LADMC LA DOWNTOWN MEDICAL CENTER LLC

DEPARTMENT:	POLICY TITLE:
☑Rosemead Campus ☑Downtown Campus ☑West Covina Campus	**CHARITY CARE**
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APPROVED BY: **Governing Board**	APPROVAL/EFFECTIVE DATE: **03/2019, 1/2022, 1/2024**
EFFECTIVE DATE/REVISED DATE (S): 01/2024	
NEXT REVIEW DATE: 1/2026	☐ RETIRED DATE:
ATTACHMENTS:	

Purpose:

To establish policies and procedures to ensure consistent identification, accountability and recording of patient's potentially eligible for charity / discounts in compliance with all applicable laws, including the California Fair Pricing Law.

This policy is intended to:

- Define the forms of available Financial Assistance and the associated eligibility criteria; and
- Establish the processes that patients shall follow in applying for Financial Assistance and the process LADMC will follow in reviewing applications for Financial Assistance; and
- Provide a means of review in the event of a dispute over a Financial Assistance determination; and
- Provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance; and
- Establish guidelines and standards that LADMC will follow with respect to the collection of patient debt including patients who are eligible for Financial Assistance.

GENERAL INFORMATION

This policy does not create an obligation for LADMC to pay for charges of physicians or other medical providers including anesthesiologists, radiologists, pathologists, etc., not included in the hospital bill.

Scope:

Patient Accounting, Admitting/Registration

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Policy:

LADMC policy is to provide Financial Assistance, consistent with this policy, in the form of free or discounted care to eligible:

(1) **Low-income Uninsured Patients**
(Full Charity Care, Partial Charity Care, Special Circumstances Charity Care)

(2) **Patients with High Medical Costs**
(High Medical Cost Charity Care)

Any modification of this policy must be approved in writing by LADMC's [Chief Executive Officer]. LADMC may also provide certain discounts for uninsured patients who do not otherwise qualify for Financial Assistance pursuant to a separate policy.

Definition(s) and Eligibility:

Financial Assistance is available to eligible patients who receive Covered Services and who follow applicable procedures (such as completing applications and providing required information).

1. Financial Assistance. The term Financial Assistance refers to Full and Partial Charity Care, Special Circumstances Charity Care, and High Medical Cost Charity Care.

2. Full Charity Care. Full Charity Care is a complete (100%) write-off of LADMC's undiscounted charges for Covered Services provided to the patient less any payments made by the patient. Full Charity Care is available to patients:

a. Whose Family Incomes are at or below 200 % of the most recent Federal Poverty Income Guidelines (Exhibit A); and

b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability.

3. Partial Charity Care. Partial Charity Care is a partial write-off of LADMC's undiscounted charges for Covered Services available to patients:

A. Whose Family Incomes are between 200 % and 500 % of the federal poverty level according to the most recent Federal Poverty Income Guidelines (Exhibit A); and

B. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability.

C. For patients whose Family Incomes are between 200% and 400% of the most recent Federal Poverty Income Guidelines (Exhibit A), LADMC shall limit expected payments for Covered Services to an amount equal to ten percent (10%) of LADMC's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. LADMC has set the amount of expected payment for patients whose Family Incomes are between 200% and 400% of the most recent Federal Poverty Income Guidelines to be less than the greatest amount LADMC would expect to receive from Medicare, Medi-Cal or another government sponsored program of health benefits and shall annually review the discounted provided under this subsection so as to ensure that the expected payment is no greater than the greatest amount LADMC would expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which LADMC participates.

D. For patients whose Family Incomes are between 400% and 500% of the most recent Federal Poverty Income Guidelines (Exhibit A) the expected payment shall limit expected payments for Covered Services to an amount equal to fifteen percent (15%) of the gross billed charges for the Covered Services provided to the patient less any payments made by the patient. LADMC has set the amount of expected payment for patients whose Family Incomes are between 400% and 500% of the most recent Federal Poverty Income Guidelines to be less than the greatest amount LADMC would expect to receive from Medicare, Medi-Cal or another government sponsored program of health benefits and shall annually review the discounts so as to ensure that the expected payment is no greater than the greatest amount LADMC would expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which LADMC participates.

4. Special Circumstances Charity Care. Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance Criteria set forth in Section 1 or 2 above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of LADMC's undiscounted charges for Covered Services, with the approval of LADMC's [Chief Executive Officer] or designee. LADMC must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non- exhaustive list of some situations that may qualify for Special Circumstances Charity Care:

A. Bankruptcy. Patients who are in bankruptcy or recently completed bankruptcy.

B. Homeless Patients. Patients without a payment source if they do not have a job, mailing address, residence or insurance.

C. Deceased. Deceased patients without insurance, an estate, or third-party coverage.

D. Medicare. Income-eligible Medicare patients may apply for Financial Assistance for denied stays, denied days of care, and Medicare cost shares. Medicare patients who execute an ABN with respect to non-covered services shall not be eligible.

E. Medi-Cal. Income-eligible Medi-Cal patients may apply for Financial Assistance for denied stays, denied days or care, and non-covered services; however, patients may not receive Financial Assistance for the Medi-Cal Share of Cost. Persons eligible for programs such as Medi-Cal but whose eligibility status is not established for the period during which the medical services were rendered may apply for Financial Assistance.

5. High Medical Cost Charity Care. High Medical Cost Charity Care for Insured Patients ("High Medical Cost Charity Care") is a partial write-off of LADMC's undiscounted charges for Covered Services. High Medical Cost Charity Care is not available for patients receiving services that are already discounted (e.g., package discounts). For Covered Services provided to patients who qualify for High Medical Cost Charity Care, LADMC shall limit expected payments to an amount equal to twenty percent (20%) of the LADMC's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. This discount is available to insured patients who meet the following criteria:

A. The patient's Family Income is less than 500% of the Federal Poverty Income Guidelines (Exhibit B);

B. The patient's or the patient's family medical expenses for Covered Services (incurred at LADMC or paid to other providers in the past 12 months provided that the patient provides written evidence of payment to LADMC) exceed 10% of the patient's Family Income; and

C. The patient's insurer has not provided a discount off the patient's bill (i.e., the patient is responsible to pay undiscounted charges).

Other Definitions

1. Covered Services:

a. Covered Services for Full Charity Care are all services that are required to be covered by a Knox-Keene licensed Health Care Services Plan, except that those services requiring administrative approval as defined below are not Covered Services.

b. Covered Services for Partial Charity Care and High Medical Cost Charity Care are all services provided by LADMC, except that those services requiring administrative approval as defined below are not Covered Services.

c. Services Requiring Prior Administrative Approval. Due to their unique nature, certain non-emergency services require administrative approval prior to admission and the provision of services. Generally, patients who seek complex, specialized, or high-cost services (e.g., experimental procedures, transplants) must receive administrative approval prior to the provision of services. Patients seeking to receive such services are not eligible for Full Charity Care, Partial Charity Care or High Medical Cost Charity Care unless LADMC's executive team makes an exception.

2. Uninsured Patient. An Uninsured Patient is a patient who has no source of payment for any portion of their medical expenses including, without limitation, commercial or other insurance, government sponsored healthcare benefit program or third-party liability, or whose benefits under insurance have been exhausted prior to admission.

3. Primary Language of LADMC's Service Area. A language is a primary language of LADMC's service area if 5% or more of LADMC's local population speaks the language.

4. Family Income. Family Income is annual family earnings from the prior 12 months or prior tax year as show by recent pay stubs or income tax returns, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates. For patients over 18 years of age, the patient's family income includes their spouse or 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.

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Procedures:

A. Applying for Financial Assistance:

1. An Uninsured Patient who indicates the financial inability to pay a bill for Covered Services shall be evaluated for Financial Assistance. To qualify as an Uninsured Patient, the patient or the patient's guarantor must verify that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill.

2. The "Statement of Financial Condition/Financial Assistance Application Form," **Exhibit B,** shall be used to document each patient's overall financial condition. This application shall be available in the Primary Language(s) for LADMC's service area.

3. A sample of the "Charity Care Calculation Worksheet," **Exhibit C,** is provided to aid in the determination of the amount and type of charity care for which the patient may be eligible.

B. Financial Assistance Determination and Notice

1. Determination:

   a. LADMC will consider each applicant's Financial Assistance application and grant Financial Assistance where the patient meets eligibility requirements and has received (or will receive) Covered Services.

   b. LADMC may make Financial Assistance approval contingent upon a patient applying for governmental program assistance, which may be prudent if the particular patient requires ongoing services.

   c. In determining whether each individual qualifies for Financial Assistance, 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 and Victims of Crime.

d. LADMC should assist the individual in determining if they are eligible for any governmental or other assistance and provide applications as requested.

e. Where administrative approval is required, LADMC will consider the request for service in a timely fashion and provide a response to the request in writing.

2. Notice

a. While it is desirable to determine the amount of Financial Assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent while in other cases further investigation is required to determine eligibility. In some cases, a patient eligible for Financial Assistance may not have been identified prior to initiating external collection action. LADMC's collection agencies shall be made aware of this policy so that the agencies know to refer back to LADMC patient accounts that may be eligible for Financial Assistance.

b. Once a Full or Partial Charity Care or High Medical Cost Charity Care determination has been made a "Notification Form" **(Exhibit D)** will be sent to each applicant advising them of the hospital's decision.

C. Dispute Resolution. In the event of a dispute over the application of this policy, a patient may seek review by notifying LADMC's Chief Financial Officer of the basis of any dispute and the desired relief. Written communication should be submitted within thirty (30) days of the patient's knowledge of the circumstances giving rise to the dispute. The Chief Financial Officer or designee shall review the concerns and inform the patient of any decision on writing.

D. Recordkeeping. Records related to Financial Assistance must be readily accessible.

E. Third Party Liens. LADMC may lien the tort recoveries of Uninsured Patients in a manner consistent with applicable law.

F. Submission to HCAI. LADMC will submit every two years on January 1 or whenever significant change are made to the California Department of Health Care Access and Information ("HCAI") in a manner prescribed by HCAI.

COMMUNICATION OF FINANCIAL ASSISTANCE AVAILABILITY

A. Information Provided to Patients

1. Preadmission or Registration. During preadmission or registration (or as soon thereafter as practicable, LADMC shall provide:

   a. All patients with information regarding the availability of Financial Assistance (Important Billing Information for Patients, **Exhibit** E).

   b. Patients who the hospital identifies as uninsured with a Financial Assistance application **(Exhibit B).**

2. All Other Times. Upon request, LADMC shall provide patients with information about their right to request an estimate of their financial responsibility for services, the Statement of Financial Condition form, and/or Important Billing Information for Patients at LADMC.

B. Postings and Other Notices. Information about Financial Assistance shall also be provided as follows:

1. By posting in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, including, without limitation, the billing offices, admitting office, and other hospital outpatient service settings.

2. By posting information about Financial Assistance on LADMC's website.

3. By including information about Financial Assistance in bills that are sent to Uninsured Patients. A sample that contains the required information is set forth on **Exhibit F.**

4. By including language on bills sent to Uninsured Patients as specifically set forth in **Exhibit G.**

C. Applications. LADMC shall make applications for Medi-Cal and any other potentially applicable governmental program readily available and accessible to Uninsured Patients and provide such applications upon request.

D. Languages. All notices/communications provided in this section shall be available in the Primary Language(s) of LADMC's service area and in a manner consistent with all applicable federal and state laws and regulations.

COLLECTION ACTIVITIES

A. Assignment to Collection. No patient debt shall be advanced/assigned to collection until the Business Office or designee has reviewed the account and approved the advancement of the account to collection. If a patient is attempting to qualify for Financial Assistance and/or is attempting to settle an outstanding bill with LADMC by negotiating a reasonable payment plan or making regular payments of a reasonable amount, LADMC shall not send the unpaid bill to collection or a collection agency. Any extended payment plans shall be interest free.

B. Use of Collection Agencies. LADMC shall obtain an agreement from each collection agency that it utilizes to collect patient debt consistent with the requirements of this policy, federal law, and state law.

patient's debt to another party, or report adverse information about the patient to consumer credit reporting agencies or credit bureaus before LADMC has made reasonable efforts to determine whether the patient is eligible for Financial Assistance and in no case shall LADMC or any collection agency utilized by LADMC shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for non-payment at any time prior to 150 days after the initial billing if the patient is an Uninsured Patient or a patient provides information that he or she may qualify for Financial Assistance. The 150-day period shall be extended if the patient has a pending appeal for coverage for the services and the patient makes a reasonable effort to keep LADMC informed of the progress of any appeals.

References:

California Hospital Fair Pricing Law SB1276 California Department of Public Health AFL 14-25-1 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-14-25-1.aspx

Hospital Fair Billing Program Laws & Regulations - HCAI

Exhibit A

Family Size	Period	Federal Poverty Guidelines	If income is below 200% (shown below) of FPIG, eligible for full charity care	If income is above 200% But below 400% (shown Below) of FPIG, eligible For partial charity care. Expected Payment= __% of Undiscounted Charges	If income is above 400%but below 500% (shown below) of FPIG eligible for partial charity Care. Expected Payment= __% of Undiscounted Charges
1	Annual	$12,140.00	$24,280	$42,490.00	$60,700.00
	Monthly	$1,011.67	$2,023	$3,540.83	$5,058.33
2	Annual	$16,460.00	$32,920	$57,610.00	$82,300.00
	Monthly	$1,371.67	$2,743	$4,800.83	$6,858.33
3	Annual	$20,780.00	$41,560	$72,730.00	$103,900.00
	Monthly	$1,731.67	$3,463	$6,060.83	$8,658.33
4	Annual	$25,100.00	$50,200	$87,850.00	$125,500.00
	Monthly	$2,091.67	$4,183	$7,320.83	$10,458.33
5	Annual	$29,420.00	$58,840	$102,970.00	$147,100.00
	Monthly	$2,451.67	$4,903	$8,580.83	$12,258.33
6	Annual	$33,740.00	$67,480	$118,090.00	$168,700.00
	Monthly	$2,811.67	$5,623	$9,840.83	$14,058.33
7	Annual	$38,060.00	$76,120	$133,210.00	$190,300.00
	Monthly	$3,171.67	$6,343	$11,100.83	$15,858.33
8	Annual	$42,380.00	$84,760	$148,330.00	$211,900.00
	Monthly	$3,531.67	$7,063	$12,360.83	$17,658.33
	Add this amount for each family member beyond 8				
Each Additional Family Member	Annual	$4,320.00	$8,640	$15,120.00	$21,600.00
	Monthly	$360.00	$720	$1,260.00	$1,800.00

Exhibit B

STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME_____ SPOUSE _____
ADDRESS _____
PHONE _____
ACCOUNT# _____ SSN _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support.

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION
Employer:_____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (Before Deductions)		
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income		
	Interest & Dividends		
	From Real Estate		
	Social Security		
	Other (Specify)		
	Alimony or Spousal Support		
Subtract:	Alimony, Support Payments Paid		
Equals	Current Monthly Income		

Total Current Monthly Income (Patient+ Spouse)=$ _____

FAMILY SIZE
Total Family Members: _____
(add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?		
Are you eligible for any government programs?		
Do you have other insurance that may apply (such as auto policy)?		
Were your injuries caused by a third party? (such as during car accident)?		

By signing this form, I agree to allow LADMC to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

_____ _____
(Signature of Patient or Guarantor) Date

_____ _____
(Signature of Spouse) Date

Exhibit C

CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account: _____

Special Considerations/Circumstances:

_____

_____

_____

_____

	Yes	No
Does Patient have Health Insurance?	____	____
Is Patient Eligible for Medicare?	____	____
Is Patient Eligible for Medi-Cal?	____	____
Is Patient Eligible for Other Government Programs?	____	____

If eligibility exists for the above programs, patient will not generally be eligible for charity care.

	Yes	No
Does Patient have other insurance (auto medpay, workers comp)?	____	____
Was Patient injured by third party?	____	____
Is Patient Self-Pay?	____	____

Charity/Financial Assistance Calculation:

Total Family Income (From Statement of Financial Condition) $_____

Family Size (From Statement of Financial Condition) _____

Qualification for Financial Assistance (Circle One) Full Partial

High Medical Cost

No Eligibility

Exhibit D

NOTIFICATION FORM

ELIGIBILITY FOR CHARITY CARE

LADMC has conducted an eligibility determination for charity care for:

PATIENT'S NAME	ACCOUNT NUMBER	DATES OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _____

The determination was completed on _____

Based on information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for charity care has been approved for services rendered on _____
After applying the charity care reduction, the amount owed is $_____

Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

Your request for charity care has been denied because:

REASON:

_____
_____
_____
_____
_____
_____

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact our Business Office at (213) 989-1697.

Exhibit E

Important Billing Information for Patients at LADMC

Thank you for choosing LADMC for your hospital services. The information below is designed to help you understand options available to assist patients pay their hospital bill. This information only applies to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc., that may bill you separately for their services.

Payment Options

LADMC has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. LADMC has staff available to assist you with applying for government assistance like Medi-Cal to pay your hospital bill. LADMC also has contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity & Discount Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of LADMC's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Admitting and our Business Office. We can also send you copies if you contact our Business Office at (213) 989-1697.

If you have any questions, or if you would like to pay by telephone, please contact the Business Office at (213) 989-1697.

Exhibit F

NOTICE OF RIGHTS

Thank you for selecting LADMC for your recent services. Enclosed please find enclosed a statement of the charges for your hospital visit. Payment is due immediately. Please be aware that this is the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital such as bills from personal physicians and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. You may receive a separate bill for these services.

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, Healthy Families, or other similar programs. If you have such coverage, please contact our Business Office at (213) 989-1697 as soon as possible so the information can be obtained, and the appropriate entity billed.

LADMC has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. LADMC has staff available to assist you with applying for government assistance like Medi-Cal to pay your hospital bill. LADMC also has contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of LADMC's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Admitting and our Business Office. We can also send you copies if you contact our Business Office at (213) 989-1697.

If you have any questions, or if you would like to pay by telephone, please contact the Business Office at (213) 989-1697.

Exhibit G

NOTICE LANGUAGE ON BILLS FOR UNINSURED PATIENTS

Our records indicate that you do not have health insurance or coverage under Medicare, Medi-Cal, or similar other programs. Patients who lack insurance and meet certain income requirements may qualify for financial assistance. Please contact the Business Office at (213) 989-1697 to obtain further information.

LADMC LA DOWNTOWN MEDICAL CENTER LLC

DEPARTMENT: BUSINESS OFFICE – NON GOVT ☐ Ingleside Campus ☐ Dow ntow n Campus	POLICY TITLE: **DISCOUNT PAYMENT**
PAGE: 1 of 2	
APPROVED BY:	APPROVAL/EFFECTIVE DATE: 03/18/2019
EFFECTIVE DATE/REVISED DATE(S): 03/18/2019, 03/18/2022	
NEXT REVIEW DATE: **03/18/2025**	☐ RETIRED DATE:
ATTACHMENTS:	

POLICY

Payment discounts may apply to those patients who do not qualify for Charity Care (free care) and whose family income is at or below 350% of Federal Poverty Level (FPL). Qualifying patients can include:

1. Uninsured patients who are unable to pay for hospital services
2. Insured patient with inadequate coverage and no ability to pay

Payment Discounts do not include administrative adjustments or contractual adjustments. Discount Payment policies and procedures will comply with all Federal and State of California regulations. Written documentation must also be maintained regarding all determinations whether approved or denied.

PROCEDURE

Every effort will be taken to determine financial status prior to application of discount. The appropriate A/R Adjustment Code (Courtesy Discount) will be utilized to record discounts granted under this policy.

Each patient who appears eligible for Payment Discount determination and who requests such determination will be required to provide supporting documentation as requested and necessary to verify the patient's financial condition with the Business Office Representative.

GUIDELINES FOR PAYMENT DISCOUNTS

Determination of Payment Discounts will be made based on:

- Family gross income, adjusted for family size, in accordance with Federal Poverty Guidelines published in the Federal Registration by the United States Department of Health and Human Services.
- The patients net worth and liquidity

- The patient or guarantor's employment status and capacity for future earnings
- Living expenses and financial obligations
- Catastrophic illnesses where the medical expense exceeds the family's gross annual income.

Supporting documentation may be required, including recent pay stubs, credit reports, bank statements, and recently files Federal Tax Returns.

Patients qualifying for payment discounts will be allowed a payment plan of the discounted price over time along with an option for the patient and their family to negotiate the terms of the payment plan.

All patient accounts qualifying for Payment Discounts under this policy should be segregated and retained for possible audit.