PROVIDENCE Health & Services	**Original Effective Date:** January 2013 **Last Revision Date:** October 2015 **Revision Effective Date:** February 5, 2016	**Page** **1 of 14**	**Policy Number CA-FIN-501**
Subject: California Charity Care and Discount Payment Policy	**Authorization: VP Revenue Cycle**		

Purpose:
The purpose of this policy is to set forth Providence Health & Services (PH&S)'s Financial Assistance and Emergency Medical Care policies, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care. These programs apply solely with respect to emergency and other medically necessary healthcare services provided by PH&S. This policy and the financial assistance programs described herein constitute the official Financial Assistance Policy ("FAP") and Emergency Medical Care Policy for each hospital that is owned, leased or operated by PH&S within the state of California.

PH&S Hospitals in California:
Providence Saint Joseph Medical Center, Providence Holy Cross Medical Center, Providence Little Company of Mary Medical Center San Pedro, Saint John's Health Center, Providence Tarzana Medical Center and Providence Little Company of Mary Medical Center Torrance.

Policy:
PH&S is a Catholic healthcare organization guided by a commitment to its Mission and Core Values, designed to reveal God's love for all, especially the poor and vulnerable, through compassionate service. It is both the philosophy and practice of each PH&S ministry that medically necessary healthcare services are available to community members and those in emergent medical need, without delay, regardless of their ability to pay. For purposes of this policy, "financial assistance" includes charity care and other financial assistance programs offered by PH&S.

1. PH&S will comply with federal and state laws and regulations relating to emergency medical services and charity care.

2. PH&S will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary PH&S healthcare services.

3. In alignment with its Core Values, PH&S will provide charity care to qualifying patients in a respectful, compassionate, fair, consistent, effective and efficient manner.

4. PH&S will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making charity care determinations.

5. In extenuating circumstances, PH&S may at its discretion approve financial assistance outside of the scope of this policy. Uncollectible/presumptive charity is approved due to but not limited to the following: social diagnosis, homelessness, bankruptcy, deceased with no estate, history of non-patient/guarantors inability to pay and why collection agency assignment would not result in resolution of the account.

6. This policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 *et. seq*., effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008, Assembly Bill 1503 effective January 1, 2011 and SB 1276 effective 01/01/2015. All collection agencies working on behalf of Providence Health and Services Southern California (PHSSC) facilities shall comply with Health and Safety Code Section 127400 *et. seq*. as amended and applicable PHSS policies regarding collection agencies. See related Regional Business Office Policy, GOV-107, Debt Collection Standards and Practices Policy.

Definitions:

7. "**Charity Care**" refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary or eligible elective health care services (full charity).

8. "**Discount Payment**" refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary or eligible elective health care services (partial charity).

9. **Gross charges** are the total charges at the facility's full established rates for the provision of patient care services before deductions from revenue are applied. Gross charges are never billed to patients who qualify for partial charity or Private Pay Discounts.

10. **Private Pay Discount** is a discount provided to patients who do not qualify for financial assistance and who do not have a third party payor or whose insurance does not cover the service provided or who have exhausted their benefits. See Private Pay Discount Policy, CA-FIN-5003.

11. **Emergency Physician** means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at PHSSC hospitals are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level.

12. **Providers Subject to PH&S's FAP:** In addition to each applicable PH&S hospital facility, all physicians and other providers rendering care to PH&S patients during a hospital stay are subject to these policies unless specifically identified otherwise. Attachment A indicates where patients may obtain the list(s) pertaining to all Providers who render care in the PH&S hospital departments, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, and is also available in paper form by request through the Financial Counselor at the Hospital.

13. **Services Eligible Under the Policy**: The charity care and discount payment policy applies to all services provided to eligible patients receiving emergency or medically necessary care or eligible elective care, including self-pay patients and co-payment liabilities required by third party payors, including Medicare and Medi-Cal cost-sharing amounts, in which it is determined that the patient is financially unable to pay. Medically necessary health care includes:

    a. Emergency services in the emergency department.
    b. Services for a condition that, if not promptly treated, would lead to an adverse change in the patient's health status.
    c. Non-elective services provided in response to life-threatening circumstances outside of the emergency department (direct admissions).
    d. Medically necessary services provided to Medicaid beneficiaries that are non-covered services.
    e. Any other medically necessary services determined on a case-by-case basis by PH&S.

14. Eligible Elective Health Care includes:

    a. Patients and their physicians may seek charitable services for elective, deferrable care. Elective care becomes eligible for charitable and discount services only when all of the following requirements are met:
        i. A member of the medical staff of a PH&S facility must submit the charitable services request;
        ii. The patients is already a patient of the requesting physician and the care is needed for good continuity of care; aesthetic procedures are not eligible for charitable services;
        iii. The physician will provide services at the same discount rate as determined by the hospital per charity guidelines of this policy, up to and including free care;
        iv. The patient lives within our services area (as determined by PH&S); and
        v. The patient completes a Financial Assistance Application and receives approval in writing from PH&S prior to receiving the elective care.

15. **Eligibility for Charity** shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

    a. **Presumptive Charity** – Individual assessment determines that Financial Assistance Application is not required because:
        i. Patient is without a residence address (e.g. homeless);

ii. Services deemed eligible under this policy but not covered by a third party payor were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigency Program (e.g. receiving services outside of Restricted Medi-Cal coverage) or services were denied Medi-Cal treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medi-Cal defined share of cost as the maximum ability to pay; and/or
iii. Patient's inability to pay is identified via an outside collection agency income/asset search. Should the agency determine that a lawsuit will not be pursued, the account will be placed in an inactive status, where a monthly PH&S review will determine further action, including possible charity acceptance and cancellation from the agency and removal of credit reporting.
iv. Patient's inability to pay is identified by Regional Business Office staff through an income/asset search using a third party entity.

b. **Charity** – Individual assessment of inability to pay requires:
i. Completion of a Financial Assistance Application for the Mary Potter Program for Human Dignity for all facilities in the PHSSC Region;
ii. Validation that a patient's gross income is less than three times (300%) the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care; and/or
iii. Validation that a patient's gross income is between 100% and 350% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (high medical costs, etc.) makes them eligible for possible discount payment (partial charity care) or 100% charity care. Facility may consider income and monetary assets of the patient in assessing the patient's individual financial situation. Monetary assets, however, shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Further, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility. Information obtained about income and monetary assets, however, shall not be used for collections activities.
iv. Patients with gross income at or below 350% of FPG will never owe more than 100% of the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored program of health benefits in which the hospital where treatment was received participates, whichever is greater. This amount shall be verified at least annually. If the hospital where treatment was received provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish and appropriate discounted payment. A patient with a gross income exceeding 350% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is less. In addition, uninsured and insured patients with gross incomes at or below 350% of FPG who incur total medical expenses in excess of ten percent (10%) of gross annual income during the prior 12 months will receive 100% charity benefit. Eligible costs for charity write off shall include only the patient liability amounts after insurance is billed and insurance liability amounts collected.

Note: Gross charges never apply to patients who qualify for partial charity or private pay discounts. Once gross charges are adjusted to the appropriate Medicare or private pay rate, the patient liability will not change even if eventually referred to a collection agency.

16. Basis for Calculating Amounts Charged to Patients Eligible for Financial Assistance

a. Categories of available discounts and limitations on charges under this policy include

i. 100 Percent Discount/Free Care: Any patient or guarantor whose gross family income, adjusted for family size, is at or below 300% of the current federal poverty level ("FPL") is eligible for a 100 percent discount off of total hospital charges for emergency or medically necessary care, to the extent that the patient or guarantor is not eligible for other private or public health coverage sponsorship.

ii. <u>Discounts Off Charges at 75 Percent</u> : The PH&S sliding fee scale set forth in Attachment B will be used to determine the amount of financial assistance to be provided in the form of a discount of 75 percent for patients or guarantors with incomes between 301% and 350% of the current federal poverty level after all funding possibilities available to the patient or guarantor have been exhausted or denied and personal financial resources and assets have been reviewed for possible funding to pay for billed charges. Financial assistance may be offered to patients or guarantors with family

income in excess of 350% of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

iii. **Limitation on Charges for all Patients Eligible for Financial Assistance**: Limitation on Charges for all Patients Eligible for Financial Assistance: No patient or guarantor eligible for any of the above-noted discounts will be personally responsible for more than the "Amounts Generally Billed" (AGB) percentage of gross charges, as defined in Treasury Regulation Section 1.501(r)-1(b)(2), by the applicable PH&S hospital for the emergency or other medically necessary services received. PH&S determines AGB by multiplying the hospital's gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. Information sheets detailing the AGB percentages used by each PH&S Hospital, and how they are calculated, can be obtained by visiting the following website: www.providence.org or by calling: **1-866-747-2455** to request a paper copy. In addition, the maximum amount that may be collected in a 12 month period1 for emergency or medically necessary health care services to patients eligible for financial assistance is 20 percent of the patient's gross family income, and is subject to the patient's continued eligibility under this policy.

17. Charity Care is not:

a. **Bad Debt**: A bad debt results from a patients unwillingness to pay or from a failure to qualify for financial assistance that would otherwise prove an inability to pay;
b. **Contractual adjustment**: The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care payor for covered services that is written off; or
c. **Other Adjustments**:
   i. **Service Recovery Adjustments** are completed when the patient identifies a less than optimal patient care experience;
   ii. **Risk Management Adjustments**: where a potential risk liability situation is identified and Providence Risk Management has elected to absorb the cost of care and not have the patient billed;
   iii. **Payor Denials**: where the facility was unable to obtain payment due to untimely billing per contractual terms; or retroactive denial of service by a managed care payor where appeal is not successful.

18. **Reasonable Payment Plan**: a default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached.SB 1276 defines the plan as monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.

a. "**Essential Living Expenses**" means, for purposes of this subdivision, 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, and other extraordinary expenses. Emergency Department physicians and their assignees may rely upon the hospital's determination of income and expenses in establishing a reasonable payment plan.

Evaluation Process:
Patients or guarantors may apply for financial assistance under this Policy by any of the following means: (1) advising PH&S's patient financial services staff at or prior to the time of discharge that assistance is requested, and submitting an application form and any documentation if requested by PH&S; (2) downloading an application form from PH&S' website, at www.providence.org, and submitting the form together with any required documentation; (3) requesting an application form by telephone, by calling: **1-866-747-2455**, and submitting the form; or (4) any other methods specified in PH&S's Billing and Collections Policy. PH&S will display signage and information about its financial assistance policy at appropriate access areas. Including but not limited to the emergency department and admission areas.

A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for charity care, an application will be provided with instructions on how to apply. As part of this screening process PH&S will review whether the guarantor has exhausted or is not eligible for any third-party payment sources. Where the guarantor's identification as an indigent person is obvious to PH&S a prima-facie determination of eligibility may be made and in these cases PH&S may not require an application or supporting documentation.

[1] The 12 month period to which the maximum amount applies shall begin on the first date, after the effective date of this policy, an eligible patient receives health care services that are determined to be eligible (e.g. medically necessary services).

A guarantor who may be eligible to apply for charity care after the initial screening will have until fourteen (14) days after the application is made or two hundred forty (240) days after the date the first post-discharge bill was sent to the patient, whichever is later, to provide sufficient documentation to PH&S to support a charity determination. Based upon documentation provided with the charity application, PH&S will determine if additional information is required, or whether a charity determination can be made. The failure of a guarantor to reasonably complete appropriate application procedures within the time periods specified above shall be sufficient grounds for PH&S to initiate collection efforts.

An initial determination of sponsorship status and potential eligibility for charity care will be completed as closely as possible to the date of service.

PH&S will notify the guarantor of a final determination in writing within ten (10) business days of receiving the necessary documentation.

The guarantor may appeal the determination of ineligibility for charity care by providing relevant additional documentation to PH&S within thirty (30) days of receipt of the notice of denial. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the guarantor and the Department of Health in accordance with state law. The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant.

PROCEDURE/GENERAL INSTRUCTIONS

III. Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774, SB 350, SB 1276 and Treasury Regulation Section 1.501(r)-4(b)(5)(i).

a. Signage about the availability of financial assistance will be clearly and conspicuously posted in registration areas of hospitals, in the Regional Business Office, and in locations that are visible to the public, including, not limited to the emergency department, billing office, admissions office, and other outpatient settings.
b. A Notice of Collection Practices shall be provided to all patients during registration and included in the final billing statement. The notice shall be provided in English, and languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the California Insurance Code.
c. This policy will be posted in an easily accessible location on each facility's internet page and will otherwise be made available upon request.
d. Financial Assistance Applications will be available in the registration areas.
e. PHSSC employees including Admitting/Registration and Financial Counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third party coverage including private health insurance (Covered California Health Exchange), Medicare, Medi-Cal, and other state programs and assist patients in applying for coverage when appropriate.
f. Self-Pay bills shall include the following:
    i. Statement of Charges
    ii. A request that the patient inform the hospital if the patient has insurance coverage and that if the patient does not have coverage that they may be eligible for Medicare, Healthy Families, Medi-Cal, insurance through the California Health Exchange, other state or county programs and charity.
    iii. A statement indicating how the patient may obtain an application or apply for the aforementioned programs along with a referral to the local consumer assistance office at a local legal services office. **Note**: If the patient or patient's representative indicates the patient has no third party coverage and requests a discounted rate or charity, the patient shall be provided with an application for the Medi-Cal program, Healthy Families program or other applicable state or county program.
    iv. Information on the hospitals financial assistance and charity program applications including a statement that if the patient lacks or has inadequate insurance and meets certain low income requirements they may qualify for discounted payment or charity care. A telephone number for additional information on the hospitals discount payment and charity program should accompany this statement.
    v. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.

IV. Patient eligibility with no application. Instances where a Financial Assistance Application is not required per charity definitions:
    a. Treatment Authorization Request (TAR) denials, Medi-Cal non-covered services, and untimely Medi-Cal billing write- offs will be recorded with their respective adjustment transaction codes. Medi-Medi accounts are written off to a unique transaction code to facilitate Medicare Bad Debt reimbursement.
        i. Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.

ii. For Medi-Medi adjustments, that portion not claimed as Medicare bad debt reimbursement will be reclassified as charity in the general ledger.

b. Services denied due to restricted Medi-Cal coverage will be written off to charity when the denial is received on a Medi- Cal remittance advice.

c. A patient may be verified as homeless at any time during the revenue cycle. The preferred method is at registration, where a lack of address documentation is indicated and coding to "Homeless" status is completed. This will generate the charity write-off at the time of billing.

d. PHSSC facilities will not engage in extraordinary collection efforts, including referral to outside collection agencies, adverse reporting to consumer credit reporting agencies, or actions requiring legal or judicial process, before making a reasonable effort to determine whether the patient qualifies for financial assistance. PHSSC, any assignee of PHSSC, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against an uninsured patient or a patient that has provided information that he or she may be a patient with high medical costs at any time prior to 240 days after initial billing.

e. Outside collection agencies shall be provided a copy of Providence's Charity Policy and when performing income and asset searches or an inability to pay may submit the account for charity approval if the account meets criteria stated herein. Collection agencies shall note that equity in a principal residence can be considered in asset determination only when income is in excess of 350% of Federal Proverty Guidelines, and a lien against that equity can be approved, but in no instance will foreclosure proceedings be initiated. PHSSC and its collection agencies will wait until the principal residence is sold or refinanced to collect its debt. California law places restrictions on monetary assests that can be considered in making an ability to pay determination. Consistent with California laws, monetary assets shall not include: (1) assets held under a qualified retirement plan; (2) the first ten thousand dollars ($10,000) of a patient's monetary assets; or (3) fifty percent (50%) of a patient's monetary assets in excess of %10,000.

V. Patient Eligibility as established by financial need per Financial Assistance Application.

a. All PHSSC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and refer patients for financial assistance. Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family. In these instances, a Financial Assistance Application can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.

b. The Financial Assistance Application must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:
   i. If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay;
   ii. If the patient/responsible party is provided services, such as room and board, etc., in lieu of pay for work performed, the person granting the services must provide a letter delineating the services provided and the value of those services; or
   iii. If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.

However, for purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

Information obtained under this section shall not be used for collections activities. This prohibition, however, shall not prohibit the use of information obtained by PHSSC, collection agency, or assignee independently of the Patient Eligibility process.

c. Patients may request a Financial Assistance Application by calling the Regional Business Office (RBO) at **1-866-747-2455**, writing to the mailing address on their patient billing statement, or downloading the form from the PHSSC websites: www.providence.org.

d. Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.

VI. Financial Assistance Application Review/Approval Process:

a. For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any RBO employee. Standard transaction approval levels will apply.

b. A Financial Assistance Application must be reviewed by a RBO financial counselor. If gross income is at or below 300% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income required). If the gross income is more than 300% but at or below 350% of FPG, an assessment for qualification of partial or full charity based on income, assets, and medical debt load will be made by the financial counselor with write-offs subject to standard approval levels.
c. Financial Assistance Applications shall be reviewed and approved, denied or returned to the patient with a request for additional information within ten (10) business days of receipt.
d. Collection agency requests for charity or Financial Assistance Applications received from a collections agency shall be reviewed by a RBO Financial Counselor. The counselor shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no charity. Standard transaction approval levels will apply.
e. An approved charity determination is applicable to all services referenced in the application AND services provided up to six (6) months after the date of the approved application, provided there is no change in the applications financial status that would warrant a reevaluation.
f. If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure; interest begins accruing on the date payment by the patient is received by PHSSC.

VII. Notification of charity determination:

a. In those instances where Medi-Cal restricted services are written off to charity, the notice of charity approval will be sent to the patient.
b. For homeless charity write-offs, no notification is necessary.
c. In all instances where a Financial Assistance Application was submitted, the person approving the application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the applications on behalf of the patient within ten (10) days of final determination of the completed application.
d. In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination. Appeals should be in writing to:

PH&S Regional Business Office
PO Box 3299
Portland, OR 97208-3395

The Regional Director, or designee, shall respond to charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be restarted to afford the patient ample opportunity to make payment, per the provisions of applicable California law.

If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. Patient and facility will negotiate the terms of the payment plan, taking into consideration the patient's family income and essential living expenses. Where patient has submitted a Financial Assistance Application and is attempting in good faith to settle an outstanding bill with PHSSC by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, PHSSC shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with California Health and Safety Code 127400 *et. seq*. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan.

Prior to declaring delinquent payment due to the fact that patient has failed to make all consecutive payments due on the payment plan during a 90-day period, PHSSC, the collection agency, or assignee shall (1) make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the payment plan may become inoperative, and of the opportunity to renegotiate the payment plan; and (2) attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient. The notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

The 90-day period shall be extended until a final determination of an appeal if the patient has a pending appeal for coverage of the service and the patient has made a reasonable effort to communicate about the progress of any pending appeals. "Pending appeals" include any of the following:

- A grievance against a contracting health care service plan, as described in Chapter 2.2 of Division 2 of the California Health and Safety Code, or against an insurer, as described in Chapter 1 of Part 2 of Division 2 of the California Insurance Code;
- An independent medical review, as described in Section 10145.3 or 10169 of the California Insurance Code;
- A fair hearing for a review of a Medi-Cal claim pursuant to Section 10950 of the California Welfare and Institutions Code; or
- An appeal regarding Medicare coverage consistent with federal law and regulations.

If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774, SB 350 and SB 1276, including not garnishing wages or placing a liens on primary residences .

VIII. Processing of charity write-off:

a. If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.
b. The 100% charity discount percentages is then applied to the account, using existing adjustment mnemonic/transaction codes.
c. A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:
    i. It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and
    ii. It will not report the delinquency to a credit-reporting agency until 150 days after the date of service, or 150 days after the patient received partial charity approval.

AUDIT/CONTROL/RECORDS/RETENTION:

All Financial Assistance Applications will be retained for a period of seven (7) years from date of completion.

The charity determinations shall be subject to outside review to determine consistency in judgment and to provide further education/training; however, a charity determination shall not be reversed at any time.

Write-off approvals are subject to internal and external audit. Standard transaction approval levels are:

Approval Limits	Approval Authority
Total Providence Facility Charges: $0 - $2,500	Financial Assistance Team member
Total Providence Facility Charges: $0 - $5,000.	Financial Assistance Lead
Total Providence Facility Charges: $2,501 - $25,000	FC Supervisor
Total Providence Facility Charges: $2,501 – 100,000	Providence Representative, Manager or Director (or designee)
Total Providence Facility Charges: $15,000.01 and over	RCM Service Area or Regional Director (or designee)

REFERENCE(S)/RELATED POLICIES

American Hospital Association Charity Guidelines
California Hospital Association Charity Guidelines
California Alliance of Catholic Healthcare Charitable Services Guidelines
Providence Health and Services Commitment to the Uninsured Guidelines
Patient Protection and Affordable Care Act of 2010 (Federal Exemption Standards) Private Pay Discounting Policy CA-FIN-5003
Regional Business Office Debt Collection Standards and Practices Policy, RBO-GOV-107

COLLABORATION

This policy was developed in collaboration with the following departments:

PHSSC Finance Division
Providence Health & Services Department of Legal Affairs

AUTHORIZATION:

Teresa Spalding
VP Revenue Cycle _____ _____
Signature on file Date

ATTACHMENT A
Hospital-Based Providers Not Subject to PH&S's Financial Assistance Policy and Associated Discounts

A list is available of all Providers who render care in the PH&S Hospital, and whether or not they are subject to the PH&S Financial Assistance Policy. This list can be accessed online at www.providence.org, or is available in paper form by request through the Financial Counselor at the Hospital. If a Provider is not subject to the Financial Assistance Policy then that Provider will bill patients separately for any professional services that that Provider provides during a patient's hospital stay, based on the Provider's own applicable financial assistance guidelines, if any.

ATTACHMENT B
PH&S CA Charity Care Percentage Sliding Fee Scale

For guarantors with income and assets above 300% of the FPL household income and assets are considered in determining the applicability of the sliding fee scale.

Assets considered for evaluation; IRA's, 403b, 401k are exempt under this policy, unless the patient is actively drawing from them. For all other assets, the first $10,000 is exempt.

Income and assets as a percentage of Federal Poverty Guideline Level	Percent of discount (write-off) from original charges	Balance billed to guarantor
0-300%	100%	0%
301-350%	75%	25%

ATTACHMENT C

NOTICE OF COLLECTION PRACTICES
PATIENT RIGHTS WITH RESPECT TO COLLECTION OF DEBTS FOR HOSPITAL SERVICES

State and Federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877- FTC-HELP (382-4357) or on-line at www.ftc.gov.

If you have coverage through group or private insurance, or other third party payer program, and you wish us to bill that organization, you must supply us with your enrollment information. This requirement is met by presenting your insurance card or other suitable document that provides policy information, (and dependent coverage, if applicable). If you require assistance in paying this debt, you may be eligible for the Medicare, Medi-Cal, Healthy Families, California Children's' Services, liability California Victims of Violent Crimes, automobile medical insurance, or other third-party programs, including charity care. Ask a hospital admissions or business office representative if you would like to pursue these options. Hospital charity and self-pay discount policies may be obtained by either asking an admissions or business office representative for assistance, or by visiting the hospital's web site for a downloadable form.

Non-profit credit counseling services may also be of assistance. Please consult a telephone directory for a listing of these programs.

The patient or responsible person will be required to sign the Conditions of Hospital Admission or Outpatient Treatment. That document will include an acknowledgment of financial responsibility for payment for services provided by the hospital. The hospital will bill any third party payer for which you provide enrollment information. You will be asked to pay co- payments, as prescribed by those payers. You may be responsible for services those programs do not cover. You will be billed following the conclusion of your service, although deposits may be requested prior to services being rendered. Should the debt remain unpaid, the account may be referred to an outside collection agency under contract with the hospital. The collection agency will abide by the above debt collection principles. Should the debt remain unpaid, the collection agency, on behalf of the hospital, will list the unpaid debt with credit-reporting agencies and may initiate legal proceedings, which may result in wage garnishment or a lien placed against an asset of the patient or responsible party. The Providence Health and Services charity policy provides that persons with household gross income below 250% of Federal Poverty Guidelines (FPG) are eligible for full assistance upon submission of a Financial Assistance Application. Persons with gross income above 250% may also be eligible for partial or full assistance, depending upon the information provided on the application.

If you have any questions about this notice, please ask any admissions or business office representative or by calling 800 (insert phone number for appropriate hospital).

ATTACHMENT D

PROVIDENCE Health & Services

Request for Financial Assistance

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER

ADDRESS STREET	CITY	STATE	ZIP	TELEPHONE HOME WORK

DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)	U.S. CITIZEN ☐ YES ☐ NO

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP

ADDRESS STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME	WORK	U.S. CITIZEN ❑ YES ❑ NO	DATE OF BIRTH

❑ Please check this box if you have not received services and are applying to pre-qualify.

Have you been approved for Financial Assistance by another Health Care organization? ❑ YES ❑ NO
If yes, please provide name of organization _____

Are you being referred by a physician or surgeon? ❑ YES ❑ NO
If yes, please provide name and phone of number of physician _____

III. Household Information – Please indicate ALL people living in your household, including applicant use additional paper if needed

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, etc.

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE	INSURED? (circle yes or no) If yes, list insurance (i.e. Blue Cross, PHP, etc.)
1.					Yes or No
2.					Yes or No
3.					Yes or No
4.					Yes or No
5.					Yes or No
6.					Yes or No
7.					Yes or No
8.					Yes or No
9.					Yes or No

Continued on the other side.

IV. Expenses and Assets

Rent _____		Recreational vehicles _____	
Mortgage payment _____	Send proof	Health insurance premiums _____	
Mortgage balance _____	Send proof	Stocks, bonds, retirement accounts, etc. _____	
Cost of Utilities _____		Monthly child care _____	
Checking account balance _____		Real estate other than primary home _____	
Savings account balance _____		Other assets _____	
Car Payment _____		_____	
Year and make of vehicle _____		_____	

Are you a full time student? _____ Please send student loan report.

Do you receive any form of public assistance (food stamps, HUD housing, etc.) _____ If yes, please send proof.

What were your total medical expenses during the prior 12 months? (Please provide proof of payment)

_____

Are you being supported by a parent or other person? ❑Yes ❑No

If yes, please provide income and tax information of the person supporting you.

If you need to write a letter explaining your individual situation please attach it to this form.

V. Required Information – Must be included with this application

Please check that you have included the following:

❑ Copy of previous year's tax returns	❑ Copy of last 3 months bank statements	❑ Income verification showing earnings or pay stubs for all income year to date

❑ If you are self-employed, please include a copy of the last 12 month's P & L statements and last year's tax return.
Additional information may be required in order to process your application. If so, we will contact you.

VI. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Providence Health & Services to verify any or all information given and understand that a credit report may be run as part of this verification process.

X _____ _____

RESPONSIBLE PERSON'S SIGNATURE DATE

Providence Health & Services strives to provide excellent service for your health care needs.

Subject: CA Private Pay Discount	Policy Number: CA-FIN-5003	
Department: Revenue Cycle	☐ New ☒ Revised ☐ Reviewed	**Date: 02/16/2015**
Executive Sponsor: Teresa Spalding – VP Revenue Cycle	**Policy Owner:** Kathryne Rouse, System Director Customer Support ORC	
Approved by: One Revenue Cycle (ORC) Leadership Council	**Implementation Date:** June 2015	

SCOPE:

This policy applies to Providence Health & Services (PH&S) ORC. This is an operational policy recommended by the VP Revenue Cycle, and approved by the ORC Leadership Council.

PURPOSE:

The purpose of this policy is to establish a discount policy for health care services provided by Providence Health and Services, Southern California Region (PHSSC) facilities which are payable by patients without coverage by a third party payer.

POLICY:

In keeping with the philosophy and mission of PH&S, it is the policy of PH&S, Southern California Region (PHSSC) to charge patients an appropriate amount for health care services. For patients covered by government programs, managed health care plans, or other third party payers, payment rates are determined by government policy or negotiated contracts. However, for patients not covered by a third party payer or whose insurance does not cover the service provided or who have exhausted their benefits; and do not qualify for financial assistance, the hospitals retail billed charges are discounted to reflect current self-pay rates for the service area/facility/service provided. Patients who qualify for financial assistance are eligible for further discounts or free care as described in the Charitable Services Policy.

The Chief Financial Officer at the regional or entity level shall be responsible for reviewing and approving self-pay rates. Self-pay rates when established or revised shall be programmed into the billing system and communicated to affected staff.

This policy applies to facility charges only and does not apply to physician services/billing.

DEFINITIONS:

Self-pay patient: a patient who is not covered by any third party payer or whose service is not a covered benefit of their health plan or whose insurance benefits have been exhausted.

Note: Where a patient has insurance coverage but the insurer applies the full amount of the claim as a patient copayment or deductible, the patient shall be responsible for the copayment/deductible and shall not be considered self-pay under this policy.

Medical Savings Accounts: An account set up by an individual to pay health care bills which has a tax benefit. Payments from a Medical Savings Account Fund Administrator are acceptable at these discounted levels, absent a managed care contract with specified contract rates.

Excluded entities: St. Elizabeth's Convalescent Center and San Fernando Valley Service Area (SFVSA) Home Health do not currently have self-pay rates in effect.

Reasonable Payment Plan: Monthly payments that are not more than 10 percent (10%) of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this policy, 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, and other extraordinary expenses.

Note: Emergency Department physicians at Providence hospitals and their assignees may rely upon the hospital's determination of income and expenses in establishing a reasonable payment plan.

PROCEDURE:

1. All patients registered as self-pay (no insurance provided) shall be given information during the registration process regarding the self-pay discount along with payment options. Self-pay patients shall receive a discounted bill based on the self-pay rates in effect for the service area/facility/service provided which will also include information on the discount and payment options. The discounted amount on the self-pay bill shall constitute the maximum amount due.

2. Providence Holy Cross Medical Center (PHCMC) Trauma patients who are eligible for reimbursement under AB-75 are not subject to this policy and should be registered utilizing the self-pay trauma insurance mnemonic. If it is determined that a Trauma patient is not eligible for AB-75 reimbursement, then the insurance code shall be changed to self-pay, appropriate discounts shall then be applied and the account managed as a self-pay account per the terms of this policy.

3. Discounted self-pay rates shall be programmed into the billing system so the patient bill calculates automatically when the final bill is generated.

4. Information in the initial bill about the self-pay discount shall advise the patient to contact a Customer Service Representative if there are questions regarding the bill, to request a payment arrangement, or to inquire regarding financial assistance, e.g. Medi-Cal enrollment or charitable assistance. See CA-FIN-501 for details on information provided with self-pay bills.

   Note: Providence will not provide a self-pay discount for an insured patient who wishes to pay the self-pay discount and bill insurance privately in order to receive excess reimbursement. Accordingly, courtesy billing or the provision of a third party claim will not be permitted for self-pay patients.

5. When a patient requests a payment plan, the remaining patient owed balance may be paid in interest free installments as mutually agreed between patient and facility. In the event an agreed upon plan cannot be reached the default plan shall be consistent with a "Reasonable Payment Plan" as defined above. Payment plans shall not be considered delinquent and further collection activity shall not occur, as long as payments due are no more than 90 days delinquent. This time frame shall be extended when the patient is in the process of appealing a health plan's decision, a medical review decision, an appeal for Medicare coverage or a fair hearing for a Medi-Cal claim. If an outside agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and abide by state law AB 774, SB 350 and SB 1276, including not garnishing wages, nor placing a lien on a principal residence. Further, if a patient disputes an assignment to self-pay or any aspect of the Private Pay Discounting process, an appeal may be submitted in writing to:

   PH&S Regional Business Office
   PO Box 3299
   Portland, OR 97208-3395

6. The discount transaction code shall be separately identified in the accounts receivable transaction reports of the PHSSC regional facilities. The discount, once applied, shall establish the permanent liability due by the patient. It will not be reversed, except for charity write-offs. It will be titled Self-Pay Discount.

7. Should the account remain unpaid and qualify for transfer to bad debt, the amount transferred shall be the net liability due (the discount remains in effect) and all collection efforts, including legal action, will be against the net liability due.

8. If the patient applies for financial assistance and qualifies for charity per the Regional Charity Policy (CA-FIN-501), the self-pay discount transaction shall be reversed to reflect full charges, which will then be adjusted to cost using the facility's cost to charge ratios in reporting charity granted.

9. If a third party payor, including retroactive enrollment into Medi-Cal, is identified after the account was initially billed as self-pay, the self-pay discount shall be reversed and the appropriate payor contractual adjustment posted.

10. Patients applying for Medi-Cal coverage shall be classified as Pending Medi-Cal. Pending Medi-Cal patient accounts shall be adjusted to reflect Medi-Cal rates by Regional Business Office staff. Should the patient not qualify for Medi-Cal, the account shall be reclassified as self-pay, and the account adjusted to reflect self-pay rates. Previously described self-pay collection efforts shall apply to the reclassified account.

11. Should a self-pay account with a payment plan be referred to an outside collection agency for further collection efforts, the collection agency must abide by the established or reasonable payment plan and should that agency determine that a lawsuit would be required to collect the amount due; the agency shall provide supporting asset/income verification to support the patient's ability to pay the debt. PH&S Revenue Cycle Business Office Director, or delegate, will evaluate each suit request for an ability to pay based on the following:

    a. Are there any assets to file a lien against?
    b. Is there a principal residence owned by the patient/guarantor (if yes, a lien may be filed against the equity of that residence, but foreclosure action will not be initiated while the patient/immediate family member(s) occupy the premises).
    c. Legal action will not be approved unless the income level is above 350% of the applicable Federal Poverty Guidelines in effect at the time of the evaluation for lawsuit.

12. Self-pay discounts may be modified or created at any time during the year but in all cases shall be communicated with an effective date. Where inpatient self-pay rates are based on Medicare DRG reimbursement, the October 1 update will be in effect for at least twelve months or until such time the subsequent annual update is made. The October 1 update shall be implemented no later than December 31st of each year.

AUDIT CONTROL:

1. The Regional Chief Financial Officer (CFO), facility CFO or delegate will annually (or more frequently as deemed necessary) review the self-pay discount rate to determine appropriateness in relation to amounts paid by government agencies and contracted managed care payors. Should a new self-pay discount rate be approved Billing Support Services staff shall perform system updates and communicate the effective date to staff.

2. The administration of this policy shall be subject to audit by internal and external auditors.

REFERENCE(S)/RELATED POLICIES:

American Hospital Association
California Hospital Association
The California Alliance of Catholic Healthcare
Providence Health & Services Commitment to the Uninsured Guidelines

COLLABORATION:

This policy was developed in collaboration with the following involved departments:

Admitting/Registration
Regional Business Office
Billing Support Services
PHSSC Finance Division Providence Health & Services Department of Legal Affairs