COTTAGE HEALTH SYSTEM
Patient Business Services

SUBJECT: Patient Financial Assistance Policy (Charity Care/Emergent)

DEPT: PBS POLICY #: 8550.01 RECOMMENDED BY: Vicky Krene DATE: 05/11

ORIGINAL POLICY EFFECTIVE DATE: 11/1/89 APPROVED BY: Karen Jones DATE: 12/14

DATE REVISED: 4/04, 01/07, 8/11, 12/11, 5/12, 7013,12/14

DATE REVIEWED: 12/90, 3/97, 3/99, 8/00, 3/01, 3/03, 2/05, 2/06

Purpose:

This policy will establish an application process and eligibility requirements for patient financial assistance (charity care) at Cottage Health System facilities listed below in a manner that is consistent with our values of excellence, integrity and compassion and compliant with all State and Federal Regulations.

Facilities Included:

Santa Barbara Cottage Hospital
Santa Ynez Valley Cottage Hospital
Goleta Valley Cottage Hospital

Policy:

Services Not Covered
Cosmetic Surgery
COPE program, Elective i.e., patients that require an elective or non-emergent medical procedure but do not have third-party insurance, Medicare, Medi-Cal or other government-sponsored insurance (collectively know as “health insurance coverage”) that covers the services provided, may qualify for financial assistance under the Non-Emergent Charity Care Policy 8560.74.(Cottage Residential and Cottage Rehabilitation Hospital will apply through for Non Emergent Charity Care 8560.74)

Notification Period

Period in which you must notify patient of the financial assistance program (FAP) starts with the date care is provided and ends 120 days after the date of the first statement. During the notification period, hospitals cannot engage in extraordinary collection activities (ECA) until the end of the notification period (unless FAP eligibility has been determined). After 120 days, the hospital can begin ECA. Hospital has met notification if patient submits an application. If a patient contacts the hospital within 120 days from the date of the first statement, the hospital must accept FAP and stop ECA.

Eligibility Requirements

Self-Pay

A self-pay patient is someone who does not have health insurance coverage for the services provided. This may include patients who are eligible for Medi-Cal but whose eligibility dates may not cover the entirety of the hospital stay. Dates of service outside the eligibility period may be considered self-pay. Eligibility for financial assistance (both free care and discounted care) for self-pay patients is based on the household income and monetary assets of the patient or the patient's guarantor. Patients will be eligible for 100% charity care coverage if their household income is less than or equal to 350% of the Federal Poverty Level (FPL) and they meet the monetary asset guidelines. Discount percentages and income levels can be found on the Patient Financial Assistance Calculation form and are based on FPL guidelines.

A patient's monetary assets will also be considered when determining eligibility. Using assets to determine eligibility is limited to monetary assets such as bank accounts and publicly traded stock. Retirement plans, deferred compensation plans qualified under the Internal Revenue Code, and nonqualified deferred-compensation may not be considered. The first $10,000.00 of a patient's assets may not be considered, and 50% of a patient's monetary assets above $10,000.00 may not be considered. A patient's remaining monetary assets may not exceed the amount owed in order to be eligible.

Hardship

Patients who have some form of third party insurance that has provided payment but are unable to pay their portion of the discounted or non-discounted bill may be eligible for financial assistance. Eligibility is based on the self-pay criteria above.

Catastrophic Eligibility

A patient who has a catastrophic medical experience is defined as a patient with a balance of over $25,000, that may or may not have a third-party insurer and if their income exceeds financial eligibility guidelines. Patients with catastrophic accounts can receive a discount of 70%. A patient is eligible for catastrophic financial assistance if their income is less than 4 times the amount owed and they meet the monetary guidelines above.

Presumptive Charity Eligibility

Patients that are homeless, undocumented, not locatable, with questionable financial resources, or that it is unreasonable to expect documentation from but are believed to qualify for financial assistance may be approved by the Director of Patient Business Services and/or Vice President of Finance dependent on account balance.

Special Circumstances

The Director of Patient Business Services and Vice President of Finance may negotiate financial assistance with patients under special circumstances in order to ensure that all members of our community have access to medical care.

Non-Discriminatory Application of this Policy

Any decisions made under this Policy, including the decision to grant or deny financial assistance under this Policy, shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Program guidelines/definitions will be reviewed periodically by the Finance Committee of the Board of Directors.

Patient Notification of Financial Assistance

Patients that do not present with evidence of a third-party insurer will receive a notification of available financial assistance, can obtain and be assisted with applications for the California Health Benefit Exchange prior to discharge. All patient registration and payment areas will post information on financial assistance. All billing notices sent to the patients will contain information on financial assistance programs. All notifications will comply with Assembly Bill 774, Hospital Fair Pricing Act (AB774).

Payment

Any patient that qualifies for financial assistance and has made a payment on the account will receive a refund. Accounts under $1000 that are refunded within 90 days of the approval will have a flat fee of $5.00 added to the refund. Account refunds that are over $1000 will include an interest payment of 5% per annum due from the date the application was approved to the date the refund was processed by Patient Business Services.

Patients who are eligible for a discounted payment will be referred to Financial Credit Network (Credit Contractor) to establish an acceptable payment plan, compliant with Assembly Bill 774, for the any remaining balance that cannot be made at receipt of the bill.

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Emergency Physician Services

An emergency physician, as defined in Section 127450 of the California Health Code, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level and in accordance with AB774 guidelines and subsequent amendments.

Approvals & Appeal

Approvals for financial assistance will be based upon account balance, as shown below.

Amount	Approver
Under $75,000	Supervisor
$75,001-100,000	Director

Over $100,000	Vice President Finance

Application & Documentation

Eligibility for financial assistance is based upon completion of the required application and presentation of required documentation. Patients may be denied if they do not produce the required documentation. All applications will be scanned into the patient's business folder. Patient Financial Counselors will be available to assist patients with filling out the application for financial assistance.

Definitions

Family members: Assembly Bill 774 defines a patient's family for person's 18 years and older as a spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18, Assembly Bill 774 defines a patient's family as parent(s), caretaker relatives, and other children less than 21 years of age of the parent or caretaker. If a student applying for assistance is claimed as a dependent on the family tax return, then the entire family income must be considered. Family size should directly correspond with the number of dependents listed on the current year tax return. If not available, or the number of dependents does not correspond with the current year tax return, the patient/responsible party must provide one or more of the following documents:

- Birth Certificate
- Baptismal Record
- U.S. Immigration Form
- Guardianship Papers

Household income: Household gross income will include the patient/responsible party's gross income and other adult members listed in the household. Acceptable income source documents are listed below.

- Patient/responsible party is required to provide prior 6 months paycheck stubs as written proof of family income. Copies of these documents will be made and the originals will be returned to the patient/responsible party. The family's total income will be computed by taking the last 6 months income and multiplying by two.

OR

- Patient/responsible party may provide the most current income tax return.

Account statements may also be requested to determine total monetary assets such as bank accounts and publicly traded stock.

Other Required Documents

- Driver's License or Photo identification issued by a government entity
- Medi-Cal Denial Letter

Process

1. If a patient does not present with a third-party insurance, the patient will be given a Notice of Financial Assistance and Preliminary Application. This application should be forwarded to eligibility services.

2. A daily report will be created for all inpatients and emergency department patients who accumulate charges over $500 who do not provide proof of third-party insurance.

3. Daily report is reviewed by eligibility services to assist patient in determining eligibility for government-sponsored insurance programs and to assist with the application process. Patients will also be assisted in applying for the CHS Patient Financial Assistance Program and other applicable assistance.

4. A Medi-Cal eligibility worker is on site at SBCH to help facilitate with Medi-Cal and California Health Benefit Exchange applications while the patient is in the hospital.

5. If the patient requests charity care after they have left the hospital:

    a. Patient will be pre-screened for Medi-Cal/CenCal or eligibility by utilizing the Medi-Cal or evaluation forms.
    b. Patient Financial Counselor will mail application and information to patient.

6. Completed applications for CHS Patient Financial Assistance Program will be sent to Customer Service, Patient Business Services.

7. Patient Financial Counselor will complete the current year's Patient Financial Assistance Calculation form to determine discount that patient is eligible for and route application to Supervisor for approval. Patient Financial Counselor will determine if patient is eligible based on the following flow chart.

8. Supervisor will make eligibility determination within one of the financial assistance and route for approval (see Approval and Appeals under Policy section), based on amount of account.

    a. **Approved 100%:** Patient's/responsible party's income and family size qualify them for 100% assistance. Forward application and supporting documentation to appropriate Director for review and approval. Director will review, approve, or deny application. If approved, document in Account Comments, apply charity adjustments and send patient letter of approval. Make certain any self-pay discounts have been reversed. Application will be scanned into patient's folder.

    b. **Discount/Approved for less than 100%:** Patient's/responsible party's income and family size qualify them for a discount based upon sliding scale guidelines. Take remaining balance and apply the self-pay discount of 30% to determine final balance. After obtaining approval, the account will be adjusted appropriately; Patient is eligible for a 180 day interest-free payment plan. If the patient will need longer than 180 days to finish the payments, the account will be referred to Financial Credit Network to establish an acceptable payment plan, compliant with Assembly Bill 774, for the remaining

balance. Return folder to the appropriate filing area (Per #8550.11). . Application will be scanned into patient's folder.

c. **Denied:** Patient/responsible party has completed application process and does not qualify for any assistance. Patient will receive a reduction in charges that is consistent with Self-Pay Discount Policy. Patient will be offered 6 month payment plan and be referred to Financial Credit Network to establish an acceptable payment plan with patient/responsible party. Application will be scanned into patient's folder.

If application is denied, patient can send an appeal to:

Patient Business Services Director
Financial Assistance Appeal
PO Box 689
Santa Barbara, CA 93102