PALOMAR HEALTH

Source:
Administrative
Financial Services
Revenue Cycle

Applies to Departments:
Patient Accounting
Patient Business Services
Registration

Procedure: Financial Assistance Full and Discount Payment Charity Care

I. PURPOSE:

This procedure defines Palomar Health's (Palomar) procedure for the identification, documentation and determination of eligibility for Palomar's Financial Assistance Programs. In accordance with its Mission Statement, it is the practice of Palomar, where warranted, to provide a reasonable amount of hospital services without charge to eligible patients who cannot afford to pay for care, or offer reduced payment arrangements for those who qualify.

The mission of Palomar is to heal, comfort and promote health in the communities it serves.

The vision of Palomar is to be the health system of choice for patients, physicians, and employees - recognized nationally for the highest quality of clinical care and access to comprehensive services.

The vision of Palomar Patient Financial Services - Palomar is a valued community resource; therefore, we will perform the following:

- Verify your insurance coverage.
- Provide you with an estimated patient portion of charges as determined by your insurance plan.
- Bill your primary and secondary insurance carriers as provided by you at the time of registration.
- Answer questions from you or your insurance carrier regarding charges incurred.
- Upon request, send you a statement showing insurance payment(s).
- Automatically generate statements for the patient responsibility as indicated by your insurance.
- Educate our community on Assistance Programs and options regarding qualifications for Full Charity Care or Discounted Partial Charity Care.
- Respect our patients' rights.

II. DEFINITION

A. **Patient:** The person receiving services at a Palomar facility, or the guarantor, who is ultimately responsible for the financial resolution of an account.

B. **Urgent / Emergent:** Compelling immediate action or attention; occurring unexpectedly and requiring care to prevent death or serious impairment of health or to avoid the likely onset of an emergency medical condition.

C. **EMTALA: Emergency Medical Treatment and Active Labor Act:** Requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay.

D. **Financial Assistance Program:** The Palomar Financial Assistance Program established by this policy for providing Full Charity Care or Discounted Partial Charity Care to qualified patients.

E. **Full Charity Care:** 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 and has met the eligibility criteria as described in this policy. Full Charity Care applies to patients qualifying under the Palomar Financial Assistance Program for services not covered by a third party payer, where the patient would otherwise be responsible for paying. If Full Charity Care is granted to a patient, it does not excuse a third party from its obligation to pay for services provided to the patient. Eligibility may be determined prior to or at the time of an admission, during 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.

F. **Discounted Partial Charity Care:** Medically necessary health care services provided at a reduced charge to the amount Medicare would pay for the same services or less 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. Discounted Partial Charity Care applies to patients qualifying under the Palomar Financial Assistance Program who have exhausted resources from third party payers prior to applying for this discounted program. If Discounted Partial Charity Care is granted to a patient, it does not excuse a third party or the patient from their respective obligations to pay for services provided to such patient. 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.

G. **Third Party Payer:** Defined as a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits, *coverage,* to a patient.

H. **Federal Poverty Level (FPL):** The FPL guidelines establish the gross income and family size eligibility criteria for Full Charity Care and Discounted Partial Charity Care status as described in this policy. The FPL guidelines are updated periodically by the United States Department of Health and Human Services.

I. **Eligibility:** Full Charity Care or Discounted Partial Charity 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 Palomar.

J. **Medically Necessary Health Care Services:** Services or supplies that are determined to be:
   1. Proper and needed for the diagnosis, or treatment of the patient's medical condition;
   2. Are provided for the diagnosis, direct care, and treatment of the patient's medical condition;
   3. Meet the standards of good medical practice in the local area; and
   4. Are not mainly for the convenience of the patient or the patient's doctor.

K. **High Medical Costs:** Defined as the patient's annual out of pocket costs incurred by the individual at a Palomar hospital that:
   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.

IV. STEPS OF PROCEDURE: (All patient documents, with the exception of internal documents C and E, are available in English and Spanish)

This procedure is to define: a charity care policy statement that explains why the hospital is charitable and how it serves the community's needs. The charity care policy will be a part of fulfilling the hospital's charitable mission.

Consistent with our mission, Palomar strives to ensure that the financial capacity of families who need healthcare services does not prevent them from seeking or receiving care. Palomar is committed to serving its community and its needs. Palomar will continually strive to not only provide quality clinical healthcare services, Palomar will continually strive to provide financial counseling healthcare services that will enhance and perpetuate patient health and the community's ability for continued healthcare services with Federal, State or County healthcare assistance programs.

The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, ethnicity, socio-economic status, sexual orientation or religious affiliation. Information on the availability of financial assistance will be readily available and accessible to patient families or representatives, and Palomar will be responsive to the patient's/guarantor's needs.

The Financial Assistance Program at Palomar Health is available to provide discounted or free care to eligible patients for medically necessary inpatient, emergency or outpatient services based upon the patients' or guarantor's income, as defined by the FPL.

THE GENERAL GUIDELINES FOR POSSIBLE NEED OF FINANCIAL ASSISTANCE

- Patients who do not have or cannot obtain adequate financial resources to pay for their health care services.
- Uninsured patients, as well as insured patients for the portion of their bill not covered by insurance, may be eligible.
- Resources from third party payers, local charitable agencies, Victim of Crime, Medi-Cal, Healthy Families, etc. must be exhausted before a Full Charity or Discount Partial Charity adjustment can be applied.
- Only hospital services provided by Palomar Health shall be considered.
- 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.
- Clinical Determination: 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 Palomar'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 shall occur only 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.

Exclusions:

1. None, all patients may apply.

Medically Necessary Health Care Services: Services or supplies that are determined to be:

1. Proper, provided and needed for the diagnosis, direct care or treatment of a medical condition and needed for the diagnosis, or treatment of the patient's medical condition;
2. Meet the standards of good medical practice in the local area and are not mainly for the convenience of the patient or the provider

High Medical Costs: Defined as the patient's annual out of pocket costs incurred by the individual at a Palomar hospital that:

3. Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. Annual out-of-pocket expenses that exceed 10 percent 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.
4. A lower level as determined by hospital administration.

Patient's Family: The following shall be applied to all cases subject to the Palomar Financial Assistance procedure:

1. For persons 18 years of age and older, spouse, domestic partner as defined in Section 297 of the California Family Code, and dependent children under 21 years of age, whether living at home or not.
2. For persons under 18 years of age and not an emancipated minor, parent or legal guardian is responsible for income verification.
3. Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and, at the time of filing, all of the following requirements are met:
    - Both persons have a common residence.
    - Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
    - The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
    - Both persons are at least 18 years of age.
    - Both persons are capable of consenting to the domestic partnership.

- Either of the following:
  a. Both persons are members of the same sex.
  b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are *over* the age of 62.

GENERAL PATIENT RESPONSIBILITIES:

To Be Honest Patients must be honest and forthcoming when providing all information requested by Palomar Health as part of the financial assistance screening process. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary for financial assistance coverage through any *government* coverage program or the Palomar Financial Assistance Program. Honesty implies and requires full and complete disclosure of required information and/or documentation.

To Actively Participate and Complete Financial Screening All uninsured patients and those who request financial assistance will be required to complete a financial evaluation form. Prior to leaving a Palomar Health facility, the patient should verify what additional information or documentation must be submitted to Palomar Health financial services. The patient shares responsibility for understanding and complying with the document filing deadlines of Palomar Health or other financial assistance programs.

To Pay any or All Required Out-of-Pocket Amounts Due Patients should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to:

- Co-Payments
- Deductibles
- Deposits
- Medi-Cal/Medicaid Share of Cost
- Good Faith Estimates

To Share Responsibility for Hospital Care: Each patient shares a responsibility for the hospital care they receive. This includes follow-up in obtaining prescriptions or other medical care after discharge. The patient also shares a responsibility to assure that arrangements for settling the patient account have been completed. It is essential that each patient or their family representative cooperates and communicates with Palomar Health personnel during and after services are rendered.

PATIENT/GUARANTOR RESPONSIBILITIES AS THEY APPLY TO CHARITY APPLICATION PROCESS INCLUDE THE FOLLOWING (BUT ARE NOT LIMITED TO):

- Providing accurate and complete information in a timely manner so Palomar can process the request for Financial Assistance;
- Follow through with any federal, state or county assistance program prior to the application for charity;
- Responsiveness - provide timely follow-up for additional documents or information Palomar Health requires for the Financial Assistance application process;
- Full disclosure of the required information;
- Satisfaction of any patient/guarantor payment obligation;
- Income verification;
- Palomar Health shall request that the patient/guarantor *verify* the income and provide the documentation requested as set forth in the Financial Assistance Application.

Note: Tax Returns and W-2's should be provided by the patient for the year prior to date of admission.

Documentation Verifying Income: Income may be verified through any of the following mechanisms:

- Tax returns (preferred income verification document)
- Recent pay stubs/paycheck remittance
- IRS form W-2
- Wage and Earnings Statement
- Social Security income
- Workers' Compensation or unemployment compensation determination letters
- Qualification within the preceding six months for governmental assistance program (including food stamps, Medi-Cal, and AFDC)

In the event that the patient/guarantor is unable to provide recent pay stubs:

- Palomar Health shall, with the patient's/guarantor's authorization, obtain telephone verification by the patient's/guarantor's employer of the patient's/guarantor's income or accept other documentation of the patient's/guarantor's income, as applicable.
- Palomar Health shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans.
- Personal bankruptcies may affect a patient's/guarantor's ability to pay all or part of the bill for healthcare services. To help avoid going into bankruptcy, Palomar Health will work with the patient/guarantor on flexible payment plans.
- The requested documents to verify income should be made available to Palomar Health within 14 business days. If documentation is not received within the 14 business days, an additional 7 business days' grace period shall be provided. Patient/guarantor may submit copies of the required documents with the Financial Assistance Application.

GENERAL PALOMAR RESPONSIBILITIES:

- To treat each and every patient/guarantor associated with our community's healthcare with the utmost dignity, respect and confidentiality.
- To ensure all applicable associated assistance programs have been reviewed and appropriately screened for patient/guarantor application for program qualification.
- To 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, CCS or Healthy Families.
- 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 initiated by the ED Registration Clerk, Financial Counselor, the patient, Patient Financial Representative (PFR) or Customer Service Representative (CSR).
    - If, after a medical screening exam, a patient in the ED is determined to have no financial means to pay, and appears that the patient may not qualify for Medi-Cal or any other service, give the patient the Palomar 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.
    - 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 Patient Service Representative shall give the patient a Financial Assistance Application.
- Patients scheduled as elective inpatient or scheduled outpatient services shall be subject to the same provisions as described in this procedure with Patient Access handling all documentation and decision making process as it relates to this procedure and Palomar guidelines for elective or pre-scheduled services. The Patient Financial Representative shall:
    - Determine if there are alternative means (i.e., external agency or foundation) to cover the cost of services.

- [0] Make appropriate referrals to the internal eligibility 1-irms designed to help patients obtain assistance program coverage, or local county agencies, Healthy Families, Medi-Cal to include any other programs to determine potential eligibility.

- 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, the Patient Services Representative shall notify the patient/guarantor within 15 business days of receipt of all documents identified in this procedure as being required to make the determination for qualification or disqualification from the Charity program.
- The Patient Service Representative will review any and all outstanding patient balances associated with the guarantor information related to the charity application and retrospectively include any and all outstanding balances in the current Application for Debt Relief.
- Palomar Health will not discriminate in any case, regardless if the account is in this retrospective review.
- The hospital will retain the current Charity Application on file and its determination for six months. After six months the hospital will anticipate a full re-application process if there is a new patient liability.

GENERAL GUIDELINES FOR REVIEWING FINANCIAL ASSISTANCE APPLICATIONS

Determination: Is based upon 400% 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).

- This means that a patient has to have an income level less than or equal to 400% of the FPG in order to qualify for either Full Charity Care or the Discount Partial Charity Care programs with High Medical Costs. These guidelines and rates of discount are noted on Attachment C.
- Patients or their guarantors who earn 250% or less of the FPG.
- Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Full Charity Care: a write-off of 100% of charges.
- Patients or their guarantors who earn between 251% and 400% of the current Federal Poverty Guidelines (based on the date of discharge of the most recent admission being considered) are eligible for Discounted Partial Charity Care.
- The billed charges for these patients will be reduced to the highest government payers (Medi-Cal, Medicare or Healthy Families) rates.
- Patients or their guarantors who earn 401% or more 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 Palomar Health Self-Pay Discount Procedure.
- 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.

GENERAL GUIDELINES FOR THE PROCESSINGTHE FINANCIAL ASSISTANCE APPLICATION

- Review each completed application upon receipt and determine if all information has been completed or attached, as applicable.
- Enter notes in the "account comments" section of Palomar Health's Electronic Health Record indicating receipt of the request for charity. If incomplete, note the follow-up action, missing items and date.
- 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 14business days (plus a 7 business day grace period as defined in patient responsibilities to respond with necessary information).
    - If the patient does not return the requested information or contact PH within 14 business days, contact the patient to inquire into the status of the additional information. Advise the patient that unless Palomar receives the information within 7 business day, 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 Palomar within the additional 7 business day period, the application should be forwarded for review and eligibility determination. Enter into the "account comments" section of Palomar's information system: "Patient did not return required financial assistance information."

- If the Financial Assistance Application is complete, prepare the Financial Assistance Checklist (Attachment E) within 24 hours.
- Once the packet is complete, forward to the appropriate person as per the following approval schedule:

- 0 $0 - $ 10,000 PFS Representative
- 0 $10,001 - $50,000 Manager Patient Financial Services
- 0 $50,001 - $99,000 Director Patient Financial Services
- 0 > $100,000 Vice President Financial Operations

- Enter the date the packet was sent into the "account comments" section of Palomar's patient accounting information system.
- If a patient is approved for Financial Assistance, the person approving the Financial Assistance shall enter the appropriate adjustment into the Palomar information system as "approved and write off completed," and complete the Financial Assistance Approval Letter (Attachment F).
- For approved Full Charity Care, the full amount of the bill is to be written off and the account documented.
- For approved Discounted Partial Charity 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.
- 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.
- If a patient is denied Financial Assistance, send the Financial Assistance Denial Letter (Attachment G).

GENERAL GUIDELINES FOR DISPUTE RESOLUTION:

- The patient's right to appeal any denial for Full Charity Care, Discounted Partial Charity Care and/or Extended Payment plan must be received within 15 working days of the denial notification.
- It is the patient's responsibility to perform a written appeal and thus it 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.
- This information should be evaluated within 5 business 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.

GENERAL GUIDELINES FOR COLLECTION ON ACCOUNTS OF PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE:

- All non-Charity Care patients must first have been offered an interest free extended payment plan subject to negotiation and Palomar procedures.
- Asset review is to be done as described in section 3(b) *above.*
- Palomar 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 180 days after initial billing. All agencies used by Palomar have been confirmed to be compliant with AB774.

- Palomar will not send any accounts to agency if the patient is attempting to qualify for Financial Assistance eligibility, or attempting in good faith to settle an outstanding bill with Palomar by negotiating a reasonable payment plan or by making regular partial payments or a reasonable amount.
- Palomar or affiliated agencies will not use wage garnishments or liens on primary residences as a means of collecting on unpaid or underpaid accounts.
- Unaffiliated agencies will not use:
  - Wage garnishments, except upon order of a court; or
  - 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.
- Discovery of Patient Financial Assistance Eligibility During Collections - While Palomar strives to determine patient

financial assistance as close to the time of service as possible, in some cases further investigation or information is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. Palomar collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance. Palomar will reverse the account out of bad debt and document the respective discount in charges as charity care.

- Documentation: Palomar shall maintain detailed records of the numbers of patients and circumstances under which it provides free or reduced cost care under this procedure. Palomar shall also maintain records of the costs incurred in providing free or reduced care to eligible patients.
- Confidentiality: Palomar shall maintain all information received from patients requesting eligibility under the Financial Assistance procedure confidential.

A. Attachment A: Application for Healthcare Financial Assistance
B. Attachment B: Financial Assistance Application
C. Attachment C: Financial Assistance Guideline Determination
D. Attachment F: Financial Assistance Approval Letter
E. Attachment G: Financial Assistance Denial Letter