PARALLON
HCA Healthcare

DEPARTMENT: Operations Support	**POLICY DESCRIPTION:** Charity Financial Assistance Policy for Uninsured and Underinsured California Patients
PAGE: 1 of 6	**REPLACES POLICY DATED:** 11/01/2017, 11/01/2019, 07/07/2020
APPROVED: 01/22/2024	**EFFECTIVE DATE: 01/01/2022**
ANNUAL REVIEW DATE:	**REFERENCE NUMBER: PARA.PP.OPS.016.CA**

SCOPE:

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

PURPOSE:

To define the policy for providing partial or full financial relief to patients who (i) have received medically necessary services, (ii) meet certain income requirements, (iii) do not qualify for state or federal assistance for the date of service, (iv) are uninsured or underinsured, and (v) are unable to make partial or full payment on outstanding balances. In addition, with respect to the Financial Assistance Application ("FAA") and income validation, to establish protocols and supporting documentation requirements.

POLICY:

Uninsured or underinsured patients or patients with High Medical Costs may qualify for a charity write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability.

1) To be eligible for a charity write-off review, a patient must have incurred medically necessary (not cosmetic) services and meet certain household income criteria.

2) For purposes of this policy, an uninsured patient is one (i) with no third party payer coverage for the services, (ii) who provides documentation that the patient is unable to pay for some or all of the provided hospital services and (iii) who satisfies the financial eligibility criteria set forth herein.

3) For purposes of this policy, an underinsured patient is (i) one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay for the services provided, (ii) who provides documentation that the patient is unable to pay for some or all of the provided hospital services and, (iii) who satisfies the financial eligibility criteria set forth herein.

4) A validation will be completed, as required in this Policy, 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. No charity write-off can be applied to any account with any outstanding payer liability.

5) Definitions:

Patients with High Medical Costs are 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 charity write-off, whose family income is at or below 400% of the Federal Poverty Level. 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. (California Health and Safety Code section 127400)

Essential Living Expenses means, for purposes of this subdivision, expenses for any of the following: 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. (California Health and Safety Code section 127400)

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. (California Health and Safety Code section 127400)

6) Supporting Income Verification Documentation & Review:

A. Medicare Accounts

i. All Medicare patients (i.e., inpatients and/or outpatients) must submit 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 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.

ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- State Income Tax Return for the most current year
- 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

iii. 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. Charity write-offs for Medi-Cal Exhausted beneficiaries may be less than $1,500.

B. 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 ii.Non-Medicare Accounts

i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:

- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Proof of Medi-Cal Eligibility
- Electronic validation of patient income and family size, such as Experian

ii. 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.

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

C. Patients/Responsible Party Deemed Eligible.

The patient/responsible party may be deemed to meet the charity guidelines if:

- 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
- the patient/responsible party presents with Medicaid, and Medicaid does not pay.

D. Charity Processing Based on Extenuating Circumstances, i.e., Potential Charity Write-off Absent Full Documentation.

There may 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 in A or B, 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:

i. *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

ii. *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.

iii. *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.

7) Pending Medi-Cal Effect on Charity Write-off:

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medi-Cal should be resolved prior to evaluating for potential Pending Charity.

8) Health Insurance Marketplace for Qualified Health Plans:

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.

9) Charity Processing based on Federal Poverty Guidelines:

A. Patients with individual or household incomes of between 0-400% of Federal Poverty Guidelines:
Patients that fall within 0-400% of the FPL will have the entire patient balance processed as charity write-off.[1]

B. Patients Who Are Uninsured:

Patients who are uninsured and who provide the supporting income verification documentation and otherwise meet the requirements of this Policy, will have their patient balance capped at the lesser of the amount calculated under 9) A above or the amount calculated pursuant to the uninsured discount model.

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

[1] 1/1/2022 forward; prior to 1/1/2022, patients between 201% and 400% FPL had balances capped at a percentage of income on a sliding scale.

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The write-off will be applied to the entire outstanding patient balance.

Non-Emergent Services: For charity eligible patients that receive non-emergent medically necessary services, the hospital is limited to collecting the amount they would expect in good faith to receive for the same service from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program, whichever is greater

10) 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.

11) Payment Plan: If the patient is eligible for a charity write-off for only some of the patient liability amount, the facility will work with the patient to establish a reasonable payment plan that complies with the California Health and Safety Code.

12) 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).

13) 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.FT.OPS.606 Federal Charity Guidelines**

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- **PARA.FT.OPS.638 Financial Assistance Application**
- **PARA.MF.OPS.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.OPS.019 Utilizing the Artiva Charity Process**