PARALLON
HCA Healthcare

DEPARTMENT: Operations Support	**POLICY DESCRIPTION:** Charity and Discount Program Policy for California Patients with Incomes Below 400% FPL (Uninsured and Underinsured)
PAGE: 1 of 6	**REPLACES POLICY DATED:** 11/01/2017, 11/01/2019, 07/07/2020, 01/01/2022, 1/23/24
APPROVED: 01/23/2024	**EFFECTIVE DATE:** 10/16/24
ANNUAL REVIEW DATE: 01/23/2024	**REFERENCE NUMBER:** PARA.PP.OPS.016CA

SCOPE:

Facility and support service areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals") in California.

PURPOSE:

This is a combined policy intended to capture both the charity care and discount plan policy requirements of Cal. Health & Safety Code §127405 in a simple charity write-off of the entire patient balance for patients that fall within 0-400% of Federal Poverty Level (FPL) who have (i) received medically necessary services, (ii) do not qualify for state or federal assistance for the date of service, (iii) are uninsured or underinsured; and (iv) have completed required documentation substantiating their income levels in the process outlined herein.

POLICY:

ELIGIBILITY CRITERIA

To be eligible for a charity write-off review, a patient must have incurred medically necessary services, have no (*uninsured*) or insufficient (*underinsured*) third party payer coverage for the services, not qualify for state or federal assistance for the date of service, and have required documentation substantiating their income levels. Financial assistance application ("FAA") and documentation processes are described below.

CHARITY WRITE OFF

After appropriate supporting income verification is completed, uninsured and underinsured patients that fall within 0-400% of the FPL will have the entire patient balance processed as charity write-off.

Note: Uninsured and Underinsured patients above 400% FPL may be eligible for other financial assistance pursuant to the facility's uninsured discount and patient liability protection policies.

A patient-friendly overview of these programs is attached hereto as Appendix A.

FINANCIAL ASSISTANCE APPLICATION & INCOME VERIFICATION DOCUMENTATION:

(1) Financial Assistance Process & Application:

Patients (including those who receive emergency and outpatient care) are provided written notice containing information about availability of the hospital's discount payment and charity care policies, as well as contact information from which the patient may obtain further information about these policies. Cal. Health & Safety Code §127410(a) Such notice shall be provided in accordance with the timelines set forth in Cal. Health & Safety Code §127410 (b). Notice of the hospital's policies shall also be clearly and conspicuously posted in physical and website locations as required in Cal. Health & Safety Code §127410(c). Hospital also includes

information regarding its charity care program as part of its billing processes. 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.

(2) Income Verification for Medicare Accounts:

All Medicare patients (i.e., inpatients and/or outpatients) must submit an FAA with supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (CMS Pub. 15-1 chapter 3, section 312).

The preferred income documentation for Medicare Accounts will be the most current year's Income Tax Return. Any Medicare patient/responsible party unable to provide their Income Tax Return may *as an alternative* provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- Recent Pay Stubs
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report

The hospital also will take into account any extenuating circumstances that would affect the determination of the patient's indigence. The hospital also will determine that no source other than the patient (such as a local welfare agency or a guardian) would be legally responsible for the patient's medical bill. The hospital will document the method by which indigence was determined in addition to all backup information to substantiate the determination.

Dual-Eligible Beneficiaries: A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be deemed indigent (PRM-I (CMS Pub. 15-1 Chapter 3, § 312) as long as the "Must Bill" requirements are met. When claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medi-Cal must be billed. In addition, the remittance advice showing non-payment must be maintained as supporting documentation for the Medicare Bad Debt adjustment.

Patients who qualify for a Medicare Savings Program (QMB, SLMB, QI, QDWI) will be eligible for a full charity write-off without the necessity of submitting either an FAA or producing documentation specified in subsection.

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(3) Income Verification for Non-Medicare Accounts:

In addition to any one of the supporting documents options listed in (2) above, the following alternatives are acceptable supporting documentation for non-Medicare Accounts:

- Written documentation from income sources
- Proof of Medi-Cal Eligibility
- Electronic validation of patient income and family size, such as Experian (supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained).

Note: To the extent required by state law, a complete FAA shall be obtained for any dollars reported as charity to the state.

(4) *Deemed Eligible / Extenuating Circumstances*

The patient/responsible party may be deemed to meet the charity guidelines if: (i) the patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy; or (ii) the patient/responsible party presents with Medicaid, and Medicaid does not pay.

There may also be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. The following may be considered by the manager to be extenuating circumstances:

Patients identified as an undocumented resident or homeless through:

- Medi-Cal Eligibility screening
- Registration process
- Discharge to a shelter
- Clinical or Case Management documentation
- Absence of a credit report

Patients that expire - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse) upon documentation and with the manager's review and approval of a policy exception.

Medically Indigent – In addition to the above, if a patient/responsible party meets the medically indigent status based upon state guidelines or requirements, a charity write-off may be applied after the manager completes a resource testing process for the patient/responsible party.

THIRD PARTY COVERAGE AND PAYMENT REVIEW

Prior to charity write-off, a validation will be completed to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medic-Cal, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been received and posted to the account. The charity write-off cannot be applied to any account with any outstanding payer liability.

Patients will also be reviewed for potential Medicaid coverage prior to application of charity write-off hereunder. Determination of Pending Medi-Cal should be resolved prior to evaluating for potential Pending Charity.

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Pending Charity process. The QHP enrollment is not retroactive. Rather, the coverage becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

REFUNDS ON CHARITY ACCOUNTS:

The general expectation is that all patients who qualify for the Charity write-off will apply in a reasonable time so as to have the Charity write-off applied to their bill before the bill comes due. However, if for some reason the patient pays for services rendered and then is later approved for the Charity write-off, the hospital shall timely (within thirty days) reimburse the patient any amount actually paid in excess of the amount due after the Charity write-off is applied plus interest at 10% annually beginning on the date the payment by the patient was received by the hospital. Hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). If the amount is less than $5.00, the hospital will provide a hospital credit for 60 days from the date the amount is due. If the credit is not used within the 60 days, then the hospital may retire the amount from its accounts. This section is in accordance with Health & Safety Code § 127400 et seq, and all patients applying for the Charity write-off shall do so in accordance with said code, and with all reasonable speed so as to avoid billing mistakes before the Charity write-off is applied.

PATIENT DISPUTE PROCESS

In the event a patient wishes to file a dispute and appeal their eligibility for a Charity write-off under this policy, the patient may seek review from the Operations Support Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.OPS.020).

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EMERGENCY PHYSICIAN NOTICE

Emergency physicians as defined in Section 127450 of the California Health and Safety Code, who provide emergency medical services in a hospital that provides emergency care are also required by law to provide write-offs to uninsured patients or patients with high medical costs who are at or below 400% of the federal poverty level.

REFERENCE:

- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.OPS.019 Utilizing the Artiva Charity Process**

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APPENDIX A

If you do not currently have health coverage,
you may be eligible for...

Medi-Cal

OR

Coverage offered through the California Health Benefit Exchange (Covered California), other state or county funded health coverage programs

OR

Our charity or uninsured discounted care program

This facility participates in the Covered California and Hospital Presumptive Eligibility Program (HPE). You may obtain an application for these programs at the time of service.

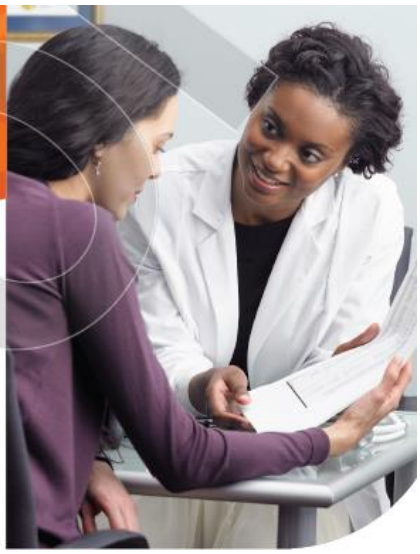
HELP PAYING YOUR BILL

There are free advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3556 or go to www.healthconsumer.org for more information.

HOSPITAL BILL COMPLAINT PROGRAM

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

<<Insert Facility Logo>>



You may qualify for a discount

on your hospital bill if you are a financially qualified patient.

<<Insert Facility Logo>>

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If you believe you may qualify for a discount or charity care, please contact our customer service representatives at 800-307-7631.

You may access the hospital's charity care policy at www.goodsamsanjose.com/patient-financial/charity-policy.

The hospital's shoppable services patient payment estimator tool may be found at www.goodsamsanjose.com/patient-financial.

Additionally, if you lack or have inadequate insurance, and meet certain income requirements, you may qualify for a discount or charity care.

- Patients that fall within 0-400% of the Federal Poverty Level (FPL) may be eligible for a full write-off if they have received medically necessary services and are unable to make partial or full payment on outstanding balances, do not qualify for state or federal assistance for the date of service, and have provided sufficient supporting documentation.
- Self pay patients with no third party payer source of payment that do not qualify for Medicaid, Charity Discounts or any other program the facility offers, will receive a discount similar to Medicaid, referred to as an "uninsured discount" (excluding elective cosmetic procedures and facility designated self pay flat rate procedures). At the time of service, patients will be asked to make payment in full or establish payment arrangements.
- The Patient Liability Protection (PLP) program provides protection for patients with household incomes above 400% of FPL. The discounts under this program help patients who find themselves unable to pay material balances due to limited or no coverage, a high deductible or other extenuating circumstances after receiving emergency and/or emergent non-elective services. These discounts are need-based and calculated on a sliding scale based on the patient's annual household income.