



Origination 8/1/1992
Last Approved 7/1/2026
Last Revised 7/1/2026
Next Review 6/30/2029

Owner Noel
Coppinger:
VP Rev
Cycle &
Managed
Care

Area BUSINESS
MANAGEMENT

Applicability Enterprise-
wide,
excluding
PHP
(Hospital-
wide as
applicable)

Policy # E.85300.600

Financial Assistance Policy (FAP) AKA Charity Care/ Uncompensated Care Program - E.85300.600

APPLICATION:

PIH Health Whittier Hospital (PHWH), PIH Health Downey Hospital - Downey (PHDH), and PIH Health Good Samaritan Hospital (PHGSH) excluding PIH Health Physicians (PHP)

PURPOSE:

To provide a reasonable amount of free or reduced cost care to patients who are unable to pay and to ensure compliance with Assembly Bill 774, SB 1276 and IRS rules.

DEFINITIONS:

AB: Assembly Bill

ECA: Extraordinary Collection Activities IRS: Internal Revenue Service

FAP: Financial Assistance Policy

HPE: Hospital Presumptive Eligibility

SB: Assembly Bill

POLICY:

- A. Recognizing its charitable mission, it is the policy of PIH Health Hospital to provide a reasonable amount of its emergency and medically necessary services without charge to eligible patients who cannot afford to pay for care. Because the hospital cannot employ physicians, this FAP applies only to hospital facility services and does not apply to emergency room physicians, radiologists, pathologists, anesthesiologists, hospitalists, surgeons or other physicians. However, AB 1503 requires Emergency Room physicians to limit expected payment from eligible patients that are uninsured or have high medical costs with income at or below 400% of the federal poverty level.
- B. Medically necessary services (*consistent with generally accepted standards of medicine in the community*) of this facility will be available as uncompensated services to eligible patients. Patients are educated as follows:
 1. In compliance with SB 1276, prior to discharge, non-insured patients are provided with the Letter to the Uninsured in English or Spanish to educate them about availability of coverage through government programs, including the Exchange and Medi-Cal and local consumer assistance offices. In addition, a Medi-Cal and charity application is provided.
 2. In compliance with IRS Section 501(r)(5)(A), the hospital limits its charges for medically necessary care provided to financial assistance policy eligible individuals to no more than "amounts generally billed to individuals who have insurance covering such care". Bills to the uninsured reflect significant self-pay discounts that equate to contracted government-sponsored plan rates (or less) and a notice that the patient may be eligible for state and/or the hospital's FAP/uncompensated care program;
 3. Signs are posted throughout the facility to provide education about charity/FAP policies;
 4. The hospital's website includes a copy of the policy and applications in English and Spanish.
- C. Eligibility for financial assistance is determined by the inability of a patient to pay, versus bad debt as the unwillingness of the patient to pay. Charity Care does not include bad debt, contractual adjustments or unreimbursed costs. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity care and bad debt.
- D. The hospital or its collection agency(s) will not exercise any Extraordinary Collection Activities (ECAs) against an individual whose eligibility has not been determined before 180 days after the first post discharge billing statement.
- E. If the patient is deemed able to pay, but unwilling or if the patient fails to complete the provided charity or Medi-Cal application within a reasonable time period and after reasonable

efforts to collect (*the patient has received the charity/FAP application, appropriate notices about the hospital FAP, three or more statements and a final statement*), or pay the discounted rate, he/she will be classified as bad debt and assigned to Collections. The hospital's collection agency(s) will be required to make reasonable efforts to initiate oral communication before implementing an ECA.

- F. If a patient applies thereafter and before 240 days after the first post-discharge bill was sent to the patient, PIH Health will stop all ECAs while it determines eligibility for financial assistance. If the patient qualifies for the FAP, the account shall be removed from assignment to the Collection agency. Delinquencies will be removed from the patient's credit report.
- G. Eligibility requirements
 - 1. Uninsured patients who do not have the ability to pay as determined by the financial guidelines in this policy.
 - 2. Patients who have Restricted Medi-Cal Emergency and Pregnancy Services coverage (and no share of cost) and whose services are not covered for a particular episode or partial episode of care. (*An uncompensated care application is not required since the patient is presumed to meet the charity care eligibility requirements*);
 - 3. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Presumptive eligibility (*application not mandatory*) for charity may be determined on the basis of individual life circumstances that may include but are not limited to:
 - a. State-funded prescription programs;
 - b. Homeless or received care from a homeless clinic or shelter;
 - c. Participation in Women, Infants and Children programs (WIC);
 - d. Food stamp eligibility;
 - e. Subsidized school lunch program eligibility;
 - f. Low income/subsidized housing is provided as a valid address;
 - g. Patient is deceased with no known estate; and
 - h. Patients who are currently eligible for Medi-Cal, but were not eligible in one to three months prior to eligibility are presumed to be eligible for charity and do not need to fill out the application.
 - i. Undocumented patients who do not qualify for Hospital Presumptive Eligibility (HPE) but meet income guidelines for charity care.
 - j. Out of state Medicaid eligibility
 - 4. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large medical bills;
 - 5. Insured and uninsured patients who demonstrate ability to pay part but not all of their liability. For example, those who have an out of pocket that exceeds 10% of their annual net family income in the prior twelve months.
 - 6. A "reasonable payment plan" must be offered to all patients when the hospital and

patient cannot agree on a plan. "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 including 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. Payment plans can be considered inoperative after the patient's failure to pay consecutive payments during a 90-day period and after sending written notice and placing a call to the patient.

- H. As required by law, PIH Health will publicize its financial assistance policy on its website, via signage in the emergency room and admission area, on billing statements, and through community health activities.
- I. In compliance with IRS rules, if a patient pays for services and applies for financial assistance within eight months of discharge and qualifies, PIH Health will refund the difference between what was paid and the qualified amount within 30 days. If the overpayment is less than \$5.00, a refund is not required.

PROCEDURE:

A. Eligibility Procedures:

1. In addition to the eligibility requirements above, consider the following factors to determine the amount of assistance for which a patient is eligible at the time of service:
 - a. Patient should reside in the hospital's primary/secondary service area and have a physician who is a member of the hospital's Medical Staff. Additionally, out of area patients who were seen in or admitted through the Emergency department will be considered for uncompensated care.
 - b. Consider the patient's individual or family income, as appropriate, using the income guidelines in this policy.
 - c. Consider individual or family net worth including all liquid and non-liquid assets owned, less liabilities and claims against assets. Monetary assets shall not include retirement or deferred-compensation plans. Furthermore, the first ten thousand (\$10,000) dollars of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50% of a patient's monetary assets over the first ten thousand (\$10,000) dollars be counted in determining eligibility.
 - d. Family income would include the income from all members of the patient's "family." For a patient 18 years of age and older, family includes the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not. For a patient under 18 years of age, family includes the patient's parents, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
 - e. Consider other financial obligations including living expenses and other items of a reasonable and necessary nature.

- f. Consider the amount(s) and frequency of hospital and other healthcare/ medication bill(s) in relation to all of the factors outlined above.
 - g. All other resources must be applied first, including third-party payers, Victims of Crime and Medi-Cal. If a patient does not have Medi-Cal but would qualify, he/she should be encouraged to cooperate with the application process. If the application is denied, consider for uncompensated care.
- B. Determine the appropriate amount of financial assistance in relation to the amounts due after applying all other eligible resources. A patient who can afford to pay for a portion of the services will be expected to do so. Reasonable payment guidelines as defined in this policy and by law will be incorporated. Part of an account might be paid by a third party, part by the patient; part may be adjusted to a charity write-off. Work with the patient to establish payment arrangements. As required by AB 774, "If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency." If the patient does not pay the amount deemed to be his/her responsibility under the FAP, for a period of 100 days and fails to renegotiate the payment plan, the uncollectible balance would become bad debt.
- C. Request evidence of eligibility especially for large balance accounts. The patient must provide supporting documentation of income which can include:
 1. Recent pay stubs such as paychecks, General Relief, Social Security, pension, unemployment or disability check stubs, or tax returns;
 2. Application verification may include accessing of the patient/guarantor's credit report. The patient must sign the charity form or Consent of Admissions prior to accessing his/her credit information.
- D. Instruct the patient to inform his/her physicians that he/she has been approved for the hospital's uncompensated care program. Some physicians will reduce or write off the patient's bill with this documentation.
- E. Eligibility may be reevaluated for a patient's eligibility when the following occur:
 1. Subsequent rendering of services;
 2. Income change;
 3. Family size change;
 4. When six months has passed since the last application or if circumstances change.
- F. Determine eligibility for financial assistance at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.
- G. Financial counselors, registration clerks, cashiers, care managers, Patient Accounting staff and patients can initiate the application process.
- H. Review Process:

1. Uncompensated Care Committee Composition:

- a. Vice President, Revenue Cycle or Patient Accounting Director
- b. Customer Service/Collection Supervisor or Manager
- c. Collectors

I. Duties of the Committee

1. Review all applications for charity care and determine eligibility based on established criteria. Application may be placed in pending status if the patient has applied for Medi-Cal, Victims of Crime benefits, or if there is insufficient information to determine eligibility for uncompensated care. Patients are not required to apply for any other assistance program before applying for charity care.

- a. Financial Counselors and Collectors will determine the patient's out-of-pocket, if any, based on the guidelines in this policy and preliminarily approve applications when the cash discount rate is expected to be less than \$3,000. If the patient does not meet the financial criteria but has extenuating circumstances such as catastrophic illness, the account will be referred to the manager who will make a recommendation to the Director. Uncompensated Care approval authority is as follows:

- i. Write-offs from \$.01 to \$14,999 require final approval by the Credit and Collections Supervisor.
- ii. Write-offs \$15,000 and over require approval by the Patient Accounting Director or Vice President, Revenue Cycle and Managed Care.

- J. Pre-approved patients will be registered to insurance plan code 9030. Community program accounts will be registered to plan code 9031.
- K. Ensure patients are notified, in writing, regarding approval, denial or pending of uncompensated care.
- L. If the application is incomplete and the discrepancy cannot be cleared up by phone, request the missing information in writing, provide a notice about potential ECAs (and an accompanying plain language summary of the FAP). Allow a minimum of 30 days for the complete application to be returned.
- M. Denials may be appealed to the committee with the following documentation:
 - 1. Appeal letter to committee from the patient or guarantor requesting reevaluation.
 - 2. Supporting documents that may prove inability to pay that weren't part of the initial consideration.
- N. The committee will review appeals and the committee will make recommendations to the Chief Financial Officer or his designee for final approval.
- O. The hospital will retain charity care/FAP applications and documents for six years.

REFERENCES:

External References: N/A

Internal Cross References: N/A

Supersedes 100.85300.600 and 200.85300.600

Amount of Financial Assistance/Charity Care Determination is Based on

Methodology: PIH Health Hospital uses the "Sliding Scale Method" to determine the dollar amount to be considered as charity care for eligible patients.

Charity Care: Patient applications that show that family income at or below 100% of Federal Poverty Guidelines (FPL) will be approved for no-cost to the patient.

Discount: Patient applications that show that family income between 101 % and 400% FPL will be granted the lesser of the self-pay rate or discounts as outlined below.

USE CURRENT YEAR FEDERAL POVERTY GUIDELINES

%FPL	Inpatient per day & Outpatient Surg	Outpatient Non-Surgery & Emergency Room visit
100%	-	\$ -
125%	\$100	\$35
138%	\$200	\$50
150%	\$300	\$65
175%	\$400	\$80
185%	\$600	\$120
200%	\$800	\$150
225%	\$1,000	\$200
250%	\$1,200	\$225
275%	\$1,350	\$275
300%	\$1,500	\$325
325%	\$1,550	\$350
350%	\$1,600	\$375
375%	\$1,700	\$425
400%	\$1,850	\$500

Patient liability is based on the **lesser of**

- 16.2% of total charges for services rendered at PHH-W
- 20% of total charges for services rendered at PHH-D (based on the amounts generally billed during the look back period calendar year 2018)
 - *Amounts generally billed is calculated from the actual past claims paid to each hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility*

- The cash discount rate (based on the rates of a government-sponsored plan agreement, or less);
- 10% of the patient's annual income; or;
- The amount outlined above.

Applicability

PIH Health Downey Hospital, PIH Health Enterprisewide, PIH Health Good Samaritan Hospital, PIH Health Whittier Hospital