SUBJECT:	SECTION:
FINANCIAL ASSISTANCE POLICY – FULL CHARITY CARE AND DISCOUNT PARTIAL	**Page 1 of 10**

PURPOSE:

Sierra View Medical Center (SVMC) is a non-profit organization, which provides hospital services to the community of Porterville and the greater area of Southeastern Tulare County. Sierra View Medical Center is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, SVMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Financial Assistance Policy. This policy defines the SVMC Financial Assistance Program; its criteria, systems, and methods.

California acute care hospitals must comply with Health & Safety Code requirements for written policies providing discounts and charity care to financially qualified patients. This policy is intended to meet such legal obligations, provides for both charity care, and discounts to patients who financially qualify under the terms and conditions of the Sierra View Medical Center Financial Assistance Program.

The Finance Department has 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 SVMC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Sierra View Medical Center.

The Financial Assistance Policy will apply to all patients who receive services at SVMC. This policy pertains to financial assistance provided by Sierra View Medical Center. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

Introduction

Sierra View Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. SVMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. These programs include government-sponsored coverage such as the California Health Benefits Exchange and other State or county funded health coverage, as well as Medicare, Medi-Cal, Healthy Families Program, California Children's Services, or other State or county funded health coverage.

AFFECTED AREAS/PERSONNEL: *PATIENT FINANCE*

PROCEDURE:

Senate Bill 1276 expands the availability of charity care and discount payment plans to all patients with high medical costs, including patients with third-party insurance coverage. It also states that a patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount payment program.

Full Charity Care and Discount Partial Charity Care Defined

Full Charity Care is defined as a full charitable deduction (100% discount) for all eligible amounts owed to Sierra View Medical Center. The applicants must have a qualifying income of 200% or less of the Federal Poverty Level. Any necessary[1] inpatient or outpatient hospital service provided to a patient who is 1) unable to pay for care 2) and who has established qualification in accordance with requirements contained in the SVMC Financial Assistance Policy.

Partial Charity Care is defined as a partial charitable deduction for all eligible amounts owed to Sierra View Medical Center. The applicants must have 1) qualifying income between 201% to 350% (or not to exceed 350%) of the Federal Poverty Level, 2) applicant with a high medical cost to include any necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and 3) desires assistance with paying their hospital bill; and who has established qualification in accordance with requirements contained in the SVMC Financial Assistance Policy.

Depending upon individual patient eligibility, 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 SVMC Financial Assistance Policy requirements or comply with the requirements established to determine eligibility.

Prompt Pay Discount

SVMC will extend a 30% prompt pay discount to those self-pay patients who wish to pay their entire outstanding balance immediately and do not wish to complete SVMC Financial Assistance/Charity Care and Discount Policy.

1. Uninsured or Insured patients with non-covered services which are deemed medically necessary and wish to pay their outstanding balance immediately (same day) will be eligible for a 30% discount upon request.
2. Financial obligations not eligible for consideration for prompt pay discount are co-pays, deductibles, co-insurance, indemnity balances and Share of Cost.
3. Patients requesting a payment plan will not be eligible for prompt pay discounts.

Full Charity Care and Discount Partial Charity Care Reporting

SVMC 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

[1] Necessary services are defined as any hospital inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded based on actual charges for services rendered.
SVMC will provide OSHPD with a copy of this Financial Assistance Policy, which includes the full charity care and discount partial 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(s) is/are made.

Full and Discount Partial Eligibility: General Process and Responsibilities

Eligibility is defined for any patient whose family[2] income is 350% or less of the current federal poverty level. Request for Financial Assistance Program can't be for services related to an injury compensable for the purpose of workers' compensation, automobile insurance or other insurance as determined and documented by the hospital and/or unable to pay for their care, based upon determination of financial need in accordance with this policy.

The Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to qualify the patient or family representative for maximum coverage under the SVMC Financial Assistance Program.

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

The SVMC 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, SVMC will use a financial assistance application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. Uninsured and underinsured patients will also be offered information, application, assistance and referral to the California Health Benefit Exchange as well as government sponsored programs (Medi-cal and the Healthy Families program) for which they may be eligible. Patients with a qualifying income of 350% or less of the current poverty level who experience high medical costs,

[2] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

including patients with a third-party insurance coverage may also be eligible for financial assistance. In addition, SVMC will provide contact information to a local consumer assistance center, Central California Legal Services, located within Tulare County and for patients residing outside Tulare County; we will provide the Health Consumer Alliance contact information. Patients presenting with these types of situations will be required to follow the same application process and approval will be reviewed on a case-by-case basis. A patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for charity care or discount payment program. Any patient who requests financial assistance will be asked to complete a financial assistance application. 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.

Qualification: Full Charity Care and Discount Partial Charity Care

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.

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. In addition, if the patient had insurance coverage but failed to provide it at the time of service and ignored all attempts to obtain insurance information, by way of patient statements, collection letters or phone contact, may be cause for the patient to be ineligible for assistance. The documentation to the facility should be provided to the hospital within the timely billing requirements for the State of California (Medi-cal), the Federal government (Medicare) which is one year from date of service, or timely guidelines established for third party payers which are defined by the contractual obligation between SVMC and the individual third party payer.

Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion,

consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Financial Counselors.

SVMC 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:

Administrative Director of Revenue Cycle: Accounts less than $25,000
Chief Financial Officer: Accounts greater than $25,000

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

- No insurance or a valid denial under any government coverage program or other third party insurer;
- Limited insurance benefits paid by third party payer
- Family income based upon tax returns or recent pay stubs (2 month)
- Family size, per tax returns
- Monetary assets as provided for under law

Qualification criteria are used in making each individual case determination for coverage under the SVMC Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this policy.

Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

When Financial Assistance is granted the patient and dependents will remain eligible for 6 months from the month of service. Accounts within the 6 month span can automatically be applied to charity, but on the 7th month and forward the guarantor/patient will need to complete another Financial Assistance application. Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance.

Patients at or below 350% of the FPL who do not qualify for 100% discount will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided by SVMC.

Full and Discount Partial Charity Care Income Qualification Levels

1. If the patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and patient has no medical coverage 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:

    a. 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 as follows:

        - 201% - 250%: Patient will be responsible for 25% of the Medicare allowable amount would have paid for the service if the patient were a Medicare beneficiary.

        - 251% -300%: Patient will be responsible for 50% of the Medicare allowable amount would have paid for the service if the patient were a Medicare beneficiary.

        - 301% - 350%: Patient will be responsible for 75% of the Medicare allowable amount the Medicare Program would have paid for the service if the patient were a Medicare beneficiary.

Payment Plans

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

The hospital and patient will work together to negotiate the terms of a payment plan. In the event the hospital and the patient cannot agree on a payment plan, SVMC will abide by the payment plan formula, defined in AB1276. SVMC will take into consideration the patient's family income and essential living expenses when determining a payment plan. The patient is responsible for providing SVMC copies of their essential living expenses. If an agreement cannot be reached with the patient, SVMC must institute a reasonable payment plan, with monthly payments not to exceed 10% of a patient's family income for a month after deductions of essential living expenses. "Essential living expenses" are defined as 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 expenses, and other extraordinary expenses. If the reasonable payment formula results in a payment of less than $10 a month, the subsequent extended payment plan shall be $10 per month.

Patients who wish to renegotiate the terms of a defaulted extended payment plan are able to enter into another extended payment plan with payments in the amount of either the reasonable payment formula or $10 per month and if the patient fails to make all consecutive payments due during a 90-day period, that extended payment plan is considered inoperative.

No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Special Circumstances

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.

If the patient is determined to be homeless, he/she will be deemed eligible for the Financial Assistance Program. No application will be required.

Other Eligible Circumstances

SVMC deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid, , California Children's Services and any other applicable 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 other programs serving the needs of low-income patients (e.g. CHDP, and CCS) 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 hospital's 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 low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care.
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:

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

2. 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.

Any patient whose income exceeds 350% of the FPL 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 discount partial 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 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 $75,000 may be considered for eligibility as a catastrophic medical event.

SVMC hospital utilizes the services of contracted emergency room physicians. These physicians are not employed by the district but provide services to SVMC patient population. In keeping with AB 1503and SB1276, any emergency room physician group that bills for services to our patient population will make available charity care and discounted payments to limit expected payment from eligible patients that are uninsured or have high medical costs who are at or below 350% of the federal poverty level. These contracted emergency room physicians will make available a policy upon request and extend this policy and all provisions found within to our mutual patient population.

SVMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at the hospital. In the event that a patient or guarantor does not respond or communicate with SVMC to resolve an open account, SVMC may forward the account to its collection agency.

Collection Guidelines

SVMC will make reasonable attempts to obtain insurance information if no insurance was provided at the time of service by sending statements, which includes language telling the patient that he or she may be eligible for coverage offered through the California Health Benefit Exchange and other state-or county-funded health coverage, as well as Medicare, Medi-cal, Health Families and California Children's Services.
Calls to obtain insurance information or set up a payment plan with patients will be made. If a patient indicates they are unable to pay, the patient will be referred to a Financial Counselor to assist them with applying for health coverage, to include the California Health Benefit Exchange and other state-or county-funded health coverage, as well as Medicare, Medi-cal, Health Families and California Children's Services along with the SVMC Financial Assistance program

SVMC will assign any financial obligation to a debt collection agency after 150 days from the date of discharge/service where the patient has failed to comply with an established payment plan or non-payment on an account where the patient guarantor is not in process with an eligibility application for a government sponsored insurance program.

Patients with pending appeal for coverage of services will not be forwarded to a third party billing agency or collection agency until a final determination of that appeal is made. If the appeal is unfavorable and the patient is responsible for the outstanding obligation, the patient will be afforded the opportunity to qualify for charity care or discount payment arrangements as prescribed above. Patient guarantors must keep SVMC Financial Counselor's updated on the coverage appeal.

Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

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.

Collection Agencies will return all accounts that meet the following guidelines; 1) Deemed patient is unable to pay, 2) Patient provides 3rd party coverage, 3) Patient requests Financial Assistance, 4) Not able to reach a reasonable payment plan.

Collection agencies have the responsibility to be familiar with SVMC policy for Financial Assistance and Charity Care and as such will be responsible for ensuring patients who meet guidelines are returned to SVMC.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the hospital within thirty days of notification of denial. 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 Administrative Director of Revenue Cycle. 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 within thirty days of appeal notification.

In the event that the patient believes a dispute remains after consideration of the appeal by the Administrative Director of Revenue Cycle, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Administrative Director of Revenue Cycle. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient within thirty days of appeal notification. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Public Notice

SVMC shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted 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 outpatient 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 primary 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 on a reasonable basis.

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

SVMC arranges 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, SVMC 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 to qualify for the Sierra View Medical Center financial assistance.

REFERENCE:

- AB774, AB1503, SB1276

Responsibility for Review and Maintenance of Policy: **Administrative Director of Revenue Cycle**	Original Creation Date: **06/01/2007**
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