

DEPARTMENT: Business Office <input checked="" type="checkbox"/> Downtown Campus <input checked="" type="checkbox"/> Rosemead Campus <input checked="" type="checkbox"/> West Covina Campus	POLICY TITLE: <p style="text-align: center;">CHARITY CARE</p>
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ATTACHMENTS:	A. Summary of Charity Care B. Discount Payment C. Amounts Generally Billed D. Statement of Certification

Purpose:

To establish policies and procedures to ensure consistent identification, accountability and recording of patient's potentially eligible for charity / discounts in compliance with an 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 facility 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 facility 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 facility 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:

Hospital 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 Hospital's [Chief Executive Officer]. Hospital 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 Hospital's undiscounted charges for Covered Services provided to the patient less any payments made by the patient. Full Charity Care is available to patients:

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- a. Whose Family Incomes are at or below 200 % of the most recent Federal Poverty Income Guidelines; 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 Hospital'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; 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, Hospital shall limit expected payments for Covered Services to an amount equal to ten percent (10%) of Hospital's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. Hospital 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 Hospital 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 Hospital would expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which Hospital participates.

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D. For patients whose Family Incomes are between 400% and 500% of the most recent Federal Poverty Income Guidelines 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. Hospital 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 Hospital 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 Hospital would expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which Hospital 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 Hospital's undiscounted charges for Covered Services, with the approval of Hospital's [Chief Executive Officer} or designee. Hospital 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.

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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 Hospital'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, Hospital shall limit expected payments to an amount equal to twenty percent (20%) of the Hospital'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 ;
- B. The patient's or the patient's family medical expenses for Covered Services {incurred at Hospital or paid to other providers in the past 12 months provided that the patient provides written evidence of payment to Hospital 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.

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- b. Covered Services for Partial Charity Care and High Medical Cost Charity Care are all services provided by Hospital, 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 Hospital'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 Hospital's Service Area. A language is a primary language of Hospital's service area if 5% or more of Hospital'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 or 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," shall be used to document each patient's overall financial condition. This application shall be available in the Primary Language(s) for Hospital's service area.
3. A sample of the "Charity Care Calculation Worksheet," 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. Hospital 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. Hospital 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.

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- d. Hospital 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, Hospital 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. Hospital's collection agencies shall be made aware of this policy so that the agencies know to refer back to Hospital 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" 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 Hospital'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.

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- E. Third Party Liens. Hospital may lien the tort recoveries of Uninsured Patients in a manner consistent with applicable law.
- F. Submission to HCAI. Hospital 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, Hospital shall provide:
 - a. All patients with information regarding the availability of Financial Assistance (Important Billing Information for Patients).
 - b. Patients who the hospital identifies as uninsured with a Financial Assistance application.
 - 2. All Other Times. Upon request, Hospital 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 Hospital.
- 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 Hospital's website.

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3. By including information about Financial Assistance in bills that are sent to Uninsured Patients.
4. By including language on bills sent to Uninsured Patients.

- C. Applications. Hospital 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 Hospital'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 Hospital by negotiating a reasonable payment plan or making regular payments of a reasonable amount, Hospital 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. Hospital 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.

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patient's debt to another party, or report adverse information about the patient to consumer credit reporting agencies or credit bureaus before facility has made reasonable efforts to determine whether the patient is eligible for Financial Assistance and in no case shall facility or any collection agency utilized by facility 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 180 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 180-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 facility informed of the progress of any appeals.

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Exhibit A: Summary of Charity Care Policy Plain Language Summary

As part of our mission, West Covina Medical Center (the “Organization”) is committed to providing access to quality healthcare for the community and treating all of our patients with dignity, compassion, and respect. This includes providing services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for care as provided by our Charity Care Policy (the “Policy”). We also offer our patients a variety of options to meet their financial needs, even if they do not qualify for assistance. This document is our plain language summary (the “Summary”) of the Policy.

Help Paying Your Bill Charity Care is available for patients receiving medically necessary services whose family income is at or below **400 percent of the Federal Poverty Level (FPL)** for the current year.

Patients whose family income is between **401 percent and 500 percent of FPL** may qualify for a **Discount Payment Program**, which provides partial discounts on a sliding scale based on family size and income.

Eligibility is based solely on verified family income—**information about assets is not required**.

Charity Care for elective or non-medically necessary procedures is limited to patients who reside within the Organization’s service area and receive prior approval from the Business Office Manager or designee.

No patient eligible under this Policy will be charged more than the **Amounts Generally Billed (AGB)** for emergency or other medically necessary care.

How to Apply Patients seeking free or discounted care under the Policy will need to complete a Charity Care application (the “Application”) and submit required documentation. The Application and documentation will be reviewed by the Organization.

Free copies of this Summary, the full Charity Care and Discount Payment Policy, and the Application are available in **all primary languages of our service area**, including **English, Spanish, Armenian, Chinese, Farsi, Korean, Russian, Tagalog, Vietnamese, Arabic, Japanese, Khmer (Cambodian), Thai, Hindi, and Punjabi**. Ask representatives at the business office.

- Call the Business Office at 213-314-1492.
- Visit the Organization’s website at www.westcovinamc.com.

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If you have a disability and need an accessible alternative format for the above materials, or if you speak another language not listed, please contact the Business Office. They can offer you an alternative format or connect you with our Interpreter Services department for further assistance.

No Deadline to Apply

Patients may apply for financial assistance **at any time**, during or after the receipt of care, as long as income documentation is provided. The Organization will review each completed application promptly and notify the applicant of the eligibility determination in writing.

Arrangements for Self-Pay

Patients who do not qualify for free or discounted care under the Policy may find other programs of the Organization helpful. Patients who lack insurance may receive a substantial discount, similar to the discounts we provide to managed-care insurance plans for eligible services.

Regulatory Notice for Collections We do refer some delinquent accounts to third-party collection agencies. These agencies must follow all California and federal laws as well as comply with the Organization’s policies and procedures. For more information about debt collection activities, contact the Federal Trade Commission by phone at 877-FTC-HELP (877-382-4357). If your account is referred to a collection agency and you experience problems, contact our Business Office for support at 213-314-1492.

Protections for Surprise Medical Bills All patients are afforded protections against surprise medical bills. Please see the “Notice to Patients – Your Rights and Protections Against Surprise Medical Bills” on our website www.ladowntownmc.com or ask for a copy.

- (3) **Hospital Bill Complaint Program** The Hospital Bill Complaint Program is a state program that 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 State of California’s Hospital Bill Complaint Program. Go to HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.
- (4) **More Help** There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or visit healthconsumer.org for more information.

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- (5) **Additional Resources and Information:** Patients may be eligible for government assistance programs, such as Medi-Cal or subsidized coverage through Covered California. The Business Office has onsite staff to answer questions and provide assistance with applying for these programs. The Business Office can be contacted at 213-314-1492 or at 1711 W Temple St, L.A., CA 90026.
- (6) For questions regarding commercial health insurance, call 213-314-1492. For information on the Organization’s pricing and tools for shoppable services, visit www.westcovinamc.com.

Notice of Language Assistance Services

Language assistance services are available **free of charge**.
 If you need help in another language, please call **213-314-1492**.

Free assistance is available in the following languages:
English, Spanish, Armenian, Chinese, Farsi, Korean, Russian, Tagalog, Vietnamese, Arabic, Japanese, Khmer (Cambodian), Thai, Hindi, and Punjabi.

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Attachment C

Amounts Generally Billed

Definition

Amounts Generally Billed (AGB)” means the maximum amount that the Organization will charge an eligible patient for emergency or medically necessary care, as determined in accordance with **26 C.F.R. § 1.501(r)-5(b)** and **California Health & Safety Code § 127405(d)(2)**.

No patient eligible for Charity Care or Discount Payment Assistance will be personally responsible for paying more than this AGB amount.

Methodology

The Organization uses the **Look-Back Method** to determine its AGB percentage.

This method calculates the average reimbursement rate for all claims that have been paid in full to the Organization by **Medicare fee-for-service** and **commercial insurers** over the most recently completed 12-month period.

Inpatient Services – The Organization determines the average combined Medicare and commercial reimbursement rates for inpatient services using the most recently closed accounts. The resulting blended rate is applied to total inpatient gross charges.

- For additional patient benefit, the Organization applies the **lower of** (a) the AGB percentage or (b) the applicable **Medicare MS-DRG reimbursement amount** when determining an eligible patient’s liability.

Outpatient Services – The Organization determines the average combined Medicare and commercial reimbursement rates for outpatient services using the same 12-month look-back period.

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Attachment D Statement of Certification

This Policy will be submitted to the Department of Health Care Access and Information (HCAI). Additionally, it will be made available on the Organization’s website.

The Organization attests under penalty or perjury to the following:

- A. The individual submitting the policy is duly authorized to submit policies on behalf of the Organization.
- B. This submitted policy is a true and correct copy of the Policy for which this certification is included.



Pedro Mercado
Business Manager

January 1, 2025

Date