☒	EH	☒	EHH- Emanate Health Hospice	☒	Policy
☒	EHMC-Inter-Community Hospital	☒	EHHC-Emanate Health Home Care	☒	Procedure
☒	EHMC-Queen of the Valley Hospital	☒	FPH- Foothill Presbyterian Hospital	☒	Attachments

Title: **Charity Care Financial Assistance Policy**		Policy #: **A009**
Type: **Corporate**		
Effective: 4/24/02	Reviewed: 7/27/11	Revised: 5/25/05, 7/27/05, 9/24/08, 5/1/2014, 4/25/18
Approved:		Date:
Approved:		Date:

I. Purpose:

It is Emanate Health's (EH) mission to help people keep well in body, mind and spirit by providing quality health care services in a safe, compassionate environment. EH fulfills its mission by providing financial assistance programs to persons who have health care needs and are uninsured or underinsured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. EH strives to meet the health care needs of all patients who seek inpatient, outpatient, and emergency services.

It is EH's mission and operational goals to ensure that all of the accounting and patient related transactions are practiced consistently throughout our patient accounting operations. Our Admitting and Patient Financial Services Department staff is responsible for assisting the patient with their financial application and handling of all patient accounting transactions. A designated representative from Patient Financial Services Department will review the individual case to determine the patient's eligibility for financial assistance and determine the discount for which the patient qualifies.

Our policy includes charity and discounts to patients who financially qualify under the terms and conditions of Emanate Health Financial Assistance Program.

EH is committed to providing financial assistance programs when patients are uninsured or underinsured or ineligible and need assistance with their hospital bill. The purpose of this policy is to define charity and discount charity care of which eligibility and financial assistance and qualification for a discount is determined by the patient's and/or family's ability to pay.

EH makes every effort to inform our patients of their Hospital's Financial Assistance Program. We do so by the following:

- Every registered patient receives a written notice of the Hospital's Financial Assistance Program language per IRC 501(r).
- Upon request, copies of the Financial Assistance Policy, Financial Assistance Application and plain summary language are made available. These documents are also available on the Hospitals website
- Uninsured patients are screened during the registration process for eligibility with government – sponsored programs and/or the Hospital Financial Assistance Program
- Public notices are posted throughout EH hospitals notifying the public of Financial Assistance Program available for those who qualify.
- EH patient billing statements provide information to assist in obtaining government-sponsored coverage and/or financial assistance.
- Community Assistance Outreach program provides assistance to patients seeking for Financial Assistance Program.

II. Financial Assistance/Eligibility for Charity Care

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit programs, and those individuals who are unable to pay for their care as determined by the patient family income relative to the current Federal Poverty Level. The charity award shall be based on an individualized determination of financial need. It shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

1. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial or other information and documentation relevant to making a determination financial need;
2. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay such as credit reporting;
3. Include reasonable effort by EH to obtain from the patient or patient's representative information whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to the patient, including but not limited to:

a. Private health insurance, including coverage offered through the California Health Benefit Exchange;

b. Medicare;

c. Medi-Cal program, the California Children's Services Program, or other state- or county-funded health coverage programs.

4. Take into account the patient's available assets and all other financial resources available to the patient.

The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. The need for payment assistance may be evaluated at each subsequent rendering of services, or at any time, additional information relevant to the eligibility of the patient for payment assistance becomes known. The Financial Assistance request must be made within one year of the service date.

Requests for payment assistance shall be processed promptly, and EH shall notify the patient or applicant about the financial assessment decision.

III. Eligibility Criteria and Amounts Charged to Patients

AGB is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charges for those claims. Emanate Health uses the "Look Back" method to determine the AGB for outpatient services. The applicable Med-Cal APR-DRG reimbursement applies to obstetrics, newborns, neonatal intensive care and pediatrics. Medicare DRG applies to all other inpatient services.

AGB % = Sum of Claims Allowed Amount $ / Sum of Gross Charges $ for those claims.

Allowed Amount = Total charges less Contractual Adjustments

If no contractual adjustment is posted then total charges equals the allowed amount.

Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

The AGB is calculated for each hospital on an annual basis.

- Look Back Method is used. A twelve (12) month period is used.
- Includes Medicare fee for service all private health insurers that pay claims to the hospital facility

- Excluded payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, Medicare facility billing, motor vehicle and liability and worker's compensation claims.

Annual adjustments are made effective February 1 of each calendar year; however, the effective date is also subject to changes.

Services eligible under this policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels in effect at the time of determination.

For the purpose of this policy, Federal Poverty Levels (FPL) is the poverty guideline that is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of section 9902 of Title 42 of the United States Code.

- Patients with monetary assets or income level is at 350**%** or less of the FPL, the entire hospital bill will be written-off regardless of net worth or size of bill;
- Patients with monetary assets or income level between 350% and 500% of the FPL, a portion of the hospital bill will be subject to write off based upon the sliding scale set forth below regardless of net worth or size of bill:
    - 351% - 400% = 75% write-off
    - 401% - 450% = 50% write-off
    - 451% -500% =25 % write-off
- Patients with hospital bill that exceeds the patient's monetary assets or net worth may qualify and be covered under this policy using the guidelines below:
    - Patients will be informed in writing of the financial assistance determination from the Patient Financial Services Department.
    - Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to the Hospital may request a payment plan from the Patient Financial Services Department.
    - In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in EH Billing and Collection policy. A copy of this policy can be obtained by contacting the Patient Financial Services Department.

NOTE: For purposes of determining monetary assets or income, the review shall not include the:

a. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans;

b. First ten thousand dollars ($10,000) of a patient's monetary assets;

c. Fifty percent (50%) of a patient's monetary assets over the first $10,000.

- The following conditions must be also satisfied:
    - If the patient is insured, the patient's liability is NOT a Medicaid share of cost.
    - A pending application for another health coverage program shall not preclude eligibility for financial assistance under this policy, however, final approval of financial assistance may be deferred until the pending application is processed and eligibility is determined.
    - Patient completes and submits a Financial Assistance Application;
    - Patient submits all required and requested documents and responds to any questions that arise from the Financial Assistance Program within 30 days.

IV. Screening Procedure and Documentation Requirement

Emanate Health, through the assistance and direction of the Patient Registration and Patient Financial Services (PFS) departments shall assist patients who may qualify for charity care.

1. During registration or admission process, the Patient Registration Financial Counselors (FC) shall:
    a. Screen all patients who may qualify for charity care;
    b. Receive requests from patient and/or patient's representatives for charity care;
    c. Discuss the EH charity care policy with the patient and/or patient's representatives;
    d. Provide the patient the charity application forms – EH Hospital Financial Screening Assessment and Income Certification forms.

        i. The Hospital Financial Screening Assessment form requests for patient information, income, monetary assets, debts, disability or injury status, and provides authorization from the patient for EH to obtain patient's credit report.
        ii. The Income Certification form requests family income, number of dependents, and copies of:
            - Completed & signed financial assistance application
            - Current pay stubs or if self- employed, current year to date profit & loss statement to determine current income.

- Recent tax returns and W-2 form
- Evidence of any General Relief program benefit, Alimony, Unemployment, Disability, SSI, award letters for social security.
- Last calendar year's filed tax return with all required schedules to determine generating assets including monetary assets;
- Prior year's 1099 for interest income, dividends, capital gains, etc.

e. Guide the patient in completing the forms and provide instruction for submission to PFS department.

2. Upon receipt of the application forms and supporting documents, PFS shall:

   a. Review the contents of the forms and supporting documents for completion;
   b. Review the applications forms and documents, and request additional information from patient;
   c. Obtain information and supporting documentation regarding patient's application for private and/or public health insurance or sponsorship which may include, but not limited to:
      i. Private health insurance, including coverage offered through the California Health Benefit Exchange;
      ii. Medicare
      iii. Medi-Cal, California Children's Services Program, or other state- or County health programs.
   d. Determine and approve charity care award following the criteria stated on section III, Eligibility Criteria and Amounts Charged to Patient;
   e. Notify the patient of the charity care award decision;

   NOTE: Patients requesting charity care are expected to complete the application forms and provide supporting documents to EH. Submission of incomplete and inaccurate information may result in denial of charity care and discounting request. 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.

The hospital's designee authorized to approve financial assistance application is based on the Financial assistance requested; larger discounts require a higher level of approval as indicated:

- Discounts from $ 1,000.00 to $ 3,999.99: Patient Account Manager
- Discounts from $ 4,000- $9,999.99: Director of Patient Financial Services Department
- Discounts $ 10,000- $49,999.99: VP of Revenue Cycle
- Discounts greater than $ 50,000.00: Executive VP & CFO

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V. Physician Independent Contractors Charity Care and Discounting Policy

Emanate Health is committed to providing care without discrimination, for emergency medical conditions in accordance with the Emergency Medical and Labor Act (EMTALA). EH facilities are prohibited from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

All emergency physicians, surgeons and allied health professions furnishing services to the patient, including, but not limited to, the radiologist, pathologist, anesthesiologist and the like, are independent contractors and are not employees or agents of the hospital. Those who provide emergency medical care to patients at acute general hospitals are required by law to provide discounts to uninsured patients or patients with high medical costs whose income is at or below 350% FPL. The law also requires the acute general hospital to notify patients of the emergency physicians' charity care and discounting program. Those providers not covered by the EH policy and there are no providers (other than EH) that are covered by this EH policy.

The FC and/or the PFS staff shall advise the patient and/or patient's representatives to contact the emergency physician billing company and request for the emergency physicians' charity care and discounting program.

VI. Communication of the EH Charity Care policy to Patients and the Public

Information about the EH's charity care policy shall be publicized to the Emergency Room and the Patient Registration departments at all EH campuses, and other areas that EH may elect.

VII. Collection Policy and Procedure

Emanate Health developed policy and procedures for internal and external collection practices that take account the extent to which the patient qualifies for charity care, a patient's good faith effort to apply for a governmental program or charity care from EH, and the patient's good faith effort to comply with his or her payment agreements with EH.

For patients who qualify for charity care and who are cooperating in good faith to resolve their discounted hospital bills, EH may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. EH will not impose extra-ordinary collection actions such as wage garnishments, liens on primary residences, or other legal actions for any patient

without first making reasonable efforts to determine whether that patient is eligible for charity care under this policy.

For patients who do not apply, do not qualify, or do not respond to required documentation requests, EH shall continue reasonable efforts to collect the balance owed. This includes but is not limited to statements, phone calls, referrals to outside collection agencies before extra-ordinary collection activity will commence no sooner than 120 days from the service date. The Patient Financial Services Department is responsible for ensuring that reasonable efforts are made to determine an individual's eligibility for financial assistance prior to any extraordinary collection actions being taken against that individual.

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

1. Patient accounts must have no applicable insurance (including government coverage programs or other third party payers)
2. The patient or family representative has not made a payment within 120 days of assignment to the collection agency;
3. The collection agency has determined that the patient/family presentative is unable to pay.

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.

VIII. Collections Procedure for Uninsured and Underinsured

It shall be the policy of EH to provide our uninsured and underinsured patients the same allowances provided to its managed care contractors.

EH will follow up on and collect all self pay account balances, as well, where third party benefits exist, all patient copay and deductibles, either at the time of service, or when they become due.

A. Procedure for the collection of self-pay accounts and patient co-pay and deductibles:

1. EH patient accounting system is designed to assist the patient business services department, through a series of billing statements and collection notices in the collection of self pay balances as well as co-pay and deductibles from our patients, without regard of their primary source of payment, i.e. Medicare, managed care, commercial coverage, etc.

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2. For co-pay and deductibles for Medicare accounts, a business services representative will not assign to bad debt until a minimum of 120 days from when Medicare payment is received, four statement notices and one phone call is made. Balances after insurances an account will not be assigned to bad debt until a minimum of 90days from an insurance payment is received, four statement notices and one call is made.

3. Balances remaining unpaid at the end of the statement cycle are subject to further collection notices by the contracted collection agency service. The collection agency will continue, but no limited to send notices, make phone calls, and pursue legal action and report information to credit bureaus no earlier than 180 days from the service.

B. The following adjustments shall be applied to self-pay accounts prior to billing for both Inpatient and Outpatient:

1. All outpatient services, the discounted balance represents the average HMO/PPO collection rate on outpatient services, not to exceed our established AGB (2017- 32%)

2. For Inpatient services, the discounted balance represents the Medicare DRG amount and the Medi-Cal APR-DRG amount for pediatric and cosmetic inpatient services, not to exceed our established AGB (2018 – 32%)

3. For patients who are unable to meet their deductible and/or copay obligation or the full amount of the bill if no third party exists:

   EH shall offer the option of an installment contract for payment. Individual plans will be negotiated between the hospital and patient 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.

4. Patients who are unable to meet any or part of their financial obligation may apply for EH's Financial Assistance Program (FAP). The balance shall be adjusted in part or in full based on the financial need and criteria are met.

C. The following coverage options should always be explored in assessing patients' ability to pay:

1. Linkage to available state aid such as:
   a. Med-Cal
   b. California Children Services
   c. Covered California
   d. Other

2. Patients under age of twenty one years, who are self pay, shall be referred to the onsite Medi-Cal eligibility worker or to either of our contracted vendors for completion of a Medi-Cal application and/or the onsite GEM (Get Eligibility Moving) program.
3. All obstetrical patients who are self pay and unable to meet their financial obligation shall be referred to the onsite Medi-Cal eligibility worker or either to
4. Our contracted vendors for completion of a Medi-Cal application and/or the on-site GEM (Get Eligibility Moving) program.

A copy of this Financial Assistance Policy and a plain language summary is available on EH's website. A hardcopy of the policy will be made available to the public upon request at any of EH hospital campuses or by mail.

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

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 and or family representative. In addition, EH reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or families representatives who have provided fraudulent or purposely inaccurate information in order to qualify for EH Financial Assistance Program.

References

California Assembly Bill 774
California Assembly Bill 1503
California Senate Bill 1276