Tri-City Regional Medical Center Policy and Procedure		**Title** **Hospital Charity Care and Discount Payment Policy and Procedures (revised)** (1) charity care policy, (2) discount payment policy, (3) eligibility procedures, and (4) review process
Policy Number: 03-0001 Business Services, Administration, Admitting		**Karen Nimniyom, Director of Finance** **_____original signed_____** **Mary Ann Ray, Director of Patient Financial Services** **□□□□□□_____original signed_____** **Lenore Robles Admitting Department Manager** **□□□□□□_____original signed_____**
1/11/11	**Supersedes prior versions; Effective 1/11/11**	**Board of Directors/Secretary David Herskovitz** **_____original signed_____**
	Reviewed 7/17/13	**By CEO Approval/James Sherman CEO** **_____original signed_____**

INTRODUCTION

Gardens Regional Hospital and Medical Center, Inc. dba Tri-City Regional Medical Center ("the Hospital") is committed to providing Charity Care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay all or part of medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, the Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Charity is not a substitute for personal responsibility. Patients are expected to cooperate with the Hospital's procedures for qualifying for charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. If a patient is unable to cooperate (i.e., mental incapacity), Hospital may make its determination using available information and observations in its discretion without a completed application. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets, in accordance with current law.

In order to manage its resources responsibly and to allow the Hospital to provide an appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity and or discounted payment plans.

DEFINITIONS

For the purpose of this Policy, the terms below are defined as follows:

A. Charity Care: Healthcare services that have or will be provided but that do not result in cash inflows or result in reduced inflow. Charity care results from Hospital's policy to provide healthcare services free or at a discount to individuals who meet established criteria.

B. Family: A group of two or more people who reside together and who are related by birth, marriage, domestic partnership or adoption or as provided by law. According to Internal Revenue

Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

C. Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count).

D. Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations, or the patient's claim for insurance or contribution by any plan of public of private insurance, or for coverage by a third party's insurance, is denied by the payor.

E. Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities, which may include a co-pay or deductible or a life-time or condition limit or coverage is partially denied by the payor.

F. Further definitions: The following are particular definitions from the law that applies generally to Charity Care policies in California and apply to the Hospital's Policy:

IN ACCORDANCE WITH CALIFORNIA HEALTH & SAFETY CODE §127400-127446, THE HOSPITAL DISCOUNT PAYMENT AND CHARITY CARE POLICIES ARE AS FOLLOWS:

As used in this Charity Care and Discount Payment Policy, the following terms have the following meanings:

(1) "**Allowance for financially qualified patient**," means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the Hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the full amount of the charges.

(2) "**Federal poverty level**" means the poverty guidelines 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.

(3) "**Financially qualified patient**" means a patient who is both of the following:(a) a patient who is a self-pay patient, as defined in subdivision A(4) or a patient with high medical costs, as defined in subdivision A(5); and (b) a patient who has a family income that does not exceed 350% of the federal poverty level.

(4) "**Self-pay patient**" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance or third party payor as determined and documented by the Hospital. This includes patients whose third party coverage is ultimately denied in whole or in part, and whose injury is not otherwise compensable. Self-pay patients may include Charity Care patients.

(5) "**A patient with high medical costs**" means a person whose family income does not exceed 350% of the federal poverty level, if that individual would not receive a discounted rate from the Hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

(a) Annual out-of-pocket medical costs incurred by the individual at the Hospital that exceed 10% of the patient's family income in the prior 12 months.

(b) Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(c) A lower level determined by the Hospital in accordance with this Policy or in the judgment of Hospital based on the circumstances affecting a particular patient.

(6) "**Patient's family**" means the following:

(a) For persons 18 years of age and older: spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not.

(b) For persons under 18 years of age: parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(7) **"Medical Denials."** A patient who is qualified for MediCal (or Medicaid for out of state patient) is also presumed to qualify for a full charity discount. Any charges for days or services written off (excluding billing timeliness, medical records, missing invoices, or eligibility issues) as a result of a MediCal denial, will be written off as non-statutory charity care.

(8) "**Restricted Medical Coverage.**" Some MediCal plans offer coverage for limited or restricted medical services. If a patient is eligible for MediCal, charges for days or services not covered will be written off to non-statutory charity and does not require a completed financial statement. This does not include any share of cost (SOC) amounts, as SOC's are determined by the State to be an amount that the patient must pay before qualifying for MediCal.

G. **Policies**. Hospital maintains an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written Charity Care Policy. Uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level, as defined in H&S subdivision (b) of Section 127400, shall be eligible to apply for consideration for participation under the Hospital's Charity Care Policy or Discount Payment Policy.

H. Eligibility. In determining eligibility under its Policy, the Hospital may consider income and monetary assets of the patient and other information Hospital may obtain. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans

qualified under the Internal Revenue Code or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall any assets be counted if prohibited by law.

I. The Hospital shall limit expected payment for services it provides to a patient who is at or below 350% of the federal poverty level, as defined in H&S Section 124700(b), eligible under its Discount Program Policy to the amount of payment the Hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the Hospital participates, whichever is greater, or as provided by applicable law. If the Hospital 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 an appropriate discounted payment using its judgment.

J. A patient, or patient's legal representative, who requests a discounted payment, Charity Care, or other assistance in meeting his or her financial obligation to the Hospital shall make every reasonable effort to provide the Hospital with documentation of income and health benefits coverage. If the person requests Charity Care or a discounted payment and fails to provide information that is reasonable and necessary for the Hospital to make a determination, the Hospital may consider that failure in making its determination. Alternatively, the Hospital may, in its discretion, deem the matter to qualify as Charity Care, using independent sources of information and its discretion.

(1) For purposes of determining eligibility for discounted payment, Hospital will provide forms for documentation of income and expenses to the patient and assist patient, as requested, in completing the forms. Other information may be used in the determination by Hospital.

(2) For purposes of determining eligibility for Charity Care, documentation of assets may include information on monetary assets, but shall not include assets on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. The Hospital may require waivers or releases from the patient or the patient's family, authorizing the Hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value and may use publically available information in making a good faith assessment. Failure to cooperate shall be considered by Hospital in making its determination.

(3) Information obtained pursuant to paragraphs J(1) or J(2) shall not be used for collection activities. This does not prohibit the use of information obtained by the Hospital, collection agency, or assignee independently of the eligibility process for Charity Care or discounted payment. All representatives of Hospital and its collection agents shall be aware of this Charity Policy and abide by it.

(4) Retrospective Consideration: A Patient’s eligibility for discounted payments or Charity Care may be determined at any time by the Hospital. On a periodic basis, Hospital may evaluate all bad debt accounts for possible consideration as charity care. Through the use of third party source that can provide both financial and demographic information specific to an account which has been classified as bad debt. It is determined that through such retrospective review the patient would have qualified for charity care, these accounts will be reclassified to charity. Any

account in collection that, as a result of this assessment, is considered charity, will be called back from any collection agency and written off to charity in accordance with these guidelines.

PROCEDURES

A. Services Eligible Under this Policy. For purposes of this Policy, "charity" refers to healthcare services provided without charge or at a discount to qualifying patients. The following healthcare services may be eligible for charity for qualified patients:

(1) Emergency medical services provided in an emergency room setting. Emergency Room physicians providing emergency care through the Hospital's Emergency Room are 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;

(2) Services for a condition that, if not promptly treated, would lead to an adverse change in the health status of an individual;

(3) Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and/or

(4) Medically necessary services, evaluated on a case-by-case basis at Hospital's discretion.

B. Services Not Covered. Professional fees such as, for example, fees for services rendered by Physicians, Radiologists, Cardiologists, Pathologists, Anesthesiologists, interpretation services, etc., are excluded from this Policy and will be handled by the service provider's own billing services. Professional fees for physicians rendering Emergency Room services are subject to charity care policies as provided by law.

C. Eligibility for Charity. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, or otherwise ineligible for full coverage by government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity 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 or any protected status. The Hospital shall use reasonable efforts to determine whether patients are eligible to receive charity for deductibles, co-insurance, or co-payment responsibilities. Medicare deductibles and co-payments may be written off to Charity Care if the Hospital determines that a Medicare patient is indigent or medically indigent, according to the Provider Reimbursement Manual. Hospital can then forego further collection effort, unless otherwise directed by policy or applicable regulation.

D. Patient Maximum Out-Of-Pocket Expense. Any payment from a patient pursuant to this policy is limited to the greater of the amount of payment Hospital would receive from Medicare for providing services.

(1) Uninsured Inpatient Maximum: Patients that were treated on an inpatient basis and qualified for a charity discount less than 100% will not be financially responsible for more than the amount of the Medicare DRG. Any difference between the charity discount applied and the inpatient maximum will be treated as an additional financial assistance discount.

(2) Uninsured Outpatient Maximum: Patients that were treated on an outpatient basis and qualified for a charity discount less than 100% will not be financially responsible for more than Hospital's average outpatient Medicare reimbursement rate.

E. Categorization of care and charges: The care provided to patients by Hospital may be categorized in whole or in part as Charity Care based on various criteria, as described below, depending on the patient's status and how the patient's account is processed through the Hospital's registration and accounting systems. All or part of the care provided to a patient may be categorized as charity for the following reasons:

(1) The patient applies and is approved for a Charity Care discount;

(2) The patient agrees to pay a portion of their bill, but is unable to pay the full cash price requested by the Hospital. The patient is given a "low-income" discount in addition to the normal cash discount;

(3) Charges for services provided to patients eligible for Medi-Cal that are not paid for by Medi-Cal will be deemed Charity Care; this includes charges related to denied stays, denied days of care, and non-covered services;

(4) Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to patients eligible for or covered by Medi-Cal will be deemed Charity Care;

(5) Co-insurance and deductibles for Medicare patients who have Medi-Cal secondary coverage will be considered Charity Care to the extent that these co-insurance and deductible amounts are not covered by Medi-Cal and Medicare does not reimburse them as bad debts; and/or

(6) Patients without coverage who were initially identified as potentially eligible for Medi-Cal or similar assistance programs, but who were eventually determined to not be eligible for Medi-Cal or assistance programs.

F. Determination of Financial Need.

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

(a) Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;

(b) Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

(c) Include reasonable efforts by the Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;

(d) Take into account the patient's available assets, and all other financial resources available to the patient;

(e) Assess the patient's ability to apply for financial assistance with other sources of payment; and

(f) Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

(2) It is preferred but not required that a request for charity and a determination of

financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle. The need for payment assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known. However, qualified recurring outpatients are covered by a charity approval for the full term of the course of treatments related to the recurring condition.

(3) The Admitting Department will make every effort to conduct a pre-admission interview with the patient, responsible party, and/or patient representative. If a pre-admission interview is not possible, the interview will take place on admission or as soon as possible thereafter. In the case of an emergency admission, Hospital's evaluation of payment alternatives will not take place until the required medical care has been provided and the patient is stable. The Hospital's Financial Counselor will attempt to interview each patient who lacks adequate insurance coverage to determine (a) those patients potentially eligible for the Medi-Cal program, and (b) those patients potentially eligible for Charity Care. Patients who are initially identified as potentially eligible for the Medi-Cal program, but who are subsequently determined to be ineligible, may qualify for Charity Care without submitting an application.

(4) Inpatients not qualifying for public assistance will be asked to complete a financial statement application form and post-discharge patients requiring financial assistance with the resolution of their hospital bill will be asked to complete a financial statement application form.

(5) The Hospital's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed within a reasonable period of time and the Hospital shall try to make its determination within 180 days of receipt of a completed application and attempt in good faith to notify the patient or applicant, preferably in writing, upon completion of the process.

G. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Charity Care discounts, but there is incomplete financial assistance information on file due to a lack of supporting documentation or unwillingness or inability on patient's part to participate. There are instances where there is adequate information provided by the patient or through other sources, which could provide sufficient evidence for the Hospital to reasonable conclude that the patient would properly be eligible for Charity Care assistance. In the event there is insufficient documentary evidence to support a patient's eligibility for Charity Care, the Hospital may use other resources to estimate income amounts or financial status for the basis of determining Charity Care eligibility and potential discount amounts. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

(1) State-funded prescription programs;

(2) Homeless or received care from a homeless clinic;

(3) Brought to Hospital by law enforcement in the course of incarceration, prior to booking by law enforcement;

(4) Participation in Women, Infants and Children programs (WIC);

(5) Food stamp eligibility;

(6) Subsidized school lunch program eligibility;

(7) Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

(8) Patient unable or unwilling to apply for assistance with other programs and in the Hospital's discretion is otherwise qualified for its Charity Care;

(9) Low income/subsidized housing is provided as a valid address;

(10) Patient is deceased with no known estate;

(11) Bankruptcy court determines patient unable to pay account;

(12) Public records searches indicate patient is more than likely to qualify; and/or

(12) Other factors to be considered in Hospital's discretion.

H. Patient Charity Guidelines. Services eligible under this Policy may also be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination, as follows:

(1) Patients whose family income is at or below 350% of the FPL are eligible to receive free care;

(2) Patients whose family income is above 250% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Hospital would receive for providing the services from Medicare, Medicaid, or any other government-sponsored health program of health benefits in which the Hospital participates, whichever is greater (or as provided by then applicable law); and

(3) Patients whose family income exceeds 350% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, in the discretion of the Hospital.

(4) Reevaluation of eligibility. Upon notification, any determination for financial assistance may be reevaluated if any of the following occur:
(i)income change; or (ii) family size change; (iii) intervening circumstances, including high medical expenses; or (iv) a determination is made that any part of the patient's application for assistance is false or misleading.

I. Communication of the Charity Program to Patients and the Public.

Hospital will post legible signs in the business office, admitting and registration areas and Emergency Department informing patients about its financial assistance and charity care discount policies. Patient statements will include standard language informing patients they may request financial screening to determine eligibility. Admitting personnel will try to inform patients as well.

(1) All notices identified above shall be available in English, Spanish, and in additional languages as required pursuant to a determination of their necessity which Hospital will make in accordance with the procedures outlined in California Government Code section 7290 et seq. Further, the publication of notices may be in other public places as Hospital may elect. Referral of patients for charity or discount consideration may be made by any member of

the staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, or law enforcement personnel, and religious sponsors. The patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws, may make a request for charity.

(2) The Hospital shall make all reasonable efforts to obtain from the patient or his/ her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to the patient, including, but not limited to, any of the following: (a) Private health insurance, (b) Medicare, (c) The Medi-Cal program, (d) the Healthy Families Program, (e) the California Children's' Services Program, or (f) other state-funded programs designed to provide health coverage.

(3) If the Hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the Hospital shall provide the patient with a clear and conspicuous notice that includes all of the following: (a) A statement of charges for services rendered by the Hospital; (b) A request that the patient inform the Hospital if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or similar coverage; (c) A statement that if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program, or Hospital's Charity Care/Financial Assistance; (d) A statement indicating how patient may obtain applications for the Medi-Cal program and the Healthy Families Program and that the Hospital will provide these applications. If the patient does not indicate coverage by a third-party payer, or requests a discounted price or Charity Care then the Hospital shall provide an application for the Medi-Cal program, the Healthy Families Program or other governmental or Hospital or other program to the patient. The application(s) shall be, when possible, provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care or it may be mailed to them; (e) Information regarding the financially qualified patient and Charity Care application, including the following: (i) A statement that indicates that if the patient lacks, or has inadequate insurance and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or Charity Care; and (ii) The name and telephone number of the Hospital staff or office from whom or which the patient may obtain information about the Hospital's discount payment and Charity Care policies, and how to apply for that assistance and Hospital will offer to help with the process.

J. Relationship to Collection Policies.

(1) The Hospital shall develop written policies and procedures for internal and external debt collection practices that, comply with the applicable law, and take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a government program or for charity from the Hospital, and a patient's good faith effort to comply with his or her payment agreements with the Hospital. Hospital will obtain written agreements from any agency that collects Hospital's receivables to adhere to the Hospital's standards and scope of practice in this regard. For patients who have established that they qualify for charity and who are cooperating in good faith to resolve their hospital bills, the Hospital may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, will not send unpaid bills to outside collection agencies, and will cease all collection efforts when merited. Non-compliant patients are defined as not providing information and/or all required documentation for MediCal screening or other program screening, but who otherwise appear to qualify for charity discount. In these cases, the Financial Counselor may process the account for a

charity discount, in Hospital's discretion, without further participation by patient.

(2) The Hospital's extended payment plan may be declared no longer operative after a patient's failure to make all consecutive payments due during any 90-day period. Before declaring the Hospital's extended payment plan no longer operative, the Hospital, collection agency, or assignee shall make reasonable attempts to contact the patient by phone and to give notice in writing that the extended payment plan may become inoperative and of the opportunity to renegotiate the extended payment plan. Prior to the Hospital's extended payment plan being declared inoperative, the Hospital, collection agency, or assignee, shall attempt to renegotiate the terms of the defaulted extended payment plan if requested by the patient. The Hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this paragraph, the notice and phone call to the patient may be made to the last known phone number and address of the patient. If patient is not reachable after reasonable attempts, Hospital may proceed to report the adverse information.

(3) Appeal process. If a patient's application for assistance is denied, patient may appeal the denial. The Business Office will make the appeals process known to the patient who requests such information.

K. Refund/Credits. As set forth in AB 774 Hospital Fair Pricing Policies sections 127405 and 127440, in cases where a patient has applied, and been approved for financial assistance, and where the patient has already made payments for those services approved under the application, the Hospital will reimburse the patient 100% of the amount (excluding pre-payments and payment plans) actually paid in excess of the amount due, including interest. If a patient has an outstanding balance from a time period outside the award period, the patient's payment will be applied against the outstanding balance prior to issuing any applicable refund.

(1) Interest shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure; beginning on the date payment by the patient is received by the hospital. The current rate is 10%.

(2) For patients who have been approved under the Discount Payment provision, the hospital can expect to be paid no more than the greater amount expected under Medi-Cal, Healthy Families, Medicare, or any other government programs.

L. Regulatory Requirements. In implementing this Policy, the Hospital shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy, including but not limited to California Health & Safety Code Sections 127400 through 127446, Chapter 2 of Div. 107, Article 3, Hospital Fair Pricing Policies; and California Code of Regulations, Title 22, Div. 7, Chapter 9, Article 2, Hospital Discount Payment and Charity Care Policies, commencing with Section 96040, copies of which are available on the internet at http://www.oshpd.ca.gov and other laws and regulations, as applicable.

This Revised Policy effective January 1, 2011 shall be electronically posted to the Office of Statewide Health Planning and Development (OSHPD) using OSHPD's online system and supercedes all prior versions of this Policy.

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*"H&S" means California Health and Safety Code