METHODIST HOSPITAL

Title: Patient Financial Assistance/ Charity Care	Page 1 of 3
Policy #: MA1023	
Type: Finance (1000)	
Standard: N/A	

POLICY:

In keeping with its social mission and responsibility to the community, Methodist Hospital of Southern California (MHSC) will assist patients without insurance coverage in obtaining coverage through government means-tested programs such as Medi-Cal, , Covered California (Affordable Care Act/ Medi-Cal HMOs) and other programs that may exist from time to time. Additionally MHSC may be able to provide temporary financial help for medical care (charity care) for uninsured patients with the greatest financial need.

In compliance with Assembly Bill 774,and Senate Bill 350, Methodist Hospital of Southern California will:

- Provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. Services provided without charge will include all medically necessary services provided by MHSC. The charity care budget will be established once a year during the annual budget process approval of the Board of Directors.
- Provide a discount from charges to patients without insurance coverage (See Cash Discount Policy MA 1035). Insured patients with a co-pay and/or deductible are not eligible for a further cash discount as the insurer has already negotiated a discounted rate with MHSC. However, payment plans may be available.
- Appropriately determine the financial status of each patient to distinguish uncompensated costs between charity care and bad debt. CHARITY is defined as the demonstrated inability of a patient to pay, versus BAD DEBT as the unwillingness of the patient to pay. For full charity care assistance, gross income should fall within 200% of the federal poverty guidelines. If gross income is between 201% to 350% of the federal poverty level, charity care may be applied (See Cash Discount Policy MA 1035). The tables used to establish the federal poverty guideline can be found at (http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html.
- Provide billing statements to all patients that reflect discounts and a notice that the patient may be eligible for state and/or other means-tested insurance programs.
- Provide reasonable notice and explanation of financial assistance options through signage at registration points and through printed documents given to each patient at the time of registration.

MHSC will include as charity care services provided to:

- Uninsured patients who do not have the ability to pay based on criteria set defined in this policy. Including::
    - Patients whose family gross income falls within 200% of the federal poverty guidelines
    - Patients 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.
- Insured patients who:
    - Are covered by government or private charitable means tested programs who require services not covered or denied for a particular episode or partial episode of care
    - Demonstrate the inability to pay part but not all of their MHSC liability, such as a patient with annual incurred out-of-pocket costs which exceed ten (10) percent of the patient's family income in the prior twelve (12) month period.
- Patients for which MHSC is unable to assess a patient's financial condition prior to rendering services as required by the Emergency Medical Treatment & Active Labor Act (EMTALA).
- In instances where MHSC determines that only a portion of a patient's financial liability qualifies as charity care due after applying all other resources, the patient is expected pay the remaining portion. If the patient does not pay the amount determined to be his/her responsibility, the uncollectible remainder would become bad debt.
- Charity care is recorded at gross charges.

In the granting of charity care, no consideration will be placed on a patient's race, religion, ethnic background, sexual orientation, gender, residency status, political affiliation, or other discriminatory factors. However, patients requesting charity care, discounted care or other financial assistance must make every reasonable effort to provide MHSC with required documentation of insurance coverage and of financial status. Failure to provide information that is reasonable and necessary may be considered by the hospital in making its determination. Additionally, patients who are eligible for coverage through government insurance or programs that provide financial assistance to pay for coverage under the ACA but refuse to obtain such coverage may be excluded from MHSC's charity program.

PROCEDURES:

1. All patients without insurance coverage will be counseled as to the financial options for paying their medical care upon registration, or as soon after presentation to the hospital as allowed under EMTALA.
2. Patients who appear to be eligible for means-tested programs will be connected to resources to assist them in applying for such coverage.
3. If the patient is not eligible for means tested programs or is denied such coverage will be invited to apply for MHSC's charity care program.

4. Charity care applications require verification of financial means through the patient/guarantor's consent to obtain a credit report and through provided documents such as:
    - Prior year tax returns
    - Current pay stubs
    - Written verification of wages from Employer
    - Unemployment letter
    - Social Security check stub
    - Disability check
    - Letter of eligibility for cash assistance

5. Charity care eligibility will be reevaluated upon registration for subsequent services.

6. Patients will be notified in writing regarding MHSC's decision to approve or, deny charity care coverage or if there is a need for additional documentation to make a decision.

7. Sliding scale based on federal poverty guidelines will be used to evaluate the level of financial assistance.

poverty	w/o %	1 Persons Annual $	2 Persons Annual $	3 Persons Annual $	4 Persons Annual $
100%	100.0%	$11,670	$15,730	$19,790	$23,850
200% and below	100.0%	$23,340	$31,460	$39,580	$47,700
250%	95.0%	$29,175	$39,325	$49,475	$59,625
260%	90.0%	$30,342	$40,898	$51,454	$62,010
270%	85.0%	$31,509	$42,471	$53,433	$64,395
280%	80.0%	$32,676	$44,044	$55,412	$66,780
290%	75.0%	$33,843	$45,617	$57,391	$69,165
300%	70.0%	$35,010	$47,190	$59,370	$71,550
310%	65.0%	$36,177	$48,763	$61,349	$73,935
320%	60.0%	$37,344	$50,336	$63,328	$76,320
330%	55.0%	$38,511	$51,909	$65,307	$78,705
340%	50.0%	$39,678	$53,482	$67,286	$81,090
350%	47.5%	$40,845	$55,055	$69,265	$83,475

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Attachments: Office Use Form, Patient Financial Statement

Approvals:
MAPPS: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 7/14

Effective Date: 5/15/1990

Reviewed Dates: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 7/14

Revised Dates: 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 7/14