PALOMAR HEALTH

Financial Assistance Operational Procedure

Disclaimer

Approvals

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Revision Insight

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Revision Note:
Updating naming of positions involved in this policy and also increasing the approval threshold for the agency liaison.

Procedure : Financial Assistance Operational Procedure

I. SUMMARY:

Defines Palomar Health's (PH) procedure for the identification, documentation and determination of eligibility for PH's discount or charity care programs. In accordance with its Mission Statement, it is the policy of PH to provide a reasonable amount of hospital services without charge to eligible patients who cannot afford to pay for care, or offer discounted payment arrangements for those who qualify.

II. DEFINITIONS:

A. Patient: defined as the person receiving services at PH or their guarantor ultimately responsible for the financial resolution of an account.
B. Charity Care: defined as medically necessary health care services provided for no charge to the patient who does not have or cannot obtain adequate financial resources to pay for his/her health care services.
C. Discounted Care: defined as medically necessary health care services provided at a reduced charge for patients who meet eligibility criteria as described in this policy. This is in contrast to bad debt, which occurs when a patient who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to resolve his/her bill. Charity or Discounted Care eligibility may be determined prior to or at the time of an admission, during a hospital stay or after a patient is discharged. Each situation is different and shall be evaluated at the time of the application based upon the patient's circumstances. Eligibility for Charity Care or Discounted Care does not apply to services rendered by any physician, whether rendered on an inpatient or outpatient basis, or to health care providers other than PH.

III. PROCEDURE :

A. Standards of Practice
    1. The General guidelines for Financial Assistance approval are:
        a. Patients who do not have or cannot obtain adequate financial resources to pay for their health care services.
        b. Uninsured patients, as well as insured patients for the portion of their bill not covered by insurance, may be eligible.
        c. Resources from third party payers, local charitable agencies, Victim of Crime, Medi-Cal, etc. should be exhausted before a charity or discount adjustment can be applied.
        d. Only hospital services provided by PH shall be considered.
        e. Eligibility determinations shall be based primarily upon income and family size. While expenses and other factors may be considered, these shall not serve as the primary basis for determining eligibility.
    2. Clinical Determination:
        a. The evaluation of the necessity for medical treatment of any patient shall be based upon clinical judgment, regardless of insurance or financial status, in compliance with PH's Mission Statement. The clinical judgment of the patient's personal physician or the Emergency Department (ED) staff physician shall be the primary determining criteria for a patient's admission. In cases where an emergency medical condition exists, any evaluation of possible payment alternatives occur after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with all applicable State and Federal laws and regulations
    3. Exclusions:
        a. All patients may apply
B. Steps of Procedure
    1. Provide uninsured patients and those with potentially high medical expenses with a copy of the Notice of Health Care Financial Assistance (Attachment A). The uninsured patients should be directed to applications, as applicable, for Medi-Cal, CMS, or CCS.
    2. For patients interested in financial assistance, complete a Financial Assistance Application for ED, Outpatients or cases identified after admission. All ED non-scheduled outpatients and patients identified after admission shall be handled as indicated below. The Financial Assistance Application process can be triggered by the Patient Access Department, Agency Liaison, or Business Office Customer Service Representatives.
        a. If, after a medical screening exam, a patient in the ED is determined to have no financial means to pay, and

appears that they may not qualify for Medi-Cal or any other service, give the patient the PH Application for Financial Assistance (Attachment B). If the patient is homeless or cannot complete the application, offer assistance in completing the form and obtain the patient's signature. If the patient is unable or unwilling to sign, then note this on the form

b. If a patient is currently in-house and it is determined that he/she may not have appropriate coverage or other means necessary to pay for services, the Financial Counselor or Patient Advocate shall give the patient a Financial Assistance Application.
    i. Patients scheduled as elective inpatient or scheduled outpatient services shall be referred to the Agency Liaison for consideration and approval.
c. Determine if there are alternative means (i.e., external agency or foundation) to cover the cost of services.
d. Make appropriate referrals to Patient Advocates or Financial Counselors, local county agencies, Medi-Cal or other programs to determine potential eligibility.
e. In the event the patient is denied or is determined to be ineligible for any of these services or it appears this may qualify as a charity case, Patient Access Department shall give the patient the Financial Assistance Application and a return envelope or refer them to a Patient Advocate. It is the responsibility of the Patient Advocates or Financial Counselors to track the receipt of the Financial Assistance Application and make sure it is complete. The documentation required to be submitted with the Financial Assistance Application shall be dependent on the amount of charity care requested. the following documents, as applicable, should submitted with the Financial Assistance Application:
    i. Current period pay stub; and/or,
    ii. Prior years tax return
    iii. If the other documents are not available, a verification of employment and wages from the employer may act as a substitute
f. Enter account comments in PH Information System: "Financial Assistance Application given to "name and relation to patient for patient's name", date(s) of service, date provided and when expected from patient." This level of documentation shall generally be placed at the specific visit level, although at times it could apply to all accounts for the patient.
g. Follow-up with patient or family member to see if they require assistance in completing the Financial Assistance Application.
    i. Offer assistance and/or meet with patient or family if guidance is needed to complete the form.
    ii. If needed, conduct a verbal interview with the patient and have them sign the form.
h. The patient should be advised to return the completed Financial Assistance Application to a PSR. If the form is incomplete or missing information, reasonable efforts should be made to contact the patient for the missing information and advise them that if the information is not provided, a decision on their eligibility will be made based on the incomplete application.
i. Forward the completed Financial Assistance Application to Patient Business Services, Attn: Customer Service for processing.

C. Guidelines for Reviewing Financial Assistance Applications:

1. Determination – is based upon 350% of the established Federal Poverty Guidelines (FPG) as published yearly by the Department of Health and Human Services (DHHS) (http://aspe.hhs.gov/poverty/index.shtml). These guidelines and rates of discount are noted on Attachment C.
    a. If a patient maintains current eligibility with local and state health programs (e.g. CMS, Medi-Cal, etc), then the patient will be determined as eligible The likelihood of future earnings sufficient to meet the obligation within a reasonable period of time shall be considered. Documentation of income may be requested of the patient if eligibility is questionable.
    b. Patients or their guarantors who earn >351% of the Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for the standard self-pay discount as defined in the PH Self Pay Discount Procedure. The patient may qualify for a discount to the highest government payer amount if their health costs exceed 10% of their annual income and they earn between 351% - 500% FPL.
    c. Patients or their guarantors who earn between 251% and 350% of the current Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Discounted Care. The billed charges for these patients will be reduced to the highest government payers (Medi-Cal, Medicare or Healthy Families) rates.
    d. Patients or their guarantors who earn 250% or less of the Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Charity Care: a write-off of 100% of charges.
    e. Assets Owned - Eligibility for Charity Care may be considered including all liquid assets owned (e.g., bonds, stocks, bank accounts) less liabilities and claims against assets. The first $10,000 in assets will not be counted in determining eligibility; in addition, 50% of all assets valued over $10,000 will also not be used in determining eligibility. Eligibility for Discounted Care does not factor in the availability of monetary assets. PH uses a credit-reporting agency. Determination of assets and their impact on eligibility will be determined on a case by case basis.
    f. Income – Examples of sources of income* include, but are not limited to:
        i. Recent pay stub
        ii. Income tax returns

iii. If the above items are not available, upon Business Office Manager's discretion, other statements or documents may be acceptable (e.g. a signed and written statement by the employer of wages)
iv. *Income source restrictions imposed by AB774:
I. Excludes the use of retirement, deferred-compensation plans and non-qualified deferred-compensation plans when determining eligibility for Charity Care.
II. Mandates that determinations for Discounted Care are to only consider recent pay stubs or income tax returns.
v. Employment status shall be considered along with future earning capacity.

g. Deductions - Other financial obligations including living expenses and other items of reasonable and necessary nature shall be considered.
h. Reevaluation-Charity Care or Discounted Care provisions shall be reevaluated when any one of the following occur:
i. Subsequent rendering of services
ii. Income change
iii. Family size change
iv. When any part of the patient's account is written off as a bad debt or is in collections
v. When an account that is closed is to be reopened
vi. When an account is equal to, or greater than 6 months old
i. Management's Discretion - PH's management shall have a reasonable amount of discretion in approving the provision of Charity Care or Discounted Care for patients who do not meet the provisions set forth above.

D. Processing the Financial Assistance Application:
1. Review each completed application upon receipt and determine if all information has been completed or attached, as applicable.
2. Enter notes in the "account comments" section of PH's Information System indicating receipt of the request for charity. If incomplete, note the follow-up action, missing items and date.
a. If additional information is required, send the Financial Assistance Request for Information Letter (Attachment D). The patient shall be requested to provide this information within 15 working days.
b. If the patient does not return the requested information or contact PH within 20 working days, contact the patient to inquire into the status of the additional information. Advise the patient that unless PH receives the information within 10 working days, a decision on their eligibility for financial assistance will be made without the requested information. If the patient does not return the requested information or contact PH within the additional 10 day period, the application should be forwarded for review and eligibility determination. Enter into the "account comments" section of PH's information system: "Patient did not return required financial assistance information."
c. If the Financial Assistance Application is complete, prepare the Financial Assistance Checklist (Attachment E) within 24 hours.
d. Once the packet is complete, forward to the appropriate person as per the following approval schedule:
i. $0 - $20,000 Agency Liaison
ii. $20,001 - $50,000 Manager Patient Financial Services
iii. $50,000.01 - $99,999.99 Director Patient Financial Services
iv. >$100,000 - Vice President Revenue Cycle
e. Enter the date the packet was sent into the "account comments" section of PH's information system.
f. If a patient is approved for Financial Assistance, the person approving the Financial Assistance shall enter the appropriate adjustment into the PH information system as "approved and write off completed," and complete the Financial Assistance Approval Letter (Attachment F).
g. For approved Charity Care, the full amount of the bill is to be written off and the account documented.
h. For approved Discounted Care, the account should be adjusted to the Medicare reimbursement rate and the remaining balance to be paid by the patient. The patient is eligible for an interest free payment plan on the remaining balance in accordance with the Self Pay Discount procedure or Extended Payment Plan (Care Payment) procedure.
i. If a patient is not approved for Financial Assistance, forward the Financial Assistance Application and the supporting documentation to the Patient Business Services manager for final review.
j. If a patient is denied Financial Assistance, send the Financial Assistance Denial Letter (Attachment G).
k. If the patient appeals the denial and submits additional information within 15 working days of the date of the denial notice, this information should be evaluated within five days. If the supplemental information results in the patient qualifying for Financial Assistance, send the Financial Assistance Approval Letter. If the supplemental information does not change the denial determination, send the patient the Financial Assistance Denial Letter (Attachment G) and edit to include the wording related to the denial based upon the additional documents submitted.

E. Guidelines for Collection on Accounts of Patients Eligible for Financial Assistance:
1. All non-Charity Care patients must first have been offered an interest free extended payment plan subject to negotiation and PH procedures.
2. Asset review is to be done as described in section 3(b) above.
3. PH and affiliated collection agencies cannot report adverse information to a consumer credit reporting agency or commence civil action against the patient for non-payment at any time prior to 150 days after initial billing. All agencies used by PH must have been confirmed to be compliant with AB774.
4. PH will not send any accounts to agency if the patient is:

a. Attempting to qualify for Financial Assistance eligibility, or
b. Attempting in good faith to settle an outstanding bill with PH by negotiating a reasonable payment plan or by making regular partial payments or a reasonable amount.

5. PH or affiliated agencies will not use wage garnishments or liens on primary residences as a means of collecting on unpaid or underpaid accounts.
6. Unaffiliated agencies will not use:
   a. Wage garnishments, except upon order of a court and approved by Palomar Health.
   b. Notice or conduct a sale of primary residence either during the life of the patient or spouse or in some instances a child of the patient that attains the age of majority.

F. Documentation:
   1. PH shall maintain detailed records of the numbers of patients and circumstances under which it provides free or reduced cost care under this procedure. PH shall also maintain records of the costs incurred in providing free or reduced care to eligible patients.

G. Confidentiality:
   1. PH shall maintain all information received from patients requesting eligibility under the Financial Assistance procedure confidential. (all patient documents, with the exception of internal documents C and E, are available in English and Spanish)
      a. Attachment A: Notice of Healthcare Financial Assistance
      b. Attachment B: Financial Assistance Application
      c. Attachment C: Financial Assistance Guideline Determination
      d. Attachment E: Financial Assistance Checklist
      e. Attachment F: Financial Assistance Approval Letter
      f. Attachment G: Financial Assistance Denial Letter

H. High Medical Costs
   1. Exceed 10% of the patient's family income in the prior 12 months; or
   2. Exceed 10% of the patient's family income in the prior 12 months, 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; or
   3. A lower level as determined by hospital administration
      a. Proper and needed for the diagnosis, or treatment of the patient's medical condition
      b. Are provided for the diagnosis, direct care, and treatment of the patient's medical condition
      c. Meet the standards of good medical practice in the local area
      d. Are not mainly for the convenience of the patient or the patient's doctor

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