

Policy

POLICY NO. E.300.85500.301
ORIGINATED 1999
REVISED 11/2017
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SUBJECT: Financial Assistance Policy (FAP) AKA Charity Care and Discount Policy

APPLICATION: PIH Health Good Samaritan Hospital (PHGSH)

PURPOSE

PIH Health Good Samaritan Hospital (PHGSH) is committed to assuring that its patients will receive necessary care without discrimination or regard to their ability to pay. The purpose of this policy is to provide guidelines for identifying and handling patients who may qualify for charity or self-pay discounts.

DEFINITION

1. Medically necessary services are those that are absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.
2. A FAP-eligible patient, or "Charity Care Patient" is a patient who is unable (versus unwilling) to pay for PHGSH services. In all cases a patient whose Family Income does not exceed 350% of the federal poverty level (FPL) can be considered under this policy. Patients from families with high incomes (or undocumented incomes) may also qualify if PHGSH staff reasonably determines the Patient is unlikely to have the resources to pay for the care.
3. A Self-Pay Patient is a patient who does not have coverage through personal or group health insurance and is not eligible for benefits through Medicare, Medi-Cal, the Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP), coverage for accidents (TPL), or any other program.
4. A High Medical Cost Patient is a patient who has insurance or is eligible for payment from another source, but who has family income at or below 350% of the FPL and out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) that exceeds 10% of Family Income.
5. Family Income would include the income from all members of the patient's "family." For a patient 18 years of age and older, family includes the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not. For a patient under 18 years of age, family includes the patient's parents, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

PRINCIPLES FOR SELF-PAY AND UNDERINSURED PATIENTS

PHGSH will adhere to the following principles in implementing this policy:

1. Fear of a hospital bill should never prevent a patient from seeking emergency health care services and inability to pay should never be a reason to deny medically necessary care.

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2. The Hospital will provide financial assistance to patients who cannot pay for part or all of the care they receive.
3. The Hospital will not financially penalize FAP-eligible patients who have no health insurance, or inadequate health insurance (in the case of High Medical Cost patients), by requiring them to pay more for care than a typical insurer or government program would pay (See below for a further discussion of the Amount Generally Billed, or AGB).
4. However, the financial assistance the Hospital provides is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay.
5. All patients will be treated with dignity, compassion and respect.
6. Our debt collection practices will be consistent with these principles and with all applicable laws.

POLICY

1. PHGSH will assist patients who do not have health insurance to identify and apply for benefits for which they may be eligible from programs including Medicare, Medi-Cal, the Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP), and coverage for accidents through third party liability (TPL). In addition, qualifying low income patients may be granted assistance for some or all of their financial responsibility through charity grant programs such as QueensCare and Good Hope. PHGSH may also provide free or greatly discounted necessary care as unfunded charity on a case by case basis.
2. Uninsured patients who do not qualify for any insurance or health coverage benefits or programs will be offered self-pay discounted rates. These rates will be set in accordance with the "Cash Price Policy."
3. Depending upon their income and assets, patients who are not insured and are not eligible for benefits from any other program may qualify for a 100% charity care discount, a partial charity care discount or self-pay discount (see further discussion below, in the Eligibility for Full or Partial Charity Care Discount section)
4. The policy does not apply to deductibles, co-payments and/or coinsurance imposed by insurance companies unless the patient qualifies for assistance as a "High Medical Cost Patient." It also does not apply to services that are not medically necessary (such as cosmetic surgery), or separately-billed physician services.
5. The policy will not apply if the patient or responsible party provides false information about financial eligibility or if they fail to make every reasonable effort to apply for and receive third party insurance benefits for which they may be eligible.
6. Any patient or patient's legal representative who requests a charity discount under this policy shall make every reasonable effort to respond to reasonable requests from PHGSH for documentation of income, assets, and all potential health benefit coverage. Failure to provide information may result in the denial of the requested self-pay or charity care discount. Financial assistance may not be denied, however, for failing to provide information or documentation not described in either this FAP or the FAP application (FAR).

PROCEDURE

1. Upon admission/registration all patients will be provided a Plain Language Summary of this Financial Assistance Policy, containing information about eligibility, and contact information (name and telephone number) for a hospital employee or office to obtain additional information. Plain Language Summaries will be provided in English and languages spoken by the lesser of 1,000 individuals or 5% of people served or likely to be served, affected, or encountered by the hospital facility (currently Spanish and Korean). Translators will be provided to translate orally the notices for patients who speak other languages.
2. Whenever possible PHGSH will provide financial screening to determine whether a Self-Pay Patient might qualify for coverage from third party payor, including any private insurer or government-sponsored programs such as Medicare, Medi-Cal, The Healthy Families program, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), California Health Insurance Program (CHIP), Victim of Crime (VOC), or any other third party, such as an employer through worker's compensation or another person due to third party liability (TPL). When feasible, PHGSH will assist patients to identify possible sources of payment and to apply for the program. This financial screening will be performed as early as possible before services are rendered except when deferred for emergency screening and evaluation (as described below). The information provided to Self-Pay patients will include a statement on how patients may obtain applications for Medi-Cal, Healthy Families, coverage through the California Health Benefit Exchange, the Los Angeles County Indigent program and any other state or county-funded health coverage programs, and that the hospital will provide these forms. The notice must also include a referral to a local consumer assistance center housed at legal services offices. When no coverage is identified, the Self-Pay patient will be provided with applications for Medi-Cal, Healthy Families and other state or county-funded health coverage programs and any charitable assistance programs that might offer financial assistance. This shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.
3. For patients who have or may have emergent conditions, the financial screening will be deferred until after the patient has received a medical screening and any necessary treatment to stabilize the patient. Treatment shall not be delayed while a patient completes an admission/registration process. At all times, full consideration must be given for the patient's medical condition and care should be taken not to let the financial review process create anxiety for the patient.
4. If financial information cannot be collected at the time of admission/registration, reasonable attempts should be made to collect the information before the patient is discharged in order to fully facilitate proper billing and access to all financial assistance to which the patient may be entitled.
5. Patients will be expected to respond when requested by providing complete and accurate information concerning their health insurance coverage and if they are applying for charity care or self-pay status, their financial assets and income so that the Hospital may assess their eligibility for government sponsored programs or for assistance from charity care programs or the self-pay discount program.
6. In general, the Hospital's experience has been that Self-Pay Patients lack the resources to pay hospital bills, and it is not necessary to obtain financial information to confirm this.

When there is a question about the patient's insurance coverage or financial resources, the Hospital may ask a Self-Pay Patient to complete a Financial Assistance Request (FAR) form. The FAR will be used to determine a patient's ability to pay for necessary services and to determine a patient's possible eligibility for public assistance, other programs, and self-pay discounts from the Hospital. The information on the FAR may be accepted without obtaining additional supporting documentation, but the Hospital may also ask for supporting documentation such as recent tax returns or paystubs, and verification from financial institutions that hold the patient's assets. The FAR and supporting documentation may be requested on a sampling basis or when the available information suggests there is a question about whether the patient qualifies for charity care. The written FAR will be provided in English and languages spoken by the lesser of 1,000 individuals or 5% of people served, or likely to be served, affected, or encountered by the hospital facility (currently Spanish and Korean), and translated for those who speak another language.

8. The Charity Care Discount financial screening and means testing will be performed by Financial Counselors in the Admissions Department and/or Collection Representatives in Patient Business Services. Patient Business Services has the final authority for determining that reasonable efforts have been made to determine FAP-eligibility have been made before the hospital or its assigns may engage in Extraordinary Collection Actions (see Patient Billing and Collections section, below, for more details).

ELIGIBILITY FOR FULL OR PARTIAL CHARITY CARE DISCOUNTS

1. Self-Pay Patients whose family incomes are at or below 350% of the FPL will be eligible for full or partial charity care discounts, depending upon family income.
 - a. Self-Pay Patients whose family income is less than 200% of the FPL will be eligible for a full, 100% charity care discount on services rendered.
 - b. Self-Pay Patients whose family income is between 200% and 350% of the FPL will be eligible for a partial charity care discount on services rendered equal to 60% of applicable cash price -- see Cash Price Policy.
2. The Hospital may ask the patient to complete a FAR form in order to assess the patient's eligibility for Self-Pay or charity care discount.
 - a. Upon the request of the Hospital, the patient may be required to document his or her family income by submitting the most recently filed Federal tax return or recent paycheck stubs.
 - b. Assets above the statutorily excluded amount will be considered exceeding allowable assets and may result in the denial of a charity care discount. However, the following assets will be excluded from consideration:
 - i. Retirement accounts and IRS-defined deferred compensation plans both qualified and non-qualified.
 - ii. The first \$10,000 of all monetary assets.
 - iii. 50% of all monetary assets above \$10,000.
 - iv. The patient's primary family residence.
3. A High Medical Cost Patient is eligible for a 100% Charity Discount on outstanding patient liability amounts if his or her family income is at or below 350% of the FPL, and his or her out-of-pocket medical expenses in the prior twelve (12) months (whether incurred in or out of any hospital) has exceeded 10% of his or her family income. Eligibility for such discounts will be reevaluated as necessary to satisfy the prior twelve-month test.

4. Accounts for Self-Pay Patients and High Medical Cost Patients who meet the eligibility criteria noted above for charity care discounts may be submitted to QueensCare, a public benefit charity, or Good Hope, a private charitable grant, when appropriate. Patients whose accounts will be submitted to QueensCare will be required to complete and sign a QueensCare certification. Good Hope patients will be required to pay a nominal amount towards their greatly discounted services.

5. Homeless patients (which includes all patients who indicate they have no address) will be asked if they would accept a referral to a program such as People Assisting the Homeless (PATH) which provides follow-up medical care after discharge through its outpatient clinic and provides a post office box service to facilitate follow-up communication with the patient. PHGSH will provide a brochure to the patient listing the services that PATH or a similar program provides. Homeless patients who accept the referral to PATH or similar programs will be asked to sign the "Referral Acceptance Confirmation Form" indicating acceptance of the referral. The patient will be given a copy of the signed document and the signed original will be placed in the patient's medical record. Staff facilitating discharge planning should make the appropriate contact with PATH or the similar program to help arrange follow-up. The PHGSH discharge planner shall send PATH or the similar program a referral form and a mailbox referral form so that the patient can be registered for postal services and facilitate follow-up care with PHGSH when the patient presents to the clinic for continuing care.

6. Patients will be offered an extended payment plan if they indicate they cannot pay their discounted bills. The terms of the payment plan will be negotiated by the hospital and the patient. Extended payment plans will be interest-free. If agreement cannot be reached on a payment plan, the hospital may require payment using the "reasonable payment formula" which "means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. 'Essential living expenses' means ... 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 childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses."

SELF-PAY CHARITY DISCOUNT

Self-Pay Patients who do not qualify for any third party payor benefits or other health coverage programs may be offered discounted Cash Price rates. See Cash Price Policy. The difference between the full costs of rendering the service and the discounted rate the patient owes is classified as charity care.

AMOUNTS GENERALLY BILLED (AGB)

Once eligibility has been determined, patients who are FAP-eligible, whether insured or uninsured, will not be charged more than the Amount Generally Billed, or AGB. PHGSH calculates AGB using the prospective method, which means using the billing and coding process which would be used if the FAP-eligible individual were a Medicare fee-for-service beneficiary, to determine the total amount which Medicare would allow for the care, including the amount that would be reimbursed by Medicare and the amount the beneficiary

would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles.

PHGSH will not have failed to meet the legal requirements related to AGB if the charge in excess of AGB was not a) made or requested as a pre-condition of providing medically necessary care, b) at the time of the charge in excess of AGB the FAP-eligible individual had not submitted a complete FAP Application (FAR) to the hospital facility to obtain financial assistance for the care and had not otherwise been determined by the facility to be FAP-eligible, and c) if the individual subsequently submits a completed FAR and is determined to be FAP-eligible for the care, the hospital refunds any amount above \$5 which was in excess of their personal responsibility that the individual paid for the care, whether to the hospital facility or any other party to whom the hospital referred or sold the debt for the care.

PATIENT BILLING AND COLLECTION PRACTICES

1. PHGSH will strive to assure that patient accounts are processed fairly and consistently. All patients will be treated with dignity, compassion and respect. Our debt collection practices will be consistent with these principles and adhere to all requirements in California and Federal law.
2. Patients who have not provided proof of coverage at or before the time care is provided will receive a statement of full charges for services rendered at the hospital. A conspicuous written notice on the billing statement notifies and informs recipients about the availability of financial assistance under this FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and the FAP application process, as well as the direct Web site address (or URL) where copies of the FAP documents may be obtained. Also, included with that statement will be a request to provide the hospital with health insurance information, and a copy of the Plain Language Summary of the FAP. In addition, the patient will be sent a notice that they may be eligible for Medicare, Medi-Cal, Healthy Families, California Health Benefit Exchange, Los Angeles County Indigent Patient Program, California Children Services (CCS), charity, or a self-pay discount. This notice will include the contact information (name and telephone number) for a hospital employee or office to obtain additional information, including how the patient can obtain the appropriate application forms. The notice must also include a referral to a local consumer assistance center housed at legal services offices. Patients who do not have coverage will be provided with applications for Medi-Cal, Healthy Families and other state or county-funded health coverage programs and any charitable assistance programs that might offer financial assistance. This shall be in addition to the notice provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.
3. If the patient does not respond to the above statement and notice within thirty (30) days, a second statement reflecting full charges will be mailed to the patient/guarantor address along with the information requesting insurance information and offering the option of applying for self-pay charity care discounts. If the patient again does not respond within another 30 days, the hospital will assume that the patient is not eligible for any coverage through personal or group health insurance and is not eligible for any third party payor benefits (e.g., Medicare, Medi-Cal, the Healthy Families program, California Health Benefit



Exchange, Los Angeles County Indigent Patient Program, California Children's Services (CCS), Victim of Crime (VOC), worker's compensation, State funded California Healthcare for Indigent Program (CHIP); and coverage for accidents (TPL.) Unless there is evidence to the contrary, the Hospital may assume that the patient is eligible for a charity discount and adjust the patient's account with a charitable discount. Subsequent statements will reflect these discounted rates.

4. If the patient fails to complete the provided charity or Medi-Cal application within a reasonable time period, and after reasonable efforts to collect (the patient has received the charity / FAP application, appropriate notices about the hospital FAP, three or more statements and a final statement), or to pay the discounted rate, he/she will be classified as bad debt and assigned to Collections. After 120 days have passed since the first post-discharge billing statement occurred, a 30-day notice informing patients or responsible parties that adverse information may be reported to a consumer credit agency and/or civil actions may be initiated against them for non-payment, will be sent. A Plain Language Summary of the FAP and information on how to apply for assistance will be included with this notice.

5. If the patient applies PIH Health Good Samaritan Hospital will stop all ECAs while it determines eligibility for financial assistance. If the patient qualifies for the FAP, the account shall be removed from assignment to the Collection agency. Delinquencies will be removed from the patient's credit report.

6. If a patient is attempting to qualify for eligibility under the hospital's Financial Aid Policy, AKA Charity Care and Discount Policy, and is attempting in good faith to settle the outstanding bill, the hospital shall not send the unpaid account to any collection agency or other assignee unless that entity has agreed to comply with this policy.

7. Eligibility for Self-Pay Charity discounts, Charity Care Discounts, and High Medical Expense may be determined at any time the Hospital has received all the information it needs to determine the patient's eligibility. Patients are required promptly to report to PHGSH any change in their financial information.

8. PHGSH or its contracted collection agencies will undertake reasonable collection efforts to collect amounts due from patients. These efforts include assistance with application for possible government program coverage, evaluation for charity care eligibility, offers of self-pay discounts and extended payment plans. PHGSH will not impose wage garnishments or liens on primary residences, and will not defer or deny medically necessary care, nor require advance payment for medically necessary care, due to non-payment of a previous bill(s) This does not preclude PHGSH or its contracted collection agencies from pursuing reimbursement from third party liability settlements or other legally responsible parties.

9. Agencies that assist the hospital in billing outstanding amounts from patients must sign a written agreement that they will adhere to the hospital's standards and scope of practices and PHGSH meets quarterly with collection agencies to ensure adherence, and review performance.

The agency must also agree:

- a. Not to report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial post-discharge billing, and to suspend such actions if a FAP application (FAR) is submitted until a determination of eligibility can be made. If the

individual is determined not to be FAP-eligible, ECAs may be initiated / resumed if all other requirements are met

b. Not use wage garnishment, except by order of the court upon noticed motion, supported by a declaration file by the movant identifying the basis for which it believes that the patient has the ability to make payment on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

c. Not place liens on primary residences.

d. Adhere to all requirements in California and Federal law.

10. If a patient is overcharged, the hospital shall reimburse the patient the overcharged amount. Interest will be paid on the overcharged amount. Interest will be based on the prevailing interest rate and calculated from the date the overpayment was received.

APPLICABILITY TO EMERGENCY AND OTHER PHYSICIANS

Because the hospital cannot employ physicians, this FAP applies only to hospital facility services and does not apply to emergency room physicians, radiologist, pathologists, anesthesiologists, hospitalists, surgeons or other physicians. However, Emergency physicians who provide emergency services at the Hospital are also required to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity. In general, the Hospital will require doctors who staff the emergency room and who serve on the emergency call panel to maintain contracted status with the plans that also contract with the Hospital and to offer discounts to patients consistent with this Charity Care and Discount Policy.

DISPUTES

Patients may disagree with the determination of their eligibility for a charity discount. A patient may request a review of the determination from the Director of Patient Financial Services at (213) 482-2700. A final decision will be made within 15 days of the patient's request for review.

REPORTING PROCEDURES

PHGSH's Charity Care and Discount Policy will be provided to the Office of Statewide Planning at least biennially on January 1, or when a significant change is made. If no change has been made by the hospital since the information was previously provided, the office will be informed that no change occurred.

COMMUNICATION OF CHARITY CARE AND DISCOUNT POLICIES

PHGSH's Patient Financial Services shall publish and maintain the Financial Aid Policy, AKA Charity Care and Discount Policy. They will also train staff regarding the availability of procedures related to patient financial assistance.

Notice of our Financial Aid Policy, AKA Charity Care and Discount Policy, will be posted in conspicuous places throughout the hospital including the Emergency Department,



Admissions Offices, Outpatient registration areas and the Patient Business Services Department, as well as on billing statements and the Hospital website. These notices will be in English and languages spoken by the lesser of 1,000 individuals or 5% of people served, or likely to be served, affected, or encountered by the hospital facility (currently Spanish and Korean).

PHGSH shares its Financial Assistance Policy with the appropriate community health agencies and organizations that assist families.

CHARITY CARE WRITE-OFFS

1. Charity Care shall include all amounts written off for Self-Pay Charity Care, Charity Care, and High Medical Cost patients pursuant to this policy.
2. Patients who qualify for Medi-Cal but do not receive payments that equal the full costs of service or do not receive approval for coverage for the entire stay are eligible for charity care write-offs. These include charges for non-covered costs, non-covered services, denied days or denied stays. Treatment Authorization Request (TAR) denials and lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity.
3. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/ deductibles, for which Medi-Cal does not make a payment, and any amount Medicare does not ultimately provide bad debt reimbursement for will also be included as charity.

CONTACT INFORMATION

Questions about financial assistance eligibility for inpatient services should be directed to the Eligibility Coordinator at (213) 482-2719.

Questions about financial assistance eligibility for emergency services should be directed to the Eligibility Coordinator at (213) 977-2421.

Questions about financial assistance eligibility for outpatient services should be directed to the Patient Accounts Supervisor at (213) 482-2700.

Questions about the implementation of this policy should be directed to the Director of Patient Financial Services at (213) 482-2700.

To obtain a copy of this Financial Aid Policy, a Financial Aid Request application, Plain Language Summary or for questions about the application process, please visit PIHHealth.org/Assistance or contact Patient Financial Services at 213-482-2700

Completed applications may be submitted via mail to:

PIH Health Good Samaritan Hospital

Attention: Patient Financial Services – FAP Unit

1225 Wilshire Boulevard

Los Angeles, CA 90017-2395

or for assistance in completing the application, patients may contact Patient Financial Services at 213-482-2700

AUTHOR

Director, Patient Financial Services



Policy Approvals

Policy Name: Financial Assistance Policy (FAP) AKA Charity Care and Discount Policy

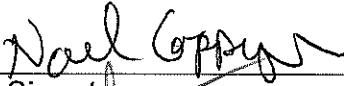
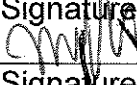
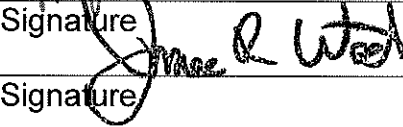
Entity: PIH Health Good Samaritan Hospital **Department:** Revenue Cycle

Originator of Policy: Noel Coppinger	Revenue Cycle	14800
Name	Department	Extension

Committee Approvals:

Committee	Date
Committee	Date
Committee	Date
Committee	Date

Signatures:

Noel Coppinger		06/07/2021
Name	Signature	Date
Vid Shivaraman		06/07/2021
Name	Signature	Date
James R. West		06/25/21
Name	Signature	Date
Name	Signature	Date
Name	Signature	Date

