POLICY NUMBER: PFS.RI.I

SUBJECT: **PATIENT FINANCIAL ASSISTANCE**

REFERENCE(S): California Health & Safety Code, Sections 1339.51, 1339.585, and 127400-127446
CHA Hospital Compliance Manual, 2019
Code of Federal Regulations, Emergency Medical Treatment and Active Labor Act (EMTALA), United States Code, Title 42
United States Department of Health & Human Services, Current Poverty Guideline Computations

PURPOSE: To define eligibility criteria for charity care and to provide administrative and accounting procedures for identification, classification and reporting of patient accounts as charity care.

AFFECTED AREAS/DEPARTMENTS: Patient Access and Patient Financial Services

POLICY:

The Finance Department of Antelope Valley Medical Center (AVMC) has overall responsibility for general accounting policies and procedures. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at AVMC. The Patient Financial Services (PFS) department of AVMC is responsible for resolving patient accounting transactions in a manner that supports the mission and operational goals of AVMC and the Antelope Valley Healthcare District.

AVMC will meet or exceed California statutory requirements to provide charity care and/or financial discounts to all patients who qualify under the AVMC Financial Assistance Program. The AVMC Financial Assistance Policy is the document explaining the requirements, explanations and procedures of the Financial Assistance Program. Financial assistance is available to any or all uninsured or underinsured patients who meet the eligibility and qualification requirements contained in this policy

I. SCOPE

This policy pertains to full and discount partial charity care (financial assistance) provided by AVMC. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

II. PHYSICIAN SERVICES

Emergency physicians providing services at AVMC are independent contractors and not employees of AVMC or the Antelope Valley Healthcare District. Charity care and discount payment options may be available separately from emergency physicians. AVMC will provide patients with contact information for emergency physician providers upon patient request.

Services rendered to patients by other physicians, including anesthesiologists, radiologists, pathologists, surgeons or other members of the AVMC medical staff are not subject to, or covered within the scope of this policy.

III. DEFINITIONS

Full Charity Care is defined as any Medically Necessary[1] inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured, has an income of 200% or less of the current federal poverty level and who has established qualification in accordance with requirements contained in the AVMC Financial Assistance Policy.

Discount Partial Charity Care is defined as any Medically Necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured, has an income greater than 200%, but less than 400% of the federal poverty level and who has established qualification in accordance with requirements contained in the AVMC Financial Assistance Policy.

Qualified Payment Plan: Payment plans established by patients who have qualified for discount payment through the Charity Care/Discount payment policy are classified as a qualified payment plan. A qualified payment plan shall have no interest charges applied to any or all balances due from the patient/guarantor. In the event that AVMC and the hospital shall use the formula described in Health & Safety Code Section 12740 (i), in order to establish terms for a "Reasonable payment plan," as defined in statute.

Depending upon individual patient qualification, financial assistance may be granted for full charity care or discount partial charity care. Financial assistance may be denied when the patient or other responsible family representative does not meet the AVMC Financial Assistance Policy requirements.

IV. FULL and PARTIAL DISCOUNT CHARITY CARE ELIGIBILITY

General Process and Responsibilities - Eligibility is defined under this policy for any inpatient or outpatient with a family[2] income of less than 400% of the current federal

[1] Medically Necessary services are defined as any hospital inpatient, outpatient, or emergency medical care that is determined by a member of the AVMC medical staff as essential to a patient's health and well-being and not entirely elective for patient comfort and/or convenience. AVMC will generally follow Medicare and/or Interqual guidelines for medically necessary covered services in order to preclude potential for abuse of the Financial Assistance Program.

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

poverty level. Patients with family incomes at or below 400% of the current federal poverty level may be eligible when:

- They do not have any type of third party insurance coverage; or
- Covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account

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

The AVMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, AVMC utilizes a single, unified patient application for both Full Charity Care and Partial Discount Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify.

Uninsured patients will also: 1) be offered information, assistance and referral to government sponsored programs for which they may be eligible and 2) provided information regarding insurance coverage through Covered California. Uninsured patients will also be provided contact information for local consumer legal assistance programs which may assist the uninsured patient with obtaining coverage

Underinsured patients whose income is below 400% of the federal poverty level and who personally owe an amount after their insurance has paid may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a Financial Assistance Application.

Eligible patients may qualify for the AVMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and/or health benefits coverage information such that the hospital may make a determination of the patient’s qualification for coverage under the program.

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

Any patient who requests financial assistance will be asked to complete a financial assistance application. Completion of a financial assistance application provides:

- Information necessary for the hospital to determine if the patient does not have income sufficient to pay for services;
- Documentation useful in determining qualification for financial assistance; and
- An audit trail documenting the hospital's commitment to providing financial assistance.

However, a completed financial assistance application is not required if AVMC, at its sole discretion determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients with family incomes below 400% of the current federal poverty level who are unable to pay patient liabilities after their insurance has paid may also be eligible to apply for financial assistance.

V. Full and Discount Partial Charity Care Income Qualification Levels

Uninsured Patients

A. If the patient's family income is 200% or less of the established Federal Poverty Level (FPL), based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off as full charity care.

B. If the patient's family income is between 201% and 400% of the established FPL, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the patient's payment obligation will be a percentage of the gross amount that the Medicare or Medi-Cal program would have paid for the service if the patient were a Medicare or Medi-Cal beneficiary. For inpatients, the amount due will be based upon the Medicare DRG or Medi-Cal per diem specific to the hospital service provided. For outpatients, the amount due will be based upon the Medicare APC specific to the hospital service provided. In the event that no Medicare DRG or APC rate is applicable to the patient's hospital service, AVMC shall establish an appropriate discount on a case specific basis. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1

Sliding Scale Payment Schedule

Family Percentage of FPL	Percentage of Medicare or Medi-Cal Amount Payable
201 – 250%	30%
251 – 300%	45%
301 – 325%	60%
326 – 400%	80%

Patient Care Covered by a Third Party Payer

If the services are covered by a third party payer, with which AVMC maintains a current contract and the patient receives a discount on the patient liability portion but is unable to pay the amount due and seeks financial assistance, the patient's payment obligation will be based on a sliding scale for the deductible or co-insurance portion. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 2 below:

TABLE 2
Sliding Scale Payment Schedule

Family Percentage of FPL	Percentage Amount Due
Less than 200%	20%
201 – 250%	40%
251 – 300%	60%
301 – 400%	80%

Qualification - Special Circumstances

A. If the patient is determined to be homeless, uninsured and unable to pay for Medically Necessary services, he/she will be deemed eligible for full charity care.
B. Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months shall be deemed eligible for full

charity care. The patient or family representative shall provide a copy of the court order document as part of their application.

C. The accounts of deceased patients who did not have any third party coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed eligible for charity care.

D. Patients seen in the emergency department, for whom AVMC is unable to issue a valid bill, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

E. Medicare rules require any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by AVMC. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
   1. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
   2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

F. AVMC deems those patients that are eligible for government sponsored low-income assistance programs (e.g. Medi-Cal/Medicaid, California Children's Services and any other applicable federal, state or local low-income program) to be indigent. Therefore such patients are eligible under the AVMC Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as all other low-income government programs where the program does not make payment for all services or days during a hospital stay are eligible for Financial Assistance Program coverage. Under the AVMC Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as charity care. Specifically included as charity care are charges related to denied hospital stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying government low-income programs, and other denials (e.g. restricted coverage) are to be classified as charity care.

G. Any patient whose income exceeds 400% of the current FPL guidelines and experiences a catastrophic medical event may be deemed eligible for

financial assistance. Such patients, who have higher incomes, do not qualify for routine full charity care or partial discount charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be at the sole discretion of AVMC management based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. AVMC Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $25,000 may be considered for eligibility as a catastrophic medical event.

Qualification Criteria for Re-Assignment from Bad Debt to Charity Care

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

A. Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); *and*
B. The patient or family representative must have a credit score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; *and*
C. The patient or family representative has not made a payment within 150 days of assignment to the collection agency; *and*
D. The collection agency has determined that the patient/family representative is unable to pay; *and/or*
E. The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score.

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by AVMC personnel prior to any reclassification within the AVMC accounting system and records.

VI. PROCESSES

Qualification for full or discount partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

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

- Family size
- Family income at or below 400% of the FPL based upon tax returns or recent pay stubs

The patient and/or patient family representative who requests assistance in meeting their financial obligation to AVMC shall make every reasonable effort to provide information necessary for AVMC to make a financial assistance qualification determination. AVMC will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program. The application and required supplemental documents are submitted to the Patient Financial Services department at AVMC. This office shall be clearly identified on the application instructions.

Financial assistance shall not be provided on a discriminatory or arbitrary basis. However, AVMC retains full discretion, consistent with all laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

AVMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response. All financial assistance applications will be reviewed and an initial determination completed within 30 days from the date AVMC obtains a completed charity care application (application plus supporting documents), or when AVMC at its sole discretion determines it has sufficient information upon which to make a case specific charity care determination.

A financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:

> Director/Manager of Patent Financial Services: Accounts $10,000 or less
> Anything above $10,000 will follow the current delegated signing authority.

Once determined, the AVMC Financial Assistance Program qualification will provide coverage for a period of 180 days from the date of qualification, unless the patient or patient's family financial circumstances change. AVMC personnel may review and update patient family financial information at any time during the 180 day coverage period.

The AVMC Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative.

In cases of continuing care relating to a patient diagnosis which requires on-going, related services for a period of greater than 180 days, AVMC, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital.

Other pre-existing patient account balances outstanding at the time of qualification *determination* by AVMC will be included as eligible for write-off at the sole discretion of AVMC management.

Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance.

Uninsured and underinsured patients at or below 400% of the FPL will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all Medically Necessary hospital inpatient, outpatient and emergency services provided by AVMC.

Patient Notification

Once a determination of qualification is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

A. **Approval**: The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient.
B. **Denial**: The reasons for denial of the financial assistance application will be explained to the patient. Any outstanding amount owed by the patient will also be identified.
C. **Pending**: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and is requested to be supplied to the hospital by the patient or family representative.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with AVMC. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the AVMC Director of Patient Financial Services. The Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the

Director shall provide the patient with a written explanation of findings and determination.

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

Qualified Payment Plans

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

AVMC personnel will discuss payment plan options with each patient that requests to make arrangements for term payments. As a general guideline, payment plans will be structured to last no longer than 12 months. However, individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. AVMC shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Once a payment plan has been approved by AVMC, any failure to pay all consecutive payments due will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the AVMC Patient Financial Services department if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, AVMC will make a reasonable attempt to contact the patient or their representative by telephone and also give notice of the default in writing.

The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Financial Services representative within Fourteen (14) days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the extended payment plan within Fourteen (14) days, the payment plan will be deemed inoperative and the account will become subject to collection.

Public Notice

AVMC shall post notices throughout the hospital informing the public of the Financial Assistance Program. Notices will include contact information on how a

patient may obtain more information on financial assistance as well as where to apply for such assistance. These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. A copy of this Financial Assistance Policy will be made available to the public upon reasonable request. It shall also be posted on the AVMC Website along with a Plain Language Summary and applications for the program.

Charity Care Reporting

AVMC will report actual charity care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulations, AVMC will maintain written documentation regarding its charity care criteria, and for individual patients, AVMC will maintain written documentation regarding all charity care determinations. As required by OSHPD, charity care provided to patients will be recorded on the basis of actual charges for services rendered.

AVMC will provide OSHPD with a copy of this Financial Assistance Policy which includes the full charity care and partial discount charity care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy shall be guided by these values.

Good Faith Requirements

AVMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family

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

RESPONSIBILITY FOR REVIEW AND MAINTENANCE OF THIS POLICY IS ASSIGNED TO: Chief Financial Officer or designee

REVIEWED AND APPROVED:

Board Chairman **DATE: 5/31/22**

Chief Executive Officer **DATE: 6/01/22**

EFFECTIVE DATE:09/19/14
REVISED DATES: 06/30/18; 03/27/19; 5/26/2022
REVIEW DATES: See Policy Manager

CROSS REFERENCE(S):

ATTACHMENT(S):