exhausted benefit portion of the account by the facility Uninsured Discount percentage.

Guidelines to determine if an uninsured discount qualifies based on Partially Exhausted Benefits (All three guidelines must be met):

- The remit indicates a Final Denial, or verbiage used on the remit such as "Exhausted Benefits" or "Maximum Coverage Exceeded" and
- The patient was considered for Charity for the remaining balance and not approved and
- Days being considered for the uninsured discount were not covered by insurer. Also, no insurance payment or contractual adjustment was received or posted for a portion of the day's charges.

Medicare Outpatient Accounts containing Self-administered Drugs:

Self-administered drugs (SADs) provided to Medicare outpatients are considered a non-covered service by Medicare. SADs will not be tracked using an IPLAN. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A manual p-line using procedure code 957983 must be performed to adjust the SAD portion of the account.

PROCEDURE:

Responsible Party	Action
Self Pay – Inpatient and Outpatient (able to pay)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.
Patient Access	Determines the patient can make payment or establish arrangements for payment.
Patient Access	Assigns the Uninsured IPLAN as the primary payor.
Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Calculates deposit from facility deposit schedule.

Patient Access	Collects deposit and documents account.

Self Pay – Inpatient (unable to pay)

Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.
Patient Access	Determines the patient cannot make payment or establish arrangements for payment.
Patient Access	Assigns the Medicaid Pending IPLAN as the primary payor.
Patient Access	Assigns the Charity Pending IPLAN as the secondary payor.
Patient Access	Assigns the Uninsured Discount IPLAN as the tertiary payor.
Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Presents the Financial Assistance Application to the patient or responsible party.
Patient Access	Documents account.

Self Pay – Inpatient and Outpatients for an Elective Cosmetic Procedure, Facility Flat Rate or a scheduled/discounted International Patients

Patient Access	Assigns the facility/SSC designated IPLAN for the elective cosmetic procedure, facility flat rate procedure or scheduled/discounted International Patient procedure.
Patient Access	Collects payment for elective cosmetic or facility flat rate procedure.
Patient Access	Documents account.

Self Pay – Non Inpatient (unable to pay and for services that exceed the facility Medicaid Eligibility threshold)

Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.
Patient Access	Determines the patient cannot make payment or arrangements for payment.
Patient Access	Determines the charges will be over the Medicaid eligibility threshold.
Patient Access	Assigns the Medicaid Pending IPLAN as the primary payor.
Patient Access	Assigns the Charity Pending IPLAN as the secondary payor.
Patient Access	Assigns the Uninsured Discount IPLAN as the tertiary payor.
Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Presents the Financial Assistance Application to the patient or responsible party.
Patient Access	Documents account.

Self Pay – Non Inpatient (unable to pay and charges for services that may not exceed Medicaid eligibility threshold)

Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.
Patient Access	Determines the patient cannot make payment or arrangements for payment.
Patient Access	Determines the complete charges for services cannot be made at time of registration or,
Patient Access	Determines the charges will not be over the Medicaid eligibility threshold.
Patient Access	Assigns the Charity Pending IPLAN as the primary payor.
Patient Access	Assigns the Uninsured Discount IPLAN as the secondary payor.

Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Presents the Financial Assistance Application to the patient or responsible party.
Patient Access	Documents account.

Self Pay – Emergency Department Registrations

Patient Access	EMTALA guidelines must be adhered to for all ED patients.
Patient Access	Assign the Charity Pending IPLAN as the primary payor.
Patient Access	Assign the Uninsured Discount IPLAN as the secondary payor.
Patient Access	Documents account accordingly.

Self Pay – Emergency Department Departures (able to pay)

Patient Access	Determines the patient can make payment or arrangements for payment.
Patient Access	Removes the Charity Pending IPLAN (if assigned at time of registration)
Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Calculates deposit from facility deposit schedule.
Patient Access	Collects deposit and documents account.

Self Pay – Emergency Department Departures (unable to pay)

Patient Access	Determines the patient cannot make payment or arrangements for payment.
Patient Access	Ensures the Charity Pending IPLAN is the primary payor

Patient Access	Ensures the Uninsured IPLAN is the secondary payor.
Patient Access	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
Patient Access	Documents account.

Monitoring Inpatient and Outpatient Uninsured Discounts

Collections and/or Support Services	Reviews Self Pay accounts with the Uninsured Discount Plan as the primary payor for appropriate posted discount.
Collections and/or Support Services	Notifies Payment Compliance Department of accounts with Uninsured Discount Plan as the primary payor that are final billed and do not reflect an Uninsured Discount.
Collections and/or Support Services	Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payor.
Collections and/or Support Services	Ensures that all Letters to a Self Pay patient/responsible party do not include the account balance until the Uninsured Discount has been posted.

Self Pay - Medicaid Eligibility Denied

Collections and/or Support Services	Determines the patient IS NOT eligible for Medicaid Coverage.
Collections and/or Support Services	Deletes the Medicaid Pending IPLAN and the system will automatically move the Charity Discount IPLAN to the primary position and the Uninsured Discount IPLAN to the secondary position.
Collections and/or Support Services	Considers the patient for a Charity Discount based on PARA.PP.OPS.016CA Charity Financial Assistance Policy for Uninsured and Underinsured California Patients.

Self Pay – Charity Discount Denied

Collections and/or Support Services	Determines the patient IS NOT eligible for a Charity Discount

Collections and/or Support Services	Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position.
Collections and/or Support Services	Processes an IZ transaction to ensure that the Uninsured Discount IPLAN Log ID performs discount calculation

Insurance Denials – No Coverage or Pre-existing

Collections and/or Support Services	Third Party payor denies coverage due to no coverage or pre-existing.
Collections and/or Support Services	Remove Third Party IPLAN from account.
Collections and/or Support Services	Add Pending Medicaid as primary payor and Charity Pending 099-50 as secondary payor.
Collections and/or Support Services	Assigns the appropriate Uninsured IPLAN in the tertiary position if the family income is known. If the family income is not known, use the PLAN 099-40 unless this is a burn or transplant patient.

Insurance Denials – Partially Exhausted Benefits

Collections and/or Support Services	Third Party Payor denies for partially exhausted benefits.
Collections and/or Support Services	Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payor IPLAN.

Collections and/or Support Services	
Medicare - Self-administered Drugs MSC Process	Processes a manual p-line for the facility approved Uninsured Discount on the portion of the account partially denied due to exhausted benefits and re-prorates to patient liability. Will identify billed claims from the billing database that require a SADs uninsured discount. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A p-line using procedure code 957983 will be entered in eTran. The p-line follows the standard approval process defined in eTran. Once the uninsured discount is posted to the account; the accounts follow the normal MSC collection process. **NOTE: Encounters reaching a zero balance will be moved to zero balance status and will not require an uninsured discount.**

REFERENCE:

PARA.FT.OPS.015 Uninsured Patient Information Document

Facility Specific Uninsured Discount Plan Deposit Schedule

Facility Specific Cosmetic Procedure Plan Policy and Procedure

PARA.PP.OPS.016CA Financial Assistance Policy for Uninsured and Underinsured California Patients

Self-Administered Drug Discount effective 04/01/2016

Self-Administered Drugs 04012016.doc

QHP- denial code 8X addendum

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QHP denial code 8X specific to collectior