Plumas DISTRICT HOSPITAL	**TITLE: Charity Care Policy and Procedure**
	DEPARTMENT/COMMITTEE: Patient Financial Services

Policy Purpose:

Plumas District Hospital is committed to providing outstanding compassionate care with exceptional customer service. This policy demonstrates Plumas District Hospital's commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and underinsured patients in our community. 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 Patient: A patient who:

1. Is a Self-Pay Patient; and
2. Has Family Income at or below 400% of the Federal Poverty Level.

Uninsured and Underinsured (Self-Pay) Patient: A patient who has no third-party source of payment for healthcare services. Self-Pay Patients include without limitation: (a) patients who qualify for a government program but receive services that are not covered under the program; and (b) patients whose benefits have exhausted prior to or during the provision of services.

High Medical Cost Indigent Patient: A patient who:

1. Is not a Self-Pay Patient; (the patient has a third-party source of payment); and
2. Has Family Income at or below the 400% of the Federal Poverty Level; and
3. Has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred at Plumas District Hospital or at other medical providers) that exceeds the lesser of 10% of the patient's current family income or family income in the prior twelve (12) months.

Policy:

This policy is to provide financial assistance to patients who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual needs. A graduated schedule based on the annual HHS Poverty Guidelines, as well as assessment of the patient's monetary assets will be used to determine the qualifying income and asset levels of applicants. Guidelines are subject to change yearly based on the HHS Poverty Guidelines. Uninsured patients who do not meet the criteria for Charity Care under this policy may be referred to the Prompt Payment or Discount Policy. Understanding this need, the hospital has chosen to fulfill their responsibility to the community by adopting the following Charity Care Policy.

Procedure:

1. **Standard Eligibility Criteria for Participation in the Charity Care Program:**
    a. A patient qualifies for Charity Care if all of the following conditions are met:
        i. The patient does not have private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, or Medi-Cal as determined and documented by the hospital;
        ii. The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital;
        iii. The patient's household income does not exceed 400% of the Federal Poverty Level; **and**
        iv. In consideration of the patient's allowable monetary assets Plumas District Hospital shall comply with California Health & Safety Code section 127405 et seq. (AB 774) ;
            1. In determining a patient's monetary assets, the hospital **shall not** consider: retirement or deferred compensation plans qualified under the Internal Revenue Code; non-qualified deferred compensation plans; the first ten thousand dollars ($10,000) of monetary assets, and fifty percent (50%) of the patient's monetary assets over the first ten thousand dollars ($10,000).

2. **Special Eligibility and Enrollment Exceptions:**
    a. High Medical Costs / Medically Indigent
        i. A patient whose family income does not exceed 400% of the federal poverty level guidelines and their annual out-of-pocket medical

expenses for non-elective/medically necessary services with Plumas District Hospital and other health care providers exceed 10% of the lessor of the patient's current family income or family income in the prior twelve (12) months.

1. For those who have been informally determined to be Medically Indigent, or have incurred high medical costs will be offered to complete a Financial Assistance application by the Patient Financial Counselor.
2. Supporting documentation to show what medical expenses have been paid in the prior 12 months are required to determine eligibility.

b. Homeless / Indigent Patients
    i. Patients who are determined to be indigent/homeless by either clinical documentation or are unable to provide sufficient demographic information such as a mailing address, phone number, or residential address will/can be considered for Charity Care.
        1. No application will be required by a patient who has been determined to be indigent/homeless.
        2. Only emergent/medically necessary services will be considered. Should a homeless/indigent patient present for non-emergent services, financial counseling will be done at the time of service.
c. Deceased No Estate
    i. Upon receipt of confirmation that a patient is deceased and who has no estate, third party coverage, nor spouse, the decedent's balance will be automatically eligible for Charity Care upon receipt of one or more of the following items:
        1. Notification from county in which patient expired;
        2. Copy of death certificate from patient family notifying PDH of death and no estate exists;
        3. Confirmation that patient does not have a living spouse who would be liable for outstanding/unpaid debt;
        4. Confirmation from another facility of patient's expiration and that no estate or pending probate exists;
d. Administrative Charity Care
    i. In cases where medically necessary services are provided to a patient who has been screened by the Patient Financial Counselor, and it has been determined that the patient is unable to complete the standard application process due to medical, social, or other documented circumstances, charges may be considered for Charity Care on a case by case basis.
        1. Account(s) shall be written up for Charity Care adjustment with all supporting documentation attached and be presented to the Chief Financial Officer or Chief Executive Officer for approval.

3. Standard Enrollment Process:

a. An informal determination of Charity Care eligibility will be determined by the Patient Financial Counselor, and the applicant may choose to fill out an application based on the recommendation of the Patient Financial Counselor; however, the recommendation of the Patient Financial Counselor is not required in choosing to fill out the Financial Assistance Application.
b. Upon being submitted for consideration by the Patient Financial Counselor, all properly submitted applications will be reviewed and considered for implementation within 10 business days.
c. All application packets must be filled out completely and accurately with each of the following required documentation attached, to be considered:
    i. Documentation of household income, as provided by:
        1. Current W-2 withholding form or Income Tax statement from the previous year, **or**
        2. Pay stubs from the previous three months
    ii. Documentation of monetary assets, to include:
        1. Most current bank statement, and any additional information or statements on all monetary assets;
            a. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans **shall not** be included.
        2. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value.
d. Any additional accounts with outstanding balances at time of application will be screened for Charity Care eligibility using the same information collected above.
e. Verification of accuracy of application information, including contacting employers for verification of employment, will be made.
f. A letter of either approval or denial will be submitted to each applicant.
    i. The approval letter will include a demand statement for the service in question with adjustments and remaining balance after charity care amount(s) applied including up to zero dollars ($0.00), and contact information for any questions that may arise;
    ii. The denial letter will include: reason for denial; indication of potential eligibility under the Discount Payment Program or other self-pay policy; and request to contact the Patient Financial Counselor (contact information provided) as soon as possible.
g. Any additional services rendered up to a year after the submission date of an approved Charity Care Application will additionally require: updated documentation of non-coverage for the service on the date performed.

h. Any disputes regarding a patient's eligibility to participate in the Charity Care Program shall be directed to the Patient Financial Services Manager and will be resolved within 10 business days.
    i. If it is determined that the patient is ineligible to participate, the number of days spent on dispute resolution shall not be counted toward the minimum 180 days prior to reporting any amount to a credit reporting bureau.

4. Participant Accounts Maintenance:

A folder (electronic) for each Charity Care applicant will be created, and will include the following items:

a. Patient information and application
b. A copy of every correspondence between Plumas District Hospital and the participant
c. Detailed bills on all accounts to be included in the application
d. Adjustment form with adjustments taken on accounts
e. Any additional notations and pertinent information

5. Availability of the Charity Care Policy:

a. Notice of the Charity Care Policy shall be posted in the following locations:
    i. Emergency department
    ii. Patient Financial Services Staff offices
    iii. Admissions office
    iv. Laboratory
    v. Imaging
    vi. Hospital Web Site
b. In the event of the hospital providing service to a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital shall provide a notice to the patient that includes, but is not limited to:
    i. A statement of charges for services rendered by Plumas District Hospital; and
    ii. A request that the patient inform Plumas District Hospital if the patient has private health insurance coverage, Medicare, Medi-Cal or other coverage, and if the patient does not, that the patient may be eligible for such coverage, and can obtain an application for such coverage from Plumas District Hospital; and
    iii. A statement that indicates the patient may qualify for Charity Care with a copy of the Charity Care Application if they meet the eligibility criteria set forth in this policy; and
    iv. The name and telephone number of the Patient Financial Counselor(s) from whom the patient may obtain information about the Charity Care policy and other assistance policies, and about how to apply for that assistance.

References:

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007) and CA AB 1020 (Statutes of 2021). Questions regarding SB 1276, AB 774, AB 1020 and SB 350 can be addressed by the Patient Financial Counselor(s) or by California's Department of Health Care Access and Information (HCAI) website, at

https://hcai.ca.gov/data-and-reports/cost-transparency/hospital-fair-pricing-policies/

https://aspe.hhs.gov/poverty-guidelines