HI-DESERT MEDICAL CENTER HI-DESERT MEMORIAL HEALTH CARE DISTRICT	**DEPARTMENT / MANUAL: PATIENT FINANCIAL SERVICES**
ORIGINAL DATE: 06/29/92	REVIEW & REVISION DATES: 10/26/92,06/01/93,12/01/95,06/01/96,03/01/97,03/31/98,02/01/05,01/07,01/08,01/12,01/14
TITLE: **Financial Assistance Policy**	APPROVED BY: DIRECTOR: _____ Date:_____ ADMIN: _____ Date:_____

PURPOSE

To define eligibility criteria for charity care and to provide administrative and accounting procedures for identification, classification and reporting of patient accounts as charity care.

California acute care hospitals must comply with Health & Safety Code Section 127400 et seq., including requirements for written policies providing discounts and charity care to financially qualified patients. This policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the Hi-Desert Medical Center (HDMC) Financial Assistance Program.

The finance department has overall responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at Hi-Desert Medical Center. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Hi-Desert Memorial Health Care District.

POLICY

Hi-Desert Memorial Health Care District's mission statement requires that "Hi-Desert Medical Center will provide superior service to improve the quality of life for the people of the Morongo Basin." This statement reflects the District's social accountability to the communities which are served by HDMC. Providing charity care to eligible patients, along with other community benefits, is important evidence of Hi-Desert's mission fulfillment. It is imperative that determination, tracking and reporting of charity care are in concert with meeting the mission and community obligations of Hi-Desert Memorial Health Care District.

SCOPE

This policy pertains to full and discount partial charity care (financial assistance) provided by Hi-Desert Medical Center. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

Physician Services

Emergency physicians providing services at HDMC are independent contractors and not employees of the Hi-Desert Memorial Health Care District. Charity care and discount payment options may be available

separately from emergency physicians. Hi-Desert Medical Center will provide patients with contact information for emergency physician providers upon patient request.

Services rendered by other physicians, including anesthesiologists, radiologists, pathologists, surgeons or other members of the HDMC medical staff are not subject to or covered within the scope of this policy.

DEFINITIONS

Full Charity Care is defined as any Medically Necessary inpatient or outpatient hospital services except Rural Health Clinic services, provided to a patient who is uninsured or underinsured, has an income below 200% of the current federal poverty level and who has established qualification in accordance with requirements contained in the HDMC Financial Assistance Policy.

Discount Partial Charity Care is defined as any Medically Necessary inpatient or outpatient hospital services, except Rural Health Clinic Services, provided to a patient who is uninsured or underinsured, has an income at or below 350% of the federal poverty level and who has established qualification in accordance with requirements contained in the HDMC Financial Assistance Policy.

Full and Discount Partial Charity Care for HDMC Rural Health Clinic patients are defined as any Medically Necessary service provided to a patient who is uninsured and has an income at or below 200% of the federal poverty level and who has established qualification in accordance with requirements contained in the HDMC Rural Health Clinic Sliding Fee Discount Program Policy.

Depending upon individual patient qualification, financial assistance may be granted for full charity care or discount partial charity care. Financial assistance may be denied when the patient or other responsible family representative does not meet the HDMC Financial Assistance Policy requirements.

FULL and PARTIAL DISCOUNT CHARITY CARE ELIGIBILITY

General Process and Responsibilities

Eligibility is delineated by this policy for inpatients and outpatients. Except for Rural Health Clinic patients, any patient with a family income less than 350% of the current federal poverty level may be eligible when:

- They are not covered by third party insurance; or
- If covered by third party insurance and they are unable to pay the patient liability amount owed after insurance has paid its portion of the account.

Rural Health Clinic patients, who receive primary care services which cost significantly less than inpatient and/or most other hospital outpatient diagnostic services, may be eligible with family incomes of up to 200% of the current federal poverty level.

Eligibility alone is not an entitlement to coverage under the HDMC Financial Assistance Program. HDMC must complete a process of applicant evaluation and determine coverage before full charity care or partial discount charity care may be granted.

The HDMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, HDMC utilizes a single, unified patient application for both Full Charity Care and Partial Discount Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify.

Eligible patients may qualify for the HDMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program.

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

Completion of a financial assistance application provides:

- Information necessary for the hospital to determine if the patient has income sufficient to pay for services;
- Documentation useful in determining qualification for financial assistance; and
- An audit trail documenting the hospital's commitment to providing financial assistance.

However, a completed financial assistance application is not required if HDMC determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.

Full and Discount Partial Charity Care Income Qualification Levels

Inpatients and Outpatients Other Than Rural Health Clinic Services

1. If the patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off.

2. If the patient's family income is between 201% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:

    - Patient's care is not covered by a payer. If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual

percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1

Sliding Scale Payment Schedule

Family Percentage of FPL	Percentage of Medicare Amount Payable
201 – 250%	50%
251 – 300%	75%
301 – 350%	100%

- Patient's care is covered by a payer.

a) If the services are covered by a third party payer with which the hospital does not maintain a current contract through which the patient receives a discount on the patient liability portion (i.e., a deductible or co-payment), the patient's payment obligation will be an amount equal to fifty percent (50%) of the outstanding patient balance due.

b) If the services are covered by a third party payer with which the hospital maintains a current contract through which the patient receives a discount on the patient liability portion, the patient's payment obligation will be for the full amount owed (i.e., a deductible or co-payment).

Rural Health Clinic Services

- If the patient’s family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the Rural Health Clinic Sliding Fee Discount Program (Attachment A) will be applied.

Qualification - Special Circumstances

1. If the patient is determined to be homeless, uninsured and unable to pay for Medically Necessary services, he/she will be deemed eligible for charity care.

2. Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months

3. Deceased patients who do not have any third party coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed eligible for charity care.

4. Patients seen in the emergency department, for whom the hospital is unable to issue a bill, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

5. Medicare rules require any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by HDMC. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

    a) The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

    b) The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

7. HDMC deems those patients that are eligible for government sponsored low-income assistance programs (e.g. Medi-Cal/Medicaid, Healthy Families, California Children's Services and any other applicable federal, state or local low-income program) to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as all other low-income government programs where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the HDMC Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as charity care. Specifically included as charity care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying government low-income programs, and other denials (e.g. restricted coverage) are to be classified as charity care.

8. Any patient whose income exceeds 350% of the current FPL guidelines and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes do not qualify for routine full charity care or partial discount charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be at the sole discretion of hospital management based upon the amount of the patient liability at billed charges, and consideration of the individual's

income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $30,000 may be considered for eligibility as a catastrophic medical event.

Qualification Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with HDMC to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to charity care:

- Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); *and*
- The patient or family representative must have a credit score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; *and*
- The patient or family representative has not made a payment within 150 days of assignment to the collection agency; *and*
- The collection agency has determined that the patient/family representative is unable to pay; *and/or*
- The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

PROCEDURE

Qualification for full or discount partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

- No insurance under any government coverage program or other third party insurer;
- Family income based upon tax returns or recent pay stubs
- Family size

The patient and/or patient family representative who requests assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program. The

application and required supplemental documents are submitted to the Patient Financial Services department at HDMC. This office shall be clearly identified on the application instructions.

Financial assistance shall not be provided on a discriminatory or arbitrary basis. However, HDMC retains full discretion, consistent with all laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

HDMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:

Patient Financial Services Representative: Accounts less than $10,000
Director of Patent Financial Services: Accounts less than $25,000
Controller: Accounts less than $50,000
Chief Executive Officer: Accounts greater than $50,000

Once determined, Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, the hospital, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital.

Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital will be included as eligible for write-off at the sole discretion of hospital management

Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance.

Uninsured patients at or below 350% of the FPL will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all Medically Necessary hospital inpatient, outpatient (except Rural Health Clinic) and emergency services provided by HDMC.

<u>Patient Notification</u>

Once a determination of qualification is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

A. **Approval**: The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient.

B. **Denial**: The reasons for denial of the financial assistance application will be explained to the patient. Any outstanding amount owed by the patient will also be identified.

C. **Pending**: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and is requested to be supplied to the hospital by the patient or family representative.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the hospital director of patient financial services. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the director of patient financial services, the patient may request in writing, a review by the hospital chief financial officer. The chief financial officer shall review the patient's written appeal and documentation, as well as the findings of the director of patient financial services. The chief financial officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the chief financial officer shall be final. There are no further appeals.

Qualified Payment Plans

When a determination of partial discount charity care has been made by the HDMC, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.

The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Once a payment plan has been approved by HDMC, any failure to pay all consecutive payments due will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the HDMC Patient Financial Services department if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, HDMC will make a reasonable attempt to contact the patient or their representative by telephone and also give notice of the default in writing.

The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Financial Services representative within Fourteen (14) days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the extended payment plan within Fourteen (14) days, the payment plan will be deemed inoperative and the account will become subject to collection.

Public Notice

HDMC shall post notices informing the public of the Financial Assistance Program (Attachment A). Such notices shall be posting in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas

or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area.

A copy of this Financial Assistance Policy will be made available to the public upon reasonable request.

Charity Care Reporting

HDMC will report actual charity care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, the hospital will maintain written documentation regarding its charity care criteria, and for individual patients, the hospital will maintain written documentation regarding all charity care determinations. As required by OSHPD, charity care provided to patients will be recorded on the basis of actual charges for services rendered.

HDMC will provide OSHPD with a copy of this Financial Assistance Policy which includes the full charity care and partial discount charity care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

Good Faith Requirements

HDMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, HDMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the HDMC Financial Assistance Program.

REFERENCES
Attachment - A